PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345090	B. WING _			08/10/2017		
	ROVIDER OR SUPPLIER	OVIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 225 SS=D	ALLEGATIONS/IND 483.12(a) The facilit (3) Not employ or of who- (i) Have been found exploitation, misapp mistreatment by a continuity of the continuity o	herwise engage individuals guilty of abuse, neglect, ropriation of property, or ourt of law; ng entered into the State concerning abuse, neglect, tment of residents or their property; or ary action in effect against his icense by a state licensure a finding of abuse, neglect, tment of residents or	F2	225	DEPICIENCT)		9/7/17	
	licensing authorities actions by a court of which would indicate nurse aide or other to the control of the course aide or other to the course that all at abuse, neglect, explincluding injuries of misappropriation of reported immediated after the allegation is cause the allegation serious bodily injury	ate nurse aide registry or any knowledge it has of flaw against an employee, e unfitness for service as a facility staff. legations of abuse, neglect, reatment, the facility must: lleged violations involving loitation or mistreatment, unknown source and resident property, are y, but not later than 2 hours is made, if the events that involve abuse or result in , or not later than 24 hours if			TITLE		(X6) DATE	

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

09/01/2017

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345090	B. WING		C 08/10/2017		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	1 06/10/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 225	abuse and do not res the administrator of th officials (including to the adult protective service for jurisdiction in long accordance with State procedures. (2) Have evidence that thoroughly investigate (3) Prevent further por exploitation, or mistre investigation is in prof (4) Report the results administrator or his or representative and to with State law, including Agency, within 5 work if the alleged violation corrective action mus This REQUIREMENT by: Based on observation interview the facility fact working report and 5 residents, Resident # grabbed by a staff met twisted. Findings included: Resident #83 was adi 6/2/17 with a diagnos hypertension, hyperlip	the allegation do not involve fult in serious bodily injury, to be facility and to other the State Survey Agency and sees where state law provides beterm care facilities) in the law through established at all alleged violations are ed. Itential abuse, neglect, atment while the gress. of all investigations to the redesignated other officials in accordance ing to the State Survey sting days of the incident, and its verified appropriate to the taken. The is not met as evidenced in, record review and staff ailed to submit a 24 hour day working report for 1 of 4 as who stated she was ember and her arm was institted to the facility on	F 22	Preparation and/or execution of this of Correction does not constitute an admission or agreement by the provice the truth of the facts alleged or conclusions set forth on the Statemer Deficiencies. This Plan of Correction prepared and/or executed solely becarequired by the provisions of Health a Safety Code Section 1280 and 42 C.F. 405.1907	der of at of is ause nd		
	Urinary Tract Infection			F225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345090	B. WING				C 10/2017
NAME OF PE	ROVIDER OR SUPPLIER	2.0000	<u> </u>	S-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017
NAME OF T	COVIDER OR SOLT LIER				, , ,		
WESTCHE	STER MANOR AT PRO	VIDENCE PLACE			795 WESTCHESTER DRIVE		
				Н	IGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 225	Continued From page	e 2	F 2	225			
	Review of Resident # (MDS) assessment of Resident #83 require one staff person in the transfers, and toileting revealed Resident #8 cognitively impaired a Interview for Mental States Resident #83 was interposed personal pm. Resident #83 states you against the interview for Mental States and you against the interview of the revealed a large, dar yellowing at edges to forearm. The bruise with no circular bruising signs of shearing or owith twisting or squeed arm. Review of the 24 hour Resident #83 indicate Resident Abuse. The stated, "Bruise to left grabbed my wrist and don't like you and way was faxed to DHHS of Review of Resident # Review of Revi	#83's Minimum Data Set lated 7/20/17 indicated d extensive assistance of e areas of bed mobility, g. The MDS further 33 was moderately as evidenced by a Brief Status (BIMS) score of 9. ### Providence of the status (BIMS) score of 9. #### Providence of the status (BIMS) score of 9. ###################################			"The plan of correcting the specific deficiency cited: An investigation of resident #83 sallegation of abuse was begun on 8/6/7 A 24 hour working report was submitted 3:06 pm on 8/6/17. An investigation in the allegation was conducted by the Director of Nursing from 8/6/17 solder 8/11/17. The Director of Nursing submitted the stay working report on 8/11/17 at 6:26 part All staff were educated as to the policy the timely submission and investigation allegations of abuse. On 8/8/17 resider #83 was observed with left arm resting WC wheel with left wrist and forearm hitting the wheels. The wheelchair was changed to avoid arms hitting the wheels "The procedure for implementing the pof correction for the specific deficiency cited: Education provided to nursing staff from 8/6/17 - 8/9/17 on Abuse and Neglect policy. All current facility staff were educated on the updated policy concerning the timely reporting and investigating of abuse and neglect 8/25 solder. The updated policy is includin new hire orientation for all new staff members and will be reviewed with all staff on an annual basis. "The monitoring procedure to ensure the staff on an annual basis."	d at to 17. 5 pm. for n of nt on lels. lan	
	psychotropic drug us depression, and psyc The goal for Residen	chotic/delusional thoughts. t #83 was to have no side choactive medications.			"The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory guidelines: The Director of Nursing or Assistant	nat	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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				17	95 WESTCHESTER DRIVE			
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F 225	diversion. Review of Mental He revealed Resident #8 secret she could not hurting her. The Mental He revealed that the resworry, psychosis, par sleeping well. Review of Mental He revealed Resident #8 paranoia. The note of for Xanax was given Review of Social Wo Resident #83 reported was scared and "that The Social Work noted."	alth Visit Note dated 7/21/17 33 stated that she has a tell but did involve someone ntal Health Visit Note further ident had symptoms of ranoid delusions, and not alth Note dated 8/2/17 33 had increased anxiety and rurther revealed that an order	F 2	2225	Director of Nursing will conduct random audits of facility staff to ensure understanding of the updated facility policy concerning the timely reporting or resident abuse and neglect daily for 30 days, then weekly for 8 weeks, then monthly for 3 months. Re-education of staff will be conducted as necessary. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or long as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that all staff are educated as the facility policy concerning timely reporting of resident abuse and neglections.	of o er		
	when the accident had person involved. The Resident #83 had incommand awake a lot of the nigman in a yellow suit in Review of Occupation Note dated 7/26/17 reported a staff personand threatening to him the resident was confurther revealed the Command Assistant notified the #83's statement.	appened or describe the enote further revealed that creased confusion, was ght, and hallucinated about a n her room. Inal Therapy Daily Treatment evealed Resident #83 on upset her by being mean ther. The note also stated fused and unclear. The note Doccupational Therapist Social Worker of Resident wite dated 8/6/17 at 12:07 pm d a 3 inch dark purple bruise			an ongoing basis and that the policy is being followed appropriately. Assistan Director of Nursing will conduct randon audits and present findings to the Director of Nursing. The Director of Nursing will prepare the Quality Assurance report for months or longer.	t n ctor		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		345090	B. WING_			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	ı	08/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	residents left wrist. #3 asked resident #8 st wrist and Resident #83 st wrist and twisted an mocking her". The in Nursing and Reside notified of the bruise. Review of nursing in revealed Nurse #3 st family member regal and concerns of the revealed a room charmember but she refiliwas afraid that the right Resident #83's conf. Interview with Famili pm revealed a famili #83 on Thursday (8), the Family Member her left wrist during stated she visited the (8/5/17) and saw the lower arm. She state about 4 inches long #83's left wrist and findicated Resident #facility at night. Resident #facility at night. Resident #83 was not able to Family Member furth confusion was worse tract infection and the "sundowner's at night stated she had never #83 before and that	The note also revealed Nurse 83 how she got the bruise ated "someone grabbed my d said I don't like you and was note revealed the Director of nt #83"s family member were st. Onte dated 8/6/17 at 2:24 pm poke with Resident #83's rading the possible allegations resident. The note further ange was offered to the family used. The family member boom change would increase	F 2	25		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTAGE CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)			(X5) COMPLETION DATE	
F 225	Family Member reveal Nurse #1 that Reside member and that she left wrist and forearm. Interview on 8/7/17 are revealed she saw the the resident's left wrist color when she was refused to 11:45am and 12:00 p	n 8/9/17 at 3:27 pm with aled the family member told nt #83 was afraid of a staff had a large bruise to her on Saturday (8/5/17). It 4:47 pm with Nurse #3 bruise to the underside of st and that it was dark in notified by Nurse #1 between m on 8/6/17. Nurse #3 also #83 reported someone	F	225				
	4:53 pm revealed that bruise to Resident #8 (8/6/17) and arrived at She stated she had not staff that had worked. Interview with Social revealed the Social Vithe Director of Nursing reported to her that social had been reported in her not worker stated Reside for the past week and delusions. She indicates speak of a man in a signing autographs, stated that the Director Sunday (8/6/17) to te a bruise and she told.	Worker on 8/7/17 at 5:55 pm Vorker had not reported to g when Resident #83 he was scared and "that girl which the Social Work ote on 7/26/17. The Social ent #83 was more confused I that she had a history of ated Resident #83 would rellow suit in her room The Social Worker also or of Nursing had called her II her that Resident #83 had staff that someone hurt her, the person that hurt her and						

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F 225	on 8/8/17 at 10:56 a reported to her on Mathematical The Occupational Trevealed she report Worker that day. Interview with NA # revealed NA #2 told that resident #83 rerough with her and wrist on Thursday & Interview with Nursevealed she was to communicated som Thursday, 8/3/17. Social Worker about the Social Worker about the Social Worker about the Social Worker about the Social Worker & Priday 8/4/17. Interview with Nurse #4 Nursing and Supervallegation before she Friday 8/4/17.	Occupational Therapy Assistant am revealed Resident #83 Monday of last week (7/31/17) Iked nasty to her and hit her". Therapy Assistant further red the incident to the Social 2 on 8/8/17 at 9:30 am I her charge nurse, Nurse #4, sported someone had been she had small bruises on her	F2	225				
	interview Nurse #2 bruise to her left low flexible wound mea the bruise was 15 c centimeters wide. Interview with NA# revealed she had o #83's left arm on Sa Interview with NA # revealed Resident a	een measured. During the measured Resident #83's ver forearm and wrist with a suring tape. Nurse #2 stated tentimeters long and 12 3 on 8/9/17 at 9:00 am bserved the bruise to Resident aturday (8/5/17). 7 on 8/9/17 at 11:00am #83 had communicated to her rough with her sometime last						

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 225	didn't like her and git. NA #7 stated Reat that time. She in tell the nurse but go patient needs and fooncern. She stated Resident #83 left has showering Resident stated by Friday (8/had gotten worse a indicated she was r#83's allegation or linterview with Nurs revealed the Family #1 on Saturday (8/s and stated she was Nurse #1 stated she halted the nurse with the E2:45pm revealed she health Visit Note dated Therapist Note dated Therapist Note dated The Director of Nur only protection put that was offered to Member which was revealed she had n regards to the Resimistreatment on 8/s	ge 7 ed Resident #83 said they prabbed her wrist and twisted sident #83 had a small bruise dicated that she was going to obt distracted with another orgot to communicate the dishe noticed the bruise on and on Friday (8/4/17) while to the fast supper body. She 4/17) Resident #83's bruise and was longer. NA#7 not interviewed about Resident bruise until Monday (8/7/17). The #1 on 8/10/17 at 10:10 am of Member reported to Nurse 6/17) Resident #83 was crying afraid of a staff member. The did not recall the Family the resident had a bruise. The edid not report Resident #83's was stating that people are considered for the Mental and 7/26/17; and the Social factor of Nursing 8/9/17 at the was unaware of the Mental and 7/26/17; and the Social factor of Resident factor of Allegations of abuse. Sing further revealed that the into place was a room change Resident #83 and her Family declined. She further of interviewed any staff in dent #83's complaint of staff 8/17. It was her expectation of abuse be reported to her,	F 22	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
			7 50.25.		С	
		345090	B. WING		08/10/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION DATE DATE	٧
F 225	the changes impleme F232 that identified rewithin 2 hours.	of Nursing, or the adicated she was unaware of ented for reporting abuse eporting allegations of abuse	F:	225		
F 226 SS=D	483.12(b)(1)-(3), 483. DEVELOP/IMPLMEN POLICIES	.95(c)(1)-(3) IT ABUSE/NEGLECT, ETC	F:	226	9/7/17	
	483.12 (b) The facility must d written policies and process and process and process are process.	levelop and implement rocedures that:				
		ent abuse, neglect, and nts and misappropriation of				
	(2) Establish policies investigate any such					
	(3) Include training as §483.95,	s required at paragraph				
	the freedom from aburequirements in § 483	nd exploitation. In addition to use, neglect, and exploitation 3.12, facilities must also bir staff that at a minimum				
		onstitute abuse, neglect, appropriation of resident at § 483.12.				
		reporting incidents of abuse, or the misappropriation of				

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F 226	prevention. This REQUIREMENT by: Based on staff interv review of facility policy their abuse policy for to the state Health Ca (HCPR) for 1 of 4 res abuse (Resident #83) The findings: Review of Facility pol Abuse-Staff Respons have an implementat It was obtained on 8/ Director of Nursing. "Any alleged violation neglect, or abuse inc unknown source and property, must be imi Administrator and to with State law (include certification agency." "A completed copy of Form and written staf must be provided to to	is not met as evidenced iew, record review and y the facility failed to follow investigating and reporting are Personnel Registry idents with allegations of). icy titled, "Resident iibilities" revealed it did not ion date or date of revision. 7/17 at 4:30 pm from the The policy stated: as involving mistreatment, luding injuries of an misappropriation of resident mediately reported to the other officials in accordance	F 2	2226	Preparation and/or execution of this P of Correction does not constitute an admission or agreement by the provide the truth of the facts alleged or conclusions set forth on the Statement Deficiencies. This Plan of Correction is prepared and/or executed solely becautequired by the provisions of Health an Safety Code Section 1280 and 42 C.F. 405.1907	of of use d R.		
	incident. An immedia provided to the Admir representative and to with State law (includ certification agency) the occurrence of suc	te investigation will be nistrator or designated other officials in accordance ing the State survey and within five working days of			staff of other agencies serving the resident, family members or legal guardians, friends or other individuals. Abuse also includes those practices ar omissions, neglect and misappropriation of resident property that left unchecked lead to abuse. It is the policy of this facility to ensure the	nd on i,		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345090	B. WING			1	10/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 226	Continued From pag	ge 10	F	226			
	with the resident dui incident". "The facility shall tak	(on all shifts) having contact ring the period of the alleged are all measures necessary to notical abuse during an			all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source at misappropriation of resident property, a reported immediately, but not later that hours after the allegation is made, if the	are n 2	
	investigation of an a				events that cause the allegation involve abuse or result in serious bodily injury, not later than 24 hours if the events that	e or	
		s that included hypertension,			cause the allegation do not involve abu		
	_	ychosis and depression.			and do not result in serious bodily injur to the administrator of the facility and to	у,	
	(MDS) assessment Resident #83 require one staff person in the transfers, and toileting revealed Resident #	•			other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) accordance with State law through established procedures.	in	
	Interview for Mental	as evidenced by a Brief Status (BIMS) score of 9. ur report for Resident #83			An investigation of resident #83□s allegation of abuse was begun on 8/6/A 24 hour working report was submitte		
	dated 8/6/17 indicate Abuse. The allegate to left wrist, resident wrist and twisted it.	ed allegation type as Resident on description stated, "Bruise stated, "she grabbed my Then said, I don't like you e." The form indicated it was			3:06 pm on 8/6/17. An investigation in the allegation was conducted by the Director of Nursing from 8/6/17 □ 8/11. The Director of Nursing submitted the day working report on 8/11/17 at 6:26 pall staff were educated as to the policy the timely submission and investigation	17. 5 om. for	
	revealed that Reside secret she could not hurting her. The Me revealed Resident # psychosis, paranoid well. The Social Wo	ealth Visit Note dated 7/21/17 ent #83 states that she has a tell but did involve someone ental Health Visit Note further 83 had symptoms of worry, delusions, and not sleeping ork note dated 7/26/17 also			allegations of abuse. "The procedure for implementing the p of correction for the specific deficiency cited: All current facility staff were educated of the updated policy concerning the time	lan on ly	
	say when the incide	was confused and unable to nt happened or describe the			reporting and investigating of abuse ar neglect 8/25/17 □ 9/1/17. The updated	t	

Facility ID: 923544

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F 226	Continued From page Resident #83 had incawake a lot of the nigman in a yellow suit in Review of Mental Herevealed Resident #85 paranoia. The note of for Xanax was given Review of the Occup note dated 7/26/17 rereported to the Occup ataff member had up threatening to hit here the Occupational The the Social Worker. Review of the Social revealed the Social Worker. Review of the Social revealed the Social Wass. Resident #83 to "was scared and that The note stated Resi when the incident haperson(s) involved. Trevealed that Reside confusion, was awak hallucinated about a room. Resident #83 was into pm. Resident #83 st slams you against the down in that bed and turned her left arm or linear, dark blue bruisten.	e 11 creased confusion, was ght, and hallucinated about a n her room. alth Visit Note dated 8/2/17 33 had increased anxiety and curther revealed that an order to help her anxiety. ational Therapy Assistant evealed Resident #83 pational Therapy Assistant a set her by being mean and a set her by being mean an		226		sis. nat nat eted of eks, on . er	DATE	
	edges to her left wris	t and lower forearm. She Nursing was looking into the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	VIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP C 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	CODE	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIAT	
F 226	revealed she worked that Nurse #1 reports and she had observe Director of Nursing b pm. Nurse #3 stated #83 stated "it happer further revealed she regarding the allegat origin on 8/6/17. Interview with the Sc pm revealed she did Nursing Resident #8 her Social Work note Resident #83 was condelusional behavior. Resident #83 would suit in her room sign Worker also stated so Director of Nursing that Resident #83 has that someone had his stated she had not in regarding the allegat origin on 8/7/17. Interview with NA #2 revealed NA #2 told that Resident #83 re rough with her and s wrist on Thursday (8 that she had not beer egarding what the rebeen asked to provide Interview with Nurse	#3 on 8/7/17 at 4:47 pm 18/6/17. Nurse #3 stated ed the resident's bruise to her ed the bruise and notified the etween 11:45 am and 12:00 I Nurse #1 reported Resident ned on night shift". Nurse #3 did not interview any staff ion or injury of unknown recial Worker on 8/7/17 at 5:55 not report to the Director of 3's allegation she recorded in red dated 7/26/17. She stated onfused and had a history of The Social Worker indicated speak of a man in a yellow ing autographs. The Social he was notified by the in Sunday (8/6/17) by phone and a bruise and had told staff urt her. The Social Worker interviewed any of the staff ion or injury of unknown on 8/8/17 at 9:30 am her charge nurse, Nurse #4, ported someone had been he had a small bruise on her //3/17). NA #2 also stated in interviewed by facility staff resident told her nor had she lie a written statement. #4 on 8/8/17 at 9:40 am d by NA #2 Resident #83	F2	226		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL		ATE SURVEY DMPLETED				
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	OVIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CO 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	Thursday (8/3/17). the Social Worker a and the Social Worker a and the Social Worker a and the Social Worker and the Social Worker and Supervallegation before sh (8/4/17). Nurse #4 interviewed or aske regarding the allegatorigin. Interview with the Con 8/8/17 at 10:56 a reported to her on Mat "a young girl ta The Occupational Trevealed she report Worker that day. The Assistant stated she statement regarding. Interview with the A 8/9/17 at 4:08 pm rethe allegation of aborigin until Monday the staff were not in #83's allegation of a origin on Monday (8 Interview with the D 2:45 pm revealed she staff regarding Resion injury of unknown Director of Nursing her Family Member but no other protect Resident #83 because with the Social Staff regarding Resion of the staff were not in the staff regarding Resion injury of unknown Director of Nursing her Family Member but no other protect Resident #83 because with the Social Resident	Nurse #4 reported she told bout the allegation on 8/3/17 ker came and spoke with the stated she told the Director of risor about Resident #83's e left work (3:15pm) on Friday stated she was not d to write a statement ation or the injury of unknown revealed Resident #83 flonday of last week (7/31/17) liked nasty to her and hit her". Therapy Assistant further ed the incident to the Social ne Occupational Therapy e was not asked to write a githe resident's allegation. Sesistant Director of Nursing on evealed she was not aware of use and injury of unknown (8/7/17) morning. She stated terviewed about Resident abuse or injury of unknown	F 2	226		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345090	B. WING		C 08/10/2017
	ROVIDER OR SUPPLIER	/IDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 253 SS=D	they assumed the injumbeelchair. The Direct her expectation is that injuries of unknown of immediately. 483.10(i)(2) HOUSER SERVICES (i)(2) Housekeeping a necessary to maintain comfortable interior; This REQUIREMENT by: Based on observation facility failed to label a care items in semi-propersidents on 1 of 6 un 100). Findings included: 1a. On 8/08/2017 9:4 in Resident # 82's see were two stacked unlone plastic bag. b. On 8/08/2017 11:3 in Resident # 107's some two unlabeled soplastic bag and one unplastic bag and one unplastic bag and one unplastic bag and one unplastic bag and one unlabeled bedpan in c. On 8/08/2017 9:52	at how the resident he wheelchair on 8/8/17 and cury was caused by the actor of Nursing stated that at allegations of abuse and rigin should be reported. ACEPING & MAINTENANCE And maintenance services in a sanitary, orderly, and This is not met as evidenced in sand staff interview the and properly store personal invate rooms occupied with 2 hits of the facility (Unit # 2 am, observation revealed miprivate bathroom, there abeled washbasins stored in 1 am, observation revealed emiprivate bathroom there tacked washbasins in one unlabeled washbasin in a unlabeled urine hat in plastic bag and one a plastic bag. am, observation revealed in	F 22	Preparation and/or execution of this P of Correction does not constitute an admission or agreement by the provide the truth of the facts alleged or conclusions set forth on the Statement Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health ar Safety Code Section 1280 and 42 C.F 405.1907 F253 "The plan of correcting the specific deficiency cited: On 8/25/17 personal care items for residents # 82,107, 6, 13 and 48 were labeled and bagged to ensure the maintenance of a sanitary, orderly and	er of of suse ad R.
	one unlabeled washb	rivate bathroom, there was asin in plastic bag.		comfortable interior. An inspection of a resident rooms on 100 hall was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345090	B. WING			C 08/10/2017		
NAME OF P	ROVIDER OR SUPPLIER	3.333	-	9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017	
NAME OF T	TO VIDER OR OUT FIER				795 WESTCHESTER DRIVE			
WESTCHE	STER MANOR AT PE	ROVIDENCE PLACE						
					IIGH POINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 253	Continued From page	age 15	F2	253				
					to ensure the proper labeling and bage	ging		
	d. On 8/08/2017 1	1:30 am, observation revealed			of resident personal single use items.			
	in Resident # 13's	semiprivate bathroom there			Any improperly stored personal care it	ems		
		d stacked washbasins in one			were corrected to ensure the maintena	ınce		
		e unlabeled washbasin in a			of a sanitary, orderly and comfortable			
		e unlabeled urine hat in plastic			interior.			
	bag and one unlab	eled bedpan in a plastic bag.						
	- 0:- 0/00/0047 4:	1.01			"The procedure for implementing the p			
		1:04 am, observation revealed semiprivate bathroom there			of correction for the specific deficiency cited:			
		stacked washbasins and one of			All nursing staff which includes nurses			
	one bedpan withou				and certified nursing assistants were			
· · · · · · · · · · · · · · · · · · ·		educated 8/25/17 - 9/1/17 as to the						
	On 8/9/17 at 10:00	am, an interview with the			expectation of labeling and bagging al	l		
		ervisor confirmed that the			personal care items such as bedpans,			
		esponsible for taking care of the			urine hats and wash basins. On 8/25/1			
	resident personal	care equipment stored in the			an inspection of all resident rooms was	s		
	bathroom.				conducted to ensure wash basins, urir			
					hats, and bedpans were labeled and v	/ere		
		1:25 pm, observation revealed			in a separate plastic bag.			
		emiprivate bathroom there was				1		
	one wash basin in	the shower unlabeled.			"The monitoring procedure to ensure t			
	a On 9/10/2017 of	1:20 nm observation revealed			the plan of correction is effective and t specific deficiency cited remains corre			
		t 1:30 pm, observation revealed miprivate bathroom there was			and/or in compliance with regulatory	cieu		
		pan and wash basin in one bag.			guidelines:			
	an anabelea bea	oan and wash basin in one bag.			Audits of resident rooms to ensure the			
	h. On 8/10/2017 a	t 1:36 pm, observation revealed			proper labeling and bagging of resider			
		emiprivate bathroom there was			personal care items to ensure the			
		ed, not labeled and one wash			maintenance of a sanitary, orderly and	i		
		t bagged, not labeled.			comfortable interior will be initiated on			
					9/8/17 by the Assistant Director of			
		pm interview ADON (Assistant			Nursing. For 30 days 2 separate resid	ent		
	-	g) confirmed that nursing		rooms will be monitored daily for the				
		re responsible for labeling all			labeling and bagging of bedpans,			
		dents' names. Items such as			washbasins and urine hats. Afterwards			
	bed pans and basi			separate resident rooms will be monito				
		the resident's bathroom or			weekly for 8 weeks. Finally, 6 rooms weekly for 8 mentioned monthly for 3 mention for			
	where they prefer	ioi il lo de Sloieu.			be monitored monthly for 3 months for	uie		

NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE (X4) ID PREFIX TAG ON 8/10/17 at 2:30 pm interview with DON (Director of Nursing) confirmed that resident personal care equipment is supposed to be stored in a bag, it should be labeled with the resident name, they should be dry and on opposite sides of the bathroom. On 8/10/17 at 2:35 pm interview with NA # 6 on 100 hall confirmed that resident personal care equipment should be stored in the bathroom, placed in clear bags and have the resident last name and an A or B labeled clearly.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
MESTCHESTER MANOR AT PROVIDENCE PLACE WESTCHESTER MANOR AT PROVIDENCE PLACE (XA) ID PREFIX TAG (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 253 Continued From page 16 On 8/10/17 at 2:20 pm interview with DON (Director of Nursing) confirmed that the NAs are responsible to tag and bag personal care equipment in clear trash bags. On 8/10/17 at 2:30 pm interview with NA # 5 on 100 hall confirmed that resident personal care equipment is supposed to be stored in a bag, it should be labeled with the resident name, they should be dry and on opposite sides of the bathroom. On 8/10/17 at 2:35 pm interview with NA # 6 on 100 hall confirmed that resident personal care equipment should be stored in the bathroom, placed in clear bags and have the resident last STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262 D PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH COR			345090					
Typs Westchester Drive High Point, NC 27262 High Point, NC 27262 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY CACH CORRECTIVE ACTION SHOULD BE CROS	NAME OF P	ROVIDER OR SUPPLIER	04000			TREET ADDRESS CITY STATE ZIP CODE	1 08/	110/2017
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CONTINUED FROM INTERPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 253	TO WILL OF TH	TO VIDER OR OUT FEILING						
F 253 Continued From page 16 F 253 Continued From page 16 On 8/10/17 at 2:20 pm interview with DON (Director of Nursing) confirmed that the NAs are responsible to tag and bag personal care equipment in clear trash bags. On 8/10/17 at 2:30 pm interview with NA # 5 on 100 hall confirmed that resident personal care equipment as supposed to be stored in a bag, it should be dabeled with the resident name, they should be dry and on opposite sides of the bathroom. On 8/10/17 at 2:35 pm interview with NA # 6 on 100 hall confirmed that resident personal care equipment should be stored in the bathroom, placed in clear bags and have the resident last PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH CORNECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (ACH CORNECTIVE ACTION SHOULD SHOU	WESTCHE	ESTER MANOR AT PROV	IDENCE PLACE					
labeling and bagging of bedpans, washbasins and urine hats. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or longer as necessary. On 8/10/17 at 2:30 pm interview with NA # 5 on 100 hall confirmed that resident personal care equipment is supposed to be stored in a bag, it should be labeled with the resident name, they should be dry and on opposite sides of the bathroom. On 8/10/17 at 2:35 pm interview with NA # 6 on 100 hall confirmed that resident personal care equipment should be stored in the bathroom, placed in clear bags and have the resident last labeling and bagging of bedpans, washbasins and urine hats. Audit findings will be presented during Quality Assurance meetings for recommendations for 6 months or longer as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and/or Assistant Director of Nursing are responsible for ensuring the completion of all staff education and proper storage and labeling of resident personal care items. Audits and reporting to the Quality Assurance Committee.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
## ## ## ## ## ## ## ## ## ## ## ## ##	F 279	On 8/10/17 at 2:20 pr (Director of Nursing) responsible to tag and equipment in clear trace. On 8/10/17 at 2:30 pr 100 hall confirmed the equipment is suppose should be labeled with should be dry and on bathroom. On 8/10/17 at 2:35 pr 100 hall confirmed the equipment should be placed in clear bags an ame and an A or B is 483.20(d);483.21(b)(COMPREHENSIVE COMPREHENSIVE COMPREHE	m interview with DON confirmed that the NAs are d bag personal care ish bags. m interview with NA # 5 on at resident personal care ed to be stored in a bag, it is the tresident name, they opposite sides of the m interview with NA # 6 on at resident personal care stored in the bathroom, and have the resident last abeled clearly. I) DEVELOP CARE PLANS st maintain all resident ted within the previous 15 it's active record and use the ments to develop, review int's comprehensive care are Plans levelop and implement a in-centered care plan for tent with the resident rights (2) and §483.10(c)(3), that			washbasins and urine hats. Audit findir will be presented during Quality Assurance meetings for recommendations for 6 months or long as necessary. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing and/or Assistar Director of Nursing are responsible for ensuring the completion of all staff education and proper storage and labe of resident personal care items. Audits and reporting to the Quality Assurance	er nt eling	9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	VIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		00/10/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pag	ne 17	F 2	279		
	and psychosocial ne comprehensive asse care plan must desc (i) The services that	medical, nursing, and mental eds that are identified in the essment. The comprehensive ribe the following - are to be furnished to attain lent's highest practicable				
	physical, mental, and	d psychosocial well-being as .24, §483.25 or §483.40; and				
	under §483.24, §483 provided due to the	would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6).				
	rehabilitative service provide as a result o recommendations. If findings of the PASA	services or specialized s the nursing facility will f PASARR f a facility disagrees with the lRR, it must indicate its ent's medical record.				
	(iv)In consultation wiresident's representa	th the resident and the ative (s)-				
	(A) The resident's go desired outcomes.	oals for admission and				
	future discharge. Fa whether the resident community was asse	reference and potential for cilities must document is desire to return to the essed and any referrals to es and/or other appropriate ose.				
		in the comprehensive care in accordance with the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345090	B. WING		C 08/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.10.2011
WESTCHE	STER MANOR AT PRO	VIDENCE DI ACE		1795 WESTCHESTER DRIVE	
WESTONE	STER WANGE AT PRO	VIDENCE PLACE		HIGH POINT, NC 27262	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
F 279	Continued From pag	ne 18	F 27	9	
	requirements set for section.	th in paragraph (c) of this			
	This REQUIREMEN by:	T is not met as evidenced			
		view and staff interviews, the		Preparation and/or execution of this	Plan
	facility failed to initiat			of Correction does not constitute an	idos of
	reviewed for urinary	Resident 134) of 4 residents		admission or agreement by the prov the truth of the facts alleged or	ider of
	Teviewed for drinary	meonunence.		conclusions set forth on the Stateme	ent of
	Findings included:			Deficiencies. This Plan of Correction	
,				prepared and/or executed solely bed	ause
		ed to the facility on 3/2/17		required by the provisions of Health	
		nronic Obstructive Pulmonary		Safety Code Section 1280 and 42 C	.F.R.
		on, Macular Degeneration,		405.1907	
	Anxiety, Bipolar Disc	D Deficiency, Anemia,			
	Alixiety, Dipolal Disc	order and msomma.		F279	
		y Minimum Data Set (MDS) ed a decline in bladder			
		nally incontinent) from		"The plan of correcting the specific	
	Admission MDS date	ed 3/10/17 (always continent).		deficiency cited:	
				On 8/9/17 resident #134 ☐s care plan	
				updated with new problem of Risk fo	
	•	I for Activities of Daily Living cits, Falls, Sensory deficit,		Incontinent Accidents added to curre comprehensive care plan. Plan inclu	
		risk, Risk for dehydration,		interventions for prompted toileting a	
	· ·	own, Respiratory Disorders,		staff assistance as needed. On 8/9/	
		se, Oxygen use, Activities		prompted toileting schedule was add	
	and Mood state.			the direct care staff instructions for c	
				On 8/9/17 direct care staff were info	med
		d review revealed no care		of the addition of toileting plan to	
	plans for incontinent	e.		instructions for care already in place	
	08/9/17 Record revie	ew for look back period		"The procedure for implementing the	e plan
	6/2/17-6/8/17 for qua	arterly MDS revealed resident		of correction for the specific deficien	-
	-	adder incontinence and 2		cited:	
		continence on the night shift.		Determine the need for new/addition	
		w revealed resident had one		care plan based on MDS data and o	
	episode of bowel and	d bladder incontinence during		clinical evaluations by the Interdiscip	ılınary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345090	B. WING _				C 10/2017
	ROVIDER OR SUPPLIER	IDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		1 00/	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279	Data Set (MDS) nurs incontinence should hincontinence was idea 08/10/2017 10:55:06 of Nursing (DON) rev problems that trigger	AM Interview with Minimum e revealed care plan for have been added after ntified on Quarterly MDS. AM Interview with Director ealed she would expect on MDS to be care planned.		279	Care Team, no less than quarterly. Initinew/additional care plan when clinically indicated. Inform direct care staff of updated care plan to include direct care interventions and goals. The MDS Coordinator to provide education training to all Interdisciplinary Care Team members involved in reviewing and updating care plans by 9/1/17. "The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory guidelines: The MDS Coordinator or Assistant MDC Coordinator will conduct random care plans and daily for 30 days, then 3 per weef for 60 days then 10 per month for 3 months. Make corrections to care plans as needed. Audit findings will be presented during the Quality Assurance meetings for recommendations and updates for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The MDS Coordinator and members of the Interdisciplinary Care Team are responsible for ensuring all clinical evaluations including MDS data are completed in a timely and appropriate manner.	y e ng nat nat cted S olan ek	9/7/17
F 280 SS=D		3),483.21(b)(2) RIGHT TO NING CARE-REVISE CP	F 2	280			9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345090	B. WING _		0.	C B/ 10/2017		
	ROVIDER OR SUPPLIER	/IDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		5/10/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE			
F 280	and implementation of plan of care, including the right to be included in the plan request meetings and revisions to the personance wisions to the personance of the personanc	ticipate in the development of his or her person-centered g but not limited to: pate in the planning process, identify individuals or roles to anning process, the right to d the right to request on-centered plan of care. Inpute in establishing the outcomes of care, the type, and duration of care, and any to the effectiveness of the It is early plan, including the nificant changes to the plan Il inform the resident of the his or her treatment and dent in this right. The st sion of the resident and/or ive.	F2	280				
	.55.21							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	VIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CO 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		00/10/2017
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pag	e 21	F 2	280		
	(b) Comprehensive (Care Plans				
	(2) A comprehensive	care plan must be-				
	(i) Developed within the comprehensive a	7 days after completion of assessment.				
	(ii) Prepared by an ir includes but is not lir	nterdisciplinary team, that nited to				
	(A) The attending ph	ysician.				
	(B) A registered nurs resident.	e with responsibility for the				
	(C) A nurse aide with resident.	responsibility for the				
	(D) A member of foo	d and nutrition services staff.				
	the resident and the An explanation must medical record if the and their resident re	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined e development of the				
		e staff or professionals in nined by the resident's needs ne resident.				
	team after each asse comprehensive and assessments. This REQUIREMEN by:	vised by the interdisciplinary essment, including both the quarterly review T is not met as evidenced on, record reviews, and staff		Preparation and/or execution	on of this Plan	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345090	B. WING				C 10/2017
	ROVIDER OR SUPPLIER	/IDENCE PLACE	•	17	TREET ADDRESS, CITY, STATE, ZIP CODE 795 WESTCHESTER DRIVE IIGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Plan for 1 of 1 sample with a dialysis access. Findings included: Resident #48 was ad 2/1/17 with diagnoses renal disease. The annual MDS (mir 5/23/17 indicated Rescognitively impaired attreatments. Review of the Care Preceived hemodialysis to ESRD (end-stage reffective since 9/3/14 site for signs and syn (redness, odorous draconfusion, elevated was maintain aseptic field fistula site. During an observation Resident was asleep bed linen. The reside with short sleeves an access site covered who noted to the resident's was no fistula site observations. During an interview of (nursing assistant) states.	refailed to update the Care ed resident (Resident #48) and evice. mitted to the facility on a which included end-stage mimum data set) dated and received dialysis flan revealed Resident #48 as three times each week due renal disease). Interventions an included: monitor fistula anotoms of infection: minum data set) dated sident #48 as three times each week due renal disease). Interventions an included: monitor fistula anotoms of infection: minum data set) dated sident #48 as three times each week due renal disease). Interventions an included: monitor fistula anotoms of infection: minum data set) dated sident #48 as three times each week due renal disease). Interventions an included: monitor fistula anotoms of infection: minum data set) dated sident #48 as three times each week due renal disease). Interventions an included: monitor fistula anotoms of infection: an a	F	280	of Correction does not constitute an admission or agreement by the provide the truth of the facts alleged or conclusions set forth on the Statement Deficiencies. This Plan of Correction is prepared and/or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F. 405.1907	of se d R. vas an es an are	
		en for over a year and the lysis treatment three times			Care Team members involved in reviewing and updating care plans by		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345090	B. WING _			1	C / 10/2017
	ROVIDER OR SUPPLIER	/IDENCE PLACE		179	REET ADDRESS, CITY, STATE, ZIP CODE 5 WESTCHESTER DRIVE 6H POINT, NC 27262	1 00	110/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 280	each week. NA#4 rev site was located in he was covered with a club During an interview o (staff nurse) revealed dialysis center on Tue Saturdays. SN#5 indiaccess site was a por right upper chest. During an interview o MDS Coordinator rev was replaced with the device in April 2016 a have been updated a correct device in use. access device care, r been documented on	realed the resident's dialysis or right upper chest area and lear bandage. In 8/9/17 at 10:56 am, SN#5 I Resident #48 went to the esdays, Thursdays, and cated the resident's dialysis rta-catheter located in her In 8/10/17 at 9:56 am, the ealed Resident #48's fistula ecurrent dialysis access and the Care Plan should to that time to reflect the She indicated dialysis not fistula care should have the resident's Care Plan would cted to reflect the	F2		9/1/17. "The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory guidelines: The MDS Coordinator or Assistant MD Coordinator will conduct random care paudits daily for 30 days, then 3 times poweek for 60 days then 10 per month formonths. Make corrections to care plan as needed. Audit findings will be presented during the Quality Assurance meetings for recommendations and updates for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The MDS Coordinator and members of the Interdisciplinary Care Team are responsible for ensuring all clinical evaluations including MDS data are completed in a timely and appropriate	nat cted S plan er r 3 s	
F 323 SS=D	(d) Accidents. The facility must ensu (1) The resident envir from accident hazard (2) Each resident reco	ure that - ronment remains as free	F 3		manner.		9/7/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	NGCOMPL		O DATE SURVEY COMPLETED
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	OVIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	CODE	33/13/2311
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	appropriate alternative bed rail. If a bed or must ensure correct maintenance of bed to the following elem (1) Assess the resid from bed rails prior to (2) Review the risks the resident or residinformed consent processing the superior of the resident for the re	refacility must attempt to use ves prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited nents. ent for risk of entrapment o installation. and benefits of bed rails with ent representative and obtain	FS	323		
	facility failed to main (#83) 1 of 2 resident (#83) 1 of 2 resident Findings included: Resident #83 was as 6/2/17 with a diagnothypertension, hypertension, hypertension, hypertension and depression of the failed from the	dmitted to the facility on sis that included lipidemia, anxiety disorder, ession. She was treated for a on and the antibiotic 8/6/17. Data Set (MDS) assessment ed Resident #83 required e of one staff person in the y, transfers and toileting. The		Preparation and/or executor of Correction does not correction does not correction of the truth of the facts alleger conclusions set forth on the Deficiencies. This Plan of prepared and/or executed required by the provisions Safety Code Section 1280 405.1907	estitute an by the provider of the provider of the Statement of Correction is solely because of Health and and 42 C.F.R.	f

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION (X3) E A. BUILDING	
		345090	B. WING		C 08/10/2017
NAME OF D	ROVIDER OR SUPPLIER	0.000	 	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2017
NAME OF FI	NOVIDER OR SUFFLIER				
WESTCHE	STER MANOR AT PROV	IDENCE PLACE		1795 WESTCHESTER DRIVE	
				HIGH POINT, NC 27262	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 323	Continued From page	25	F 32	23	
F 323	Review of Resident # revealed Resident #8 risk of falls due to impression of falls. Resident related to falls. Residentified upper side related to pure revealed a large light and lower forearm. The shape and did not have that appeared to be the During an interview with 1:30 am she measured lower forearm/wrist be wound measuring tap measurement of the belong and 12 centimeter linterview with NA #1 revealed Resident #8 functioning properly. Resident #83's left side weekend (August 5, 2) She indicated she beloat was missing a scraid was missing a scraid would drop deattempted to use the positioning. She further drop after staff put the care. NA #1 stated No during the weekend of 6, 2017 due to Residentification.	83's Care Plan dated 6/3/17 3 was care planned as at paired balance, muscle in use, and history of falls. It #83 was to have no injury lent #83's care plan also rails for bed mobility as an ent #83 on 8/7/17 at 3:46 inear bruise to her left wrist the bruise was rectangular in we circular areas or areas in eshape of fingerprints. Fifth Nurse #2 on 8/8/17 at red the Resident #83's left ruise. She used a flexible in eand stated that the bruise was 15 centimeters ers wide. 100 18/9/17 at 11:50 am 3's left side rail was not She stated she recalled de rail dropping last 2017 and August 6, 2017). Hieved Resident #83's side few and was bent. The left fown when the resident rail to assist staff with their indicated the rail would be rail up when providing larse #1 had assisted her of August 5, 2017 and August ent #83 not being able to use	F 32	member had submitted a request for maintenance in regards to resident a bed rail prior to 8/8/17. All staff are instructed to submit maintenance requests into the facilities work order system as soon as they become awar a maintenance issue. "The procedure for implementing the of correction for the specific deficiencited: All facility staff were educated as to expectation of submitting maintenar requests into the work order system soon as they are aware of maintenarissues. Reviews of the facility maintenance work order system are conducted multiple times per day as maintenance requests are submitted. Maintenance staff are alerted by electronic means when a new maintenance request has been substituted and the prioritization of maintenance request that maintenance staff can address most critical issues first. The timely submission of maintenance request allow for the maintenance departmer repair any malfunctioning bed rails the ensure resident safety. An inspection facility bed rails was conducted by the Maintenance Director or Maintenance Technician 8/28/17 9/1/17. Any brails found to be malfunctioning wer repaired/replaced as necessary.	r are of e plan acy the ace as noce d. d. mitted. ts so the s will not to oo on of the ce ed ed ee
	the left side rail to ass and bed mobility.	sist one staff in transferring		"The monitoring procedure to ensur the plan of correction is effective an specific deficiency cited remains con	d that

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			ATE SURVEY DMPLETED
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		345090	B. WING _			08/10/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
				1795 WESTCHESTER DRIVE		
WESTCHE	ESTER MANOR AT PI	ROVIDENCE PLACE		HIGH POINT, NC 27262		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	HE APPROPRIATE	COMPLETION DATE
F 323	Continued From p	age 26	F 3	323		
	Interview with NA	#2 on 8/9/17 at 1:50pm		and/or in compliance with re	egulatory	
		eft side rail to Resident #83's		guidelines:	,	
		or at least a week and had not		Maintenance staff will contin	nue to review	
	functioned properl	y for the past two weekends.		facility work order system d	aily to ensure	
		e had told Nurse #1 about the		work orders are completed		
	left side rail not fur	nctioning properly. She stated,		manner. Priority will be place	ced on	
	"you had to pull re	al hard for it to stay up".		completing any work order	that effects	
				resident safety. Re-prioritiz	ation of work	
		#2 on 8/9/17 at 1:50pm		orders will be made as need	ded to ensure	
	revealed that the I	eft side rail to Resident #83's		any resident safety issues a	are addressed	
		or at least a week and had not		in the appropriate time fram		
		y for the past two weekends.		Director of Nursing, Assista		
		e had told Nurse #1 about the		Nursing or Maintenance Dir		
		nctioning properly. She stated,		conduct audits beginning 9/		
	you had to pull re	al hard for it to stay up".		broken equipment issues a	-	
				addressed timely and appro	•	
		#2 on 8/9/17 at 1:50pm		initiation 2 different rooms v		
		eft side rail to Resident #83's		monitored daily for 30 days		
		or at least a week and had not		equipment. Then 4 rooms v		
	1	y for the past two weekends.		monitored weekly for 8 wee		
		e had told Nurse #1 about the nctioning properly. She stated,		equipment. Finally, 6 room		
				monitored monthly for 3 mo Audit findings will be preser		
	you had to pull re	al hard for it to stay up".		Quality Assurance meetings	•	
	In an interview wit	h the Maintenance Director on		recommendations for 6 mor		
		m revealed he received work		Tecenimendations for emission	101.	
		Ily. The Maintenance director		"The title of the person resp	onsible for	
		I a work order in regards to		implementing the acceptabl		
		d rail on 8/8/17 and made the		correction:	o p.a o.	
		He indicated he had no work		The Maintenance Director of	or Maintenance	
	1 -	17 for needed repairs to		Technician is responsible for		
		d rails. The Maintenance		submitted work requests are	•	
		vas his expectation that staff		a timely and appropriate ma	•	
		ronic work order as soon as		Director of Nursing and Ass		
	broken equipment			of Nursing are responsible t		
				facility staff are submitting r		
	Interview with Dire	ector of Nursing on 8/9/17 at		requests in a timely and app		
	2:45 pm revealed	she wasn't aware of the broken		manner.		
	side rail until 8/0/1	7 and she revealed a work				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
			71. 501251			С
		345090	B. WING			08/10/2017
	ROVIDER OR SUPPLIER	VIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP COI 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	also revealed therapy 8/9/17 in her wheelch when the resident se the wheel of the whe concluded the bruise wheel. She stated he order should be compa danger to the resid	7. The Director of Nursing y evaluated Resident #83 on nair and they observed that If-propelled her left arm hit elchair. She stated therapy came from the wheelchair er expectation was a work pleted immediately if there is ent.		323		
F 431 SS=D	The facility must providrugs and biologicals them under an agree §483.70(g) of this parameters and personne law permits, but only supervision of a licental supervision, and admition biologicals) to meet to the pharmacist who (2) Establishes a systiation of all contal detail to enable an admitional supervision of all contal detail to enable an admitional supervision of all contal supervision of all contal supervision and supervision of all contal supervision and supervision of all contal supervision and sup	vide routine and emergency to its residents, or obtain the ment described in the residents of the facility may permit and the general ased nurse. cility must provide ces (including procedures the acquiring, receiving, inistering of all drugs and the needs of each resident. tion. The facility must services of a licensed the most records of receipt and the records of receipt and the records are in order and controlled drugs is		431		9/7/17

A. BUILDING		MPLETED				
		345090	B. WING _			C 08/10/2017
	ROVIDER OR SUPPLIER	VIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CO 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	•	0.10.2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		ORRECTION DN SHOULD BE LE APPROPRIATE)	(X5) COMPLETION DATE
F 431	labeled in accordance professional principle appropriate accessor instructions, and the applicable. (h) Storage of Drugs (1) In accordance with the facility must store locked compartments controls, and permit have access to the kind (2) The facility must permanently affixed controlled drugs liste Comprehensive Drug Control Act of 1976 abuse, except when package drug distributed quantity stored is min be readily detected. This REQUIREMENT by: Based on observation record review, the favial of Tuberculin Ppinjectable in 1 of 2 min Findings included: Review of Medication Storage Policy provided for the factor of Nursing (ADON) or revealed that the factor instructions in the factor of the factor of the factor of the factor of Nursing (ADON) or revealed that the factor instructions in the factor of the fac	s and Biologicals. s used in the facility must be e with currently accepted es, and include the ry and cautionary expiration date when and Biologicals. th State and Federal laws, e all drugs and biologicals in s under proper temperature only authorized personnel to eys. provide separately locked, compartments for storage of d in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit aution systems in which the nimal and a missing dose can If is not met as evidenced ons, staff interview and cility failed to date an open D (purified protein derivative) edication room refrigerators. In Ordering, Receiving and ded by the Assistant Director in 8/10/17 at 2:11 PM	F	Preparation and/or execution of Correction does not constant admission or agreement by the truth of the facts alleged conclusions set forth on the Deficiencies. This Plan of Coprepared and/or executed so required by the provisions of Safety Code Section 1280 at 405.1907	itute an the provider of or Statement of orrection is olely because f Health and	
		r the policy guidelines, in		F431		

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STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE COMP	SURVEY LETED
		345090	B. WING _			08/	0 10/2017
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STATE, ZIP CODE	1 00/	10/2017
WESTSHES		WIDENOE DI AGE		1795 WESTC	HESTER DRIVE		
WESTCHES	TER MANOR AT PRO	VIDENCE PLACE		HIGH POIN	T, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
p ir th re a o th re b ir T	ncomplete, improper the dispensing pharm egarding returning of the facility of the facility of the dispensing pharm egarding returning of the facility of the facility of the dispensing pharm egarding returning of the facility of the facil	on containers have missing, or or incorrect labels, contact macy for instructions or destroying these items", whas discontinued, outdated cations or biologicals, contact macy for instructions or destroying these items". Observation of medication second floor revealed 1 dated vial of Tuberculin PPD kin test in the diagnosis of the linterview with ADON sectation was that if ened, they should be dated.	F 4	"The pladeficient On 8/10 tubercu injectable of corrected: Audit of medical consultate ensure labeled educate Nursing labeling 8/25/21 "The methe planspecific and/or inguideling Audits of medical 9/8/17 to Nursing medical expired for 30 docarts and audited medical four meroom w	an of correcting the specific ncy cited: 0/17, the open but undated vial alin PPD (purified protein derivation of the was destroyed. cocedure for implementing the pection for the specific deficiency and tions rooms was completed by ant Pharmacy on 8/25/17 to that all medications were proposed by the Assistant Director of gon the proper procedure for gmedications when opened, 7 - 9/01/17. conitoring procedure to ensure the deficiency cited remains correction is effective and the deficiency cited remains correction rooms will be initiated on by the Assistant Director of go. One medication carts and/or tion room will be audited daily for improperly dated medication and/or medication rooms will be audited dor medication rooms will be a for expired or improperly dated rections weekly for 8 weeks. Finally and the dated medications monthly determined to the dated medications monthly dated medic	tive) blan the erly hat hat cted r	

Facility ID: 923544

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345090	B. WING			08/	10/2017
	ROVIDER OR SUPPLIER STER MANOR AT PROV	/IDENCE PLACE		17	TREET ADDRESS, CITY, STATE, ZIP CODE 795 WESTCHESTER DRIVE IGH POINT, NC 27262		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page	83.10,483.25,483.90		431	3 months. Audit findings will be present during Quality Assurance meetings for recommendations for 6 months. "The title of the person responsible for implementing the acceptable plan of correction: The Director of Nursing or Assistant Director of Nursing is responsible for ensuring that the nurses have properly labeled and dated all medications.		9/7/17
SS=D	as specified in §483.9 483.25 (n)(4) Follow the man recommendations an and maintaining bed 483.90 (c)(3) Conduct Regul- frames, mattresses, a of a regular maintena areas of possible entr and mattresses are u separately from the b	coset on each resident room, and (e)(e)(2)(iv); furfacturers' of specifications for installing rails. ar inspection of all bed and bed rails, if any, as part ince program to identify rapment. When bed rails sed and purchased ed frame, the facility must ails, mattress, and bed					
	Bearooms must						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345090	B. WING _			C 8/10/2017	
	ROVIDER OR SUPPLIER	/IDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		0/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 461	(vii) Have a floor at o (e)(2) -The facility mu with (i) A separate bed of the safety and conve (ii) A clean, comfortal (iii) Bedding, appropric climate; and (iv) Functional furnity resident's needs, and the resident's bedroof shelves accessible to the resident's person shelves accessible to the resident shell by: Based on record revinterview the facility for side rails for 1 of 2 Resident #83's bed returned to the up position during Findings included: Resident #83 was ad 6/2/17 with a diagnose	r above grade level. Ist provide each resident proper size and height for nience of the resident; ble mattress; iate to the weather and ure appropriate to the dindividual closet space in m with clothes racks and of the resident. T is not met as evidenced iew, observation and staff ailed to provide maintenance residents (Resident #83). ail would not stay locked in gractivities of daily living.	F 4	,	ate an e provider of atement of ection is ely because lealth and		
	date 7/20/17 indicate extensive assistance areas of bed mobility MDS further revealed	Data Set (MDS) assessment d Resident #83 required of one staff person in the , transfers and toileting. The d Resident #83 was ly impaired as evidenced by		"The plan of correcting the spe deficiency cited: On 8/8/17 resident #83 □s bed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345090	B. WING		0.0	C
NAME OF D	ROVIDER OR SUPPLIER	0-10000	1	STREET ADDRESS, CITY, STATE, ZIP CO		3/10/2017
NAME OF FI	NOVIDER OR SUFFLIER					
WESTCHE	STER MANOR AT PRO	VIDENCE PLACE		1795 WESTCHESTER DRIVE		
				HIGH POINT, NC 27262		
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 461	Continued From pag	e 32	F 4	61		
	of 9.	Mental Status (BIMS) score		repaired by the maintenance A review of the facility maint order system revealed that r	enance work no staff	
		#83's Care Plan dated 6/3/17		member had submitted a red	•	
		33 was care planned as at		maintenance in regards to re		
		paired balance, muscle		bed rail prior to 8/8/17. All s		
		n use, and history of falls.		instructed to submit mainten		
		t #83 was to have no injury		requests into the facilities we		
		dent #83's care plan also rails for bed mobility as an		system as soon as they beca a maintenance issue.	ome aware or	
				"The procedure for impleme	nting the plan	
	Review of Work Orde	er Report dated 8/8/17		of correction for the specific		
		room 608 (rail on hallway		cited:	•	
		ow side of room) can fall		All facility staff were educate	ed as to the	
	unexpectedly. Rail fi	ramework is bent and can		expectation of submitting ma	aintenance	
	easily open up enoug	gh to release restraining pin		requests into the work order	system as	
	that holds rail in up p	osition." The Work Order		soon as they are aware of m	naintenance	
	dated 8/8/17 was clo	sed on 8/8/17.		issues. Reviews of the facili	ity	
				maintenance work order sys		
		lent #83 on 8/7/17 at 3:46		conducted multiple times pe	-	
		linear bruise to her left wrist		maintenance requests are s		
		Γhe bruise was rectangular in		Maintenance staff are alerte	,	
	shape.			electronic means when a ne		
				maintenance request has be		
		on 8/9/17 at 11:50 am		The alert system allows for t		
		33's left side rail was not		prioritization of maintenance	•	
		She stated she recalled		that maintenance staff can a		
	Resident #83's left si	· · · · ·		most critical issues first. The	•	
		2017 and August 6, 2017).		submission of maintenance	•	
		elieved Resident #83's side		allow for the maintenance de	•	
	_	rew and was bent. The left		repair any malfunctioning be		
		down when the resident		ensure resident safety. An i		
		rail to assist staff with		facility bed rails was conduc		
	, ·	her indicated the rail would		Maintenance Director or Mai		
		e rail up when providing		Technician 8/28/17 ☐ 9/1/17	•	
		Nurse #1 had assisted her		rails found to be malfunction	-	
		of August 5, 2017 and August ent #83 not being able to use		repaired/replaced as necess Maintenance Director on 8/2		

Facility ID: 923544

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345090	B. WING _				C 10/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
				1	1795 WESTCHESTER DRIVE		
WESTCHE	STER MANOR AT PRO	VIDENCE PLACE		ı	HIGH POINT, NC 27262		
(V4) ID	SLIMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 461	Continued From pag	e 33	F 4	461			
	the left side rail to as and bed mobility.	sist one staff in transferring			the task of monthly checks of bed rails ensure proper functioning. The electro	nic	
		on 8/9/17 at 1:50pm side rail to Resident #83's			work order system will alert maintenant of the task for inspecting bed rails beginning 9/1/17. Any broken or	ce	
		at least a week and had not			malfunctioning bed rails will be repaired	d or	
	functioned properly f	or the past two weekends.			replaced as necessary.	<i>1</i> 01	
		nad told Nurse #1 about the			"The manitoring procedure to ensure the	- c+	
		tioning properly. She stated, hard for it to stay up".			"The monitoring procedure to ensure the plan of correction is effective and the		
	you had to pull real	naid for it to stay up .			specific deficiency cited remains correct		
	In an interview with t	he Maintenance Director on			and/or in compliance with regulatory	<i>i</i> led	
		revealed he received work			guidelines:		
		The Maintenance director			Maintenance staff will continue to revie	·W	
		work order in regards to			facility work order system daily to ensu		
		ail on 8/8/17 and made the			work orders are completed in a timely		
	repairs on 8/8/17. H	e indicated he had no work			manner. Re-prioritization of work order	rs	
	order prior to 8/8/17	for needed repairs to			will be made as needed to ensure any		
	Resident #83's bed r	ails. The Maintenance			resident safety issues are addressed in	1	
	Director stated it was	s his expectation that staff			the appropriate time frame. Priority wil	l be	
		nic work order as soon as			placed on completing any work order the		
	broken equipment wa	as identified.			effects resident safety. The Maintenan		
					Director or Maintenance Technician wil		
		or of Nursing on 8/9/17 at			inspect bed rails weekly for 4 weeks, th		
		e wasn't aware of the broken			twice a month for 3 months, then month	-	
		and she revealed a work			going forward to ensure the monthly ta	SK	
		17. The Director of Nursing			of inspecting bed rails is completed.		
		le had therapy evaluate the lchair and they observed that			Inspection findings will be presented during Quality Assurance meetings for		
		elf-propelled her left arm hit			recommendations for 6 months.		
		elchair. She stated therapy			recommendations for a mentile.		
		came from the wheelchair			"The title of the person responsible for	ſ	
		of Nursing stated her			implementing the acceptable plan of		
	expectation was a w	•			correction:		
	-	ely in the electronic system.			The Maintenance Director or Maintena	nce	
	•	•			Technician is responsible for ensuring		
					submitted work requests are completed		
					a timely and appropriate manner. The		
					Director of Nursing and Assistant Director	tor	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345090	B. WING _				C 10/2017
	ROVIDER OR SUPPLIER	IDENCE PLACE	•	17	REET ADDRESS, CITY, STATE, ZIP CODE 795 WESTCHESTER DRIVE IGH POINT, NC 27262	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 461	Continued From page	2 34	F.	461	of Nursing are responsible for ensuring facility staff are submitting maintenance requests in a timely and appropriate manner.		
F 490 SS=B	ADMINISTRATION/R 483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each restricted to the second of the s	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial	F	490			9/7/17
	facility failed to update the timely reporting of Findings included: Review of the Facility Abuse-Staff Responshave an implementati	policy titled, "Resident ibilities" revealed it did not on date or date of revision. 7/17 at 4:30 pm from the			Preparation and/or execution of this Plof Correction does not constitute an admission or agreement by the provide the truth of the facts alleged or conclusions set forth on the Statement Deficiencies. This Plan of Correction is prepared and/or executed solely becaurequired by the provisions of Health an Safety Code Section 1280 and 42 C.F. 405.1907	er of of use d	
	Form and written stat any, must be provided twenty-four (24) hours incident. An immedia investigation will be p agency within five wo of such incident."	the Resident Abuse Report ements from witnesses, if d to the administrator within s of the occurrence of such the investigation will be rovided to certification rking days of the occurrence ector of Nursing on 8/9/17 at facilities abuse policy and			"The plan of correcting the specific deficiency cited: On 8/10/17 the facility updated the policoncerning the timely reporting of abus and neglect to include the following: It is the policy of this facility that all resident have the right to be free from abuse the includes but is not limited to verbal,	e s ts	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE SU COMPLE	
		345090	B. WING _			C 08/10	0/2017
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE,	ZIP CODE	1 00/10	
				1795 WESTCHESTER DRIVE			
WESTCHE	ESTER MANOR AT PRO	VIDENCE PLACE		HIGH POINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI O TO THE APPROPRIA CIENCY)	_	(X5) COMPLETION DATE
F 490	Continued From pag procedure had not be reporting within two has suspicion if the even result in serious bodi hours if the events the not result in serious IN Nursing stated she was to the abuse reporting February 2017. Interview with the As 8/9/17 at 4:08 pm result in the changes to the abuse beginning February 2017.	een updated to include hours after forming the ts that caused the suspicion ily injury, or not later than 24 hat caused the suspicion do bodily injury. The Director of was not aware of the changes ag regulation beginning esistant Director of Nursing on evealed she was not aware of buse reporting regulation 2017. Iministrator on 8/9/17 at 4:46 not aware of the change to	F 4	physical, sexual and m corporal punishment at seclusion or exploitation other residents, consul staff of other agencies resident, family member guardians, friends or on Abuse also includes the omissions, neglect and of resident property that lead to abuse. It is the policy of this far all alleged violations in neglect, exploitation or including injuries of unimisappropriation of resident property that lead to abuse. It is the policy of this far all alleged violations in neglect, exploitation or including injuries of unimisappropriation of resident that cause the allegative events that cause the allegative events that cause the allegation do and do not result in serion that administrator of other officials (including Survey Agency and ad services where state la jurisdiction in long-term accordance with State established procedures. "The procedure for import of correction for the sp	dental abuse, and involuntary on by facility staff tants or voluntees serving the ers or legal ther individuals. ose practices and misappropriation at left unchecked acility to ensure the volving abuse, amistreatment, known source are sident property, abut not later than on is made, if the allegation involve abut not involve abut in the facility and to not involve abut in the facility and to go to the State of the sta	ers, ers, ad an hat are er er or at ase y, or at	
				cited: All current facility staff the updated policy con reporting and investiga neglect 8/25/17 policy is included in ne	cerning the time iting of abuse an 17. The updated	ly d	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		1	A. BOILDING			С		
		345090	B. WING			08/	10/2017	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WESTCHE	STER MANOR AT PROV	IDENCE PLACE		17	795 WESTCHESTER DRIVE			
112010112				Н	IGH POINT, NC 27262			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 490	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36		F			nat nat nat cted or of s to ed ng or of		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(COMMITTEE-MEMB		F:	520			9/7/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ·	PLE CONSTRUCTION G		COMPLETED		
		345090	B. WING _			C 08/10/2017	
NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262		08/10/2017		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 520	and assurance comminimum of: (i) The director of numbers of of num	ent and assurance. aintain a quality assessment mittee consisting at a rsing services; ctor or his/her designee; her members of the facility's who must be the c, a board member or other	F 5				
	Secretary may not re records of such com such disclosure is re such committee with section. (i) Sanctions. Good	equire disclosure of the mittee except in so far as lated to the compliance of the requirements of this					
	committee to identify	and correct quality					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345090	B. WING			C 8/10/2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL		0/10/2017	
				1795 WESTCHESTER DRIVE			
WESTCHE	STER MANOR AT PRO	/IDENCE PLACE		HIGH POINT, NC 27262			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 38	F 52	20			
	deficiencies will not b	e used as a basis for					
	sanctions. This REQUIREMENT by:	is not met as evidenced					
	•	iews and record reviews the		Preparation and/or execution	า of this Plan		
	_	ssment and Assurance		of Correction does not consti			
		led to maintain implemented		admission or agreement by the	•		
	procedures and moni			the truth of the facts alleged of			
		e following the 7/28/16 The facility received a recited		conclusions set forth on the S Deficiencies. This Plan of Co			
		of accidents F323 again on		prepared and/or executed so			
	_	complaint investigation		required by the provisions of			
	_	d failure of the facility during		Safety Code Section 1280 ar			
	two surveys of record			405.1907			
	deficiency showed a	pattern of inability to					
	maintain an effective	QAA program.					
				F520			
	Findings include:			" - "			
	This tag is arose refer	ranged to:		"The plan of correcting the sp	ecitic		
	This tag is cross reference F323 - Accidents/haz			deficiency cited: On 8/8/17 resident #83□s be	d rail was		
		I review the facility failed to		repaired by the maintenance			
		bed rails for 1 of 2 residents.		An inspection of facility bed r	•		
	_	ure correct maintenance of		conducted by the Maintenand			
	bedrails to prevent ac			designee 8/28/17 □ 9/1/17. A			
	During the recertificat	tion survey 7/28/16 the		found to be malfunctioning w	ere		
	facility failed to secur	e oxygen cylinder bottles in 1		repaired/replaced as necessa	•		
		On the current recertification		Maintenance Director on 8/28			
	_	facility failed to maintain		the task of monthly checks of			
	functioning bed rails f	for 1 or 2 residents.		ensure proper functioning into			
	Intensions of Director	of Nursing on 9/10/17 of 2:20		electronic work order system			
		of Nursing on 8/10/17 at 2:20 ities Quality Assurance		electronic work order system maintenance of the task for in			
		every quarter on the third		bed rails beginning 9/1/17. A			
	Wednesday of the mo			malfunctioning bed rails will be	•		
	Nursing stated the Ac			replaced as necessary. On 9	•		
		er, Infection Control Nurse,		facility Quality Assurance Co			
		the Director of Nursing		began reviewing plan of corre			
	_	mmittee meetings. The		and any newly discovered gu			

NAME OF PROVIDER OR SUPPLIER 345090 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
00/10/2	0/2017
NAME OF PROVIDER OR SUPPLIER	
WESTCHESTER MANOR AT PROVIDENCE PLACE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE DEFICIENCY)	(X5) COMPLETION DATE
Director of Nursing further revealed the facilities QAA Committee monitored a Plan of Correction for the failure to secure oxygen cylinder bottles which ended in February 2017. The Director of Nursing stated her expectation is that employees will report hazards immediately in the facilities computer generated reporting system. F 520 F 520 Concerns on a weekly basis for 4 weeks then monthly for 6 months or longer as deemed necessary. Afterwards the Quality Assurance Committee will meet on a quarterly basis going forward. "The procedure for implementing the plan of correction for the specific deficiency cited: All facility staff were educated as to the expectation of submitting maintenance requests into the work order system as soon as they are aware of maintenance issues. Reviews of the facility maintenance work order system are conducted multiple times per day as maintenance request has been submitted. Maintenance staff are alerted by electronic means when a new maintenance request has been submitted. The alert system allows for the prioritization of maintenance requests so that maintenance staff can address the most critical issues first. The timely submission of maintenance requests will allow for the maintenance department to repair any maifunctioning bed rails to ensure resident safety. The Maintenance Director on 8/28 /17 included the task of monthly checks of bed rails to ensure proper functioning. The electronic work order system will alert maintenance of the task for inspecting bed rails beginning 9/1/17. Any broken or maifunctioning bed rails will be repaired or replaced as necessary. The increased Quality Assurance Committee meetings and reviews will assist in ensuring continued	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345090	B. WING				0
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				08/	10/2017		
NAIVIE OF F	ROVIDER OR SUFFLIER				795 WESTCHESTER DRIVE		
WESTCH	ESTER MANOR AT PROV	/IDENCE PLACE			IGH POINT, NC 27262		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 520	Continued From page	e 40	F	520	improvement. "The monitoring procedure to ensure the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory guidelines: Maintenance staff will continue to reviet facility work order system daily to ensure work orders are completed in a timely manner. Priority will be placed on completing any work order that effects resident safety. The Director of Nursin or designee will conduct daily audits for days, weekly audits for 2 months then monthly to ensure. Audit findings will presented during Quality Assurance meetings for recommendations for 6 months. The Quality Assurance Committee will meet weekly for 4 week then monthly for 6 months or longer as deemed necessary and finally on a quarterly basis moving forward. Residuality assurance meetings. "The title of the person responsible for implementing the acceptable plan of correction: The Quality Assurance Committee lead is responsible for ensuring an effective QAA program and that the facility appropriately addresses areas of conceidentified through the routine QAA process. All monitoring information will taken to the Quality Assurance Committee weekly focusing on Ftags 225, 226, 25 279, 280, 323, 431, 461 and 490 on a weekly for 4 weeks then monthly for 6	enat cted w re g r 30 be s, ent l be ttee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l	E CONSTRUCTION	COMPLETED			
		345090	B. WING		C 08/10/2017		
NAME OF PROVIDER OR SUPPLIER WESTCHESTER MANOR AT PROVIDENCE PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1795 WESTCHESTER DRIVE HIGH POINT, NC 27262	00/10/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC			SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PF REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 520	Continued From pag	e 41	F 520		ary.		