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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 on 11/25/2024 through 11/27/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # XCHS11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 11/25/2024 through 11/27/2024. Event ID# XCH11.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		12/22/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Electronically Signed — 12/17/2024

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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(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and interviews with staff and resident representative, the facility failed to provide personal privacy when a resident's door to the room was left open during incontinent care allowing the resident to be visible from the hallway for 1 of 2 residents (Resident #16) reviewed for privacy. A reasonable person has an expectation of privacy during care and would have experienced feelings such as embarrassment.

The findings included:

Resident #16 was admitted to the facility on 2/12/24 with diagnoses including dementia, anxiety disorder, glaucoma, and age-related physical debility.

Resident #16's Minimum Data Set (MDS) dated 11/2/24 indicated the resident had severe cognitive impairment, was always incontinent of bowel and bladder, and was totally dependent on staff for toilet hygiene.

Observation on 11/25/24 at 10:38 a.m. revealed Resident #16's room was close to the nurses' station at the beginning of the hallway.

F 583

The preparation or execution of this plan of correction does not constitute an admission or an agreement by Windsor Point of the truth of the facts alleged or conclusions set forth in this statement of deficiency. Although Windsor Point does not agree with some of the findings made by the surveyors, we have implemented this plan of correction to demonstrate our ongoing efforts to provide quality care for our residents. This plan of correction is prepared and executed solely because it is required by the Federal and State regulation. This plan of correction is submitted in order to respond to the allegation of noncompliance cited during the 11/25/2024-//27/2024 recertification survey.

Tag 0583-483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records (Long Term Care Facilities)

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A continuous observation on 11/27/24 from 5:01 a.m. through 5:06 a.m. revealed Resident #16's room door was open approximately 12 inches and Nursing Assistant (NA) #8 was in the room. Resident #16 resided in a room without a roommate. NA #8 was putting a brief onto the resident, who slept in the bed by the door, and the resident's legs and the brief were in view. If the brief was not being put on the resident, her private areas would have been in view. NA #8 had not pulled a privacy curtain. NA #9 walked down the hall, stopped by Resident #16's room, spoke to NA #8, then grabbed the trash bag outside of the room.

In an interview on 11/27/24 at 5:06 a.m., NA #8 said that she must have left the door open when she had to get the nurse to change the resident's dressing. She said she should have shut it for privacy when she finished providing care.

In an interview on 11/27/24 at 9:15 a.m., Resident #16's representative said she was a very private person who kept to herself.

In an interview on 11/27/24 at 11:12 a.m., the Director of Nursing (DON) said NA #8 should have closed the door and pulled the curtain to provide privacy during care.

F 583

NA #8 was immediately educated by the Administrator to pull the privacy curtain completely around the resident and close the door completely prior to providing personal care.

NA #9 was immediately educated by the Administrator to close the door completely to any room observed with the door open prior to speaking to any NA providing care.

The clinical staff will be educated by the Infection Preventionist/designee regarding Tag 0583-483.10(h)(1)-(3)(i)(ii) Personal Privacy regarding pulling the privacy curtain all the way around residents and closing the door while rendering personal care.

The Director of Nursing/designee will observe five residents three times per week for four weeks for the provision of privacy to include pulling the privacy curtain all the way around residents and closing the door for semi private rooms and closing the door for private rooms without privacy curtains while personal care is provided.

The results of the observations will be reported to the Quality Assurance Process Improvement Committee by the Director of Nursing for review and discussion. Audits of the observations will either

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F 583	Continued From page 3	F 583	continue randomly or the above established five residents three times per week for four weeks will continue for eight weeks.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Gradual Dose Reduction (Residents #16 and #13) and Restraints (Resident #8) for 3 of 12 residents reviewed. Findings included: 1. Resident #13 was admitted on 4/24/24 with diagnoses including dementia and major depressive disorder. A psychiatric Nurse Practitioner progress note dated 10/03/24 recorded Resident #13 was to continue taking quetiapine (an antipsychotic medication used to treat mental health conditions) 25 milligrams (mg) and apriprazole 2.5 mg. Her medications were reviewed for possible Gradual Dose Reduction (GDR- to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and it was noted a GDR was not recommended at that time. Review of Resident #13's October 2024	F 641	Tag 0641-483.20(g) Accuracy of Assessments (LONG TERM CARE FACILITIES) Resident #13, Resident #16, and Resident #8 did not experience any adverse reactions related to Tag 0641-483.20(g) Accuracy of Assessments. Resident #13 Minimum Data Set (MDS) dated 10/05/2024 was modified and resubmitted by the MDS Coordinator on 12/03/2024 to reflect the review date of the gradual dose reduction. Resident #16 Minimum Data Set (MDS) dated 11/02/2024 was modified and resubmitted by the MDS Coordinator on 12/03/2024 to reflect the review date of the gradual dose reduction. Resident #8 Minimum Data Set (MDS) dated 09/21/2024 was modified and resubmitted by the MDS Coordinator on 12/03/2024 to correct the coding of bedrails as a restraint as Resident #8	12/25/24

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F 641	Continued From page 4 Medication Administration Record revealed she had received quetiapine and aripiprazole daily. Resident #13's significant change MDS assessment dated 10/05/24 indicated she had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. The date when a GDR review was completed and not recommended was blank. In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said the information provided by the psychiatric Nurse Practitioner should have been used in the MDS and it was an error to not indicate a GDR review was done and to leave the date it was done blank. 2. Resident #16 was admitted on 2/12/24 with diagnoses including dementia and bipolar disorder. A psychiatric Nurse Practitioner progress note dated 10/22/24 recorded Resident #16 was to continue taking apriprazole (an antipsychotic medication used to treat mental health conditions) 5 milligrams (mg) in the morning and 2 mg at bedtime. Her medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and it was noted a GDR was not recommended at that time. Review of Resident #16's October 2024 Medication Administration Record revealed she had received aripiprazole twice daily.	F 641	does not need nor does he use a restraint. The Director of Nursing will audit the most recent comprehensive MDS assessments for all current 16 active residents to ensure MDS coding accuracy for gradual dose reductions and unnecessary restraints. Education will be provided to the MDS Nurse by the Interim MDS Nurse to include Tag 0641- 483.20(g) Accuracy of Assessments as it relates to the importance of coding the MDS accurately to include gradual dose reductions (GDR) and unnecessary restraints. An MDS audit tool will be developed by the Interim MDS Nurse to include a review of the 16 most recent comprehensive assessments to ascertain the accuracy of MDS coding gradual dose reductions and unnecessary restraints. The Director of Nursing will utilize the audit tool developed by the Interim MDS Nurse and will review 4 of the most recent comprehensive MDS assessments for coding accuracy related to gradual dose reductions (GDR) and unnecessary restraints weekly for four weeks and then monthly for three months. Ongoing reviews will be determined by the prior four months of reviews. The results of the MDS audits will be reviewed and presented by the Director of Nursing each at the Quality Assurance Performance	

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Resident #16's quarterly MDS assessment dated 11/02/24 indicated she had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. The date when a GDR review was completed and not recommended was blank.

In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said the information provided by the psychiatric Nurse Practitioner should have been used in the MDS and it was an error to not indicate a GDR review was done and to leave the date it was done blank.

3. Resident # 8 was admitted to the facility on 11/16/21 with diagnoses including depression and heart failure.

Resident #8's annual Minimum Data Set (MDS) dated 9/21/24 indicated he was cognitively intact, had no behaviors, and needed assistance with bed mobility and transfers. The MDS also documented that Resident #8 had bed rails used as a physical restraint daily during the observation period.

Review of Resident #8's physician's orders from 7/1/24-11/27/24 did not reveal an order for bed rails as a restraint.

Review of Resident #8's progress notes from 7/1/24-11/27/24 did not reveal notes that he had any behaviors or any indications of a need for a restraint. The notes did not document that a restraint was used.

In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said Resident #8 did not use bed rails as a restraint and the MDS was coded in error.

Provider's Plan of Correction (F 641): Improvement (QAPI) meeting.

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F 641	Continued From page 6 She said Resident #8 used his bed rails for mobility and assistance for bed mobility and transfers. In an interview on 11/27/24 at 8:50 AM, the Director of Nurses (DON) said Resident #8 did not use his bed rails as a restraint and the MDS was coded incorrectly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		12/25/24

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F 656	Continued From page 7 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive care plans for the care areas of use of anticoagulant medication {medications that prevent or treat blood clots in the heart and blood vessels} (Resident #22), the use of antipsychotic medications {a class of drugs used to treat symptoms of psychosis, such as hallucinations, delusions, and disordered thinking} (Resident #14), and for the care area of respiratory care (Resident #5) for 3 of 14 residents whose comprehensive care plan were reviewed. Findings included: 1. Resident #22 was admitted to the facility on 5/10/24. Her diagnoses included heart failure (a condition where the heart is unable to pump enough oxygen-rich blood to the body) atrial fibrillation (a heart condition that causes an	F 656	Tag 0656-483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan (LONG TERM CARE FACILITIES) Resident #22's care plan dated 9/9/2024 and revised on 9/24/2024 was revised again on 11/26/2024 to include a focus for anticoagulant use along with the goal and interventions. Resident #14's care plan last reviewed on 9/25/2024 was revised on 11/26/2024 to include a focus for an antipsychotic medication as ordered for dementia and agitation with an established goal and interventions. Resident #5's care plan was revised and updated on 11/27/2024 to include oxygen therapy as needed for shortness of	

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irregular and often fast heartbeat), and deep vein thrombosis or DVT (a condition that occurs when a blood clot forms in a vein deep within the body, usually in the lower extremities).

Resident #22's quarterly Minimum Data Set (MDS) assessment dated 8/23/2024 revealed she was cognitively intact and was coded for anticoagulant use (a substance or medication that prevents or treats blood clots in the heart and blood vessels).

Review of Resident #22's medication administration record (MAR) dated August 2024 revealed she was receiving an anticoagulant medication.

Review of Resident #22's care plan dated 9/9/24 and revised on 9/24/24 revealed she did not have a care plan for anticoagulants.

An interview was conducted on 11/27/24 at 12:25 PM with MDS Nurse #1. She stated she was an interim MDS nurse and was responsible for care plans. She stated this resident should have been care planned for anticoagulants. She was unable to offer a reason why Resident #22 did not have a care plan for anticoagulants.

An interview was conducted on 11/27/24 at 12:33 PM with the Director of Nursing (DON). She stated she expected Resident #22 would have an anticoagulant care plan.

2. Resident #14 was admitted to the facility on 11/24/2023 with diagnoses including dementia.

Physician orders dated 9/3/2024 included

F 656

breath, hypoxia, and comfort at 2 liters per minute (Lpm) by nasal canula to maintain oxygen saturation levels above 90% with interventions along with a goal for oxygen use.

100% of all care plans have been audited by the care plan team on 12/18/2024. The care plans of residents who receive anticoagulants, antipsychotics and oxygen have been reviewed and are in place to indicate anticoagulants, antipsychotic therapy and oxygen use.

A MDS Nurse has been hired and was educated by the Administrator on ensuring care plans are developed and are in place for anticoagulants, antipsychotic therapy and oxygen use. The MDS Coordinator will review the daily order report and identify any new orders for anticoagulants, antipsychotics and oxygen. A care Plan will be developed and put in place to indicate the use of antipsychotics, oxygen therapy and anticoagulants.

The Director of Nursing/designee will conduct an audit of 12 care plans per week to ensure compliance with adding anticoagulants, antpsychotics, antianxiety and oxygen to the care plans of any identified resident. These audits will be conducted weekly for eight weeks then monthly for four months. Audit results will be reviewed and discussed in the Quality Assurance Performance Improvement Committee meeting to review and make revisions as warranted on the basis of compliance.

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Quetiapine Fumarate (an antipsychotic medication) half of a 25 milligram tablet twice a day for dementia with agitation.

The quarterly Minimal Data Set (MDS) assessment dated 9/08/2024 indicated Resident #14 was severely cognitively impaired and was receiving antipsychotics on a routine basis.

Resident #14's care plan last reviewed 9/25/2024 did not include a focus for the use of antipsychotic medications.

A review of Resident #14's Medication Administration Record from 9/3/2024 to 11/26/2024 recorded Resident #14 received Quetiapine Fumarate half of a 25 milligram tablet twice a day.

In a phone interview with the MDS Nurse #1 on 11/27/2024 at 12:14 pm, she explained she worked part-time on weekends and she had been working as the MDS nurse since the last full time MDS Nurse left the facility in September 2024. She stated as the MDS Nurse, she was responsible for developing the initial care plan and updating residents' care plan quarterly. She stated Resident #14's Quetiapine Fumarate medication was an antipsychotic and Resident #14 was scheduled to receive daily. She stated Resident #14's care plan should have included the use of antipsychotics. She explained with her only working weekends, she had been trying to keep care plans up-to-date and did not know why Resident #14's care plan did not include a focus for the use of antipsychotics.

In an interview with the Director of Nursing on 11/27/2024 at 11:17 am, she stated residents'

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care plans were updated quarterly by the MDS nurse. She explained Resident #14 was receiving Quetiapine Fumarate, an antipsychotic, and should have been care planned for the use of antipsychotics.

In an interview with the Administrator on 11/27/2024 at 3:28 pm, she explained the MDS Nurse, who worked part-time, had access to Resident #14's electronic medical records to gather information to care plan for the use of antipsychotic medications when ordered. She stated Resident #14 should have been care planned for the use of antipsychotics.

3. Resident #5 was admitted to the facility on 7/18/23 with diagnoses including dementia and respiratory failure.

Resident #5's physician's orders revealed an order dated 9/4/24 for oxygen supplementation as needed for shortness of breath, hypoxia, and comfort at 2 liters per minute (Lpm) by nasal canula as needed to maintain oxygen saturation levels above 90%.

Resident #5's Minimum Data Set (MDS) dated 10/25/24 indicated the resident had severe cognitive impairment, had shortness of breath or trouble breathing with exertion, while sitting at rest, and while lying flat. The MDS indicated she used oxygen therapy and received hospice services.

Resident #5's care plan last reviewed 10/22/2024 did not include a focus for the use of oxygen.

Observation on 11/25/24 at 10:06 a.m. revealed

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WINDSOR POINT CONTINUING CARE	1221 BROAD STREET FUQUAY VARINA, NC 27526

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 Resident #5 asleep in low bed. She had a nasal cannula on and oxygen was running from her concentrator at 2 Lpm. Observation on 11/26/24 at 11:40 a.m. revealed Resident #5 in bed. She had removed her nasal cannula, but the oxygen concentrator was running at 2 Lpm. In a phone interview with the MDS Nurse #1 on 11/27/2024 at 12:14 pm, she explained she worked part-time on weekends and she had been working as the MDS nurse since the last full time MDS Nurse left the facility in September 2024. She stated as the MDS Nurse, she was responsible for developing the initial care plan and updating residents' care plan quarterly. She stated if Resident #8 was using oxygen, there should be a focused care plan for the use and care of her oxygen. In an interview with the Director of Nursing on 11/27/2024 at 11:50 am, she stated Resident #8 should have had a care plan for the use of oxygen. In an interview with the Administrator on 11/27/2024 at 3:10 pm, she said Resident #8 had a care plan for the use of oxygen and provided a copy of the hospice agency's care plan for pulmonary/dyspnea (shortness of breath), which included instructing the patient and patient caregiver in safe oxygen use. The care plan provided did not include interventions and goals for oxygen usage.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		12/22/24

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F 695	Continued From page 12 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record review, the facility failed to ensure an oxygen filter was clean of dust and debris for 1 of 2 residents (Resident #5) reviewed for oxygen use. The findings included: Resident #5 was admitted to the facility on 7/18/23 with diagnoses including dementia and respiratory failure. Resident #5's physician's orders revealed an order dated 9/4/24 for oxygen supplementation as needed for shortness of breath, hypoxia, and comfort at 2 liters per minute (Lpm) by nasal canula as needed to maintain oxygen saturation levels above 90%. Resident #5's Minimum Data Set (MDS) dated 10/25/24 indicated the resident had severe cognitive impairment, had shortness of breath or trouble breathing with exertion, while sitting at rest, and while lying flat. The MDS indicated she used oxygen therapy. Observation on 11/25/24 at 10:06 a.m. revealed Resident #5 asleep in low bed. She had a nasal	F 695	Tag 0695-483.25(i) Respiratory/Tracheostomy Care and Suctioning (LONG TERM CARE FACILITIES) Resident #5's oxygen filter in the oxygen concentrator was cleaned on 11/27/2024 by the Charge Nurse. Resident #5 received a new concentrator on 11/27/2024 that has to be serviced by an established vendor. The filter was checked and was clean. The Administrator will contact the oxygen supplier in order to establish a schedule to clean the oxygen filters and to provide a sticker/tag system attached to the oxygen concentrator in order to track the servicing/changing/and cleaning of the oxygen filters. On 11/27/2024 the Director of Nursing identified and documented all residents utilizing oxygen concentrators in order to examine the filters for cleanliness. All of the filters were free of dust.	

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F 695	Continued From page 13 cannula on and oxygen was running from her concentrator at 2 Lpm. The external air filter had a buildup of dust-like gray and white particles. Observation on 11/26/24 at 11:40 a.m. revealed Resident #5 in bed. She had removed her nasal cannula, but the oxygen concentrator was running at 2 Lpm. The external air filter had a build-up of dust-like gray and white particles. In an interview on 11/26/24 at 11:42 a.m., Nurse #10 said that the night shift nurse was normally supposed to change and clean the oxygen filters. When Nurse #10 saw the filter, she said it was "extremely dirty" and took the filter off to clean it. In an interview on 11/27/24 at 5:15 a.m., the nurse on the night shift, Nurse #11 said she never thought about checking and cleaning the filter when she changed the oxygen tubing. In an interview on 11/27/24 at 11:12 a.m., the Director of Nursing (DON) said the nurses should be monitoring and cleaning the oxygen concentrator filters when they were dirty.	F 695	The Infection Preventionist/designee will educate all nurses regarding the need to check filters for cleanliness weekly. The cleanliness required for oxygen filters will be added to the orientation syllabus for all newly hired nurses. The Director of Nursing/designee will audit all residents requiring oxygen three times per week for four weeks utilizing an oxygen audit worksheet to ensure that the oxygen filters are cleaned. The Quality Assurance Performance Improvement (QAPI) will review the results of the oxygen filter audits for an identification of trends and action taken to ascertain the need for continued audits for ongoing compliance.	
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a	F 728		12/25/24

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F 728	Continued From page 14 competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure 2 of 5 staff reviewed who were assigned nurse aide tasks met the minimum qualifications for working as a nurse aide when Staff #1 and Staff #2 were performing nurse aide tasks without having completed a training and competency evaluation program, or a competency evaluation program approved by the State and were not in a state approved training and competency evaluation program.	F 728	Tag 0728-483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide (LONG TERM CARE FACILITIES) Staff #1 is no longer assigned nurse aide tasks. Staff #2 is no longer assigned nurse aide tasks. 100% of all Certified Nursing Assistants	

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F 728	Continued From page 15 The findings included: The North Carolina (NC) Department of Health and Human Services (DHHS) Health Care Personnel Education and Credentialing Section's website indicated under the section of Nurse Aide I, last updated 1/24/24, that in accordance with federal law, a facility may employ a nurse aide (NA) for a period of up to 4 months under the following conditions: -"During the 4-month grace period, an individual must be deemed competent to provide nursing or nursing-related services by a Registered Nurse and work toward meeting the training and testing requirements by participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program." The website clarified that the individual must be "actively participating" in a state-approved Nurse Aide I training and competency evaluation program during the 4-month grace period. It further indicated the NC Nurse Aide I Registry was a registry of all people who met the state and federal training and testing requirements to perform Nurse Aide I tasks. a. Review of the facility records revealed Staff #1 was hired on 10/23/24. Review of Staff #1's human resource file revealed there was no evidence she had completed a state approved NA training and competency evaluation program, or a competency evaluation program approved by the State. Review of the nursing schedule dated 11/25/24	F 728	currently working at Windsor Point were reviewed on 12/19/2024 to determine their certification status and their expiration date via the NC Nurse Aide Registry by the Director of Nursing/designee. The Director of Nursing will review all new hires for the next 90 days to ensure all nursing assistants are either certified or that the individual has enrolled in a Nurse Aide Training Competency Evaluation Program by retrieving the listing from the CNA registry or by requesting paperwork supporting enrollment in a NATCEP. The Director of Nursing was educated regarding the hiring procedures for nursing assistants to include verification of enrollment in a NATCEP or up to date listing on the NC Nurse Aide 1 Registry by the Administrator. The Director of Nursing will report the results of the Registry review to the Quality Assurance Performance Improvement committee to address any trends or patterns associated with applicant for nursing assistant positions who are not certified and simultaneously enrolled in a (NATCEP)Nurse Aide Training Competency Evaluation program in North Carolina or who are not listed on the registry. The results from the Director of Nursing report will be discussed and reviewed in the Quality Assurance Performance Improvement committee meeting and will become a part of the Quarterly QA	

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F 728	Continued From page 16 through 11/29/24 revealed Staff #1 was scheduled to work 8-hour shifts and was assigned NA tasks on 11/25/24, 11/26/24, 11/27/24, and 11/28/24. During an interview on 11/26/24 at 2:19 PM Staff #1 stated she moved to the United States (US) from another country. She further stated while in that other country, she worked as a certified NA. She stated she planned to apply to take the CNA certification test here as a challenge, as North Carolina (NC) did not recognize her certification from her country of origin. She verified she had not completed a state-approved nurse aide training and competency evaluation program or competency evaluation program and that she was not participating in a state approved training and competency evaluation program. b. Review of the facility records revealed Staff #2 was hired on 9/16/24. Review of Staff #2's human resource file revealed there was no evidence she had completed a state approved NA training and competency evaluation program, or a competency evaluation program approved by the State. Review of the nursing schedule dated 11/25/24 through 11/29/24 revealed Staff #2 was scheduled to work 8-hour shifts and was assigned NA tasks on 11/25/24, 11/26/24, 11/27/24, and 11/28/24. During an interview on 11/26/24 at 3:25 PM with Staff #2 he stated he moved to the US from another country. He stated he worked in a hospital in his country of origin as a caregiver, providing direct patient care. He further stated he	F 728	program to ensure that all certified NAs or all NAs enrolled in a NATCEP are providing nurse aide tasks.	

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F 728	Continued From page 17	F 728		

is registered to begin a CNA certification program in December 2024. He verified he had not completed a state-approved nurse aide training and competency evaluation program or competency evaluation program and that he was not participating in a state approved training and competency evaluation program.

An initial interview was conducted on 11/26/24 at 12:03 PM with the Business Administrator, who was also in charge of Human Resources. She stated she thought nurse aides could work if they were in competency skills training at the facility. In a subsequent interview on 11/26/24 at 3:33 PM she explained her role in the hiring process. This included checking the nurse aide registry for certification and placing the information in a folder. The Director of Nursing (DON) retrieves the folder and was responsible for following up on certification status.

An interview was conducted with the Director of Nursing (DON) on 11/26/24 at 3:44 PM. She indicated if a potential NA hire did not have a CNA certification, she talked to them about enrolling in CNA "school". She stated she was aware Staff #1 and Staff #2 were not certified as CNAs, however she was aware Staff #1 planned to take a "challenge exam" and Staff #2 was registered to begin a CNA certification program in December 2024.

During an interview on 11/27/24 at 12:43 PM with the Administrator she stated if an NA did not have certification, the facility informed them they needed to register for a class within the 4-month period from date of hire. She further stated if they did not complete the class or get their certification within 4 months the employee was let go. She

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F 728	Continued From page 18 indicated she was unaware the regulation required an NA who had not completed a state-approved training and competency evaluation program and/or competency evaluation program to be actively participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program.	F 728		