STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345090	A. BUILDING _____ B. WING _____	C 05/17/2013

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F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, nurse practitioner interview and physician interview the	F 157	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907_____ F157 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #25 was discharged from facility to hospital on 3/23/13. Resident did not return to facility. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The facility is conducting a daily review of all resident progress notes and SBAR's for physician, responsible party and nurse administration notification and communication since 6/4/13.	6/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James A. Newman, Jr. | TITLE: Administrator | (X6) DATE: 6/21/13

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

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F 157	Continued From page 1 facility failed to notify the physician of a fall with head injury and increased pain for 1 of 1 (Resident #25) resident who sustained a head injury. Resident #25 developed a subdural hematoma with a brain shift to the left placing pressure on the brain stem. The resident was sent to the hospital on 3/23/13 for evaluation and expired 3/28/13. Immediate jeopardy began on 3/15/2013 and was identified on 5/16/2013 at 5:30 PM. The immediate jeopardy is present and ongoing. Findings included: The record review indicated that the resident was admitted on 2/14/13 at 2:13 PM for rehabilitation following an ischemic cerebral vascular accident (a lack of blood supply in the brain). Admission diagnosis included hemiplegia, stroke, fracture of the lumbar spine, lack of coordination, dementia, previous stomach ulcers that required a surgical procedure that stopped the bleeding. Resident #25's admission medications included: Tylenol 650 mg (milligrams) by mouth every 6 hours as needed for pain. The record review revealed that the Minimum Data Set (MDS) dated 2/21/13 indicated Resident #25 was severely cognitively impaired. There were no mood disorders noted and there were no behaviors noted. There were no pain problems noted. The resident required extensive assistance with activities of daily living (ADL) with at least one person assistance at all times. Resident #25 had an unsteady gait and required	F 157	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: An in-service education program was conducted by the Director of Nursing or designee with all licensed and certified staff addressing change in condition and communication of such that require notification of the resident's physician, legal representative or family member and nursing. Implementation and training on Situation, Background, Assessment, Recommendation/Request (SBAR) communication tool and utilization of therapy referral process. Training sessions completed on 5/30/13. Daily IDT meeting to review, monitor and manage resident care. Director of Nursing or designee is completing a SBAR tracking log.	

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F 157	Continued From page 2 one person assistance for transfer and for toileting. Upon review of Resident #25's medical chart and electronic chart, there was no information noted that the resident had a chronic pain issue or that the resident was constantly anxious. From admission date of 2/14/13 to 3/13/13 the resident had no behavior problems charted and had no pain problems charted. On 2/21/13 Ativan 0.5 mg by mouth every 6 hours as needed for agitation was ordered. The resident was medicated on 2/27/13, 2/28/13, and 3/10/13 with Ativan for agitation prior to her fall on 3/14/13. The record review indicated the medical physician saw and evaluated the resident on 2/21/13. The evaluation stated that the resident denied pain. The record review indicated that the care plan dated 2/22/13 did include interventions for falls related to use of psychotropic medications for dementia, recent stroke and hospitalization. The resident was not care planned for pain, mood disorder, or behavior problems. The record review stated that the resident fell on 3/14/13 at 4:14 AM. The resident was found on the floor in her room by Nurse #2. A Nurses note by Nurse #1 stated " fall with head injury. Attempted to go to bathroom unassisted. Hit back of her head. Neuro (neurological) checks WNL (within normal limits). " Neurological checks compare a person's baseline to a current assessment of level of consciousness (alertness/behavior), vital signs, pupil response to	F 157	4. Indicate how the facility will monitor its performance: The Director of Nursing or Assistant Director of Nursing will conduct a daily audit of generated SBAR communication tools for four (4) consecutive weeks. Residents will be assessed by generated SBAR communication tool to ensure that any changes in condition have been identified, properly evaluated and communicated to the appropriate people. Results will be presented to Quality Assurance team for recommendations and follow up for 6 months.	

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F 157	Continued From page 3 light, eye response to stimuli, level of consciousness, speech pattern, and motor response. An interview on 5/15/13 at 11:20 AM with Nurse #1 revealed that Nurse #2 found the resident on the floor in her room. Nurse #1 came to the resident's room to assess the resident for injury and determined Resident #25 was without major injury. Nurse #1 stated that the resident had equal grips, no more than normal confusion, no lacerations, and did not appear to be harmed other than the " bump " to the back of her head. The nurse's notes by Nurse #2 indicated that on 3/14/13 at 6:25 AM the neuro checks were still in progress and within normal limits. The resident complained of pain around her head area where her head had hit the floor. No swelling was noted at that time. According to Nurse #2's notes, the physician was notified of the resident's fall via the facilities communication board. During record review of the communication notes on 5/15/13 at 11:00 AM the note for 3/14/13 could not be located for Resident #25. At that time the Director of Nursing (DON) was asked if she had a copy of that communication sheet, she stated that she did not. During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/15/13 at 12:30 PM the DON indicated that the protocol for falls was to have the charge nurse evaluate the resident for injury, after that, they assisted with getting the resident back to bed or bathroom. The DON stated the physician would be called if there were serious injuries to the resident. The DON indicated that	F 157		

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F 157	Continued From page 4 a serious injury would be a skin tear that kept bleeding, abnormal neuro checks, deviation from the resident's baseline, dislocation or odd positioning of the extremities. If there were no serious injuries then the resident's fall would be placed on the communication board which was seen by the physician or NP on a daily basis. The facility was unable to show any communication regarding Resident #25 on the communication board sheets from February through May 2013 about Resident #25's fall. The record review revealed no other notes in Resident #25's chart from a physician or NP for the dates following the fall. The DON stated her expectation would be the nurse would have contacted the physician per the facilities recognized protocol. The ADON indicated that the MD or the NP would see the communication board on a daily basis while doing rounds. On 3/14/13 at 9:32 AM the record review of the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation. During an interview on 5/15/13 at 11:12 AM, Nurse #2 indicated that the resident's neuro checks were normal during her time with the resident immediately following the fall. Nurse #2 stated that the medical physician would not be called unless neuro checks deviated from normal or if the resident showed signs of injury at the time of the fall that required immediate evaluation. On 3/14/13 at 9:35 PM the record review of the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation.	F 157		

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F 157	Continued From page 5 A nursing note dated 3/14/13 at 10:42 PM included, " Resident alert, oriented, and verbally responsive. " The note also indicated the resident received Tylenol 650 mg (milligram) and Ativan (anxiety medication) given for back pain and anxiety respectively. The nurse's note indicated that neuro checks continued. A nurse's note entry by Nurse #2 on 3/15/13 at 6:21 AM stated that the neuro checks were still in progress and Resident #25 was within normal limits. There were no delayed injuries noted. The nurse's note also stated Resident #25 woke up at 4:00 AM yelling out and complaining of back pain. Nurse #2 gave Resident #25 Tylenol 650 mg. Nurse #2 indicated Resident #25 started yelling out again in pain after 15 minutes and stated she wanted to lie down again. Resident #25 was then transferred back to bed. The nursing notes stated Resident #25 began yelling out again at 5:00 AM requesting to get out of bed because of her back pain. Resident #25 was placed in a wheelchair but continued to yell out when approached. Nurse #2 stated " resident unsure of what help she needs, not easily redirected. " The record review of Resident #25's medication record indicated that she was medicated with Tylenol at 4:10 AM. Nurse #2 indicated Resident #25 Resident didn't yell and call out that she was in pain prior to her falling. An interview with Nurse #3 and Nurse #4 on 5/17/13 at 3:00 PM revealed that they would use the facial recognition system to evaluate pain on a resident who was severely cognitively impaired. Nurse #3 and Nurse #4 both indicated a 0-10 pain scale would not be reliable on a resident who is cognitively impaired because the resident	F 157		

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

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F 157	Continued From page 6 would not be able to use the scale. They stated that it would be better to judge the resident by his/her normal baseline and compare it to how have they changed since an incident. Record review revealed that on 3/15/13 at 3:29 PM a nurse's note written by Nurse #3 indicated that the resident was alert and oriented to herself and place with no complaints noted. The resident's level of care or ADLs did not change per the nurse's note. On 3/15/13 at 7:18 PM the MAR indicated Resident #25 was medicated again with Ativan 0.5 mg by mouth for agitation. Record review revealed that on 3/15/13 10:20 PM Nurse #4 wrote " Resident alert, oriented, and verbally responsive. PRN (as needed for) pain med (medication) Tylenol 650 mg and Ativan given for back pain and anxiety respectively. F/U (follow up) fall day 1 with neuro checks continuing. Ate supper at substation, extensive assistance with ADL's and tranfers. Family visits often, in bed with call light in reach. " Record review revealed that on 3/16/13 05:45 AM Nurse #2 wrote " S/P (status post) fall day 2 with neuro checks completed this shift and no delayed injuries noted. " The record review of Resident #25's therapy notes indicated that on 3/16/13 Occupational Therapist #1 charted a note that stated Resident #25 continued to " c/o (complain of) back and head pain which is effecting her performance. " In an interview on 5/15/13 at 10:31 AM	F 157		

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F 157	Continued From page 7 Occupational Therapist #1 revealed she remembered Resident #25 as having had severe head pain during her session on 3/16/13. Occupational Therapist #1 (OT #1) told a Physical Therapist Assistant (PTA) that Resident #25 was complaining and that they should tell the nurse. The OT #1 stated that she couldn't remember who the nurse was or if the nurse had been told of the resident's increased pain. The record review revealed a note on 3/16/13 from physical therapy that read " Pt (Patient) with c/o lower back pain today with difficulty performing sit to stand and unable to tolerate standing. " The physical therapy note also indicated that the physical therapist had spoken with nursing staff and included, " No documentation seen regarding x-rays to rule out injury. Discussed with nursing possibility of x-rays if pain does not improve. " The Physical Therapist was called on 5/16/13 at 4:00 PM. A message was left to return the phone call, by 5/17/13 at 5:00 PM the Physical Therapist had not returned the phone call. On 3/16/13 at 5:40 PM the MAR indicated Resident #25 was medicated again with Ativan 0.5 mg by mouth for agitation. The record review revealed a nurses note dated 3/17/13 at 05:48 AM included that on the 3rd day after her fall Resident #25 had no delayed injuries noted, no acute distress noted, and that monitoring would continue. On 3/17/13 at 1:41 PM the MAR indicated Resident #25 was medicated again with Ativan	F 157		

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F 157	Continued From page 8 0.5 mg by mouth for agitation. On 3/18/13 Occupational therapist #2 charted " Pt crying out and stating ' my back hurts worse than ever! My back! ' Pt. performed 2 standing trials with minimal assist to reach forward to grasp parallel bar. 1 minute 1st trial, 30 seconds 2nd trial. " please let me sit down. " OT #2 ' s notes indicated that a back massage was done but the resident stated " ' it helps but it still hurts so bad. ' " During an interview on 5/15/13 at 9:55 AM Occupational Therapist #2 (OT #2) said she found Resident #25 crying out in the hallway that day. Occupational Therapist #2 indicated that what she wrote was a true assessment of the residents back pain as being severe on those specific dates and that she did seem more in pain after her fall. On 3/18/13, the Nurse Practitioner ordered " ibuprofen 800 mg tablet give 1 tablet (800 mg) by oral route once daily as needed only to be given after resident has eaten /1st dose asap (as soon as possible). " On 3/18/13 at12:40 PM the MAR indicated Resident #25 was medicated with Ibuprofen for pain. A nurse's note entry by Nurse #3 stated the Nurse Practitioner (NP) saw Resident #25 concerning an order for pain. Nurse #3 wrote, " Resident continues to cry and call staff for pain meds even if she just received them. " On 5/15/13 at10:05 AM an interview with the Nurse Practitioner (NP) was obtained. The NP didn't remember the resident and stated " If there	F 157		

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F 157	Continued From page 9 Is no note in the chart or progress notes then I didn't see her. " During the survey there were no physician notes or nurse practitioner notes found in Resident #25's chart to indicate the resident was seen by either the MD or NP following her fall and head trauma. The facility could not provide any further documentation that showed the NP or the MD saw Resident #25 following her fall. According to the resident's medical record, Resident #25 was not seen by occupational therapy or physical therapy on 3/17/13 but did return to occupational therapy on 3/18/13 and complained of severe pain. On 3/19/13 Resident #25 returned to physical therapy. There was no pain noted during physical therapy on that day. Resident #25 was considered on 3/19/13 for discharge from physical therapy related to resident meeting her maximum level of functional capability. According to nurse's notes on 3/19/13 at 11:53 AM Resident #25 was medicated with ibuprofen 800 mg for a complaint of pain. A nurses noted charted by Nurse #3 stated " No change in level of care, ADL's or behavior. " The note also included that the resident " Continues to yells and screams for attention " and made frequent requests to go from the bathroom to her recliner. On 3/19/13 at 3:51 PM the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation. During record review of the physician's order, the order for Ativan was changed on 3/20/13 by the NP to Ativan 0.5 mg by mouth or sublingual (under the tongue) every 6 hours as needed for agitation.	F 157		

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F 157	Continued From page 10 During the NP's interview 5/15/13 at 10:05 AM she stated that she did not remember Resident #25 and did not recall writing any orders for this resident. On 3/20/13 at 9:37 am the MAR indicated the resident was medicated with Ibuprofen 800 mg PO for pain. No nurse's note was written. On 3/20/13 at 1:54 PM a nurse note stated " Alert and oriented to self. No acute complaints nor in any apparent acute compromising condition. " According to the MD's communication board, on 3/21/13 a note was left on the communication board about the family wanting to have the ibuprofen discontinued because of the resident ' s history of an ulcer and pain whenever she uses it. This was observed on 5/15/13 at 11:00 AM. On 3/21/13 at 8:56 am the record review indicated that the resident was medicated with 800 mg of Ibuprofen PO for pain. No nurse's note were written on 3/21/13. On 3/21/13 the social worker saw Resident #25 on 3/21/13 and wrote a note. The social worker noted the resident " continues to exhibit behaviors of yelling and crying per nurses notes 3/14 - 3/19/13 per nurses notes 3/14 and 3/15 resident was medicated with Ativan for " anxiety. " During an interview on 5/15/13 at 9:25 AM the social worker indicated the resident was always looking for her family but didn't have any behaviors other than calling for her family that she was aware of.	F 157		

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F 157	Continued From page 11 On 3/21/13 at 1;45 PM nurses note entry read " alert and verbal. No signs and symptoms of any apparent acute compromising condition. Continue to yells but soon as staff talk to her she stop then yell later on again. No change in level of care or ADL's (activities of daily living). " On 3/22/13 at 1:13 PM a nurse's note entry read " Resident continues to yell and scream of back pain. No change in level of care or ADL's. " A new order written on 3/22/13 and signed by the Nurse Practitioner stated " Tramadol (narcotic like pain medication) 25 mg PO (by mouth) BID (twice a day) and every 6 hours as needed for pain. Hold for sedation. X-ray of lumbar and thoracic spine. " Results from portable x-ray done on Resident #25 were sent to the facility on 3/22/13 with negative results for any acute findings. On 3/22/13 at 3:20 PM a telephone order was written for Tylenol for arthritis every 8 hours and Tylenol 325 mg, 2 tablets orally every 6 hours PRN for break through pain. The order for Tramadol was discontinued. This order was taken by the assistant director of nursing from the NP. The order was then signed by the MD. On 3/23/13 at 7:32 AM nurse #7 charted " At 5:45 AM NA noted resident was lethargic and was assessed by this writer. " " Resident c/o neck pain and scheduled Tylenol was given. " At 7:56 AM nurse #1 charted that the resident was more alert and was able to recall friends and family names. The communication board had a note to the medical physician dated 3/23/13 was	F 157		

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(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 157	Continued From page 12 observed on 5/15/13 at 11:00AM. At 10:12 AM Nurse # 7 obtained a urine sample per standing orders because of the resident ' s new lethargy. Nurse #7 ' s note included, " Resident complained of headache this morning and was given pain medication that was effective. " At 1:56 PM nurse #7 charted " resident in bed finishing eating lunch, ate 25%. Alert and verbally responsive, able to make needs known. Writer assisted resident in drinking juice, resident had difficulty swallowing and juice dripping to her mouth. Writer observed slurred speech and left sided weakness. Notified supervisor, RP, and MD. " An interview with nurse #7 on 5/15/13 at 11:00 am revealed the resident was in bed in the morning which wasn ' t normal and heard that the resident had a rough night. She noted that the resident didn ' t seem " right. " The urine sample was collected per standing orders and sent out because of resident's frequent urinary tract infections. By 1:00 PM the resident wasn't able to eat lunch without dribbling fluid down mouth and was still lethargic. The on call medical physician was called and orders taken for the resident to be transferred to the hospital for further evaluation. At 1:15 PM Resident #25 was transferred to emergency department for evaluation. According to the admission history and physical report dated 3/23/13, once at the hospital the resident was sent for a CT (Computed Tomography) scan (which created a 3-dimentional image of the brain/skull) where it was noted Resident #25 had a 14 millimeter thick subdural hematoma that had caused a shift of	F 157		

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F 157	Continued From page 13 Resident #25's brain 8 millimeters to the left place pressure on the brain stem. The resident was also found to be anemic with a hemoglobin of 5.8. There was black stool noted but was not tarry in nature. The family reported to the ER physician that they were unaware of any bowel problems related to dark stool having been occurring at the facility. The resident was transfused with 1 unit of packed red blood cells. The resident was seen by a Neuro Surgeon and discussed with the family the prognosis for the resident if she underwent surgery. The decision was made to place the resident in Hospice care with comfort measures only. Resident #25 died on 3/28/2013. An interview with the facilities medical physician (MD) was conducted on 5/16/13 at 2:45 PM. The MD stated that he did not remember being told about this residents fall. He stated that his expectation following a resident fall was that the nurses would assess the resident, determine if there were any injuries and start neuro checks if the fall involved head trauma. He stated that the only time a nurse would directly call him or the on call doctor would be when the resident started to have neurological changes showing during the neuro checks. The doctor stated that he expected the nurses to contact him or the on call MD directly if a cognitively impaired resident started complaining of more pain following a fall or had behavior changes such as more agitation and anxiety following a fall. The MD stated that according to the resident's chart that the resident was not seen by himself or the Nurse Practitioner following the residents fall. He stated " If I lay eyes on them (resident) or put my hands on them (resident) I leave a note in the chart. " He stated that his expectation was that the NP did the	F 157		

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F 157	Continued From page 14 same. When asked directly if the resident was seen by himself or the NP following the fall he stated " no, based on what is in this chart. " The MD stated that if the nurses had called him or the on call MD and reported that the resident was experiencing more pain and more anxiety following the fall that he would have been able to pick up on pupil changes or focal defects of the resident's arms and legs. If these changes were picked up by him or his NP, then the resident would have been sent to the Emergency Room (ER) for a CT scan of the head at that time. The CT report from the hospital was read and shown to the MD. The MD stated that based on the CT report from the hospital that " her fall (the residents) could be a cause of her subdural hematoma and subsequent death. It is most likely the cause and I ' m sure the fall contributed to her death. " An interview with the Nurse practitioner on 5/16/13 at 2:30 PM revealed that she does not remember this resident, did not remember writing orders on the resident and that it is possible that she was called for orders and never physically saw the resident. She stated that if there are no notes in the chart that state she assessed the resident, then she didn't visually assess the resident prior to giving orders for the resident. The NP stated that she doesn't normally write orders on residents she doesn't evaluate but it could happen if she was not in the building. On 5/16/13 at 5:00 PM the MD stated that the resident received 4 doses of Ibuprofen after her fall and before she was sent to the hospital for evaluation. The MD stated it could have been a contributing factor in an increase of a slow bleed	F 157		

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F 157	Continued From page 15 from a traumatic injury such as a subdural hematoma. The death certificate dated 3/28/13 stated the immediate cause of death was a subdural hematoma due to (or as a consequence of) a fall.	F 157		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility failed to provide assistance with toileting when requested to maintain dignity for 1 of 1 resident (Resident #17) reviewed for dignity. Findings included: Resident #17 was admitted to the facility on 3/10/05 and had diagnoses including hypertension, urinary tract infection, diabetes, osteoporosis, fatigue and stroke. The care plan dated 9/11/12 revealed the resident required assistance with activities of daily living (ADL) task performance related to a diagnosis of osteoporosis, decreased mobility, and being non-ambulatory. Interventions included extensive assistance with toileting and transfers. The care plan dated 9/11/12 revealed an	F 241	F241 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #17 had a voiding diary initiated for a period of 10 days. Resident referred to therapy for possible bladder retraining. Resident also has a scheduled urology appointment regarding the necessity to void frequently and recurrent urinary tract infections. Director of Nursing on 5/27/13 spoke with resident with the charge nurse present and resident stated that she is not having any difficulty with staff providing assistance. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Residents will be given assistance on request to meet their needs and maintain dignity. If the resident need cannot be met at the immediate time an explanation will be given and an estimated time of return to assist with task.	6/14/13

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F 241	Continued From page 16 alteration in elimination as evidenced by frequent episodes of urinary incontinence. Interventions included utilize prompted voiding (meaning staff would prompt the resident to use the toilet) every 1-2 hours. The MDS quarterly assessment dated 1/22/13 indicated the resident was frequently incontinent. The MDS annual assessment dated 5/13/13 indicated the resident was cognitively intact, did not reject care - including activities of daily living (ADL), required extensive assistance and two-person assistance with transfers and toilet use. The assessment further indicated Resident #17 required extensive assistance with personal hygiene, was not steady moving on and off the toilet, was only able to stabilize with staff assistance, and used a wheelchair for mobility. She was frequently incontinent. The resident participated in the assessment. On 5/14/13 at 2:52 pm Resident #17 stated, " I have to go to the bathroom almost every hour. The nurse aide (NA) at night - she won't come but every 3 or 4 hours to help me to the bathroom. If I ring the bell she still won't come. When you have to go to the bathroom, it is very hard to lay in the bed wet. If you wet the bed sooner or later she will come to change it. There are two gowns in the bathroom hanging up from last night and the night before that I wet. She is so hateful. When I tell her I have to go to the bathroom she says, ' It's not time yet. ' She is training a girl to take her place and she does the same thing. It makes me feel terrible to lay there with wet clothes. During the day when I push the call bell someone comes pretty quickly and I make it to	F 241	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Staff Development Coordinator and Social Workers will provide education to all Licensed and certified staff regarding the maintaining of residents rights and dignity. Training will include staff assisting with care with an emphasis on anticipating resident's needs and providing prompt care. 4. Indicate how the facility will monitor its performance: Director of Nursing or Assistant Director of Nursing will interview 10% of resident population weekly for four weeks to confirm that resident's dignity is maintained with ADL needs. Results will be presented to Quality Assurance team for recommendations and follow up for 6 months.	

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F 241	Continued From page 17 the bathroom and don't have to sit or lay around wet. " An observation on 5/14/13 at 2:56 pm revealed a solid lavender gown and a floral lavender gown hanging in the resident's bathroom. She indicated they were the gowns that were hung up because she wet them on the previous two nights. On 5/16/13 at 8:25 am the resident indicated when the " other " NA and the " new " NA worked at night she frequently had to wet herself and lay wet in her bed for lengthy periods of time. The resident stated she had not spoken to anyone about being left wet. On 5/16/13 at 9:15 am the Director of Nursing (DON) stated, " The expectation is NAs will get a resident up as many times as needed, unless someone else is receiving care. It wouldn't happen that a resident had to wait on a regular basis or for an extended period of time. " During a phone interview on 5/16/13 at 9:45 am, NA#7 indicated she worked 11p-7a on 200 hall, Resident #17's hall. She also indicated she would check on a resident quickly if the call bell rang and would not tell a resident they had to wait to go to the bathroom, she would get them up. Regarding Resident #17, NA #7 stated, "She gets in the wheelchair by herself. I roll her to the bathroom, she holds on to the handrails and gets on the toilet by herself. I come back and get her when she is done." On 5/16/13 at 10:48am the Restorative Nurse stated, " When [Resident #17] gets off the toilet she needs help adjusting her clothing and getting back in the wheelchair. She requires limited to extensive assistance with pivoting and in the	F 241		

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F 241	Continued From page 18 restroom getting off the toilet. After her fall in March we recommended 2 person assistance and therapy evaluated. One person is sufficient with transfer and toileting, but she does require limited to extensive assistance especially with toileting."	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to allow a resident to honor a choice by not keeping fluids in her room thereby allowing her to drink when she chooses for 1 of 1 resident (Resident #49) reviewed for choices. Findings included: Resident #49 was admitted on 3/27/07 with diagnoses including gastrostomy, epilepsy, reflux, stroke, and urinary tract infection (UTI). The care plan note dated 2/19/13 indicated consistency of diet changed to mechanical soft with nectar thick liquids per speech therapy. The Minimum Data Set (MDS) quarterly	F 242	F242 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #49 was provided with fluids at bedside and was rescreened by Speech Therapy on 5/15/13. Resident was determined to be safe with nectar thick fluids. A cooler was placed at bedside with nectar thick liquids available at all times for resident. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: A review of all residents identified as currently receiving thicken liquids was conducted on 5/27/13 to ensure placement of cooler with thicken liquids available at bed side.	6/14/13

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F 242	Continued From page 19 assessment dated 4/1/13 indicated the resident was severely cognitively impaired, had no swallowing disorders, required oversight, encouragement or cueing with eating, had a feeding tube, was on a mechanically altered diet, and received Speech Therapy that was ongoing. On 05/14/2013 at 11:40 am Resident #49 stated, "I get water sometimes if I ask for it. I don't have a water pitcher or cups. "She indicated she would like to have fluids in her room. On 5/14/13 at 11:40 am an observation of the resident's room revealed no water pitcher or cooler for thickened liquids in the resident's room. On 5/16/13 at 3:30 pm an observation of the resident's room revealed no water pitcher or cooler for thickened liquids in the resident's room. On 5/17/13 at 6:42 am an observation of the resident's room revealed no water pitcher or cooler for thickened liquids in the resident ' s room. On 5/17/13 at 6:43 am Nurse Aide (NA) #8 indicated water pitchers or coolers that contained cartons of thickened liquids were kept at the bedside for residents "who can drink." She stated Resident #49 "has a feeding tube for fluids so she doesn't have a pitcher." On 5/17/13 at 6:45 am Nurse #8 indicated the resident was not on any fluid restrictions, received fluid boluses through her tube if she did not eat enough, and could drink by mouth. On 5/17/13 at 6:55 am Nurse #7 indicated	F 242	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Staff education provided to Licensed and certified staff in regards to resident rights and maintaining dignity in providing fluids unless fluid restrictions have been determined by the resident's physician. 4. Indicate how the facility will monitor its performance: Director of Nursing or Assistant Director of Nursing to interview 5 residents weekly for four weeks to confirm that residents have appropriate fluids at bedside. Results will be presented to Quality Assurance team for recommendations and follow up for 6 months.	

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F 242	Continued From page 20	F 242		

Speech Therapy wanted the resident to be monitored with oral intake so fluids were not kept in her room and she was "brought to the common area and assisted."

On 5/17/13 at 9:15 am the Dietician stated, "[Resident #49] eats and drinks well, 50% or better at the majority of meals. She is not on a fluid restriction. I have not seen her with any trouble drinking."

On 5/17/13 at 9:45 am Speech Therapist (ST) #1 indicated Resident #49 was discharged from speech therapy on 4/2/13 and was on nectar thick liquids. She stated, "The evaluation and treatment indicated that she was safe and independent with the nectar thick liquids. She should have fluids at her bedside. Everyone should have fluid at their bedside if they are able to drink themselves."

On 5/17/13 at 9:55 am NA #9 stated, "[Resident #49] comes out to the common dining to be observed for safe eating. She drinks nectar thick liquids and drinks fine by herself." She indicated thickened liquids are kept at the bedside in a blue cooler. Upon walking to and observing the resident's room, NA #9 indicated resident did not have a cooler for thickened liquids, a pitcher for thin liquids, or any other fluids in her room.

On 5/17/13 at 10:01 am Nurse #7 indicated he was not aware that the resident was safe to be independent with thick liquids.

On 5/17/13 at 10:43 am Nurse #6 indicated a cooler is kept at the bedside for residents on thickened liquids and stated, "Even if they cannot

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F 242	Continued From page 21 drink independently we still keep one there so the aides can give fluids when they go in the room. If the resident is on thin liquid, a water pitcher should be kept at the bedside." On 5/17/13 at 2:00pm Resident #49 was observed in the common dining area, located on her hallway, eating and drinking (juice and coffee) without difficulty. The resident stated, "[Staff] just put water in my room so I can get it when I want." An observation of the resident's room revealed a water pitcher on the bedside table. There were no visible cups.	F 242		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, nurse practitioner interview and physician interview the facility failed to recognize a significant change in condition for 1 of 1 (Resident #25) resident who sustained a head injury during a fall. Resident #25 developed a subdural hematoma with a brain shift to the left placing pressure on the brain stem. The resident was sent to the hospital on 3/23/13 for evaluation and expired on 3/28/13. Immediate jeopardy began on 3/15/2013 and was	F 309	F309 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #25 was discharged from facility to hospital on 3/23/13. Resident did not return to facility. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Director of Nursing is conducting a daily review of all resident progress notes and SBAR's for change of condition and post event evaluation since 6/4/13.	6/14/13

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F 309	Continued From page 22 identified on 5/16/2013 at 5:30 PM. The immediate jeopardy is present and ongoing. Findings included: The record review indicated that the resident was admitted on 2/14/13 at 2:13 PM for rehabilitation following an ischemic cerebral vascular accident (a lack of blood supply in the brain). Admission diagnosis included hemiplegia, stroke, fracture of the lumbar spine, lack of coordination, dementia, previous stomach ulcers that required a surgical procedure that burned the bleed so that it would stop. Resident #25's admission medications included: Tylenol 650 mg (milligrams) by mouth every 6 hours as needed for pain The record review revealed that the Minimum Data Set (MDS) dated 2/21/13 indicated Resident #25 was severely cognitively impaired. There were no mood disorders noted and there were no behaviors noted. There were no pain problems noted. The resident required extensive assistance with activities of daily living (ADL) with at least one person assistance at all times. Resident #25 had an unsteady gait and required one person assistance for transfer and for toileting. Upon review of Resident #25's medical chart and electronic chart, there was no information noted that the resident had a chronic pain issue or that the resident was constantly anxious. From admission date of	F 309	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: An in-service education program was conducted by the Director of Nursing or Staff Development Coordinator with all licensed and certified staff addressing change in condition and communication of such that require notification of the resident's physician, legal representative or family member and nursing. Implementation and training on Situation, Background, Assessment, Recommendation/Request (SBAR) communication tool and utilization of therapy referral process. Training sessions completed on 5/30/13. Nurses educated as to procedure for shift change reporting. Training will be completed on 6/14/13. Nurses conducting a shift to shift review of progress notes to monitor resident change of condition or other resident events. Nurse management to conduct a 24 hour review of all progress notes, accident/incident reports with review of SBAR's . Daily IDT meeting to review, monitor and manage resident care. Director of Nursing is completing a SBAR tracking log.	

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F 309	Continued From page 23 2/14/13 to 3/13/13 the resident had no behavior problems charted and had no pain problems charted. The nurse's notes indicated Resident #25 would call for her family because of her dementia and new surroundings. The family was involved with the resident care on a daily basis. On 2/21/13 Ativan 0.5 mg by mouth every 6 hours as needed for agitation was ordered. The resident was medicated on 2/27/13, 2/28/13, and 3/10/13 with Ativan for agitation prior to her fall on 3/14/13. The record review indicated the medical physician saw and evaluated the resident on 2/21/13. The evaluation stated that the resident denied pain. The record review indicated that the care plan dated 2/22/13 did include interventions for falls related to use of psychotropic medications for dementia, recent stroke and hospitalization. The resident was not care planned for pain, mood disorder, or behavior problems. The record review stated that the resident fell on 3/14/13 at 4:14 AM. The resident was found on the floor in her room by Nurse #2. A Nurses note by Nurse #1 stated " fall with head injury. Attempted to go to bathroom unassisted. Hit back of her head. Neuro (neurological) checks WNL (within normal limits). " The nurse's note also indicated the resident's range of motions was within normal limits. Neurological checks compare a person's baseline to a current assessment of level of consciousness (alertness/behavior), vital signs, pupil response to light, eye response to stimuli, level of consciousness, speech pattern, and motor	F 309	4. Indicate how the facility will monitor its performance: Director of Nursing or Assistant Director of Nursing will conduct a daily audit of generated SBAR communication tools for four (4) consecutive weeks. Residents will be assessed by generated SBAR communication tool to ensure that any changes in condition have been identified, properly evaluated and communicated to the appropriate people. Results will be presented to Quality Assurance team for recommendations and follow up for 6 months.	

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WESTCHESTER MANOR AT PROVIDENCE PLACE	1705 WESTCHESTER DRIVE HIGH POINT, NC 27262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 24 response. An interview on 5/15/13 at 11:20 AM with Nurse #1 revealed that nurse #2 found the resident on the floor in her room. Nurse #1 came to the resident ' s room to assess the resident for injury and determined Resident #25 was without major injury. Nurse #1 stated that the resident had equal grips, no more than normal confusion, no lacerations, and did not appear to be harmed other than the " bump " to the back of her head. The nurse's notes by Nurse #2 indicated that on 3/14/13 at 6:25 AM the neuro checks were still in progress and within normal limits. The resident complained of pain around her head area where her head had hit the floor. No swelling was noted at that time. According to Nurse #2's notes, the resident's responsible party was notified and the medical physician was notified of the resident's fall via the facilities communication board. During record review of the communication notes on 5/15/13 at 11:00 AM the note for 3/14/13 could not be located for Resident #25. At that time the Director of Nursing (DON) was asked if she had a copy of that communication sheet, she stated that she did not. The resident was not medicated for pain at this time according the medication administration record (MAR). During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 5/15/13 at 12:30 PM the DON indicated that the protocol for falls was to have the charge nurse evaluate the resident for injury, after that, they assisted with getting the resident back to bed or bathroom. The DON stated they were to look at interventions that could be put in	F 309		

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place to help the resident to be safe, the family should be notified and the physician would be called if there were serious injuries to the resident. The DON indicated that a serious injury would be a skin tear that keeps bleeding, a resident has neuro checks that are abnormal, abnormal pain from the resident, dislocation or odd positioning of the extremities. If there were no serious injuries then the residents fall would be placed on the communication board which was seen by the physician or NP on a daily basis. The facility was unable to show any communication regarding Resident #25 on the communication board sheets from February through May 2013 that indicated a fall by Resident #25. The record review revealed no other notes in Resident #25's chart from a physician or NP for the dates following the fall. The DON stated her expectation would be the nurse would have contacted the physician per the facilities recognized protocol. The ADON indicated that the MD or the NP would see the communication board on a daily basis while doing rounds.

On 3/14/13 at 9:32 AM the record review of the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation.

During an interview on 5/15/13 at 11:12 AM, Nurse #2 indicated that the resident's neuro checks were normal during her time with the resident immediately following the fall. Nurse #2 stated that the medical physician would not be called unless neuro checks deviated from normal or if the resident showed signs of injury at the time of the fall that required immediate evaluation.

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F 309	Continued From page 26 During an interview on 5/15/13 at 11:12 AM, Nursing Assistant #1 indicated Resident #25 yelled out often. Nursing Assitant #1 who worked the 7 AM to 3 PM shift stated that the resident was no different to her following her fall. A nurse's note entry by Nurse #3 on 3/14/13 at 1:18 PM included that there had been no change in the resident's level of care or behaviors. The nurse's note indicated the resident yelled and cried out but would settle down once others talked to her or while she was eating her meals. The nurse's note also included, " Family visited earlier and resident was calmer. " The record review indicated that a family member stated " oh mother you always have headache and back pain. " During an interview on 5/15/13 at 9:00 AM with Nurse #3 she stated that she remembered Resident #25 would call out often for her family. When asked if she called out all the time before and after her fall she stated yes. Stated that the resident was " very verbal and always calling for her family " Stated she couldn't remember if the resident was complaining of back pain or head pain after her fall, just remembered her yelling out and being verbal. On 3/14/13 at 9:35 PM the record review of the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation. The record review stated a nursing note dated 3/14/13 at 10:42 PM that " Resident alert, oriented, and verbally responsive. " The note also indicated the resident received Tylenol 650	F 309		

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F 309	Continued From page 27 mg (milligram) and Ativan (anxiety medication) given for back pain and anxiety respectively. The nurse's note indicated that neuro checks continued. A nurse's note entry by Nurse #2 on 3/15/13 at 6:21 AM stated that the neuro checks were still in progress and Resident #25 was within normal limits. There were no delayed injuries noted. The nurse's note also stated Resident #25 woke up at 4:00 AM yelling out and complaining of back pain. Nurse #2 gave Resident #25 Tylenol 650 mg. Nurse #2 indicated Resident #25 started yelling out again in pain after 15 minutes and stated she wanted to lie down again. Resident #25 was then transferred back to bed. The nursing notes stated Resident #25 began yelling out again at 5:00 AM requesting to get out of bed because of her back pain. Resident #25 was placed in a wheelchair but continued to yell out when approached. Nurse #2 stated " resident unsure of what help she needs, not easily redirected. " The record review of Resident #25's medication record indicated that she was medicated with Tylenol at 4:10 AM using the 1-10 pain scale, with 10 being the most severe pain. Resident #25 was assessed as having back pain rating a 3 with a reassessment pain level of a 1. Nurse #2 indicated Resident #25 Resident didn ' t yell and call out that she was in pain prior to her falling. An interview with Nurse #3 and Nurse #4 on 5/17/13 at 3:00 PM revealed that they would use the facial recognition system to evaluate pain on a resident who was severely cognitively impaired. Nurse #3 and Nurse #4 both indicated a 0-10 pain scale would not be reliable on a resident who	F 309		

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is cognitively impaired because the resident would not be able to use the scale. They stated that it would be better to judge the resident by his/her normal baseline and compare it to how have they changed since an incident.

Record review revealed that on 3/15/13 at 3:29 PM a nurse's note written by Nurse #3 indicated that the resident was alert and oriented to her self and place with no complaints noted. The resident's level of care or ADL change per the nurse's note.

On 3/15/13 at 7:18 PM the MAR indicated Resident #25 was medicated again with Ativan 0.5 mg by mouth for agitation.

Record review revealed that on 3/15/13 10:20 PM Nurse #4 wrote " Resident alert, oriented, and verbally responsive. PRN (as needed for) pain med Tylenol 650 mg and Ativan given for back pain and anxiety respectively. F/U (follow up) fall day 1 with neuro checks continuing. Ate supper at substation, extensive assistance with ADL's and tranfers. Family visits often, in bed with call light in reach. "

Record review revealed that on 3/16/13 05:45 AM Nurse #2 wrote " S/P (status post) fall day 2 with neuro checks completed this shift and no delayed injuries noted. "

The record review of Resident #25's therapy notes indicated that on 3/16/13 Occupational therapist #1 charted a note that stated Resident #25 continued to " c/o (complain of) back and head pain which is effecting her performance. "

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In an interview on 5/15/13 at 10:31 AM Occupational Therapist #1 revealed she remembered Resident #25 having severe head pain during her session on 3/16/13. Occupational Therapist #1 (OT #1) told a Physical Therapist Assistant (PTA) that Resident #25 was complaining and that they should tell the nurse. The OT #1 stated that she couldn't remember who the nurse was or if the nurse had been told of the resident's increased pain.

The record review revealed a note on 3/16/13 from physical therapy that read " Pt (Patient) with c/o lower back pain today with difficulty performing sit to stand and unable to tolerate standing. " The physical therapy note also indicated that the physical therapist had spoken with nursing staff and included, " No documentation seen regarding x-rays to rule out injury. Discussed with nursing possibility of x-rays if pain does not improve. " The Physical Therapist was called on 5/16/13 at 4:00 PM. A message was left to return the phone call, by 5/17/13 at 5:00 PM the Physical Therapist had not returned the phone call.

On 3/16/13 at 5:40 PM the MAR indicated Resident #25 was medicated again with Ativan 0.5 mg by mouth for agitation.

The record review revealed a nurses note dated 3/17/13 at 05:48 AM included that on the 3rd day after her fall Resident #25 had no delayed injuries noted, no acute distress noted, will c/t (continue to) monitor.

On 3/17/13 at 1:41 PM the MAR indicated Resident #25 was medicated again with Ativan

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F 309	Continued From page 30 0.5 mg by mouth for agitation. On 3/18/13 Occupational therapist #2 charted " Pt crying out and stating " my back hurts worse than ever! My back! " Pt. performed 2 standing trials with minimal assist to reach forward to grasp parallel bar. 1 minute 1st trial, 30 seconds 2nd trial. " please let me sit down. " The OT #2 ' s notes indicated that a back massage was done but the resident stated " it helps but it still hurts so bad. " During an interview on 5/15/13 at 9:55 AM Occupational Therapist #2 (OT #2) said she found Resident #25 crying out in the hallway that day. Occupational therapist #2 indicated that what she wrote was a true assessment of the residents back pain as being severe on those specific dates and that she did seem more in pain after her fall. On 3/18/13, the Nurse Practitioner ordered " ibuprofen 800 mg tablet give 1 tablet (800 mg) by oral route once daily as needed only to be given after resident has eaten /1st dose asap. " On 3/18/13 at12:40 PM the MAR indicated Resident #25 was medicated with Ibuprofen for pain. A nurse's note entry by Nurse #3 stated the Nurse Practitioner (NP) saw Resident #25 concerning an order for pain. Nurse #3 stated " Resident continues to cry and call staff for pain meds even if she just received them. " On 5/15/13 at10:05 AM an interview with the Nurse Practitioner (NP) was obtained. The NP didn't remember the resident and stated " if there is no note in the chart or progress notes then I	F 309		

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didn't see her. " During the survey there were no physician notes or nurse practitioner notes found in Resident #25's chart that indicated that the resident was seen by either the MD or NP following her fall and head trauma. The facility could not provide any further documentation that showed the NP or the MD saw Resident #25 following her fall.

According to the resident's medical record, Resident #25 was not seen by occupational therapy or physical therapy on 3/17/13 but did return to occupational therapy on 3/18/13 and complained of severe pain. On 3/19/13 Resident #25 returned to physical therapy. There was no pain noted during physical therapy on that day. Resident #25 was considered on 3/19/13 for discharge from physical therapy related to resident meeting her max functional capability.

According to nurse's notes on 3/19/13 at 11:53 AM Resident #25 was medicated with ibuprofen 800 mg for a complaint of pain. A nurses noted charted by Nurse #3 stated " No change in level of care, ADL's or behavior. " The note also included that the resident " continues to yells and screams for attention " and made frequent requests to go from the bathroom to her recliner.

During record review of the physician's order, the order for Ativan was changed on 3/20/13 by the NP to Ativan 0.5 mg by mouth or sublingual (under the tongue) every 6 hours as needed for agitation. On 3/19/13 at 3:51 PM the MAR indicated Resident #25 was medicated with Ativan 0.5 mg by mouth for agitation.

During the NP's interview 5/15/13 at 10:05 AM

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she stated that she did not remember Resident #25 and did not recall writing any orders for this resident.

On 3/20/13 at 9:37 am the MAR indicated that the resident was medicated with ibuprofen 800 mg PO for pain. No nurse ' s note written. On 3/20/13 at 1:54 PM a nurse note stated " Alert and oriented to self. No acute complaints nor in any apparent acute compromising condition. "

According to the MD's communication board, on 3/21/13 a note was left on the communication board about the family wanting to have the ibuprofen discontinued because of the resident's history of an ulcer and pain whenever she uses it. This was observed on 5/15/13 at 11:00 AM.

On 3/21/13 at 8:56 am the record review indicated that the resident was medicated with 800 mg of Ibuprofen PO for pain. No nurse ' s note were written on 3/21/13.

On 3/21/13 the social worker saw Resident #25 on 3/21/13 and wrote a note. The social worker noted the resident " continues to exhibit behaviors of yelling and crying per nurses notes 3/14 - 3/19/13 per nurses notes 3/14 and 3/15 resident was medicated with Ativan for " anxiety. "

During an interview on 5/15/13 at 9:25 AM the social worker indicated the resident was always looking for her family but didn't have any behaviors other than calling for her family that she was aware of.

On 3/21/13 at 1:45 PM nurses note entry read "

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F 309	Continued From page 33 alert and verbal. No signs and symptoms of any apparent acute compromising condition. Continue to yells but soon as staff talk to her she stop then yell later on again. No change in level of care or ADL's (activities of daily living). " On 3/22/13 at 1:13 PM a nurse's note entry read " Resident continues to yell and scream of back pain. No change in level of care or ADL's. A new order written on 3/22/13 and signed by the Nurse Practitioner stated " Tramadol (narcotic like pain medication) 26 mg PO (by mouth) BID (twice a day) and every 6 hours as needed for pain. Hold for sedation. X-ray of lumbar and thoracic spine. " Results from portable x-ray done on Resident #25 were sent to the facility on 3/22/13 with negative results for any acute findings. On 3/22/13 at 3:20 PM a telephone order was written for Tylenol arthritis every 8 hours and Tylenol 325 mg, 2 tabs = 650 mg PO every 6 hours PRN break through pain. The order for Tramadol was discontinued. This order was taken by the assistant director of nursing from the NP. The order was then signed by the MD. On 3/23/13 at 7:32 AM nurse #7 charted " At 5:45 AM NA noted resident was lethargic and was assessed by this writer. " " Resident c/o neck pain and scheduled Tylenol was given. " At 7:56 AM nurse #1 charted that the resident was more alert and was able to recall friends and family names. Note to MD/NP communication board. The communication board had a note to the medical physician dated 3/23/13 that was observed on 5/15/13. This note on the communication board was observed on 5/15/13	F 309		

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F 309	Continued From page 34 at 11:00AM. At 10:12 AM Nurse # 7 obtained a urine sample per standing orders because of the resident ' s new lethargy. Resident complained of headache this morning and was given pain medication that was effective. At 1:56 PM nurse #7 charted " resident in bed finishing eating lunch, ate 25%. Alert and verbally responsive, able to make needs known. Writer assisted resident in drinking juice, resident had difficulty swallowing and juice dripping to her mouth. Writer observed slurred speech and left sided weakness. Notified supervisor, RP, and MD. " An interview with nurse #7 on 5/15/13 at 11:00 am revealed that the resident was in bed in the AM which wasn't normal and heard that the resident had a rough night. She noted that the resident didn't seem " right. " The urine sample was collected per standing orders and sent out because of resident's frequent urinary tract infections. By 1:00 PM the resident wasn't able to eat lunch without dribbling fluid down mouth and was still lethargic. The on call medical physician was called and orders taken for the resident to be transferred to the hospital for further evaluation. At 1:15 PM Resident #25 was transferred to emergency department for evaluation. According to the admission history and physical report dated 3/23/13, once at the hospital the resident was sent for a CT (Computed Tomography) scan (which created a 3-dimentional image of the brain/skull) where it was noted Resident #25 had a 14 millimeter thick subdural hematoma that had caused a shift of Resident #25's brain 8 millimeters to the left place pressure on the brain stem. The resident was	F 309		

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also found to be anemic with a hemoglobin of 5.8. There was black stool noted but was not tarry in nature. The family reported to the ER physician that they were unaware of any bowel problems related to dark stool having been occurring at the facility. The resident was transfused with 1 unit of packed red blood cells. The resident was seen by a Neuro Surgeon and discussed with the family the prognosis for the resident if she underwent surgery. The decision was made to place the resident in Hospice care with comfort measures only. Resident #25 died on 3/28/2013.

An interview with the facilities medical physician (MD) was conducted on 5/16/13 at 2:45 PM. The MD stated that he did not remember being told about this residents fall. He stated that his expectation following a resident fall was that the nurses would assess the resident, determine if there were any injuries and start neuro checks if the fall involved head trauma. He stated that the only time a nurse would directly call him or the on call doctor would be when the resident started to have neurological changes showing during the neuro checks. The doctor stated that he expected the nurses to contact him or the on call MD directly if a cognitively impaired resident started complaining of more pain following a fall or had behavior changes such as more agitation and anxiety following a fall. The MD stated that according to the resident's chart that the resident was not seen by himself or the Nurse Practitioner following the residents fall. He stated " If I lay eyes on them (resident) or put my hands on them (resident) I leave a note in the chart. " He stated that his expectation was that the NP did the same. When asked directly if the resident was seen by himself or the NP following the fall he

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F 309	Continued From page 36 stated " no, based on what is in this chart. " The MD stated that if the nurses had called him or the on call MD and reported that the resident was experiencing more pain and more anxiety following the fall that he would have been able to pick up on pupil changes or focal defects of the resident's arms and legs. If these changes were picked up by him or his NP, then the resident would have been sent to the Emergency Room (ER) for a CT scan of the head at that time. The CT report from the hospital was read and shown to the MD. The MD stated that based on the CT report from the hospital that " her fall (the residents) could be a cause of her subdural hematoma and subsequent death. It is most likely the cause and I'm sure the fall contributed to her death. " An interview with the Nurse practitioner on 5/16/13 at 2:30 PM revealed that she did not remember this resident, did not remember writing orders on the resident and that it is possible that she was called for orders and never physically saw the resident. She stated that if there are no notes in the chart that state she assessed the resident, then she didn't visually assess the resident prior to giving orders for the resident. The NP stated that she doesn't normally write orders on residents she doesn't evaluate but it could happen if she was not in the building. On 5/16/13 at 5:00 PM the MD stated that the resident received 4 doses of Ibuprofen after her fall and before she was sent to the hospital for evaluation. The MD stated it could have been a contributing factor in an increase of a slow bleed from a traumatic injury such as a subdural hematoma.	F 309		

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F 309	Continued From page 37 The death certificate dated 3/28/13 stated the immediate cause of death was a subdural hematoma due to (or as a consequence of) a fall.	F 309	F315 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 97 had her supra-pubic catheter secured to resident's leg on 5/17/13. Proper care which includes cleansing securing of catheter and securing of urinary drainage bag was provided with ADL care. Resident # 17 was placed on voiding diary and a therapy referral was made. A consult appointment with the Urologist is schedule for 5/30/13. Resident is toileted as needed. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Resident's that currently have a catheter (supra-public/indwelling) will be provided with a securing device at all times. The securing device will be removed during ADL care and replaced once care is complete. Charge nurses will check for placement and proper function each shift.	6/14/13
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 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 record review, observation and staff and resident interviews the facility failed to secure a supra-pubic catheter for 1 of 5 residents who used an in dwelling catheter, and failed to re-evaluate and provide services to restore as much normal bladder function as possible for 1 of 4 sampled residents with urinary incontinence (Resident #17). Findings Included: 1) Resident #97 was admitted on 12/20/12, with the diagnoses of hemiplegia, hypertension and neurogenic bladder. The most current Minimum Data Set (MDS) dated 3/15/13, indicted she had no long and short term	F 315		

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F 315	Continued From page 38 memory loss, and had an indwelling catheter. Review of the physician's order dated 5/10/13, Supra-pubic catheter to gravity drainage. During an interview and observation on 5/17/13 at 9:54am, Nursing Assistant #3 and Nursing Assistant #4 had indicated Resident #97 had a supra-pubic catheter and never used a catheter strap to secure the tubing. Nursing Assistant #3 indicated the female residents do not use catheter straps and male residents use the catheter straps to the leg for the indwelling catheters. During interview on 5/17/13 at 9:58 am Nurse #5, indicated she had never seen an anchor to secure the supra-pubic catheter tubing. During an interview on 5/17/13 at 10: 11 am, Resident # 97 indicted she had never had anything to secure her supra-pubic tubing to her abdomen or her leg. When the tubing pulled that was when she called and had the bag emptied. Observation revealed the bag had 600 cc (cubic centimeters) of clear yellow urine and taunt tubing pulling from the unbandaged incision. She called for the bag to be emptied. During an interview on 5/17/13 at 10:13 am, Nursing Assistant #5 indicated Resident #97 had a supra-pubic catheter and she did not require a catheter strap to secure the tubing. Nursing Assistant #5 returned at 10:24 am, and indicated she had gotten clarification and a catheter strap should be used when Resident #97 was up in a chair.	F 315	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Education provided to Licensed and certified staff regarding the securing (anchoring) and placement of catheter and proper catheter care. Also educated regarding perennial care with incontinent residents to assist in the prevention of urinary tract infections. 4. Indicate how the facility will monitor its performance: Director of Nursing or Assistant Director of Nursing will monitor 5 residents per week for four weeks to ensure the securing of supra-pubic or indwelling catheter. Results will be presented to the Quality Assurance team for recommendations and follow up for 6 months.	

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F 315	Continued From page 39 During an interview on 5/17/13 at 10:27 am, Nurse #8, indicated the nursing staff had just been reassigned to do catheter care because of the increases in urinary tract infections. A catheter strap was to be used most of the time with a leg bag or a gravity bag to prevent trauma. The band aide strap would be used with a supra-pubic catheter to the abdomen. It would be removed while the resident was getting dressed or bathing. During an interview on 5/17/13 at 1:51pm, Nurse #7, indicated a supra-pubic catheter doesn't use an anchor, the physician would write the order for it to be secured. During an interview on 5/17/13 at 1:56 pm, Physician indicated, he would not write an order to secure or anchor for a supra-pubic catheter. He expected the facility policy and nursing would determine how to secure the catheter. During an interview on 5/17/13 at 2:46pm, Director of Nursing indicated an island strap or an anchor strap should be used at all times with a supra-pubic catheter, unless bathing. The physician would not write the order to secure an indwelling catheter. It was secured per facility protocol and nursing judgment. The expectation was for the catheter to be secured. 2) Resident #17 was admitted to the facility on 3/10/05 and had diagnoses including hypertension, urinary tract infection, diabetes, osteoporosis, fatigue and stroke. The Minimum Data Set (MDS) annual assessment dated 9/10/12 indicated the resident	F 315		

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F 315	Continued From page 40 was frequently incontinent and was not on a urinary toileting program (a behavior training program to improve or eliminate incontinent symptoms, including urinary frequency). The care plan dated 9/11/12 revealed the resident required assistance with activities of daily living (ADL) task performance related to a diagnosis of osteoporosis, decreased mobility, and being non-ambulatory. Interventions included extensive assistance with toileting and transfers. The care plan dated 9/11/12 revealed an alteration in elimination as evidenced by frequent episodes of urinary incontinence. Interventions included utilize prompted voiding (meaning staff would prompt the resident to use the toilet) every 1-2 hours. A Voiding Diary, to evaluate the need for a toileting program, was dated 11/20/12-11/22/12 and revealed the resident had two episodes of incontinence at 2 am and 4 am. The MDS nurse note dated 11/23/12 stated, " Resident does not participate [with] toileting diary on occasion to determine need for [bowel and bladder] program. Resident noted to be continent of bowel and bladder [with] only a couple of incontinent episodes. Resident will be monitored. " The MDS quarterly assessment dated 1/22/13 indicated the resident was frequently incontinent and was not on a urinary toileting program. A nurse ' s note dated 4/9/13 stated, " Resident has had frequent urination and states, ' It burns. ' Urine collected and sent to be tested for UTI	F 315		

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F 315	Continued From page 41 [urinary tract infection]." A nurse ' s note dated 4/11/13 stated, " Continues to have urinary urgency and still awaiting results of [urinalysis]. " A nurse ' s note indicated Resident #17 was started on an antibiotic for a urinary tract infection on 4/13/13. A nurse ' s note indicated Resident #17 was started on an antibiotic for a urinary tract infection on 5/12/13. The MDS annual assessment dated 5/13/13 indicated the resident was cognitively intact, did not reject care - including activities of daily living (ADL), required extensive assistance and two-person assistance with transfers and toilet use. The assessment further indicated Resident #17 required extensive assistance with personal hygiene, was not steady moving on and off the toilet, was only able to stabilize with staff assistance, and used a wheelchair for mobility. She was not on a urinary toileting program and was frequently incontinent. The resident participated in the assessment. The care plan dated 5/13/13 revealed altered urinary elimination related to urinary tract infection (UTI). Interventions included encourage frequent voiding to promote bladder emptying. On 5/14/13 at 2:52 pm Resident #17 stated, " I have to go to the bathroom almost every hour. The nurse aide at night - she won't come but every 3 or 4 hours to help me to the bathroom. "	F 315		

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F 315	Continued From page 42 On 5/16/13 at 9:15 am the Director of Nursing (DON) stated, " The expectation is NAs will get a resident up as many times as needed, unless someone else is receiving care. It wouldn't happen that a resident had to wait on a regular basis or for an extended period of time. " During a phone interview on 5/16/13 at 9:45 am, NA#7 indicated she worked 11p-7a on 200 hall, Resident #17 ' s hall. She also indicated she would check on a resident quickly if the call bell rang and would not tell a resident they had to wait to go to the bathroom, she would get them up. She also indicated she did not do prompted voiding with Resident #17. Regarding Resident #17, NA #7 stated, "She gets in the wheelchair by herself. I roll her to the bathroom, she holds on to the handrails and gets on the toilet by herself. I come back and get her when she is done." On 5/16/13 at 10:48am the Restorative Nurse stated, " When [Resident #17] gets off the toilet she needs help adjusting her clothing and getting back in the wheelchair. She requires limited to extensive assistance with pivoting and in the restroom getting off the toilet. After her fall in March we recommended 2 person assistance and therapy evaluated. One person is sufficient with transfer and toileting, but she does require limited to extensive assistance especially with toileting." On 5/16/13 at 1:24 pm the DON indicated that whether to place a resident on a toileting program is an interdisciplinary team decision. She stated, " We do a 3-day review of the resident ' s toileting habits, completing bowel and bladder logs. I have always known [Resident #17] to be someone up and down to the bathroom. It isn ' t a recent change. " She indicated that someone with frequency of this nature would be appropriate	F 315		

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for a toileting program.
On 5/16/13 at 2:00 pm the DON indicated the resident had not been placed on any toileting program for the past year and referenced the 3-day Voiding Diary done November 2012 when the resident only had two incontinent episodes.
On 5/16/13 at 2:05 pm the physician indicated the [medication prescribed for bladder spasms and urinary frequency] at the time of Resident #17 ' s UTIs were to " acutely treat frequency but the resident ' s chronic frequency was most likely anatomical and would require the facility to develop a toileting program. "
On 5/16/13 at 2:26 pm the Assistant Director of Nursing (ADON) indicated the voiding diary was an evaluation tool, showing when the resident would void or refuse, and was used to determine if they need a bowel or bladder program. She indicated the MDS nurse would determine if the resident should do a program and that occasional refusal did not mean the resident did not want to participate or would not benefit from a program.
On 5/16/13 at 2:40 pm Nurse #6 was interviewed regarding Resident #17 ' s voiding diary. She indicated the resident " would be continent sometimes and would push the call bell then have to be taken to the bathroom in between times. She would refuse sometimes when it was time to be taken to bathroom. We do the diary for 3 days then determine whether to put the resident on a program. She was only incontinent twice in those 3 days. Her incontinent episodes are few and in between. The voiding diary was done because she was complaining of not making it to the bathroom on time. We wanted to see how many times she was incontinent. We made the decision as an interdisciplinary team to not proceed with a toileting program based on her 2

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F 315	Continued From page 44 incontinent episodes and her occasional refusals On 5/16/13 at 3:00 pm Resident #17 indicated she did not remember anyone talking to her about the voiding diary or a bladder program and stated she would participate in a toileting program if one was offered to her. On 5/17/13 at 6:30 am NA #1 indicated when she takes care of Resident #17, she waits for her to ring her call bell to go to the bathroom and does not do prompted voiding.	F 315		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents #29, #76, #95 and #18 were reviewed for changes in behavior and side effects of prescribed medication. No adverse side effects noted. New behavior flow sheets implemented on 5/15/13 to include behaviors and side effects. A call was placed to the Medical Director for resident #53 and an order was obtained for a Vitamin B12 level on 5/16/13. Lab obtained on 5/21/13. Physician provided results and made changes to medication as indicated.	6/14/13

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F 329	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview with staff the facility failed to monitor behaviors by not completing the behavior flow sheet each shift for 4 of 8 residents reviewed with antidepressants or antipsychotics (Resident #29, 76, 95, and 18) and failed to obtain a vitamin B12 level on a resident taking Vitamin B12 for 1 of 5 (Resident #53). Findings included: 1)Resident #29 was admitted on 4/18/13 with diagnoses that included weakness, history of falls, and depression. The Minimum Data Set (MDS) admission assessment dated 4/25/13 indicated the resident was cognitively intact, did feel down or depressed occasionally, had a diagnosis of depression, received a medication for depression for 7 of 7 days, and participated in the assessment. The care plan dated 4/26/13 indicated Resident #29 received an anti-depressant medication on a routine basis and stated she felt down from time to time. Interventions included to monitor for side effects of medication, report promptly to physician, and record moods and behaviors. During an interview on 5/15/13 at 6:20 am, the Assistant Director of Nursing (ADON) and the Staff Development Coordinator (SDC) indicated that monitoring of behaviors should be done on each shift and should be documented on the "	F 329	2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: An audit of all residents receiving antidepressants or antipsychotics completed to ensure behaviors and effects are being monitored and proper completion of behavior flow sheets on 5/15/13. An audit of all residents receiving oral vitamin B12 will be conducted. Physician will review and respond as necessary. The Medical Director and the pharmacy provider collectively review and revise pharmacy lab protocol as indicated.	

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F 329	Continued From page 46 Documentation of Behavior " sheet. They further indicated that if there were no behaviors the nurse should initial the sheet every shift and if there were behaviors staff should indicate what behavior was seen and make a detailed note of that behavior in the nurse's notes. After review of the Documentation of Behaviors notebook containing the behavior sheets for both 100 and 200 halls, the ADON indicated that behaviors were not documented as expected. The Documentation of Behavior sheet dated May 2013 revealed there were no staff initials or indication behavior was assessed for 10 of 14 first shifts, 10 of 14 second shifts, and 5 of 14 third shifts. The behavior sheet and current physician orders indicated the resident was prescribed an antidepressant to be taken daily for depression. During an interview on 5/15/13 at 6:32 am, Nurse #5 stated, "We should document behaviors every shift on the documentation of behaviors sheet. If they don't have any behaviors, we initial. If they do have a behavior that shift, we write a note in the progress notes." 2) Resident #76 was admitted on 12/21/10 with diagnoses that included anxiety and depression. The Minimum Data Set (MDS) annual assessment dated 2/20/13 indicated the resident was moderately cognitively impaired, had a diagnosis of depression, had no behavioral symptoms, received medication for depression for 7 of 7 days, and participated in the assessment.	F 329	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: Licensed and certified staff will be educated in regards to resident monitoring of behavior and the need to monitor effects of medication by the Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator. Staff including RN's, LPN's, Nursing Aides, Social Workers and therapists will be educated on the communication between departments to identify behaviors and the effects of medication. The staff will be educated on non-pharmacological interventions to attempt prior to medications. Licensed staff will be educated on the use of the required AIM's testing every 6 months and with changes in medication. The implementation of a new behavior monitoring sheet and education on use of monitoring tool will be provided to licensed staff.	

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F 329	Continued From page 47 The care plan dated 1/1/13 indicated the resident exhibited socially inappropriate behavior as evidenced by inappropriate sexual comments and gestures towards female residents and staff. Interventions included to monitor and document in the medical record the intensity, duration, or frequency of behaviors. The care plan also indicated the resident was on an antidepressant. Interventions included to assess behavioral pattern, document, and report concerns to physician. The care plan dated 1/1/13 indicated the resident was on an antidepressant related to a diagnosis of depression. Interventions included assess behavioral pattern, document, report concerns to physician, and monitor for side effects of medication. During an interview on 5/15/13 at 6:20 am, the Assistant Director of Nursing (ADON) and the Staff Development Coordinator (SDC) indicated that monitoring of behaviors should be done on each shift and should be documented on the " Documentation of Behavior " sheet. They further indicated that if there were no behaviors the nurse should initial the sheet every shift and if there were behaviors staff should indicate what behavior was seen and make a detailed note of that behavior in the nurse's notes. After review of the Documentation of Behaviors notebook containing the behavior sheets for both 100 and 200 halls, the ADON indicated that behaviors were not documented as expected. The Documentation of Behavior sheet dated May 2013 revealed there were no staff initials or indication behavior was assessed for 12 of 14	F 329	4. Indicate how the facility will monitor its performance: Director of Nursing or Assistant Director of Nursing will review 10% of residents weekly for four weeks who are receiving antidepressants or antipsychotics to ensure behaviors and effects are being monitored and documented using behavior flow sheets. Results will be presented to the Quality Assurance team for recommendations and follow up for 6 months.	

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first shifts, 6 of 14 second shifts, and 5 of 14 third shifts. The behavior sheet and current physician orders indicated the resident was prescribed 3 antidepressants to be taken daily for depression and anxiety.

During an interview on 5/15/13 at 6:32 am Nurse #5 stated, "We should document behaviors every shift on the documentation of behaviors sheet. If they don't have any behaviors, we initial. If they do have a behavior that shift, we write a note in the progress notes."

During an interview on 5/15/13 at 7:23 am Nurse #9 indicated she worked first shift on Resident #76's hall, was assigned to the resident, and was unable to state what side effects or behaviors should be monitored with the use of psychotropic medications. When asked how a resident's behaviors were documented she stated, "We document it in the behavior notebook." Upon inspection of the May Documentation of Behavior sheet for Resident #76, and noting 12 days were not initialed, she stated, "I should have initialed those days. I guess I will go back and do that." She indicated that her initials were not on any days in May.

The Documentation of Behavior sheet revealed on 5/15/13 at 8:20 am Nurse #9's initials had been added on 5/15/13 for 8 days in May.

3) Resident #95 was admitted on 3/10/09 with diagnoses that included depression and dementia.

The Minimum Data Set (MDS) annual assessment dated 4/19/13 indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345090	A. BUILDING _____ B. WING _____	C 05/17/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 49 was moderately cognitively impaired had diagnoses of depression and dementia, had no behavioral symptoms, received an antipsychotic and antidepressant for 7 of 7 days, and participated in the assessment. The care plan dated 6/15/12 indicated the resident was at risk for falls related to psychotropic medication use. Interventions included to monitor for side effects of medications such as dizziness and drowsiness, and notify the physician for any behavioral changes. The care plan dated 6/15/12 indicated the resident was on an antidepressant and antipsychotic medication related to depression and delusions. Interventions included to monitor for mood, behaviors, and side effects of medications and report to the physician. During an interview on 5/15/13 at 6:20 am, the Assistant Director of Nursing (ADON) and the Staff Development Coordinator (SDC) indicated that monitoring of behaviors should be done on each shift and should be documented on the " Documentation of Behavior " sheet. They further indicated that if there were no behaviors the nurse should initial the sheet every shift and if there were behaviors staff should indicate what behavior was seen and make a detailed note of that behavior in the nurse's notes. After review of the Documentation of Behaviors notebook containing the behavior sheets for both 100 and 200 halls, the ADON indicated that behaviors were not documented as expected. The Documentation of Behavior sheet dated May 2013 revealed there were no staff initials or	F 329		

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F 329	Continued From page 50 indication behavior was assessed for 12 of 14 first shifts, 5 of 14 second shifts, and 5 of 14 third shifts. The behavior sheet and current physician orders indicated the resident was prescribed an antidepressant and an antipsychotic to be taken daily for depression and delusions. During an interview on 5/15/13 at 6:32 am Nurse #5 stated, "We should document behaviors every shift on the documentation of behaviors sheet. If they don't have any behaviors, we initial. If they do have a behavior that shift, we write a note in the progress notes." During an interview on 5/15/13 at 7:23 am Nurse #9 indicated she worked first shift on Resident #95's hall, was assigned to the resident, and was unable to state what side effects or behaviors should be monitored with the use of psychotropic medications. When asked how a resident's behaviors were documented she stated, "We document it in the behavior notebook." Upon inspection of the May Documentation of Behavior sheet for Resident #95, and noting 12 days were not initialed, she stated, "I should have initialed those days. I guess I will go back and do that." She indicated that her initials were not on any days in May. The Documentation of Behavior sheet revealed on 5/15/13 at 8:20 am Nurse #9's initials had been added on 5/15/13 for 8 days in May. 4) Resident #18 was admitted on 10/25/10 with diagnoses that included Alzheimer's and depression. The Minimum Data Set (MDS) quarterly	F 329		

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	34509D	A. BUILDING _____ B. WING _____	C 05/17/2013

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F 329	Continued From page 51 assessment dated 2/21/13 indicated the resident was severely cognitively impaired, had diagnoses of Alzheimer's and depression, had no behavioral symptoms, received an anti-psychotic and anti-depressant for 7 of 7 days, and participated in the assessment. The care plan dated 9/10/12 indicated the resident was at risk for falls related to use of a psychotropic medication. Interventions included monitor for side effects of medications such as dizziness and drowsiness. The care plan dated 9/11/12 indicated the resident was receiving antipsychotic medication on a regular basis and had periods of hallucinations and delusions. Interventions included to record behaviors, monitor for patterns of behaviors, monitor for hallucinations or delusions, document and report concerns to the physician. During an interview on 5/15/13 at 6:20 am, the Assistant Director of Nursing (ADON) and the Staff Development Coordinator (SDC) indicated that monitoring of behaviors should be done on each shift and should be documented on the " Documentation of Behavior " sheet. They further indicated that if there were no behaviors the nurse should initial the sheet every shift and if there were behaviors staff should indicate what behavior was seen and make a detailed note of that behavior in the nurse's notes. After review of the Documentation of Behaviors notebook containing the behavior sheets for both 100 and 200 halls, the ADON indicated that behaviors were not documented as expected.	F 329		

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F 329	Continued From page 52 The Documentation of Behavior sheet dated May 2013 revealed there were no staff initials or indication behavior was assessed for12 of 14 first shifts, 5 of 14 second shifts, and 5 of 14 third shifts. The behavior sheet and current physician orders indicated the resident was prescribed an antidepressant and an antipsychotic to be taken daily for hallucinations, delusions, and depression. During an interview on 5/15/13 at 6:32 am Nurse #5 stated, "We should document behaviors every shift on the documentation of behaviors sheet. If they don't have any behaviors, we initial. If they do have a behavior that shift, we write a note in the progress notes." During an interview on 5/15/13 at 7:23am Nurse #9 indicated she worked first shift on Resident #18 ' s hall, was assigned to the resident, and was unable to state what side effects or behaviors should be monitored with the use of psychotropic medications. When asked how a resident's behaviors were documented she stated, "We document it in the behavior notebook. " Upon inspection of the May Documentation of Behavior sheet for Resident #18, and noting 12 days were not initialed, she stated, "I should have initialed those days. I guess I will go back and do that. " She indicated that her initials were not on any days in May. The Documentation of Behavior sheet revealed on 5/15/13 at 8:20 am Nurse #9's initials had been added on 5/15/13 for 8 days in May. 5) Resident #53 was admitted on 10/28/11 with diagnosis including Vitamin B12 deficiency. A	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 53 review of the physician orders indicated that there were no orders written for the resident to have a Vitamin B12 level drawn from 5/16/12 through 5/13/13. Review of the hospital records dated 2/24/13 indicated Resident #53 had been placed on Vitamin B12 on 2/24/13. The resident was readmitted to the facility on 2/24/13. The physician order on admission read " Vitamin B12 1000 mcg PO daily. " There were no changes in physician order for Vitamin B12 since admission. The record review of Resident #53's lab results from 5/16/12 to 5/13/13 did not indicate that the resident had a Vitamin B12 level drawn. The hospital records dated 2/24/13 did not have a Vitamin B12 level noted in their lab reports. An interview with Nurse #1 on 5/17/13 at 7:14 AM revealed that the electronic lab report did not have a Vitamin B12 level. Nurse #1 was unable to provide a Vitamin B12 level that had been drawn on Resident #53 after being started on the Vitamin B12 medication. During an interview on 5/17/13 at 12:00 PM the physician stated that any resident taking Vitamin B12 should have a Vitamin B12 level drawn to monitor the level and adjust the medication accordingly. During an interview on 5/17/13 at 2:00 PM the Director of Nursing stated that her expectation was residents that were on Vitamin B12 would have Vitamin B12 levels drawn and monitored.	F 329		

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
	345090	A. BUILDING 03 - 0303 - REPLACEMENT BLDG B. WING _____	06/05/2013

JUN 19 2013

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

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K 000	INITIAL COMMENTS Surveyor: 10904 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Wednesday 6/5/13 the following was noted: 1) The Central supply corridor door was found wedged open and would not close, latch and seal when the wedged was removed. 2) The corridor door doors to the soiled linen	K 029	K-029 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The central supply corridor door along with the soiled linen doors on 200 and 400 halls were repaired to ensure that they would close, latch and seal properly. 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will complete an audit of all facility doors to ensure they close, latch and seal properly. Repairs completed as indicated.	7/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James A. Newman Jr.	Administrator	6/17/13

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.

B-PASS 030007

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345090	A. BUILDING 03 - 0303 - REPLACEMENT BLDG B. WING _____	06/05/2013

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K 029	Continued From page 1 rooms located on 200 and 400 hall would not close latch and seal. 42 CFR 482.41(a)	K 029	3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete a monthly inspection of 25% of facility doors to inspect for proper closing, latching and sealing. Repairs will be completed as indicated. 4. Indicate how the facility will monitor its performance: Results will be presented to Quality Assurance team for recommendations and follow up for 3 months.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 10904 Based on observation on Wednesday 6/5/13 the following was noted: 1) At 100 Hall exit the exterior discharge lighting consisted of a single bulb fixture. Illumination of means of egress including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness 2) The exit pathway leading from the sensory garden to the public way was not properly illuminated. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	K-045 1. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: An additional fixture (bulb) was added to the 100 hall exit exterior. Additional lighting was placed in the sensory garden to provide proper illumination to the public way.	7/20/13

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K 045	Continued From page 2 42 CFR 483.70(a)	K 045	2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: The Maintenance Director or designee will complete an audit of all hall exit exteriors and pathways leading to public ways to ensure proper lighting in place. Additional lighting will be installed as indicated. 3. Measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Maintenance Director or designee will complete a monthly inspection of exterior lighting to ensure proper functioning of fixtures with repairs or replacement as indicated. 4. Indicate how the facility will monitor its performance: Results will be presented to Quality Assurance team for recommendations and follow up for 3 months.	