STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345090	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER MANOR AT PROVIDENCE PLACE	1795 WESTCHESTER DRIVE , HIGH POINT, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/21/25 through 7/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D0EA4-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/21/25 through 7/24/25. Event ID#1DOEA4-H1. The following intakes were investigated: NC703704 and NC2561100. 2 of 2 complaint allegations did not result in deficiency.	F0000		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to place a resident's call light within reach to allow for the resident to request staff assistance. This was for 1 of 3 residents reviewed for accommodation of needs (Resident #47). The findings included: Resident #47 was admitted to the facility on 06/04/25 with diagnoses that included repeated falls, type 2 diabetes mellitus, and dementia. Resident #47's significant change Minimum Data Set (MDS) assessment dated 07/14/25 indicated her cognition was severely impaired and she had no behaviors or rejection of care. She required moderate assistance of	F0558		

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 reverse for further 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.

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

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F0558 SS = D	Continued from page 1 one person for toileting hygiene, dressing, personal hygiene, transfers, and bed mobility. Resident #47 had no range of motion impairments, was frequently incontinent with bladder, and occasionally incontinent with bowel. Resident #47's active care plan indicated she was at risk for falls related to impaired cognition, impaired vision, impaired mobility, and incontinent episodes. The interventions included for staff to provide Resident #47 with reminders to use call bell when needing assistance as many times as needed and to keep call bell within reach and to answer it timely. An interview and observation were conducted with Resident #47 on 07/21/25 at 10:01 AM. A saturated brief was observed on the floor on the right side of the bed. Resident #47 stated the brief was wet and making her itch, so she took it off and threw it on the floor. The surveyor could see sheets were not wet when Resident #47 moved the sheet exposing her perineal area to show she did not have a brief on. Her perineal area was not red, and skin was intact. Resident #47 then stated she did not know where her call bell was so that she could call for assistance. A pad style call bed was observed at the head of the bed lying over the mattress with the call bell pad hanging off the mattress towards the floor. Resident #47 asked this surveyor to please hand her the call bell so she could call for assistance. The call bell was given to Resident #47, and she pressed the pad to put the call light on. This surveyor went into the hall outside of the residents' room to wait for staff. An interview and observation were conducted on 07/21/25 at 10:11 AM with Nursing Assistant (NA) # 1. She verified she was assigned to Resident #47 during the first shift on 07/21/25. NA #1 was made aware Resident #47 had thrown her saturated brief onto the floor prior to her entering her room. During the observation NA #1 entered Resident #47's room and closed the door. An interview and observation were conducted on 07/21/25 at 10:15 AM with NA #1. She verified she was assigned to Resident #47 during the first shift on 07/21/25. NA #1 stated she last checked Resident #47 after breakfast around 9:30 AM and she was dry. She stated Resident #47 would use her call light to call for assistance and she had not done that. This surveyor explained that she could not reach her call bell because it was out of reach. She stated "Oh, I thought I put it where she could reach it". During an observation on 07/21/25 at 10:29 AM Resident	F0558		

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F0558 SS = D	Continued from page 2 #47's call light was observed on, and NA #2 was observed entering Resident #47's room and closing the door. An interview was conducted on 07/21/25 at 10:36 AM with NA #2. NA #2 indicated she had worked with Resident #47 at times and that Resident #47 did utilize her call bell to request assistance. She stated she had just provided Resident #47 incontinence care and put Resident #47's call bell within reach. A follow up interview was conducted on 07/23/25 at 1:32 PM with NA #1. NA #1 explained that she fed Resident #47 her breakfast on the morning of 07/21/25. However, she did not look to see where her call bell was located prior to exiting the room, she did not think about doing so. NA #1 also stated Resident #47 did utilize her call bell to request assistance. An interview was conducted on 07/21/25 at 10:40 AM with Nurse #1. She verified she was the nurse for Resident #47 on 07/21/25 and that she normally worked on the 400 hall. She stated Resident #47 did utilize her call light when she needed assistance. An interview was conducted on 07/24/25 at 1:23 PM with the Director of Nursing. She stated her expectation was for staff to ensure the call light was within the residents' reach prior to exiting the room.	F0558		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641		

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F0641 SS = D	Continued from page 3 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) Level II status for 2 of 24 residents (Resident #3 and Resident #11) whose MDS assessments were reviewed. The findings included: 1. Resident #3 was admitted to the facility on 5/2/23 with cumulative diagnoses which included major depressive disorder. A PASRR Level II Determination Notification letter dated 4/28/23 for Resident #3 was reviewed. This letter noted Resident #3 had a PASRR number ending with the letter “B,” which was indicative of a PASRR Level II determination with no expiration date. The results of the evaluation, including the determination of a PASRR Level II status, are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Resident #3’s annual Minimum Data Set (MDS) assessment dated 10/8/24 was reviewed. The “Identification Information” section of the MDS reported the resident was not considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. Resident #3’s most recent comprehensive MDS was an annual assessment dated 6/6/25. The “Identification Information” section of this MDS also reported Resident	F0641		

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F0641 SS = D	Continued from page 4 #3 was not determined to have a PASRR Level II status. An interview was conducted on 7/24/25 at 10:43 AM with MDS Nurse #1 related to the PASRR determination reported on Resident #3's annual MDS assessments dated 10/8/24 and 6/6/25. Upon review of these two annual MDS assessments, MDS Nurse #1 confirmed the assessments indicated Resident #3 did not have a PASRR Level II status. When asked whether the MDS assessments correctly reported the resident's PASRR status, the MDS Nurse stated the facility did not report residents with PASRR authorization codes of "H" or "B" as having a PASRR Level II status based on previous practices. She was not aware these authorization codes should be reported as a PASRR Level II on an MDS assessment. On 7/24/25 at 3:55 PM, an interview was conducted with the facility's Administrator in the presence of the Director of Clinical Services and Campus Executive Director. At that time, the Administrator reported she had been made aware of the issues related to the incorrect reporting of PASRR Level II on residents' MDS assessments and had no questions. 2. Resident #11 was admitted to the facility on 10/8/24 with cumulative diagnoses which included bipolar disorder, major depressive disorder, post-traumatic stress disorder and dementia. A PASRR Level II Determination Notification letter dated 12/10/24 for Resident #11 was reviewed. This letter noted Resident # 11 had a PASRR number that ended with the letter "H," which was indicative of a PASRR Level II determination with no expiration date and required no additional screening. Resident #11's annual Minimum Data Set (MDS) assessment dated 5/19/25 was reviewed. The "Identification Information" section of the MDS reported the resident was not considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview was conducted on 7/24/25 at 10:43 AM with MDS Nurse #1 related to the PASRR determination reported on Resident #11's annual MDS assessment dated 5/19/25. Upon review of the annual MDS assessment, MDS Nurse #1 confirmed the assessment indicated Resident #11 did not have a PASRR Level II status. When asked whether the MDS assessment correctly reported the resident's PASRR status, the MDS Nurse stated the facility did not report residents with PASRR authorization codes of "H" or "B" as having a PASRR	F0641		

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F0641 SS = D	Continued from page 5 Level II status based on previous practices. She was not aware these authorization codes should be reported as a PASRR Level II on an MDS assessment. On 7/24/25 at 3:55 PM, an interview was conducted with the facility's Administrator in the presence of the Director of Clinical Services and Campus Executive Director. At that time, the Administrator reported she had been made aware of the issues related to the incorrect reporting of PASRR Level II on residents' MDS assessments and had no questions.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) Level II status for 2 of 24 residents (Resident #3 and Resident #11) whose MDS assessments were reviewed. The findings included: A PASRR Level II Determination Notification letter issued for Resident #25 (dated 9/9/24) was reviewed. The letter noted Resident #25 had a PASRR number ending with the letter "F," which was indicative of a PASRR Level II determination. The letter reported that Nursing Facility placement was appropriate for a 90 day	F0644		

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F0644 SS = D	Continued from page 6 period with the provision of specialized services, which included follow-up psychiatric services and rehabilitative services. The letter also indicated if the resident's placement was expected to extend beyond the end date (90 days), further approval and screening was required. The results of the evaluation, including the determination of a PASRR Level II status, are used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. Resident #25 was admitted to the facility on 11/1/24 from another skilled nursing facility. Her cumulative diagnoses included recurrent major depressive disorder, generalized anxiety disorder, and vascular dementia. The resident's most recent comprehensive Minimum Data Set (MDS) was an admission assessment dated 11/8/24. The "Identification Information" section of the MDS assessment indicated Resident #25 was determined to have a PASRR Level II status due to serious mental illness. Resident #25's electronic medical record (EMR) included a Halted PASRR Level II Determination Notification letter dated 12/4/24. The 12/4/24 letter revealed Resident #25 was determined to have a PASRR number ending with the letter "H" with no restrictions and no end date (due to the resident having a primary diagnosis of dementia). This Determination Notification letter included a notation that read, in part, "No further Level I screening is required unless a significant change occurs with the individual's mental status which suggests a psychiatric disorder that is not dementia." The resident's current care plan dated "5/6/25 – Present" was reviewed. This review revealed the "Problems" addressed in the care plan did not include an area of focus related to Resident #25's Halted PASRR Level II determination or include guidance for future care decisions related to her PASRR status. An interview was conducted on 7/24/25 at 12:00 PM with MDS Nurse #1 related to Resident #25's PASRR determination and care plan. When asked, the nurse stated that Resident #25's current care plan likely did not include her Halted PASRR Level II status due to her PASRR authorization code changing from an "F" to an "H." MDS Nurse #1 further explained that the facility did not report residents with PASRR authorization codes of "H" or "B" as having a PASRR Level II status on an MDS assessment (based on the facility's previous practices). Therefore, the facility may not have	F0644		

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F0644 SS = D	Continued from page 7 incorporated a PASRR Level II finding coded with an “H” into Resident #25’s care plan Upon request, an interview was conducted on 7/24/25 at 1:37 PM with the Director of Clinical Services. During the interview, the Director reported Resident #25 was currently care-planned for the medications she received, followed by a psychiatric service, and noted as having no behaviors. She provided a copy of Resident #25’s previous care plan and noted the resident’s PASRR Level II had initially been included on the old care plan (documented as last reviewed on 5/25/25). However, the Halted PASRR Level II determination was no longer included in Resident #25’s current care plan after her PASRR authorization code was changed to an “H.” On 7/24/25 at 3:55 PM, an interview was conducted with the facility’s Administrator in the presence of the Director of Clinical Services and Campus Executive Director. At that time, the Administrator reported she had been made aware of the issues related to both the reporting of residents’ PASRR Level II status on the MDS assessments and the failure to incorporate PASRR findings into a resident’s care plan. She had no further questions.	F0644		
F0809 SS = E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is NOT MET as evidenced by:	F0809		

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F0809 SS = E	Continued from page 8 Based on staff and Registered Dietitian (RD) interviews and record review, the facility failed to have no greater than a 14 hour lapse between the provision of a substantial evening meal and breakfast the following day for residents served their meals on 6 of 6 halls (400 Hall, 500 Hall, 600 Hall, 300 Hall, 200 Hall and 100 Hall). The findings included: A schedule of the Meal Service Times (Starting January 1, 2025) was provided upon entry to the facility. A review of this schedule indicated the delivery times for each hallway allowed 14 hours and 30 minutes to elapse between the last meal of the day and first meal of the following day as follows: --The 400 Hall meals were scheduled to be delivered at 5:15 PM for dinner and at 7:45 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). --The 500 Hall meals were scheduled to be delivered at 5:30 PM for dinner and at 8:00 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). --The 600 Hall meals were scheduled to be delivered at 5:45 PM for dinner and at 8:15 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). --The 300 Hall meals were scheduled to be delivered at 6:00 PM for dinner and at 8:30 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). --The 200 Hall meals were scheduled to be delivered at 6:15 PM for dinner and at 8:45 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). --The 100 Hall meals were scheduled to be delivered at 6:30 PM for dinner and at 9:00 AM for breakfast (indicative of a 14-hour and 30-minute time span between the two meals). An interview was conducted with the facility's Dining Services Director and Chef Manager on 7/24/25 at 10:28 AM. During the interview, concerns were shared regarding the meal delivery schedule allowing a lapse of greater than 14 hours between dinner and the breakfast meal the following day. The Dining Services	F0809		

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F0809 SS = E	Continued from page 9 Director and Chef Manager confirmed the meal schedule was changed within the last several months and reported that prior to the change, the scheduled mealtimes between dinner and the next day's breakfast were within the 14-hour requirement. The Chef Manager stated, "It'll be easy to change back." When asked, the Dining Services Director reported that bedtime snacks were available on the halls upon resident request. However, these snacks primarily included packaged items such as crackers, cookies, and chips. Bedtime snacks were not necessarily served or provided to all residents. An interview was conducted on 7/24/25 at 1:59 PM with the facility's Registered Dietitian (RD) to discuss concerns regarding the timing of the meal delivery schedule. During the interview, the RD stated he wasn't aware the facility failed to meet a requirement by scheduling a lapse of greater than 14 hours between the dinner meal and breakfast the following day. On 7/24/25 at 3:55 PM, an interview was conducted with the facility's Administrator in the presence of the Director of Clinical Services and Campus Executive Director. At that time, the Administrator confirmed they had been made aware there was a lapse of more than 14 hours between the meal service provided for dinner and breakfast the following day and were working to change the meal schedule.	F0809		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F0812		

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F0812 SS = E	Continued from page 10 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews with the facility staff, the facility failed to: 1) Label, date, and seal opened food items stored in the Dietary Department's walk-in freezer; 2) Dispose of expired food items stored in the reach-in refrigerator; and 3) Cover facial hair for 2 of 2 Dietary staff observed with facial hair and working with food preparation in the kitchen (Dining Services Director and Cook #1. These practices had the potential to affect food being served to residents. The findings included: 1) Accompanied by the Dining Services Director, an initial tour was conducted of the Dietary Department on 7/21/25 at 9:29 AM. Observations made at the time of the initial tour identified the following concerns in the walk-in freezer: --An opened cardboard box dated 5/6/25 was observed to contain an opened plastic bag containing 5 salmon patties. The plastic bag was not dated as to when it had been opened and was not sealed, leaving the salmon patties open to air. --An opened cardboard box dated 7/16/25 was observed to contain approximately 25 chicken tenders stored in an unsealed plastic bag. Underneath this plastic bag was another opened, unsealed plastic bag containing 2 or 3 hamburger patties. The hamburger patties were observed to have ice crystals on them, making it difficult to determine exactly how many patties were stored in the bag. Neither the plastic bag containing the chicken tenders nor the bag containing the hamburger patties were dated as to when they had been opened. The Dining Services Director was observed to discard the salmon patties, chicken tenders, and hamburger patties when these concerns were identified during the initial tour conducted on 7/21/25 at 9:29 AM. On 7/21/25 at 9:50 AM, an interview was conducted with the facility's Dining Services Director. During the interview, the Director was asked what education was provided to his staff with regards to the storage of open food products. He reported the facility's policy was to label and date food products when received, when	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345090	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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

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F0812 SS = E	Continued from page 11 "pulled" (referring to when the box was removed from the refrigerator or freezer), and when opened. He stated that the containers of all opened food products should be sealed for storage. 2) Observations made during the initial tour of the Dietary Department conducted on 7/21/25 at 9:29 AM identified the following food items were expired in the reach-in refrigerator: --A one-quart container of pork gravy was labeled with two dates. One date indicated the gravy was made on 7/17/25 while the second date reported the gravy had an expiration date of 7/20/25. --A plastic container containing approximately 16 ounces of coleslaw was labeled with two dates. One date indicated the coleslaw was made on 7/17/25 while the second date reported it had an expiration date of 7/20/25. During the initial tour conducted on 7/21/25 at 9:29 AM, the Dining Services Director was observed as he pulled the pork gravy and coleslaw containers from the refrigerator and reported they would be discarded. On 7/21/25 at 9:50 AM, an interview was conducted with the facility's Dining Services Director. When asked, the Director stated that education needed to be provided to the staff related to the facility's policy for labeling, dating, and discarding expired food items. 3) Upon entry to the Dietary Department on 7/21/25 at 9:29 AM for an initial tour, the facility's Dining Services Director and Cook #1 were observed to have facial hair without wearing a beard restraint while working with food in the kitchen. The Dining Services Director was observed at that time to be working at the stove top dishing up eggs for a meal tray while Cook #1 was working on food preparation. On 7/23/25 at 10:38 AM, the Dining Services Director was observed to be working in the Dietary Department as he approached the dishwashing area. At that time, the Dining Services Director was wearing a beard restraint positioned below his mouth. The beard restraint covered his beard but did not cover his mustache. An interview was conducted with the Dining Services Director on 7/23/25 at 11:40 AM. During the interview, the observations conducted on 7/21/25 and 7/23/25 when a beard restraint was not used or was not properly positioned to cover facial hair were discussed. The	F0812		

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F0812 SS = E	Continued from page 12 Dining Services Director acknowledged the staff (including himself) knew what needed to be done but needed to consistently implement the required measures for covering facial hair. An interview was conducted on 7/24/25 at 1:59 PM with the facility's Registered Dietitian (RD). When asked, the RD reported he would agree that facial hair needed to be covered in the kitchen and stated, "That's pretty standard."	F0812		