PRINTED: 11/02/2011 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: 5 2011 A BUILDING AND PLAN OF CORRECTION B. WING 10/20/2011 345500 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1221 BROAD STREET WINDSOR POINT CONTINUING CARE FUQUAY VARINA, NC 27526 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this 483.15(a) DIGNITY AND RESPECT OF F 241 Plan of Correction to the extent that the INDIVIDUALITY summary of findings is factually correct and SS=G in order to maintain compliance with the The facility must promote care for residents in a applicable release provisions of residents. manner and in an environment that maintains or The Plan of Correction is submitted as a enhances each resident's dignity and respect in written allegation of compliance. Windsdr full recognition of his or her individuality. Point's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of This REQUIREMENT is not met as evidenced Deficiencies, nor does it constitute an admission that any deficiency is accurate. by: Based on observations, staff interviews and Further, Windsor Point reserves the right to record review, the facility failed to maintain the submit documentation to refute any of the dignity of 1 of 3 sampled residents whose stated deficiencies on the Statement of personal hygiene was observed. Findings Deficiencies through informal dispute include: resolution, formal appeal process, and/or, any other administrative or legal proceeding. 1. Resident # 18 was admitted on 07/20/10 with cumulative diagnoses of debility, depression, blindness, anxiety, and dementia. Resident # 18's care plan, dated 03/25/11, F 241 identified an inability to perform activities of daily living independently related to cognitive loss. The Windsor Point will ensure the services goal to have her needs met and to keep Resident provided or arranged by the facility will meet # 18 clean, neat and well groomed daily would be professional standards of quality. achieved by routine nail care, morning and evening care and routine oral care. The i. Corrective action will be accomplished approaches included to anticipate the resident's for Resident #18 found to have been needs for activity of daily living assistance. affected by the deficient practice as follows: The Annual Minimum Data Set (MDS), dated 1. On 10/18/11 the Director of Nursing 07/20/11, indicated Resident # 18 was severely asked NA #2 to complete proper personal cognitively impaired. She was identified as totally hygiene care. Director of Nursing dependent on staff for toilet use and personal monitored care until resident #18 had hygiene. Rejection of care was not exhibited received proper nail and oral care. during the assessment period. Resident #18 was coded as always incontinent of bowel and

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

bladder.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: L3Q411

Facility ID: 956929

TITLE

ADMINISTRATOR

If continuation sheet Page 1 of 46

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		0.5500	B. WIN		,	C	1
		345500		_		10/20	/2011
	OVIDER OR SUPPLIER POINT CONTINUING CA	ARE		1:	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
			1	<u> </u>	PROVIDER'S PLAN OF CORRI	ECTION	~
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	An observation was a medication pass at 3: #3 entered Resident stated the resident hagain. Black matter resident's right hand. giving the resident has supplement. As the medication which was commented she had #3 continued to place and encouraged her supplement. Once s medication and the sroom. Nurse #3 did offering the supplement pass. The nurse the reported to the Nursi Resident #18 had "b The NA commented not down south, wen stayed approximately down the hall to anothe door. Resident # nurse stated the NA resident he was assi care of Resident # 15 medication pass. Resident # 16 medication pass. Resident was pM of Nursing Assis	nade of Nurse # 3 during 45 PM on 10/18/11. Nurse # 18's room. The nurse ad been playing in her brief was noted on 4 fingers of the Nurse # 3 was observed by medications and a liquid		241	II. Corrective action will b	pe accomplished ential to be lent practice as sheld on 11/4/1 espect" of sput into place so I not recur will be checks will be lenger Nail Care" enture/Mouth ling these pred through the A monitoring too soure the followled or Finger Nail Carenture/Mouth and audited as obliance is reached.	o e: e"
	cleaned the resident back. The folded sha resident was on the on the left side of the	s perineum from front to eet used in moving the ped. Brown stains were seen turn sheet and pencil eraser are seen on the right side of			b. All findings will be rep V. December 5, 2011	orted to QA.	12/5/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345500	B. WIN	G		10/20/2011
	ROVIDER OR SUPPLIER	ARE		122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET	
				FU	QUAY VARINA, NC 27526	
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F 241	the turn sheet. NA # : balls as feces. Resid	e 2 2 identified the stains and lent # 18's hand was laying n the left. Brown stains	F	241	F 279 Windsor Point will ensure the	services
	were seen under Res around the nail beds. resident's nails, nor d	sident # 18's fingernails and The NA did not clean the lid he provide oral care. The			provided or arranged by the fa professional standards of qual I. Corrective action will be a	lity.
	resident was dressed wheelchair and taker				for Resident #45 and #18 to he affected by the deficient pract	ave been
	4:29 PM. NA # 2 sta care and had cleaned best he could. The N	ted he did not provide oral di Resident # 18's nails the IA stated Nurse # 3 had nt # 18 had feces around her			 Resident #45's care plan (developed and evaluated on 1 (EXHIBIT 3) 	
	mouth. He added the face. NA # 2 stated or clean under the re	at was why he wiped her ne did not provide oral care sident's nails because o orange sticks or oral swabs			 Resident #18's care plan (developed and evaluated on 1 (EXHIBIT 4) 	
	in her room. He add available in the facilit have gotten someon	ed these items were y. NA # 2 stated he could e to retrieve those items in care and oral care for			II. Corrective action will be a for all residents having potent affected by the same deficien follows:	tial to be
	The nurse stated Reputting her hands in	iewed at 5:00 PM on 10/18//. sident # 18 had a habit of her brief and playing in her			 A facility audit of all resid was completed for accuracy o (EXHIBIT 5) 	. 1
	feces in her mouth. what Resident # 18 h	sident # 18 also put the Nurse # 3 stated that was had done that afternoon. She			III. The systemic changes pu that deficient practices will no	ot recur will be:
	included a consultan Nurse # 3 stated she feces on Resident #	provided by the facility t psychiatric assessment. had seen what looked like 18's chin but thought it was			 Care plans will be update daily review of physicians, 24 and incidents and accidents. 	
	she touched the spo area was dried and o	nt. The nurse added when t on Resident # 18's chin, the did not move, so she figured arse stated she continued to			IV. Performance correcting deficiencies will be monitored following methods. A QA m has been put in place to assur	d through the onitoring too

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND I DAY OF	OOM LONG		A. BUII	DING	3	ا ر	:
		345500	B. WN	G		1	/2011
	OVIDER OR SUPPLIER	ARE		1	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET FUQUAY VARINA, NC 27526		
				L	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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F 241	Continued From page	lications and the	F	241			
	incident to NA # 2 ad moved quicker in clean	# 3 stated she reported the ding that he should have aning Resident # 18. The see Resident # 18 smeared			a. Daily until 100% complian weekly x 4, monthly x 3 and rathereafter. (EXHIBIT 2)		,
	feces on her face and have washed the res	if her chest, the NA should ident's hands and provided could offer no explanation			b. All findings will be reporte V. December 5, 2011	ed to QA.	12/5/11
	as to why she did not	offer to assist the resident ut after discussion stated					•
	5:10 PM on 10/18/11 situation included the	ng (DON) was interviewed at . Her expectations for this nurse stopping medication			F 312 Windsor Point will ensure the		ot.
	hands and providing medication and supp	e resident by washing her oral care prior to giving lements. The DON stated			provided or arranged by the formal professional standards of qual i. Corrective action will be a	lity.	
	clean the resident's r	to provide oral care and nails to remove the feces. thought the entire incident			for Resident #18 and #46 to h affected by the deficient prac	ave been	
	An observation was hands at 5:34 PM on	made of Resident # 18's 10/18/11. Resident # 18 ident lounge. The resident's			On 10/18/11 resident #18 immediately provided genera well as, oral and nail care.		
	left hand had spots of matter observed und nail beds. The right	of brown matter with brown Her the nails and around the hand had brown specks of			2. On 10/20/11 resident #4/ immediately shaved.		
		atter under the nail and The DON stated the nails eaned and oral care			II. Corrective action will be for all residents having poten affected by the same deficier follows:	tial to be	
F 279 SS=G	483.20(d), 483.20(k) COMPREHENSIVE	CARE PLANS	F	27	1. Between 10/20/11 and 1 residents were checked for ir	nproper	
	A facility must use the to develop, review a	ne results of the assessment and revise the resident's			grooming (nail, oral, shaving grooming). Any resident for improper grooming was corre	und with ected.	
FORM CMS-25	67(02-99) Previous Versions Ol	osolete Event ID: L3Q411		1	Facility ID: 956929	continuation she	eet Page 4 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		MEDICAID SERVICES	1000.11		I F ACUSTOM	(X3) DATE SUR	/EV
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION	COMPLETE	
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					(EXHIBIT 2)		
F 279	279 Continued From page 4 comprehensive plan of care.		F	279	III. The systemic changes put that deficient practices will no		
	plan for each resident objectives and timetal medical, nursing, and	elop a comprehensive care t that includes measurable bles to meet a resident's i mental and psychosocial fied in the comprehensive	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		In-service for staff was he focusing on "Providing ADL Ca "Grooming" of residents. (E)	re" and also (HIBIT 6)	•
	assessment. The care plan must o	lescribe the services that are			a. "Competency Evaluations completed on CNAs by 12/5/1		
	to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).				IV. Performance correcting to deficiencies will be monitored following methods. A QA mon has been put in place to assur systems are in place. 1. The following systems chaimplemented:	through the onitoring too e the followir	g
	ł	T is not met as evidenced			a. "Systems Check for Finge	r Nail Care"	
	facility failed to deve	riew and record review the lop a care plan to address			b. "Systems Check for Oral C	Care"	
	6 sampled residents	of Nutritional Status for 1 of (Resident #45) reviewed for			c. "Systems Check for Incon	tinence Care"	
		sampled residents (Resident			d. "Systems Check for Show	ers"	
		pehaviors. Findings include:			The above "Systems Checks" completed as follows:	will be	
	08/31/10 and readm	s admitted to the facility on itted on 10/07/10. The ed diagnoses included a and glaucoma.			Daily until 100% compliance is weekly x 4, monthly x 3 and ra thereafter. (EXHIBIT 2)		
	documented she we	nly/Weekly Weight Record ighed 106.8 pounds on			b. All findings will be report	ed to QA.	, ,
	01/03/11, 104.8 pou	nds in February 2011, and			V. December 5, 2011		12/5/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SEKVICES		_		1	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURY COMPLETE	
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					F315		
F 279	Continued From page		F	279	NI MATERIAL PARKAGE	1	
	100 pounds on 03/03	3/11.			Windsor Point will ensure the		
					provided or arranged by the f		ŧt
	A 03/24/11 physician	's order for Resident #45			professional standards of qua	lity.	
	-	of ice cream with her lunch			Connection assign will be a	ccomplished	
	and supper trays.				 Corrective action will be a for Resident #46 and #32 to h 		
	The resident's Anril 2	2011 through October 2011			affected by the deficient prac		
	Medication Administr	ration Records (MARs)			affected by the deficient prac	tice as rollows	•
	documented the FYI	(for your information), "Add			1. Resident #46's Foley Cath	neter was	
	ice cream to lunch a	and supper tray."			discontinued on 10/18/11.		
					4.550		
	The Care Area Asse	ssment (CAA) Summary			2. NA #3 was retrained on p	roper perined	ļ
	generated by Reside	ent #45's 09/30/11 Significant			care on 10/19/11. (EXHIBIT		
	Change Minimum Da	ata Set (MDS) documented		,			
	the care area Nutrition	onal Status triggered, and I in the resident's care plan.			 Corrective action will be 		
	was to be addressed	i ili tile lesident's care plan.	}		for all residents having poten		
	The resident's Nutriti	ional Status CAA		1	affected by the same deficier	it practice as	
		ent is at risk for weight loss.			follows:		
	Complicating factors	include impaired cognition,			to the College to the college	aawawlatad	
	refusal of care, bilate	eral hand ROM (range of			 A Foley Catheter Audit w on all residents with Foley Ca 		
	motion), sleep patter	rn disturbance, confusion,			on all residents with Foley Ca	tileter usage c	711
		fects of xanax, percocet,		ļ	10/19/11. (EXGIDITE		
	atrial fib (fibrillation),	dementia, disorientation, and		l	2. Between 10/20/11 and 1	0/21/11 all	
	multiple medical con	norbidities. Will care plan		İ	residents were checked for in		
	with resident receiving	ng assistance for eating,			grooming (nail, oral, shaving		
		labs as ordered, PO intake onitored and MD (doctor of			grooming). Any resident fo	und with	
		n for decreased intake,			improper grooming was corr	ected.	
	Hospice services as	ordered, dietary evaluation		ł	(EXHIBIT 2)		
	and recommendatio	ns, supplements as ordered		ļ			
	with snacks offered	on hydration rounds, diet		i	III. The systemic changes p	ut into place s	þ
	mechanical soft with				that deficient practices will n	ot recur will b	e :
	Davidson of Davidson	#451a care plan revealed the			 The following systems cl 	necks will he	
	Review of Resident	#45's care plan revealed the			implemented:		
	resident being at risi	k for weight loss was not em with interventions			unpiementea.		
	developed to address	es the problem.			a. "Systems Check for Fole	y Catheter"	

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLANTOF	OSINGOTION .			DING		С
		345500	B. WiN	G		10/20/2011
	OVIDER OR SUPPLIER POINT CONTINUING CA	ARE		122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET IQUAY VARINA, NC 27526	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 279	(DON) stated, after re Significant Change M resident's care plan we resident being at risk reported the care plan problem, but she countritional Status cardocumented on the Carea would be addreplan. At 11:34 AM on 10/1 she just started work after reviewing Resident Significant Change M she reported the care resident being at risk have. She explained triggered, and were addressed in the carshould be identified.	9/11 the Director of Nursing eviewing Resident #45's MDS assessment, the was supposed to address the for weight loss. She in did not address this old not explain why the MDS ed through since the earea triggered, and it was CAA Summary that the care in the resident's care 9/11 the MDS Nurse stated in the facility this week, but dent #45's 09/30/11 MDS and current care plan, e plan did not address the story weight loss like it should	F	279	b. A review of physicians' or of Foley Catheters will also be 2. In-service for staff was he focusing on "Providing ADL Ca "Grooming" of residents. (Examples of the completed on CNAs by 12/5/17) IV. Performance correcting to deficiencies will be monitored following methods. A QA me has been put in place to assur systems are in place. 1. The following systems challengemented: a. "Systems Check for Foley (EXHIBIT 2) 2. The following systems challengemented: a. "Systems Check for Finge (EXHIBIT 2)	completed. Id on 11/7/11 re" and also (HIBIT-6) " will be 1. (EXHIBIT these through the onitoring too e the following ecks will be Catheter"
	cumulative diagnose hypothyroidism, hyp osteoporosis and de The Annual Minimur	n Data Set (MDS), dated			b. "Systems Check for Oral of 2) c. "Systems Check for Incom (EXHIBIT 2) d. "Systems Check for Show The above "Systems Checks"	tinence Care' vers" (EXHIBIT 2)
	07/20/11, indicated to cognitively impaired.	Resident # 18 was severely She was identified as			completed as follows:	
FORM CMS-25	67(02-99) Previous Versions O	bsolete Event ID: L3Q41	1	Fac	Daily until 100% compilance ciity ID: 956929	s reached, continuation sheet Page 7 of 46

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUR COMPLETI	
AND FIRM OF	October		A. BUII	DING			
		345500	B. WIN	G		10/20	0/2011
•	OVIDER OR SUPPLIER	ARE		12:	EET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET JQUAY VARINA, NC 27526		
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F 279	requiring extensive a and total dependence personal hygiene. Reexhibited during the a Resident # 18 was considered bowel and bladder. For having behaviors that including smearing of Resident # 18's care 07/29/11, did not idea Resident # 18. The Resident # 18 was in did not identify any be with bowel incontiner	ssistance with bed mobility e on staff for toilet use and ejection of care was not assessment period. oded as always incontinent of desident # 18 was coded as t did not affect others, f feces on a daily basis. plan, with an onset date of ntify any behaviors for care plan did identify acontinent of bowel. The plan ehavioral issues associated nce. Resident # 18's care	F	279	weekly x 4, monthly x 3 and r thereafter. (EXHIBIT 2) b. All findings will be report V. December 5, 2011 F 325 Windsor Point will ensure th provided or arranged by the professional standards of qu 1. Corrective action will be for Resident #45 #36 and #2	e services facility will me ality. accomplished	
	decisions and the ina daily living independent	he had difficulty making ability to complete activities of ently. There were no entries vioral issues associated with lems.	A CALL TO STATE OF THE STATE OF		affected by the deficient pra 1. Resident #45's ice crean discontinued on 10/19/11.		5
	indicated the resident complaints and reperson 09/30/11, a physical Haldol (an antipsych milligrams twice daily developed for the meassociated with recent the September 2011 Sheet, indicated beh	Summary, dated 09/30/11, at had repetitive health titively calling out for help. ician's order was received for otic medication) 0.5 y. There was no care plan edication or the behaviors iving the medication. 1 Documentation of Behavior aviors on an almost daily and 3 to 11 shift. The care			 a. Following the exit interv 10/20/11, Resident #45's ice monitored to be on her tray dinner. As follow-up on 10 #45's ice cream was discontive weight stability. 2. Resident #36's ice cream discontinued on 10/19/11. a. Pudding was added as a supplement in place of the interval in the supplement in place of the interval interva	cream was at lunch and /27/11 Reside nued due to n was nutritional	nt
	plan for Resident # 1 The Physician's prog	8 did not identify behaviors. gress note, dated 10/06/11, an issued an order for a			lunch and dinner. 3. Resident #23's double r was discontinued on 10/27/	neat and eggs 11.	

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPL	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND PLAN OF	CORRECTION	PENTITION TON NUMBER.	A. BUI	LDING			
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	OVIDER OR SUPPLIER POINT CONTINUING CA	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
		The second secon	1 45		PROVIDER'S PLAN OF CORRECT	ion	(X5)
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F 279	Continued From page addressed on Reside the Haldol to 1 milligr milligrams every more identifying behaviors care plan. An observation was remedication pass at 3 # 3 entered Resident stated the resident had again. Black matter resident's right hand, the supplement and stated the resident had stated the resident had nurse then exited the Nursing Assistant (Number of Nurse # 3 was interventing her hands in feces adding that Refeces in her mouth, what Resident # 18 had stated interventions included a consultant. The Director of Nurse 5:10 PM on 10/18/11 situation included the pass and assisting the hands and providing medication and supplemedication and s	and the table to the table to the A) that Resident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 had a habit of the rore and playing in her sident # 18 also put the Nurse # 3 stated that was and done that afternoon. She provided by the facility the psychiatric assessment. Ing (DON) was interviewed at the resident by washing her oral care prior to giving elements. The DON stated at to provide oral care and		279	10/20/11, Resident #23's double ggs were provided on meal to meal. As follow-up, the double ggs was monitored to be on lunch and dinner. As follow-10/27/11 Resident #23's order meat and eggs was discontinution. Il. Corrective action will be a for all residents having potent affected by the same deficient follows: 1. An audit was completed of the Executive Director on tray physicians' orders. a. Dietician performed a tray physicians' orders audit on 11 100% compliance. III. The systemic changes put that deficient practices will not 1. Dietary Manager, or designandomly monitor tray card a ensure proper diets are follow "System Check for Diet Order (EXHIBIT 2) a. An in-service will be given staff from 11/9/11 through 1 regarding "tray cards." b. Dietician will complete a "versus" physicians' orders at random selection of residents.	ble meat and rays for each ble meat and her tray at up on r for double led. accomplished lal to be t practice as on 10/22/11 in cards "versury card "versury card "versury lat into place so to recur will be gnee will ccuracy to ved using the Accuracy." In to dietary 1/11/11 tray card udit for a seach month in the card will be a	oy s" ch o
	clean the resident's r	nails to remove the feces. thought the entire incident			IV. Performance correcting deficiencies will be monitored	d through the	

PRINTED: 11/02/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	/Y2\M	II TIPI F	E CONSTRUCTION	(X3) DATE SUR	VEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUII		200000000000000000000000000000000000000	COMPLETE	
	Manager	• •				c	;
		345500	B. WIN	G		10/20	/2011
	ROVIDER OR SUPPLIER	CARE		122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET IQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	AM. The nurse repextensive/total ass living. Nurse # 4 s behaviors included An interview was h 10:32 AM. The NA played in her brief A telephone intervi Coordinator on 10/she was new to the resident behaviors behaviors and psy be addressed on a added if a resident	rviewed on 10/20/11 at 10:12 ported Resident # 18 required istance for activities of daily tated Resident # 18's playing in her brief/feces. reld with NA # 5 on 10/20/11 at reported Resident # 18 reported Resident	F	279	has been put in place to ass systems are in place. 1. Dietician performed at physicians' orders audit on 100% compliance. b. Dietician, or designee, tray card "versus" physician for a random selection of remonth. V. December 5, 2011 Windsor Point will ensure the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the professional standards of one of the provided or arranged by the provided or arranged b	tray card "versus 11/9/11 to read will complete a ns' orders audit esidents each che services e facility will me wality. e accomplished affected by the s: an in-service on the following: emperatures, sposal/sanitizatig and dating. an in-service on the following: emperatures, sposal/sanitizatig and sanitizatig and sanitizatig and sanitizatig and sanitizatig and sanitizatig sanitizatig sanitizatig sanitizatig sanitizatig sanitizatig sanitizatig sanitizatig	12)5)1) et

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F 279	Continued From page	∍ 10	F	279	 Dietary Manager and Dieta Manager audited all kitchen ut on 10/19/11. Any device fou sanitary for use was immediate or properly sanitized. 	ensils/device nd to not be ely discarded	
F 312 SS=G	DEPENDENT RESID	DENTS	F	312	 a. Dietary Manager held an in 10/20/11 and 10/21/11 on the correct hot and cold food temposanitization procedures, dispose of utensils/devices, labeling an (EXHIBIT 10) 	e following: peratures, sal/sanitization	on
	daily living receives the	able to carry out activities of he necessary services to on, grooming, and personal			 Dietary Manager and Diet Manager audited all kitchen for 10/19/11. Any food item fou labeled/dated was immediatel labeled/dated or discarded. 	ood items on and to not be	
	by: Based on observation record review, the factors of the personal hygiene for	r is not met as evidenced ons, staff interviews and cility failed to provide proper 2 of 3 sampled residents Resident # 46) whose care ngs include:			 Dietary Manager held an in 10/20/11 and 10/21/11 on the correct hot and cold food temps an itization procedures, dispos of utensils/devices, labeling an (EXHIBIT-10) 	e following: peratures, sal/sanitizati nd dating.	
	cumulative diagnoses	s admitted on 07/20/10 with s of debility, depression, artension, blindness, anxiety, mentia.	The first of the f	The state of the s	 Medical Records Clerk and nourishment refrigerator food 10/20/11. Any food item foo labeled/dated was immediate labeled/dated or discarded. 	l items on and to not be	
	identified an inability living independently a goal to have her need # 18 clean, neat and acheived by routine a evening care and rou	plan, dated 03/25/11, to perform activities of daily related to cogntive loss. The ds met and to keep Resident well groomed daily would be nail care, morning and utine oral care. The I to anticipate the resident's	The state of the s	THE PARTY OF THE P	 a. A thermometer was place nourishment freezer on 10/21 b. Dietary Manager held an 10/20/11 and 10/21/11 on the correct hot and cold food tem sanitization procedures, dispo of utensils/devices, labeling an 	./11. in-service on e following: iperatures, isal/sanitizati	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF	CORRECTION	IDENTI IDATION NOMBER	A. BUII	.DING		c
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F 312	Continued From pageneeds for activity of of the Annual Minimum 07/20/11, indicated Formatively impaired. The Annual Minimum 07/20/11, indicated Formatively impaired. The Annual Minimum of the Annual Minimum of the Resident House of the Annual Minimum of the	e 11 laily living assistance. In Data Set (MDS), dated tesident # 18 was severely. She was identified as a sistance with bed mobility to on staff for toilet use and ejection of care was not assessment period. The order of the control of the cont		312	II. Corrective action will be a for all residents having potent affected by the same deficient follows: 1. Dietary Manager held an 10/20/11 and 10/21/11 on the correct hot and cold food tem sanitization procedures, dispo of utensils/devices, labeling at (EXHIBIT 10) 2. Dietary Manager held an 10/20/11 and 10/21/11 on the correct hot and cold food tem sanitization procedures, dispo of utensils/devices, labeling a (EXHIBIT 10) 3. Dietary Manager and Die Manager audited all kitchen uton 10/19/11. Any device for sanitary for use was immediator properly sanitized. a. Dietary Manager held an 10/20/11 and 10/21/11 on the correct hot and cold food tem sanitization procedures, dispo of utensils/devices, labeling a (EXHIBIT 10) 4. Dietary Manager and Die Manager audited all kitchen file	in-service on e following: peratures, sal/sanitization and dating. in-service on e following: peratures, sal/sanitization and dating. in-service on e following: peratures, sal/sanitization and dating. tary Assistant attensils/devices and to not be tely discarded in-service on e following: peratures, sal/sanitization and dating. in-service on e following: peratures, sal/sanitization and dating.
	and then he would to The nurse continued Resident # 18 remain				10/19/11. Any food item fo labeled/dated was immediate labeled/dated or discarded. a. Dietary Manager held an	ely
	An observation was	made on 10/18/11 at 4:15			10/20/11 and 10/21/11 on th	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	,			ru	JQUAY VARINA, NC 27526		
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F 312	PM of Nursing Assist incontinent care to Recleaned the resident' back. The folded she resident was on the key on the left side of the sized brown balls we the turn sheet. NA # balls as feces. Resident have seen under Resident's nails, nor cresident was dressed wheelchair and taker. An interview was held 4:29 PM. NA # 2 state care and had cleaned best he could. The hinformed him Reside mouth. He added the face. NA # 2 stated or clean under the received have gotten someon order to provide nail Resident # 18, but, hinformed him Resident # 18, but, hinformed # 18, but, hinformed him Resident # 18, but, hinformed hi	ant (NA) # 2 providing esident # 18. The NA s perineum from front to set used in moving the bed. Brown stains were seen turn sheet and pencil eraser re seen on the right side of 2 identified the stains and tent # 18's hand was laying on the left. Brown stains sident # 18's fingernails and The NA did not clean the lid he provide oral care. The d and placed in her on to the lounge area. Id with NA # 2 on 10/18/11 at ted he did not provide oral d Resident # 18's nails the NA stated Nurse # 3 had ont # 18 had feces around her at was why he wiped her he did not provide oral care sident's nails because o orange sticks or oral swabs ed these items were ly. NA # 2 stated he could e to retrieve those items in care and oral care for	F	312	sanitization procedures, disposof utensils/devices, labeling and (EXHIBIT 10) 5. Medical Records Clerk aud nourishment refrigerator food 10/20/11. Any food item four labeled/dated was immediated labeled/dated or discarded. a. A thermometer was place nourishment freezer on 10/21 b. Dietary Manager held and 10/20/11 and 10/21/11 on the correct hot and cold food tem sanitization procedures, disposof utensils/devices, labeling and (EXHIBIT 10) III. The systemic changes pur that deficient practices will not 1. Dietary Manager, or design complete "Dietary System Chemical Complete "Dietary System Chemical Complete "Dietary System Chemical Complete Complet	dited all litems on and to not be ly din /11. in-service on e following: peratures, sal/sanitization and dating. It into place so be recur will be: gnee, will eck." (EXHIBIT purchased by these I through the onitoring too e the following ck" will be	
FORM CMS-25	1 67(02-99) Previous Versions Ob	solete Event ID: L3Q4	111	Fa	weekly x 4, monthly x 3 and recility ID: 956929	andomiy ontinuation sheet Pag	e 13 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	COVIDER OR SUPPLIER R POINT CONTINUING CA		I ID	12	EET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET JQUAY VARINA, NC 27526 PROVIDER'S PLAN OF CORRECT	ION	(%5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 312	included a consultant psychiatric assessment. Nurse # 3 stated she had seen what looked like feces on Resident # 18's chin but thought it was		F	312	thereafter. (EXHIBIT:11) V. December 5, 2011		12/5/11
	she touched the spot area was dried and dit was feces. The nu give the resident med supplement. Nurse incident to NA # 2 ad moved quicker in cleanurse added that sing feces on her face and have washed the resoral care. The nurse as to why she did no with personal care, by she should have clear.	feces on Resident # 18's chin but thought it was chocolate supplement. The nurse added when she touched the spot on Resident # 18's chin, the area was dried and did not move, so she figured it was feces. The nurse stated she continued to give the resident medications and the supplement. Nurse # 3 stated she reported the incident to NA # 2 adding that he should have moved quicker in cleaning Resident # 18. The nurse added that since Resident # 18 smeared feces on her face and her chest, the NA should have washed the resident's hands and provided oral care. The nurse could offer no explanation as to why she did not offer to assist the resident with personal care, but after discussion stated she should have cleaned the resident. The Director of Nursing (DON) was interviewed at 5:10 PM on 10/18/11. Her expectations for this			Windsor Point will ensure the provided or arranged by the fa professional standards of qual. Corrective action will be at for Residents to have been aff deficient practice as follows: 1. On 10/19/11 the Director provided antimicrobial wipes for all medication carts through a. In-service on proper sanit glucometers was held on 10/1 (EXHIBIT.12)	ed by the facility will meet ands of quality. on will be accomplished we been affected by the as follows: the Director of Nursing whial wipes (CaviWipesXL) carts throughout facility. Topper sanitization of	
	pass and assisting the hands and providing medication and supp she expected the NA clean the resident's rathe DON added she was disgusting. An observation was hands at 5:34 PM on was sitting in the resident hand had spots of matter observed undurail beds. The right matter with brown m	ne resident by washing her oral care prior to giving elements. The DON stated to provide oral care and nails to remove the feces. Thought the entire incident made of Resident # 18's 10/18/11. Resident # 18 ident lounge. The resident's of brown matter with brown the nails and around the hand had brown specks of atter under the nail and The DON stated the nails			b. "Blood Sugar Monitoring updated on 10/19/11. (EXHID 10/19/11. (EXHID 10/19/11.) 2. The Director of Nursing has in-service on infection control (EXHIBIT-13) a. QA Action Plan was initiated (EXHIBIT-13) II. Corrective action will be a for all residents having potential affected by the same deficient follows:	eld an on 10/17/11 d on 10/17/1 accomplished tial to be t practice as	1.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	ROVIDER OR SUPPLIER	ARE		122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET IQUAY VARINA, NC 27526		
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F 312	Continued From page should have been cle provided.		F	312	provided antimicrobial wipes (for all medication carts throug a. In-service on proper saniti glucometers was held on 10/1 (EXHIBIT 12)	hout facility. ization of 9/11.)
	06/03/11. Cumulative disorder, anemia, Pa hypertension, osteop gastroesophageal ref healed stage 2 press According to the mos (Minimum Data Set) Resident #46 require use, bathing and hyg behaviors noted. Resident #46 was ob AM in her wheelchair	orosis, gout, flux disease and history of a ure ulcer. It recent Quarterly MDS assessment of 08/21/11, ed total assistance with toilet iene. There were no served on 10/18/11 at 8:30 out in the front of the facility. we long white chin hairs and			b. "Blood Sugar Monitoring I updated on 10/19/11. (EXHI L.) 2. The Director of Nursing he in-service on infection control (EXHIBIT 13) a. QA Action Plan was initiated (EXHIBIT 13) III. The systemic changes put that deficient practices will not 1. Antimicrobial wipes (Cavit continue to be used to ensure sanitization of glucometers. 2. Proper infection control p	BIT 12) eld an on 10/17/11 d on 10/17/1 t into place so it recur will b WipesXL) will proper	i. o
	4:00 PM with long who brownish hair on her Resident #46 was ob wheelchair by staff or She remained unshat During an interview with cooperative with care	served being pushed in her n 10/19/11 at 10:55 AM.			including handling of linen, wi and monitored during weekly control rounds by the Director designee. (EXHIBIT 14) iV. Performance correcting t deficiencies will be monitored following methods. A QA monitored has been put in place to assure systems are in place. 1. Medication pass observat completed by Director of Nursidesignee, to ensure proper sa glucometers. (EXHIBIT 13)	infection f of Nursing, of these through the conitoring too e the following tions will be sing, or	Þr

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 312	Resident #46 was ob staff in her wheelchai She had long white chair on her upper lip. During an interview w 10/20/11 at 1:30 PM, scheduled for showel bed baths on the other commented that residuance shower days. NA#4 were shaved daily an needed. When quest she reported she had She stated she was residued to the stated she was residued to	served being pushed by ir on 10/20/11 at 11:30 AM. hin hairs and light brownish vith Nurse Aide#4 (NA#4) on she stated residents were rs every other day and partial	F	312	2. Director of Nursing, or design monitor proper infection control completing infection control rot follows: a. Weekly x 4, monthly x 3 and thereafter. (EXHIBIT 14) b. All findings will be reported V. December 5, 2011	ol practices unds as ad randomly	12/5/11
F 315 SS=D	(DON) on 10/20/11 a expectation was for frequency. She stated staff to shave the lad during morning care. On 10/20/11 at 3:00 to in the activity room regremained unshaven. 483.25(d) NO CATHI RESTORE BLADDE: Based on the resider assessment, the facility resident who enters to indwelling catheter is resident's clinical concatheterization was resident was resident.	PM, Resident #46 was noted eading a magazine. She ETER, PREVENT UTI, R nt's comprehensive lity must ensure that a	F	315			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SUF COMPLETE	
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	OVIDER OR SUPPLIER	CARE	I	12	EET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET JQUAY VARINA, NC 27526		
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F 315	infections and to res function as possible	ces to prevent urinary tract store as much normal bladder	F	315			
	Based on observation interviews the facility justification for the ucatheter for 1 of 3 si #46) who had an included facility also failed to care for 1 of 3 samp	ions, record review and staff y failed to have medical use of an indwelling urinary ampled residents (Resident dwelling urinary catheter. The provide adequate incontinent bled residents (Resident #32) served. Findings include:					
	06/03/11. Cumulati disorder, anemia, P hypertension, osteo	porosis, gout, eflux disease and history of a					
	to change Resident catheter every 2 we	n orders of 06/03/11 indicated #46's indwelling urinary eks. There was no he size of the catheter.					and the state of t
		ng assessment of 06/03/11 #46 was admitted with a 22 fr urinary catheter.					
	assessment, Reside	ay Minimum Data Set (MDS) ent #46 had a stage 2 n admission that was red					
	According to the mo	ost recent Quarterly MDS					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 315	(Minimum Data Set) a Resident #46 scored total assistance with hygiene. It was note urinary catheter. According to the stan found in Resident #4 urinary catheter was admission to the facil diagnosis or bladder A telephone physicial indicated Resident #4 urinary catheter chan needed). A nurse's note of 08/6 that Resident #46's in had been changed at been inserted. A nurse's note of 08/6 Resident #46 was sc PM. The nurse docu urine smell in the roo the drainage bag. The the catheter tubing be the tubing was totally indicated she had ins urinary catheter. Resident #46's care identified a potential related to "foley" catt catheter). Included in was to change the ca	assessment of 08/21/11, 8 out of 15. She required toilet use, bathing and dishe had an indwelling ding physician's orders 6's record, the indwelling to be discontinued upon ity if there was no supporting retrain orders. In's order of 07/13/11 6 was to have the indwelling ged monthly and PRN (as 04/11 at 1:00 AM indicated indwelling urinary catheter and a new 16 fr catheter had 09/11 at 1:00 AM indicated reaming for help at 11:00 mented there was a strong in and very minimal urine in the nurse attempted to irrigate ut was unable to do so and	F	315			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ĒĎ
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	OVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
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F 315	A Bowel/Bladder assing Resident #46's record the indwelling urinary issues and recurrent (methicillin resistant street (DON) on 10/17/11 and Resident #46 had the originally for a pressurb healed. She stated for the urologist who had due to her recurrent to skin issues. She states sediment as well. Resident #46 was ob AM to have an indwe connected to straight in a privacy bag. A physician's telephor PM was to discontinucatheter. During an interview with the states of the	essment of 08/24/11 in dindicated the rationale for catheter was multiple skin decubitus ulcers with MRSA staphylococcus aureus). with the Director of Nurses to 11:39 AM, she stated andwelling urinary catheter are area but it had long since Resident #46 had been out to digiven the order to leave it in urinary tract infections and ted her urine was thick with served on 10/17/11 at 11:50 Illing urinary catheter drain with the drainage bag with the hall nurse (Nurse with the hall nurse (Nurse	F	315			

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		345500	B. WIN	IG		1)/2011
	OVIDER OR SUPPLIER POINT CONTINUING CA	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	indwelling urinary cate creams but as yet he DON stated one of the him earlier this week remove the catheter. every 2 hour toileting she had been confusion the justification for catheters and though	heter as well as the skin had not evaluated her. The e nurses had telephoned and obtained the order to She added that she was on . The DON commented that ed as to what was included the indwelling urinary t a stage 2 was justification. dent #46 had a history of	F	315			
	Basic Care, indicated cleansed from front to cleansed from front to Resident # 32 was recumulative diagnoses infection and acute retained in the resident's care programmer of a UTI in the resident	radmitted on 03/15/10 with so of dementia, urinary tract enal failure. Ilan with an onset date of tesident # 32 had a potential tions (UTI) related to urinary pal of being free of signs and included approaches of and symptoms of a UTI, culture and sensitivities as cian, toilet increase fluid the day and limiting fluid at					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,			(X3) DATE SUR COMPLETE	
	345500			•	10/20)/2011
OVIDER OR SUPPLIER	ARE		1:	221 BROAD STREET		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOUL	D BE	(X6) COMPLETION DATE
06/23/11, indicated R cognitively impaired. extensive assistance eating and was dependance and bathing. Resident # 32 as alw bladder with no toileti was not identified as days. Urine was obtained for and sensitivity on 08/cloudy (normal is cleated in sensitivity on 08/cloudy (normal is cleated in sensitivity on 08/cloudy (normal is no bacteria on 08/26/11 with a recolonies per milliliter rods. On 08/25/11, the phyand Physical (H & P) recent UA showed pyand 4 to 8 WBC's. To resident had a UTI at used for treatment. A Physician's Fax, da Resident # 32 had reculture and sensitivity resistant. The physical UTI. A Pharmacy Review	She was coded as needing with transfer, dressing, and ndent for toilet use, personal The MDS identified ays incontinent of bowel and ing program in place. She having a UTI in the past 30 or a urinalysis (UA), culture 24/11. The urine color was ar), with large blood (normal nitrite (normal is negative), 4 (WBC's), 2 + bacteria a). The culture was returned sult of greater than 100,000 of urine of gram negative sician completed a History. The H & P indicated a positive nitrites, large blood the physician determined the indicated Cipro would be atted 08/30/11, indicated ceived Cipro, but when the y returned, the organism was cian ordered Macrobid.	F	315			
	CORRECTION OVIDER OR SUPPLIER POINT CONTINUING CA SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page 06/23/11, indicated R cognitively impaired. extensive assistance eating and was depet hygiene and bathing. Resident # 32 as alw bladder with no toileti was not identified as days. Urine was obtained for and sensitivity on 08/ cloudy (normal is cleaties in o blood), positive to 8 white blood cells (normal is no bacteria on 08/26/11 with a re colonies per milliliter rods. On 08/25/11, the phy and Physical (H & P) recent UA showed pot and 4 to 8 WBC's. To resident had a UTI at used for treatment. A Physician's Fax, da Resident # 32 had re culture and sensitivity resistant. The physical The care plan was re an actual UTI. A Pharmacy Review 09/15/11 identified the	CORRECTION JA5500 COVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 06/23/11, indicated Resident # 32 was severely cognitively impaired. She was coded as needing extensive assistance with transfer, dressing, and eating and was dependent for toilet use, personal hygiene and bathing. The MDS identified Resident # 32 as always incontinent of bowel and bladder with no toileting program in place. She was not identified as having a UTI in the past 30 days. Urine was obtained for a urinalysis (UA), culture and sensitivity on 08/24/11. The urine color was cloudy (normal is clear), with large blood (normal is no blood), positive nitrite (normal is negative), 4 to 8 white blood cells (WBC's), 2 + bacteria (normal is no bacteria). The culture was returned on 08/26/11 with a result of greater than 100,000 colonies per milliliter of urine of gram negative rods. On 08/25/11, the physician completed a History and Physical (H & P). The H & P indicated a recent UA showed positive nitrites, large blood and 4 to 8 WBC's. The physician determined the resident had a UTI and indicated Cipro would be used for treatment. A Physician's Fax, dated 08/30/11, indicated Resident # 32 had received Cipro, but when the culture and sensitivity returned, the organism was resistant. The physician ordered Macrobid.	OWIDER OR SUPPLIER POINT CONTINUING CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 G6/23/11, indicated Resident # 32 was severely cognitively impaired. She was coded as needing extensive assistance with transfer, dressing, and eating and was dependent for toilet use, personal hygiene and bathing. 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The physician ordered Macrobid. The care plan was revised on 08/30/11 to reflect an actual UTI. A Pharmacy Review note to the physician, dated 09/15/11 identified the previous UTI as caused by	CONDER OR SUPPLIER POINT CONTINUING CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 06/23/11, indicated Resident # 32 was severely cognitively impaired. She was coded as needing extensive assistance with transfer, dressing, and eating and was dependent for toilet use, personal hygiene and bathing. The MDS identified Resident # 32 as always incontinent of bowel and bladder with no toileting program in place. She was not identified as having a UTI in the past 30 days. Urine was obtained for a urinalysis (UA), culture and sensitivity on 08/24/11. 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The culture was returned on 08/26/11 with a result of greater than 100,000 colonies per milliller of urine of gram negative rods. On 08/25/11, the physician completed a History and Physical (H & P). The H & P indicated a recent UA showed positive nitrites, large blood and 4 to 8 WBC's. The physician determined the resident had a UTI and indicated Cipro would be used for treatment. A Physician's Fax, dated 08/30/11, indicated Resident # 32 had received Cipro, but when the culture and sensitivity returned, the organism was resistant. The physician ordered Macrobid. The care plan was revised on 08/30/11 to reflect an actual UTI. A Pharmacy Review note to the physician, dated 09/15/11 identified the previous UTI as caused by	OVIDER OR SUPPLIER 345500 SIRRET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET FUULY YARINA, TO ZF526 SUMMANY STATEMENT OF DEFORMATION, REGULATORY OR LSC IDENTIFYING INFORMATION, REGULATORY OR LSC IDENTIFY OR LSC IDENTIFY IN TAIS REGUL

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	:D
		345500	B. WIN	iG		10/20)/2011
	OVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X6) COMPLETION DATE
F 315	The Quarterly MDS, oresident had impairm memory and severely daily decision making as being dependent or daily living and was idincontinent of bowel a was identified as having the memory and severely daily living and was identified as having the memory of the physician ordere resident # 32. October 2011 physician as a completion of the memory of the	dated 09/22/11, indicated the ent of short and long term impaired cognitive skills for a Resident # 32 was coded on staff for all activities of dentified as being totally and bladder. Resident # 32 ing a UTI in the last 30 days. as obtained for a UA. e. The urine culture was indicating greater than milliliter of urine of gram as sensitive to Macrobid. If this medication for the dealer of t		315			
	hands, donned glove 32 for incontinence. It resident's perineum f same part of the disp Resident # 3 had a b stain, resembling stor disposable wipe as the	rom back to front using the osable wipe multiple times. owel movement. A brown					

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345500	B. WIN			10/20)/2011
	OVIDER OR SUPPLIER	ARE	<u>, , I</u>	1:	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	cleansed Resident # NA affirmed she norm care on female reside # 3 disposed of the s gloves, washed her h gloves. The NA then again removing stool An interview was hele 2:59 PM. The NA st a female from bottom not seen the stool on cleansed Resident # cleansing the resider stool could cause an An interview was hele (DON) on 10/19/11 a the expectation was be cleansed using a clean part of a cloth of if a resident was clean perineum to the top, contamination with b UTI. 483.25(i) MAINTAIN UNLESS UNAVOIDA Based on a resident assessment, the faci resident - (1) Maintains accept status, such as body unless the resident's demonstrates that the	32 from bottom to top. The hally provided incontinent ents from bottom to top. NA colled brief, removed her hands and donned cleaned cleansed Resident # 32 using a bottom to top action. If with NA # 3 on 10/19/11 at ated she was taught to wipe to top. She added she had the cloth until after she had 32. NA # 3 stated that at with a cloth that contained infection. If with the Director of Nursing to 3:47 PM. The DON stated for the female residents to top to bottom motion with a with each swipe. She stated insed from the bottom of the there was a risk of acteria that could cause a nutration state of the state o		315			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345500	B. WIN			10/20)/2011
	OVIDER OR SUPPLIER	ARE	I	1:	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 325	Continued From page	e 23	F	325			
	by: Based on observation review the facility fail interventions ordered or to help promote we sampled residents (F	r is not met as evidenced on, staff interview, and record ed to implement nutrition I to help prevent weight loss ound healing for 3 of 6 tesident #23, #36, and #45) or nutritional concerns.	Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-Landauder-				
	08/31/10 and readmi	a admitted to the facility on tted on 10/07/10. The ed diagnoses included a and glaucoma.					
	documented she wei	lly/Weekly Weight Record ghed 106.8 pounds on nds in February 2011, and 8/11.					
		's order for Resident #45 n of ice cream with her lunch					
	03/24/11, present in	mmunication form dated the resident's active medical to add an ice cream cup to and supper trays.					
		nly/Weekly Weight Record ghed 102.4 pounds on					
	The registered dietiti	an's (RD's) 08/15/11 nutrition					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345500	B. WIN	G		10/20	;)/2011
	ROVIDER OR SUPPLIER	ARE		1:	REET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 325	cream on the resident was still being utilized prevent further weight. The resident's Month documented she weight. The RD's 09/12/11 in Resident #45 documersident's lunch and utilized as an interve weight loss. The resident's Month documented she weight loss. The resident's Month documented she weight loss. Resident #45's Octol Administration Record was receiving treatm great toe which had her right lower extremed to which had her right lower extremed as ordered." On 10/17/11 from 12 the resident was take Resident #45 was of where staff were feen o ice cream on the staff obtained ice creams.	sident #45 documented ice It's lunch and supper trays d as an intervention to it loss. Ily/Weekly Weight Record ghed 103 pounds in utrition progress note for ented ice cream on the supper trays was still being intion to prevent further Ily/Weekly Weight Record ghed 104.6 pounds on per 2011 Treatment rd (TAR) documented she ents to a blister on the left opened and to skin tears on mity and her left thumb. Illiant identified "Has stage 2 ot great toe" as a problem on ons to this problem included nutritional support to resident	F	325			

Event ID: L3Q411

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		345500	B, WING		10/2	C 20/2011
	OVIDER OR SUPPLIER	ARE	S	STREET ADDRESS, CITY, STATE, ZIP 1221 BROAD STREET FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED I DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 325	slip. On 10/18/11 from 12: the resident was take Resident #45 was ob where staff were feed no ice cream on the resident. The promeals was not docum slip. On 10/18/11 from 5:5 the resident was take Resident #45 was ob where staff were feed no ice cream on the resident. The promeals was not docum slip. At 10:12 AM on 10/19 (DON) stated the nur order for supplement and Communication yellow copy of this fodepartment. According the dietary department the form into the communication is such as ice cream, yetrays this would be cathed dietary employee the dietary employee.	nented on the resident's tray 02 PM until 12:39 PM (when in back to her room) served in a dining room ling residents. There was resident's meal tray, and no am from the kitchen to feed evision of ice cream with mented on the resident's tray 00 PM until 6:27 PM (when	F 32	25		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) DATE SUF COMPLET	
		345500	B. WING			1	C 0/2011
	ROVIDER OR SUPPLIER			12	EET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET JQUAY VARINA, NC 27526	1 10/2	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	At 10:18 AM on 10/19 Resident #45's chart, stated the resident wice cream at lunch ar commented he was represented the resident with the responsibility of the resident trays. At 2:12 PM on 10/19 Assistant Dietary Mainformation from Diet forms into the computation of the resident tray slips we would know to place resident trays during According to the DM Resident #45's meal intake. (In addition, the would be beneficial intake.)	2/11, after reviewing the Dietary Manager (DM) as supposed to be receiving at supper. The DM not sure the dietary a copy of the Diet Order and which documented the enting the resident's lunch th ice cream. 2/11 Nurse #1 stated it was the dietary department to cods, ordered to help or promote wound healing, on 2/11 Nurse #2 stated it was the dietary department to cods, ordered to help or promote wound healing, on 2/11 the DM stated he or his mager (ADM) entered the corder and Communication ther system so it would print ster system so it would print ster system so it would print ster system so it would print the operation of the trayline. The cream was added to trays to increase her caloric the protein in the ice cream in wound healing. The II pressure ulcer to her left	F	325			

Facility ID: 956929

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345500	B. WIN	G		C 10/20/2011	
	OVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	Continued From pag	e 27 admitted to the facility on	F	325			
		live diagnoses of dementia,					
	(MDS) dated 7/19/11 had short and long to was severely impaire	terly Minimum Data Set I indicated that Resident #36 erm memory problems and ed in daily decision making. Itally dependent on one	Managham register				
	2011 showed that Remechanical soft with meats diet. Liquids v	cian Orders dated October esident #36 was to receive a finger foods and chopped yere to be nectar thick. Ice luded on the lunch and dinner					
	4/14/11 indicated the	ess Notes (Dietary) dated at Resident #36 was receiving ncluding the ice cream.					TO THE PERSON NAMED IN COLUMN 1
	dated 4/30/11 indica #36's diet. The diet with finger foods, ch	der and Communication sheet ated a clarification of Resident was to be mechanical soft copped meat, nectar thick with lunch and dinner.					
	7/16/11 indicated th	ess Notes (Dietary) dated at Resident #36 was receiving including the ice cream.					
	updated 7/19/11 ind loss related to leavil uneaten at most me	#36's Care Plan (CP) last licated a potential for weight ng 25% or more of food als. Approaches included red: mechanical soft diet with					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	'	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
		345500	B. WN			10/20)/2011
	OVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	chopped meat and fir liquids and ice cream Review of the Progre 10/12/11 indicated th receiving the diet as cream. In an observation on Resident #36 was sit small dining room. Si Therapist (ST) #1. The Resident #36's tray. It chopped up fish, stea of cake with pudding Resident #36 did not the meal. The dietary add ice cream to Resident #36 had received ice 10/18/11. In an observation on Resident #36 was sit fed by the administration the dinner tray. The state to add ice cream In an interview on 10 Dietary Manager (Dietary Manager (Dietary Manager (Dietary Manager)).	nger foods, nectar thick at lunch and dinner. ss Notes (Dietary) dated at Resident #36 was ordered including the ice 10/18/11 at 12:04 PM, ting in a reclining chair in the ne was being fed by Speech nere was no ice cream on Resident #36 received at fries, cole slaw and a slice and fruit cocktail on top. feed herself any portion of meal card did not state to sident #36's trays. ation Administration Record urses initials that Resident cream for lunch on 10/18/11 at 6:05 PM, ting in a reclining chair being stor. There was no ice cream ne dietary meal card did not m to Resident #36's trays. 1/19/11 at 11:00 AM with the M, he indicated that when neg a communication slip dietary department. When m was not on the meal card heck his paperwork to see if	F	325			

Event ID: L3Q411

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIP	LE CONSTRUCTION	(X3) DATE SUR	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING.		COMPLETE	
		345500	B. WIN	G	and the state of t	1	C 0/2011
	OVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	Resident #36 was sit fed lunch. There was tray. The dietary meaice cream to Resident In an interview on 10 #1, she stated that sl #36's diet yesterday. longer be receiving it provided instead. In an interview on 10 DM, he stated that the Resident #36 had be had not been served. In an interview on 10 Registered Dietician assessment process weights and to go the she did not watch tracards, or watch meal at the orders in the cito see what the nurse not visualize Resider the ordered ice crear. In an interview on 10 Director of Nursing (I her expectation that diets that were order were supposed to inishe expected them to ask the appropriate states.	10/19/11 at 12:10 PM, ting in a reclining chair being no ice cream on the lunch all card did not state to add at #36's trays. /19/11 at 2:00 PM with ST ne had changed Resident Resident #36 would no be cream. Pudding would be /19/11 at 3:10 PM with the e ice cream ordered for en overlooked and ice cream to her as ordered. /20/11 at 8:52 AM with the (RD), she indicated that her was to look at resident rough their charts. She stated by preparation, check meal s. She indicated she looked that and looked in the MAR's best were signing for. She did at #36 eating a meal to see if an was given or consumed. /20/11 at 3:10 PM with the DON), she stated that it was residents were given the ed for them. If the nurses tial something on the MAR, to either give it themselves or the present of the information. The the nurse to just initial the	F	325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345500	B. WIN				C 0/2011
	ROVIDER OR SUPPLIER			1221	ADDRESS, CITY, STATE, ZIP CODE BROAD STREET UAY VARINA, NC 27526	1 10/20	<i>3</i>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE
F 325	3. Resident # 23 was 3/2/98 and re-admitt cumulative diagnose glaucoma and peripl Resident #23's quar (MDS) dated 9/25/1 was moderately imp #23 was independer Review of the Medic dietary likes or dislik Review of the Physic 2011 showed an ord double meat and eg Review of the Progres/8/11 indicated that regular diet. Review of the Progres/12/11 indicated that regular diet with double Review of the Progres/15/11 indicated that regular with double Review of the Progres/15/11 indicated that regular diet with double Review of the Progres/15/11 indicated that regular diet with double Review of the Progres/15/11 indicated that regular diet with double regular diet with	s admitted to the facility on ed on 12/2/09 with as of Parkinson's disease, heral vascular disease. Iterly Minimum Data Set 1 indicated that Resident #23 aired in cognition. Resident at with eating after set-up. Ital Record did not show any es. Ician's Orders dated October ler for a regular diet with gs. Iters sets Notes (Dietary) dated at Resident #23 received a less Notes (Dietary) dated at Resident #23 received a lable meat and eggs. Iters of the fact of the fac	F	325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. BUILDING C 345500 B. WING			(X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA (X2) M		LE CONSTRUCTION	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE CAH DEFICIENCY MUST BE PRECEDED BY FULL TABLE	AND PLAN OF	- GORRECTION	IDEMILLICATION NOMBER:	A. BUII	DING.				
WINDSOR POINT CONTINUING CARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 325 Continued From page 31 updated 9/26/11 listed a stage 2 sacral ulcer and bilateral ankle stasis ulcers as a problem. Approaches listed a diet high in protein. In an observation on 10/18/11 at 12:40 PM, Resident #23 was sitting up at the bedside with the meal tray on the over bed table. There were 4 fish nuggets provided to Resident #23. In an observation on 10/19/11 at 8:40 AM, an aide was observed setting up Resident #23's breakfast. Resident #23 received 2 strips of bacon, 1 slice of toast, ½ banana, orange juice, milk, and coffee. There were no eggs provided. The diet slip read double eggs. Also listed was that Resident #23 did not like eggs. In an interview on 10/19/11 at 11:00 with the Dietary Manager (DM), he stated that he did not put resident likes or dislikes in the chart but put them directly into the dietary system. He indicated that Resident #23 did like eggs but did not want them everyday. He indicated that a normal portion of breakfast probein would have been 2 slices of bacon. He indicated that a normal portion of fish nuggets would have been			345500	B. WIN	G		10/3	_	
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX RECH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROMDERS PLAN OF CORRECTION SHOULD BE COMMERTION PREFIX TAG PROMDERS PLAN OF CORRECTION SHOULD BE COMMERTION PREFIX TAG PROMDERS PLAN OF CORRECTION SHOULD BE COMMERTION PREFIX TAG PROMDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) PREFIX TAG F 325 Continued From page 31 Updated 9/26/11 listed a stage 2 sacral ulcer and bilateral ankle stasis ulcers as a problem. Approaches listed a diet high in protein. In an observation on 10/18/11 at 12:40 PM, Resident #23 was slitting up at the bedside with the meal tray on the over bed table. The meal card read double meat portions. There were 4 fish nuggels provided to Resident #23 s breakfast. Resident #23 received 2 strips of bacon, 1 silice of toast, ½ banana, orange juice, milk, and coffee. There were no eggs provided. The diet slip read double eggs. Also listed was that Resident #23 did not like eggs. In an interview on 10/19/11 at 11:00 with the Dietary Manager (DM), he stated that he did not put resident #23 did like eggs but did not want them everyday. He indicated that a normal portion of breakfast protein would have been 2 silces of bacon and that Resident #23 should have received 4 silces of bacon. He indicated that a normal portion of fish nuggels would have been 2 silces of bacon and that Resident #23 should have received 4 silces of bacon. He indicated that a normal portion of fish nuggels would have been 2 silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a silces of bacon and that Resident #23 should have been a s			ARE		12	221 BROAD STREET			
updated 9/26/11 listed a stage 2 sacral ulcer and bilateral ankle stasis ulcers as a problem. Approaches listed a diet high in protein. In an observation on 10/18/11 at 12:40 PM, Resident #23 was sitting up at the bedside with the meal tray on the over bed table. The meal card read double meat portions. There were 4 fish nuggets provided to Resident #23. In an observation on 10/19/11 at 8:40 AM, an aide was observed setting up Resident #23's breakfast. Resident #23 received 2 strips of bacon, 1 slice of toast, ½ banana, crange juice, milk, and coffee. There were no eggs provided. The diet slip read double eggs. Also listed was that Resident #23 did not like eggs. In an interview on 10/19/11 at 11:00 with the Dietary Manager (DM), he stated that the did not put resident likes or dislikes in the chart but put them directly into the dietary system. He indicated that Resident #23 did like eggs but did not want them everyday. He indicated that a normal portion of breakfast protein would have been 2 slices of bacon and that Resident #23 should have received 4 slices of bacon. He indicated that a normal portion of fish nuggets would have been	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	OULD BE	COMPLETION	
received 6-8 nuggets for a double portion. He indicated that when there was a diet change a communication slip was provided to the dietary department. He stated that Resident #23 should have received double meat and egg portions and that the kitchen staff needed to be more careful when they were preparing the trays. In an observation on 10/19/11 at 12:15 PM,	F 325	updated 9/26/11 liste bilateral ankle stasis Approaches listed a lin an observation on Resident #23 was sit the meal tray on the card read double me fish nuggets provided. In an observation on aide was observed sibreakfast. Resident bacon, 1 slice of toamilk, and coffee. The The diet slip read do that Resident #23 did the mean tray on 10 Dietary Manager (Dietary Manager (Dietar	ad a stage 2 sacral ulcer and ulcers as a problem. diet high in protein. 10/18/11 at 12:40 PM, tiling up at the bedside with over bed table. The meal rat portions. There were 4 dto Resident #23. 10/19/11 at 8:40 AM, an retting up Resident #23's #23 received 2 strips of st, ½ banana, orange juice, are were no eggs provided. The were no eld to high edgs. 20/19/11 at 11:00 with the eld not dislike in the chart but put eld diske eld that a normal portion would have been 2 slices of dent #23 should have bacon. He indicated that a h nuggets would have been t Resident #23 should have so for a double portion. He there was a diet change a was provided to the dietary ed that Resident #23 should le meat and egg portions and f needed to be more careful paring the trays.	F	325				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345500	B. WIN			10/	C (20/2011
	OVIDER OR SUPPLIER	CARE	1	1221	ADDRESS, CITY, STATE, ZIP CODE BROAD STREET UAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	which was a doub In an interview on Registered Dieticia assessment proce weights and to go she did not watch cards, or watch m at the orders in the s to see what the did not visualize F she was getting de In an interview on Director of Nursin Nursing Assistant what a double por that she expected diet that was orde 483.35(i) FOOD F STORE/PREPAR The facility must- (1) Procure food f considered satisfa authorities; and	lived 2 chicken thighs for lunch le portion. 10/20/11 at 8:52 AM with the an (RD), she indicated that her ass was to look at resident through their charts. She stated tray preparation, check meal eals. She indicated she looked e chart and looked in the MAR 'nurses were signing for. She desident #23's meals to see that puble portions. 10/20/11 at 3:10 PM with the g (DON), she indicated that the s would not necessarily know tion consisted of. She indicated the kitchen staff to provide the red. PROCURE, E/SERVE - SANITARY		371			
	by: Based on observ	ENT is not met as evidenced ation and staff interview the aintain a cold salad made with	and the second s				

PRINTED: 11/02/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345500	B. WIV			C 10/20/20	
	OVIDER OR SUPPLIER	CARE	J	1221	T ADDRESS, CITY, STATE, ZIP CODE BROAD STREET RUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	during operation of sink used for prepar replace or discard c and failed to label at the kitchen and the refrigerator. Finding 1. At 11:40 AM on a calibrated thermor salad at the trayline Fahrenheit. The trasteam well which we of chicken salad, refreezer, registered 4. At 11:42 AM on 10/trayline temperature were taken on any the 10/18/11 lunch this time the cook stake hot and cold for the trayline began of Dietary Manager (Dietary Manager (Diet	elow 41 degrees Fahrenheit the trayline, failed to sanitize a ing raw chicken, failed to compromised kitchenware, and date opened food items in mourishment room gs include: 10/18/11, when checked with meter, the tray pan of chicken registered 53.6 degrees y pan was sitting above a as filled with ice. A new pan moved from the reach-in 15.9 degrees Fahrenheit. 18/11 a review of the log of as revealed no temperatures not or cold foods before or as trayline began operation. At tated he was supposed to od temperatures just before operation at each meal. The M) reported the cook was reparation tasks so that may on he forgot to obtain a the trayline began operation. d that the resident trays for y left the kitchen. He stated hicken salad at the trayline, in freezer, and lower the continuing to serve it to	F	371			
	salad was back on he was able to lowe	18/11 a tray pan of chicken the trayline. The DM reported or the temperature to 45 iso it was safe to continue					

Event ID: L3Q411

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED					
		345500	B. WING_		10/	C 20/2011
	ROVIDER OR SUPPLIER	ARE		TREET ADDRESS, CITY, STATE, ZIP COE 1221 BROAD STREET FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 371	calibrated thermome registered 45.3 degree At 12:12 PM on 10/1 croissants were asseresident trays. After croissants were pulle the chicken salad was the trayline. The DM remain at or below 4 operation of the trayline he trayline he trayline powder, and of the DM, the chicken it was served, rather before serving as recepted temperature recorded in the trayline before they were serrefrigerator after prepreferred to place ico pans of cold salads trying to place the serice. The cook commodit foods away from cold foods away from cold foods away from cold foods away from the cold foods away from cold foods away from cold foods away from the col	lents. When checked with a ster, the chicken salad ees Fahrenheit. 8/11 two chicken salad embled and placed on surveyor intervention, the ed from resident trays, and as once again removed from it stated all cold foods should 5 degrees Fahrenheit during line per ServSafe guidelines.	F 37	1		

Event ID: L3Q411

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345500	B. WIN	'G		10/20	;)/2011	
	ROVIDER OR SUPPLIER	ARE		122	ET ADDRESS, CITY, STATE, ZIP CODE 11 BROAD STREET QUAY VARINA, NC 27526			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 371	should be kept at 40 during the entire open 2. At 8:34 AM on 10/chicken directly into the was rinsed under run cutting board to be fricken directly into the sink afterwards at 9:30 AM on 10/18/chicken diverse washed down the led poultry sink. No sand to the sink afterwards at 9:30 AM on 10/18/chicken diverse support of the sink afterwards at 2:12 PM on 10/19/chicken and sanitize materials and sanitize materials and sanitize materials and sanitize materials and sanitizing solution from sink dispensing system sanitizing food preparation staff were supposed sanitizing food preparation staff was in sinks so it would not tasks, especially whe placed directly in the At 2:48 PM on 10/19/was trained to use a	s trained that all cold foods degrees Fahrenheit or below ration of the trayline. (18/11 the cook poured raw he poultry sink. The chicken ining water and placed on a immed. (11 the cook obtained a not solution from the ink dispensing system, and lage, sides, and bottom of the intizing solution was applied is. (11 the cook stated he had be poultry sink, and did not inseed to sanitize the sink. (11 the Dietary Manager staff were trained to wash, eat and poultry sinks after tasks in them. He reported to obtain quaternary of the three-compartment is in the inseed to sinks. The DM inportant to kill bacteria in the multiply between preparation of meat and poultry were sinks. (11 the PM cook stated she spray bottle of sanitizer on ter completion of poultry or	F	371				

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345500	A. BUII B. WIN	G		1	0/2011	
	ROVIDER OR SUPPLIER		<u> </u>	1221	FADDRESS, CITY, STATE, ZIP CODE BROAD STREET UAY VARINA, NC 27526			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 371	10/17/11, beginning pan which was hang which was scratched. At 9:54 AM, during a kitchenware on 10/1 hanging in storage h scratched. At 10:08 AM on 10/1 mugs were stained of the compromised or dar trained to bring it to the compromised or dar trained to bring it to the commented kitch surfaces could incre could grow on it, and off kitchenware could sick. According to the facility was even current coffee mugs making a decision at the facility was even current coffee mugs making a decision at the put stained kitches solution weekly. He say for sure when the mugs in a bleach solution when the coffee that a bleach solution dark brown staining.	tour of the kitchen on at 9:42 AM, a saute/frying ing in storage had a coating which was in the Dietary Manager to the chance that bacteria in the DM, using metal utensils in the DM, using to replace the pout which cups to purchase. The dietary staff was supposed in the staff last submerged the staff last submerged the staff last submerged the unugs were so badly stained an would no longer remove the	Ę.	371				

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				LDING		C	;
		345500	B. Wil	<u></u>		10/20	/2011
	ROVIDER OR SUPPLIER R POINT CONTINUING CA	ARE		12:	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET JQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACT		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION SHOULD BE HE APPROPRIATE	
F 371	kitchenware to replace scratched, cracked, a increased the chance residents sick. The control of the staff was supposed to weekly to remove the explained this was not could not say for sure was occurring. 4. During initial tour beginning at 9:42 AM frozen biscuits and on cinnamon roll dough on them. These item freezer. In the dry st packet of onion soup marshmallows, a 24 mix, and a 24 ounce were opened and resilabels or dates on the opened bag of steak had a label on it, but Bags of French fries, and sausage which with e walk-in freezer, or reflecting when they During a follow-up to at 10:03 AM a bag of walk-in refrigerator will did not have a label of the bottom of a crate bags containing two	cose of it and reorder new see it. She reported and chipped kitchenware that bacteria could make sook commented the dietary to soak stained kitchenware discoloring. However, she of her responsibility so she if the weekly de-staining of the kitchen on 10/17/11, for three bags of opened ne bag of opened frozen did not have labels or dates as were found in the reach-in orage room a 5.7 ounce of mix, a 16 ounce bag of ounce bag of lemon gelatin bag of strawberry gelatin mix sealed, but did not have em. In the walk-in freezer an se, which had been resealed, the date was unreadable. In hamburger patties, tortelini, were opened and resealed in the did not have labels and dates were opened. The provided have labels and dates were opened and resealed, but or date on it. In addition, in the walk-in freezer two different types of sausages sealed, but did not have a	F	371			

Event ID; L3Q411

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUII		LE CONSTRUCTION	COMPLETE	DATE SURVEY COMPLETED	
		345500	в. wn	G		C 10/20/20		
	ROVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 221 BROAD STREET UQUAY VARINA, NC 27528			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION ICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
F 371	layer cake, which wa reach-in freezer, did it. At 2:12 PM on 10/19. Assistant Dietary Ma monitored the storag food items which we using plastic wrap, la addition, the DM repremoved from their cache should have labels at At 2:48 PM on 10/19 DM, ADM, and cook daily. In addition, she person also monitore placing newly deliver cook reported all sto daily to make sure for opened, leftovers, and	711 a boxed whipped cream s opened and stored in the not have a label and date on 711 the DM stated he, the nager (ADM), and the cooks e areas daily to make sure re opened were resealed beled, and dated. In orted leftovers and foot items riginal packaging/containers	F	371				
	refrigerator that cont observed. Nursing A attendance during the refrigerator there wan jelly, mustard, mayo opened date. Also of pitcher of a red fluid with a golden colore	50 AM the nourishment ained resident's food was Assistant (NA) # 1 was in the observation. In the s an opened container of nnaise with no name or observed was an uncovered with no date and a pitcher d fluid covered with tin foil er pitcher dated 10/19/11						

Facility ID: 956929

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		E CONSTRUCTION	(X3) DATE SURY COMPLETE	
		345500	B. WN			10/20	l.
	COVIDER OR SUPPLIER			122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET IQUAY VARINA, NC 27526	10/20	,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 371	of the pitcher. There was no thermore the freezer container filled with a brown sure on the container, but did not know why the the freezer since the unit. There was no container had it coutside of the containames on the containames on the containames. In the freezer loosely covered by the was ice cream with a There was no name stated she thought the for keeping the refriguithout names and cowas unable to determine the freezer loosely covered by the was no name stated she thought the for keeping the refriguithout names and cowas unable to determine the container that the cont	e 39 Illow substance on the bottom ometer in the freezer section. d a plastic container half abstance. There was a name no date. NA # 1 stated she container would even be in resident did not live in the date on the container. There if vanilla ice cream opened. be cream frozen to the ner. There were no dates or ners. A plastic container that substance had no date or r was seen a styrofoam cup in foil. In the 1/2 filled cup a spoon in the ice cream. or date on the cup. NA # 1 he 3rd shift was responsible gerator clean. She stated dates on the food items, she mine how long the items had tor or to whom the items	F	371			
	(DON) on 10/20/11 ato NA # 1 speaking whousekeeping was refrigerator. The DO the facility system for the nourishment refrithe 3rd shift nurse with the this was done without freezer. The DON step to NA # 10 # 10 # 10 # 10 # 10 # 10 # 10 # 1	Id with the Director of Nursing at 9:28 AM. She stated prior with her, she thought esponsible for cleaning the DN stated she was unclear of or dating/labeling and cleaning rigerator. The DON stated was responsible for recording stated she was unsure how but a thermometer in the stated the Administrator had ing would be responsible for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345500	B. WING		C 10/20/2	1011
	OVIDER OR SUPPLIER	<u> </u>	122	ET ADDRESS, CITY, STATE, ZIP CODE 1 BROAD STREET QUAY VARINA, NC 27526		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371 F 441 SS=D	cleaning the refrigers department would be food items were date	ator and the dietary e responsible for making sure	F 371			
	Infection Control Pro safe, sanitary and co	ablish and maintain an ogram designed to provide a omfortable environment and levelopment and transmission tion.				
	Program under which (1) Investigates, con in the facility; (2) Decides what proshould be applied to	ablish an Infection Control th it - trols, and prevents infections ocedures, such as isolation, an individual resident; and rd of incidents and corrective				
	prevent the spread of isolate the resident. (2) The facility must communicable disertion direct contact will track to the facility must (3) The facility must	on Control Program esident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which licated by accepted				
	(c) Linens Personnel must har	ndle, store, process and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S EOD MEDICARE & I	MEDICAID SERVICES), <u>0938-039 </u>
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLI	E CONSTRUCTION	(X3) DATE SUI COMPLET	
AND PLAN OF	CORRECTION	DENTIFICATION NUMBER.	A. BUI	LDING			С
		345500	B. WN	IG		1	0/2011
	ROVIDER OR SUPPLIER			122	ET ADDRESS, CITY, STATE, ZIP CODE 21 BROAD STREET		
WINDSOF	R POINT CONTINUING CA	ARE		FU	IQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	1 =	e 41 s to prevent the spread of	F	441			
	by: Based on observation interviews the facility glucose meter after a glucose was perform during medication parameters and washing hygier properly to prevent the findings include: 1. According to the the manufacturer's racturer's racturer's racturery and the glucose monitor disinfected. The usus dampened with soa was to be used to a glucose meter. For meter it indicated to household bleach (solution) in 9ml of with the maintenance seguide it indicated to There was no frequence of the puring medication at 4:00 PM, Nurse and the maintenance of the puring medication at 4:00 PM, Nurse and the maintenance of the puring medication at 4:00 PM, Nurse and the puring medication at 4:00 PM and the puring medication a	ne and handling soiled linens the spread of infection. Infection control section of ecommendations for the onitor (meter) (revised 6/07), was to be cleaned and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
			A. BUI	LDING	<u> </u>	l c	;
		345500	B. WI	4G		10/20)/2011
	OVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	POINT CONTINUING CA	ARE		F	UQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 441	procedure for disinfed glucose meters she suse alcohol wipes. On 10/19/11 at 9:30 / always cleaned blood use. She stated she alcohol prep pad from During an interview w (DON), on 10/19/11 a kept a disinfectant so disinfecting the blood stated the same solut room. The DON reports to the medication meters in between reoffice was always operalcohol wipes was not blood glucose meters revised guidance inforblood glucose meters office as she had just DON also reported the had the manufacturer available in her office questions in regards On 10/20/11 at 11:20 antimicrobial wipes he the medication carts	AM, Nurse #1 stated she is glucose meters after each cleaned them using an in the medication cart. With the Director of Nurses at 11:40 AM, she stated she lution in her office for glucose meters. She also stion was in the medication borted staff were expected to broom to clean/disinfect the sidents. She added that her en. The DON stated using at sufficient for disinfecting as was in the Administrator's a obtained it from him. The part the medical records staff it's recommendations after staff if they had to disinfecting the meters. AM, the DON stated ad been provided for all of as of today and an inservice in the proper way to disinfect	F	441			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE LDING	E CONSTRUCTION	(X3) DATE S COMPLE	
		345500	B. WI	lG		10/	C 20/2011
	ROVIDER OR SUPPLIER	ARE	•	122	ET ADDRESS, CITY, STATE, ZIP CODE 11 BROAD STREET QUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From page	э 43	F	441			
	cumulative diagnoses blindness, anxiety, as blindness, anxiety, as An observation was a PM of Nursing Assist incontinent care to Rethe room, the resider were lying on the floowith the top sheet fro completing incontinent soiled brief with the fincontinent pad and the where it landed on the bed. The turn sheet Smeared feces was at the turn sheet and er were left on the right Without changing his the clean brief over the fastened the brief on used the soiled glove.	made on 10/18/11 at 4:15 ant (NA) # 2 providing esident # 18. On entering at's personal blankets (2) or at the end of the bed along and the bed. After ant care, the NA rolled the eces inside the quilted hrew both over the resident e floor on the left side of the was left on the bed. abserved on the left side of aser sized balls of feces side of the turn sheet. dirty gloves ,the NA placed are balls of feces and Resident # 18. The NA then as to pick up clean pants					
	removed and a clean gloves. NA # 2 used opened the resident's shoes. At this point, After dressing Reside the soiled clothing ite without bagging the hall to the dirty linen room, he used the so the resident to the wito the soiled linen room, he assist	the resident's shirt was shirt applied using the same the soiled gloves and dresser to find socks and the NA changed his gloves. In the 18, NA # 2 picked up ms and sheets/pad and drems, took them across the room. Coming back to the diled gloves and transferred dreelchair. NA # 2 went back to m. Upon leaving the soiled ed another NA to push a other resident's room. The					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345500	B. WING			1	C 0/ 2011
	ROVIDER OR SUPPLIER	ARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 121 BROAD STREET JQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	۲	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	then went to the clean clean linen using the resident's bed was m picked up off the floor bed. After completion disposed of the soiled hands. An interview was held 4:29 PM. He stated it dirty linen by putting I adding he was taught the floor. NA # 2 state put the linen on the floor to been taught to chand clean. He acknowled diaper on top of the diffeces. NA # 2 stated The NA stated the da contamination. The commonly put items to back on the bed, but was not thinking. An interview was held (DON), who had prev Development Coordin The DON stated the ewash their hands before added staff had been the hall. An in-service presented on infection borne pathogens, etc soiled with stool were possibly transport sto cross contamination.	the soiled gloves. NA # 2 In linen room and retrieved soiled gloves. The ade, her personal blankets of and placed on the clean of making the bed, the NA digloves and washed his If with NA # 2 on 10/18/11 at the had been taught to handle inens in the dirty linen bin to to place soiled linen on ed he did not know why he cor. The NA stated he had ange gloves between dirty wiledged he put the clean traw sheet with the visible he had not been thinking, nger could be cross NA stated he would not hat had been on the floor did that today because he with the Director of Nursing iously served as the Staff nator at 5:10 PM on 10/1811. Expectation was for staff to one and after any care. She taught not to wear gloves in	F	441			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION 3	(X3) DATE SU COMPLET	LED
		345500	B. WIN	IG_			C 20/2011
	ROVIDER OR SUPPLIER	ARE		1:	REET ADDRESS, CITY, STATE, ZIP CODE 1221 BROAD STREET FUQUAY VARINA, NC 27526	•	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULÐ BE	(X5) COMPLETION DATE
F 441		ad been taught to bag linens	F	441			
			A CALLES AND A CAL				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER (DENTIFICAL (X1) PROVIDER (DEN			(X2) MULTI A BUILDIN B WNG _	IPLE CONSTRUCTION G	C 10/20/2011	
NAME OF P	ROMOER OR SUPPLIER		STREET AD	DRESS, CITY ST	ATE ZIP CODE		
WINDSOF	R POINT CONTINUING C	ARE	ł .	DAD STREET VARINA, NC 2	7525		
(X4) ID PREFIX FAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X3) COMPLE DATE
	(a) An adult care horn preparation and admir prescription and non-post staff are in accordance (1) orders by a licensis which are maintained (2) rules in this Section and procedures. This Rule is not met a Based on observation, interviews, the facility foxygen for 1 of 1 (Residents reviewed for Findings include: Resident #58 was admitted the facility on the facility of the faci	Medication Administrate shall assure that the inistration of medication prescription, and treatmence with: ed prescribing practition in the resident's recording and the facility's policion and the facility and the facility and the facility and the facility and facility	s, ents ner and cies	D 358	Windsor Point acknowledges restatement of Deficiencies and p Plan of Correction to the extent summary of findings is factually in order to maintain compliance applicable release provisions of The Plan of Correction is submit written allegation of compliance Point's response to the Stateme Deficiencies and Plan of Correct denote agreement with the Stat Deficiencies, nor does it constituadmission that any deficiency is Further, Windsor Point reserves submit documentation to refute stated deficiencies on the State Deficiencies through informal diresolution, formal appeal procesany other administrative or legal	roposes this that the correct and with the residents. ited as a e. Windsor ent of ion does not tement of ute an accurate. is the right to e any of the ment of ispute ss, and/or,	
R A Opport re th po po an	howed an order for oxy is nasal cannula to run eview of an In-Service ttendance packet show aygen had been done or ovided the following in sident is on oxygen been concentrator make intable tank to use and onot remove the concentrator distributed in the correct lite.	Summary and yed an in-service on 8/24/11. The in-service formation: "When a fore taking them off of sure that they have a that it has oxygen until on wheelchair, turned o	ice		Windsor Point will ensure the se provided or arranged by the faci professional standards of quality. I. Corrective action will be according for Resident #58 found to have I affected by the deficient practic. 1. On 10/19/11 Resident #58's oxygen was turned on to 3 liters by MD. II. Corrective action will be according to the second standard will be according to the second standard standard will be according to the second standard	omplished been e as follows: s portable as as ordered	

LABORATORY DIRECTOR'S OR PROVICER/SUPPLIER REPRESENTATIVE'S SIGNATURE

WILL

ADMINISTRATOR

LJQ411 BATOT

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULT	PLE CONSTRUCTION	(X3) DATE : COMPL					
		NH0580		B WNG _		10	C //20/2011				
NAME OF P	PROVIDER OR SUPPLIER		STREET AD	ORESS, CITY, ST	ATE, ZIP CODE	. 10	720/2011				
WINDSO	R POINT CONTINUING CA	ARE		ROAD STREET Y VARINA, NG 27528							
(X4) IO PREFIX FAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROMOER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE				
In Me	and making sure that oxygen. If you find a retheir portable tank, imit to their room and put the until another portable to notify the Med-Tech or immediately. If you care your half a supervisor or change out portable ta Review of the Adult Ca Physician Authorization 9/7/11 showed Resident liters per minute continuates per minute continuates per minute continuates per minute working with Resident #58 and that oworking with Resident #58 was sitting nain dining room. Portain intule was provided via cortable tank was approximated in a nobservation on 10/10/10/10/10/10/10/10/10/10/10/10/10/1	residents do not run our esident without oxygen mediately take them bathem on their concentratank can be used. Their supervisor on duty mot find the Med-Techor a nurse can help your net." The Home Personal Carriand Care Plan dated in #58 used oxygen at Suously. The Health Professional on and Quarterly Review 1 showed that oxygen itoring was being done competency of the staff is 8 had been validated. The table oxygen at 3 liters per nasal cannula. The ximately 25% full. The in a wheelchair in the personal cannula. The ximately 25% full. The oxygen was attached on the contract of the staff is shortness of breath are plete sentences without sues were observed.	for for he ar	D 358	follows: 1. Staff were in-serviced on or from 10/19/11 – 10/21/11. (i) 2. All other residents receiving were checked for proper liters distribution. III. The systemic changes put that deficient practices will not 1. "System Check for Oxygen implemented. (EXHIBIT 2) IV. Performance correcting the deficiencies will be monitored following methods. A QA most has been put in place to assure systems are in place. 1. "System Check for Oxygen completed as follows: daily used to complete the day of the resident of the reside	exhibit 1) ag oxygen and oxygen into place so recur will be: " will be mese through the nitoring tool the following " will be ntil 100% x 4, monthly x er. (EXHIBIT	26/11				

L3Q411

STATEMENT OF SERVICENCES MOPPLAN OF CORRECTION MOPPLAN OF CORRECTION MINESSO MINE	CIVIS	on or health Service Rec	Injation				•				
WINDSOR POINT CONTINUING CARE STREET ADDRESS, CITY STATE LIP CODE 1221 BROAD STREET FUCUATY VARINA, NC 27528 DAMMY STATE LIP CODE REGULATORY OR LSC DENT-PY-MO INFORMATION) DISPREY REGULATORY OR LSC DENT-PY-MO INFORMATION) PRESS DESCRIPTION REGULATORY OR LSC DENT-PY-MO INFORMATION) PRESS DENT-PY-MO INFORMATION REGULATORY OR LSC DENT-PY-MO INFORMATION REGULATORY OR LSC DENT-PY-MO INFORMATION) PRESS DENT-PY-MO INFORMATION REGULATORY OR LSC DENT-PY-MO INFORMATION REGULATORY O	AND PLAN OF CORRECTION DENTIFICATE		DENTIFICATION NUM	CLIA BER	A BUILDING			COMPLETED			
WINDSOR POINT CONTINUING CARE IZE BROAD STREET FUGUAY VARINA, NO 27526 PRETEX REGULATORY ORLS GENEROPY NALL REGULATORY ORLS							10/				
SUMMY STATEMENT OF DEPICEMENTS PRETX IRACH DEPICEMENT STATEMENT OF DEPICEMENTS OBTICAL STATEMENT OF DEPICEMENT OF DEPCEMENT OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE ZIP CODE							
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get up and changing oxygen tanks when needed. She indicated that portable oxygen tanks were checked daily. She stated that she did not know Resident #58's portable oxygen was empty and that the aide who got Resident #58's by should have checked the lank and told her it was low. In an interview on 10/18/11 at 5:55 PM with Personal Care Assistant (PCA) #1, she indicated that her responalibilities included getting residents up and making sure they were dry. She stated that she looked at Resident #55's portable oxygen tank and saw that it was registering in the red. She indicated that she "hoped" it would tast through dinner and took resident #58's to the dining room. She stated and took resident #58's to the dining room. She stated she did not notify the Med-Tech that the portable oxygen tank was low. In an observation on 10/19/11 at 8:15 AM, Resident #58's was sitting up in a wheelchair in the main dining room. The oxygen cannula was in place and connected to the portable oxygen tank. The portable oxygen gaupe needle was in the red and on zero. Nursing Assistant (NA) #1 approached Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident. Resident #58 and stated she would bring a new portable oxygen tank to the resident processes of breath and was able to speak in complete sentences without pausing. No respiratory issues were observed. In an interview on 10/19/11 at 8:20 AM with PCA #2 she stated she got Resident #58 to the main duning room at approximately 7 35 AM She indicated that took Ne	PREF	X : LEACH DEFICIENC	Y MUST BE PRECEDED BY FU	FULL PREFIX (E.		(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
		get up and changing. She indicated that po checked daily. She st Resident #58's portable that the aide who got have checked the tank. In an interview on 10/1 Personal Care Assista that her responsibilities up and making sure the that she looked at Resoxygen tank and saw it red. She indicated that through dinner and tool room. She stated she detail that the portable oxygen fan an observation on 10 Resident #58 was sitting main dining room. The coplace and connected to The portable oxygen gar and on zero. Nursing As approached Resident #58 was not exported the portable oxygen gare and connected to the portable oxygen gare and on zero. Nursing As approached Resident #58 was not exported the portable oxygen gare and on zero. Nursing As approached Resident #58 was not exported the portable oxygen gare observed.	oxygen tanks when nee rable oxygen tanks were ated that she did not know the oxygen was empty a Resident #58 up should k and told her it was low to the task and told her it was low to the task and told her it was low to the task and told her it was low to the task as included getting reside ey were dry. She stated ident #58's portable that it was registering in she "hoped" it would tak resident #58 to the dir it has to the Med-Ten tank was low. If 1 at 8:15 AM, grup in a wheelchair in to the portable oxygen tank to the resident periencing any shortness of speak in complete and stated she would gen tank to the resident periencing any shortness of speak in complete and to the to the main type the tank. She int #58 to the main type to the tank to the main type to the tank to the complete thank. She int #58 to the main type to the key used to ated that she told	ted ants the ast aning ach he tt.	D 358						

1498

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES IX11 PROVIDER/SUPPLIER/CLIA (XJ) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION *OENTIFICATION NUMBER* COMPLETED A BUILDING 8 WING NH0580 10/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE, ZIP CODE 1221 BROAD STREET WINDSOR POINT CONTINUING CARE FUQUAY VARINA, NC 27528 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION IEACH DEFICIENCY WUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY D 358 Continued From page 3 D 358 to be turned on. In an interview on 10/19/11 at 8:50 AM with NA #1, she indicated that Resident #58's oxygen was supplied by a different vendor than the one the facility provided. If a tank was not available from Resident #58's supply the facility oxygen could be used. She stated that when an aide gets a resident up the portable oxygen tank should be checked. If the lank reading was low or empty the Med-Tech should be notified. The aide should not remove the resident from the room with an empty tank. In an interview on 10/19/11 at 9:26 AM with Med-Tech #2, she stated that she had not been told by anyone that Resident #58 needed the portable oxygen tank turned on. She indicated that PCA #2 should not have taken Resident #58 to the dining room without the oxygen being turned on. She stated she was always available and that Resident #58 had never run out of oxygen before this. In an observation on 10/19/11 at 9:45 AM, Resident #58's portable oxygen tank was approximately 25% full. In an interview on 10/19/11 at 10:45 AM with the Adult Care Home Supervisor, she indicated it was the responsibility of the Med-Techs to check the portable oxygen tanks each time the residents left their rooms. She stated that the PCA's needed to get the Med-Techs prior to taking a resident with portable oxygen out of their rooms so the tanks could be checked. She indicated that it was her expectation that a PCA would not remove a resident from their room with an empty portable

oxygen tank.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>MB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3 DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345500 12/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1221 BROAD STREET** WINDSOR POINT CONTINUING CARE FUQUAY VARINA, NC 27526 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Windsor Point acknowledges receipt of Statement of Deficiencies and proposes this K 051: NFPA 101 LIFE SAFETY CODE STANDARD K 051 Plan of Correction to the extent that the SS=D summary of findings is factually correct and A fire alarm system with approved components. In order to maintain compliance with the devices or equipment is installed according to applicable release provisions of residents. NFPA 72, National Fire Alarm Code, to provide The Plan of Correction is submitted as a effective warning of fire in any part of the building. Activation of the complete fire alarm system is by written allegation of compliance. Windsor Point's response to the Statement of manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in Deficiencies and Plan of Correction does not patient sleeping areas may be omitted provided denote agreement with the Statement of that manual pull stations are within 200 feet of Deficiencies, nor does it constitute an nurse's stations. Pull stations are located in the admission that any deficiency is accurate. path of egress. Electronic or written records of Further, Windsor Point reserves the right to tests are available. A reliable second source of submit documentation to refute any of the : power is provided. Fire alarm systems are stated deficiencles on the Statement of maintained in accordance with NFPA 72 and Deficiencies through Informal dispute records of maintenance are kept readily available. resolution, formal appeal process, and/or There is remote annunciation of the fire alarm any other administrative or legal proceeding. system to an approved central station. 9,6 K 051 Windsor Point will ensure the services provided or arranged by the facility will meet professional standards of quality. I. Corrective action will be accomplished by · This STANDARD is not met as evidenced by: Windsor Point to correct the deficient By observation on 12/8/11 at approximately noon practice as follows: there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of 1. A visual/audible trouble signal will be telephone line connection, nor at the panel at the Installed at the Fire Alarm Control Panel; side entrance near the manned nursing station. (FACP) located at the front entrance of the K 144 · NFPA 101 LIFE SAFETY CODE STANDARD facility. This area is likely to be seen or ; K 144 SS≍D heard by Windsor Point staff. Generators are inspected weekly and exercised under load for 30 minutes per month in

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is defermined 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.

FORM CMS-2667(02-99) Previous Versions Obsolete

NOT

LABORATORY DIRECTOR'S OR PROVIDEN/SUPPLIER REPRESENTATIVE'S SIGNATURE

Event ID: L3Q421

Facility ID: 956929

TITLE

OMINISTRATOR

If continuation sheet Page 1 of 3

(X6) DATE

		E & MEDICAID SERVICES	····		OMB NO. 0938-03	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		345500	B. WING	· · · · · · · · · · · · · · · · · · ·	40/00/0044	
NAME OF	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP COD	12/09/2011	
WINDSC	R POINT CONTINUIN	G CARE	1221	BROAD STREET QUAY VARINA, NC 27526	.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE COMPLETIC	
K 144	Continued From page 1 accordance with NFPA 99. 3.4.4.1.		K 144	II. Windsor Point will identify other life safety Issues having the potential to affect residents by the same deficient practice accorrective action will be taken as follows:		
				 A visual/audible troubl installed at the Fire Alarm ((FACP) located at the front facility. This area is likely heard by Windsor Point sta 	Control Panel entrance of the to be seen or	
:	42 CFR 483,70(a) By observation at ap dld not meet NFPA 9 Annunclator which si	not met as evidenced by: proximately noon the facility 9 3-4.1.1.15 Alarm ates: A remote annunclator, inced, shall be provided to	:	 III. The measures/systems into place so that deficient recur will be: 1. A visual/audible trouble installed at the Fire Alarm C (FACP) located at the front of 	oractices will not e signal will be ontrol Panel	
operate outside of the generaling room in a location readily observed by operating personnel at a regular work station. (see NFPA 70, National Electrical Code, Section 700-12). The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:			a: C delle parente delle	facility. This area is likely the heard by Windsor Point staff. IV. Performance correcting deficiencies will be monitore following methods:	o be seen or f. g these	
			1. Audits of the visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone connection will be completed using the "Telephone Connection Loss Audit" by Administrator or designee as follows: weekly for 4 weeks and at least annually thereafter.			
	 Low lubricating Low water tem equired in 3-4.1.1.9) 	oll pressure perature (below those	are a date of degree of the second	V. February 6, 2012	2/6/12	
00	3. Excessive water 4. Low fuel - when	i the main fuel storage tank	; ;	К 144	-	
- CC	ntains less than a 3-hour operating supply 5. Overcrank (falled to start)			Windsor Point will ensure the provided or arranged by the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A BUILDING 01 - MAIN BUILDING 01 B. WING _ 345500 12/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1221 BROAD STREET** WINDSOR POINT CONTINUING CARE FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX : (X6) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 144 Continued From page 2 K 144 professional standards of quality. 6. Overspeed I. Corrective action will be accomplished by Where a regular work station will be unattended Windsor Point to correct the deficient periodically, an audible and visual derangement practice as follows: signal, appropriately labeled, shall be established at a continuously monitored location. This 1. A remote annunclator, storage battery derangement signal shall activate when any of powered, will be provided to operate outside the conditions in 3-4.1.1.15 (a) and (b) occur, but of the generating room. The remote need not display these conditions individually. annunciator will be moved to the facility's [110: 3-5,5,2] nurses' station. This area is a regular work station and is likely to be seen or heard by : Specific findings include the annunciator panel Windsor Point staff. , was located in an area that is not a regular work station or likely to be readily observed. 2. An audible/visual derangement signa), appropriately labeled, will be established at the facility's nurses' station. II. Windsor Point will identify other life safety issues having the potential to affect residents by the same deficient practice and corrective action will be taken as follows: 1. A remote annunciator, storage battely powered, will be provided to operate outside of the generating room. The remote annunclator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. III. The measures/systemic changes put into place so that deficient practices will not recur will be:

PRINTED: 12/10/2011

		E & MEDICAID SERVICES			OMB NO. 0938-0	
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į.	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A BUILDING	01 - MAIN BUILDING 01	COMPLETED	
		346500	B. WING		12/09/2011	
VAME OF I	PROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODI		
WINDSO	R POINT CONTINUIN	IG CARE	12	21 BROAD STREET	•	
			FU	IQUAY VARINA, NC 27528		
(X4) ID PREFIX TAG	 (EACH DEFICIENC) 	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET	
К 144	Continued From			powered, will be provided to	operate outside	
17 1-4-4	Continued From pa	ge	K 144	of the generating room. The		
:			į į	annunclator will be moved to		
Į		ĺ		nurses' station. This area is station and is likely to be seen		
				Windsor Point staff.	To heard by	
!				2. An audible/visual derange	ement signal.	
i		1		appropriately labeled, will be		
		!	1	the facility's nurses' station.		
		,	F	3. Staff will be in-serviced or	the generator	
				annunciator panel to identify a		
		ŧ	•	the following individual audibl	e/visual	
• :			:	signals;		
		:	1	 a. Individual visual signals sh following: 	all indicate the	
			į	 When the emergence 		
			i	power source is oper		
i		}	į	supply power to load		
				 When the battery ch malfunctioning. 	arger is	
ı				b. Individual visual signals plu	is a common	
!				audible signal to warn of an		
:		- Tananananananananananananananananananan		engine-generator alarm conditions in the second in the sec	on shall	
		;	į	Low lubricating oil pr	essure	
		į		 Łow water temperatu 		
		!	. :	 Excessive water temp 	•	
;		!		 Low fuel – when the i 	į	
		·	i	storage tank contains		
•				3-hour operating supOvercrank (failed to s		
		;	1	Overspeed Overspeed	iai (j j	
			· :	IV. Performance correcting th	ese	
		1	!	deficiencies will be monitored t		
		• •	ĺ	following methods:	i l	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/10/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING 01 - MAIN BUILDING 01 8. WING 346500 12/09/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINDSOR POINT CONTINUING CARE 1221 BROAD STREET FUQUAY VARINA, NC 27528 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) K 144 Continued From page 1. A remote annunclator, storage battery K 144 powered, will be provided to operate outside of the generating room. The remote annunciator will be moved to the facility's nurses' station. This area is a regular work station and is likely to be seen or heard by Windsor Point staff. 2. An audible/visual derangement signal, appropriately labeled, will be established at the facility's nurses' station. 3. Staff will be in-serviced on the generator annunclator panel to identify and monitor the following individual audible/visual signals: a. Individual visual signals shall indicate the following: When the emergency or auxillary power source is operating to supply power to load. When the battery charger is malfunctioning. b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall Indicate the following: Low lubricating oil pressure Low water temperature Excessive water temperature Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply Overcrank (failed to start) Overspeed

March 9, 2012