STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345500	A. BUILDING ______ B. WING ______	C 03/17/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification Survey was conducted 03/15/2021 through 03/17/2021. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b) (6), Subpart B-Requirements for Long Term Care Facilities. Event ID# F28P11.	E 000		
F 000	INITIAL COMMENTS A Recertification Survey and Complaint Investigation was conducted 03/15/2021 through 03/17/2021. Event ID# F28P11. One of the four allegations was substantiated.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		4/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/29/2021

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 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an annual resident	F 636	Windsor Point proposes this plan of correction in order to maintain compliance	

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F 636	Continued From page 2 comprehensive assessment for 1 of 9 residents assessments reviewed. (Resident #174) Findings Included: Resident #174 was admitted to the facility on 11/13/2015. Four consecutive quarterly assessments were completed on Resident #174 with the most recent quarterly assessment dated 3/1/2021. The last annual comprehensive assessment was dated 3/1/2020. On 3/16/2021 at 2:16pm in an interview with the Minimum Data Set Coordinator, she stated the quarterly assessment dated 3/1/2021 should had been an annual comprehensive assessment. When asked if there was a reason the quarterly assessment was completed instead of the annual comprehensive assessment, she was unable to provide a reason and stated, "I missed it." On 3/16/2021 at 2:59pm in an interview with the Administrator, she stated there was a regulated schedule for the facility to follow when conducting assessments on residents. She stated the quarterly assessment dated 3/1/2021 should had been an annual comprehensive assessment.	F 636	with all applicable rules set forth by the Federal and State regulations. We will continue to serve quality care to all of our residents. This plan of correction is submitted as our written allegation of compliance. Windsor Point's response to this statement of deficiency does not constitute agreement with the deficiencies nor does it decree concurrence that any deficiency imposed an adverse effect upon the quality care that is delivered to our residents. Corrective action for the resident affected by the alleged deficient practice: The annual assessment for Resident #174 was completed on March 16, 2021. There was no negative outcome identified for the alleged deficient practice. Corrective action taken for other residents having the potential to be affected by the alleged deficient practice: A 100% audit of all active annual comprehensive assessment will be completed by the MDS Coordinator and/or designee to ensure that all other residents had a comprehensive assessment conducted not less than once every 12 months. The audit will be documented via the development of a Minimum Data Set (MDS) Tracking form commencing on March 16, 2021. All negative findings will be reported to the Director of Nursing for	

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F 636	Continued From page 3	F 636	immediate correction. Measures/Systematic changes put into place to ensure that the alleged deficient practice will not recur: The MDS Coordinator will be educated by the Director of Nursing regarding Comprehensive Assessments & Timing to ensure that comprehensive assessments are completed not less than once every 12 months. Performance will be monitored to make sure that the solutions are sustained: The Director of Nursing and the Administrator are responsible for monitoring compliance. The comprehensive assessment audit coinciding with the MDS calendar. will be completed weekly x 4 weeks, then 5 residents per month for 3 months until 100% compliance is fulfilled. All negative findings from the audit will be reported to the Quality Assurance and Performance Improvement Committee for review, analysis and recommendation(s) for change in facility policy, procedure and/or practice.	