

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/18/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2017
NAME OF PROVIDER OR SUPPLIER WINDSOR POINT CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1221 BROAD STREET FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272 SS=E	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>(b) Comprehensive Assessments</p> <p>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the _____ care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct _____ observation and communication with the resident, as well as communication with licensed and _____ 	F 272		10/12/17	

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

TITLE

(X6) DATE

Electronically Signed

10/05/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	<p>Continued From page 1</p> <p>non-licensed direct care staff members on all shifts.</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews, the facility failed to comprehensively assess side rails for 5 of 23 residents reviewed (Residents #15, #38, #36, #24 and #28), and failed to comprehensively assess 1 of 23 residents reviewed for contractures/range of motion (Resident #24).</p> <p>Findings included:</p> <p>Side Rails-</p> <p>1-Record review revealed Resident #15 was admitted to the facility on 4/12/2012 with diagnoses which included Insomnia, Osteoporosis, and Hypertension. The Quarterly Minimum Data Set (MDS) dated 7/5/2017 indicated the resident was severely cognitively impaired and required extensive assistance of 1 person with all activities of daily living (ADLs). The MDS indicated the resident did not have restraints or side rails.</p> <p>An observation of Resident #15 on 9/12/2017 at 9:20 AM revealed the resident was lying in bed with half side rails raised on each side of the bed. Observations were made of Resident #15 on 9/12/ at 2:50 PM, 9/13/2017 at 10:29 AM and 9/13/2017 at 2:10 PM. The resident was in bed during each observation, and side rails were in</p>	F 272	<p>Windsor Point Continuing Care proposes this plan of correction in order to maintain compliance with all applicable rules set forth by the Federal and State regulations. We will continue to serve quality care to all of our residents. This plan of correction is submitted as our written allegation of compliance. Windsor Point's response to this statement of deficiencies does not constitute agreement with the deficiencies nor does it decree concurrence that any deficiency imposed an adverse effect upon the quality care that is delivered to our residents.</p> <p>Corrective action was accomplished for Resident #15, Resident #38, Resident #36, Resident #24, Resident #28 who were found to have been affected by our failure to assess for side rails and just Resident #24 for contractures. A Side Rail Assessment was completed for each resident by the Interdisciplinary Team on 9/13/2017.</p> <p>Resident #24 was assessed for contractures by a corrected MDS submitted by the MDS Nurse on 10/3/2017.</p>		

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F 272	<p>Continued From page 2</p> <p>the same position as the first observation on 9/12/2017 at 9:20 AM.</p> <p>An interview was conducted with the MDS Nurse on 9/13/2017 at 10:45 AM. The MDS nurse stated the basis for the information used for the restraint section of the MDS assessments came from the state level several years ago. The MDS nurse indicated if the side rails were half, quarter, or grab bars, they were not coded as restraints. The MDS nurse indicated even if the rails were used for a safety intervention for falls, any rails half-length or less were not considered restraints, and did not need to be coded on the MDS.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated the facility did not code any rails as restraints because they thought only full rails were considered restraints. The DON reported the facility did use the half rails for safety to help prevent the residents from falling out of bed. The DON stated the expectation was all residents were accurately assessed and the MDS assessments contained correct information.</p> <p>2-Record review revealed Resident #38 was admitted to the facility on 12/10/2015 with diagnoses which included Anemia and Hypertension. The most recent comprehensive MDS dated 9/11/2017 indicated the resident was severely cognitively impaired and required extensive to total assist of 1 person with all ADLs. The MDS indicated the resident had no restraints or side rails.</p> <p>An observation of Resident #38 was made on 9/11/2017 at 2:45PM. The resident was observed in bed with half side rails raised on each side of the bed. The resident was sleeping during the observation.</p> <p>On 9/13/2017 at 1:40PM an observation was</p>	F 272	<p>All skilled residents having the potential to be affected by the same deficient practice were audited for side rail use by the Interdisciplinary Team on 9/13/2017. All residents who were identified with side rails had a Side Rail Assessment completed by the Interdisciplinary Team on 9/13/2017.</p> <p>All skilled residents having the potential to be affected by a failure to assess range of motion/contractures were audited by the Interdisciplinary Team on 9/14/2017. There were no other residents found with contractures that were not identified on the MDS as of 9/14/2017.</p> <p>Education was provided to the MDS Coordinator on 9/26/2017 and 9/27/2017, by Mrs. Mary Mass the NC RAI Clinical Coordinator addressing the importance of comprehensive assessments and coding. The DON, the Social Worker and the Administrator also received training by Mrs. Mary Maas on 9/27/2017.</p> <p>Windsor Point's monitoring procedure to ensure that the plan of correction is effective and remains corrected and in compliance with the regulatory requirements to ensure that residents will be comprehensively assessed for side rails and contractures will include a random audit of 2 MDS per week for a period of 4 weeks. The Director of Nursing will check section P and section G for accurate coding in correlation with the side rail assessment form. Any</p>		

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F 272	<p>Continued From page 3</p> <p>made of the resident. The resident was in bed and the half side rails were raised on each side of the bed.</p> <p>An interview was conducted with the MDS Nurse on 9/13/2017 at 10:45 AM. The MDS nurse stated the basis for the information used for the restraint section of the MDS assessments came from the state level several years ago. The MDS nurse indicated if the side rails were half, quarter, or grab bars, they were not coded as restraints. The MDS nurse indicated even if the rails were used for a safety intervention for falls, any rails half-length or less were not considered restraints, and did not need to be coded on the MDS.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated the facility did not code any rails as restraints because they thought only full rails were considered restraints. The DON reported the facility did use the half rails for safety to help prevent the residents from falling out of bed. The DON stated the expectation was all residents were accurately assessed and the MDS assessments contained correct information.</p> <p>3-Record review revealed Resident #36 was admitted to the facility on 9/2/2015 with diagnoses which included abnormalities of gait and mobility and Parkinson's disease. The quarterly MDS dated 6/3/2017 revealed the resident was rarely/never understood and required extensive to total assist of 1 to 2 people with all ADL's. The MDS indicated the resident did not have side rails or restraints.</p> <p>An observation was conducted on 9/11/2017 at 3:31PM and revealed the resident to be resting in bed. There were half side rails on each side of the bed, and both rails were raised.</p> <p>An observation was conducted of the resident on</p>	F 272	<p>inaccurate coding will be corrected immediately and all findings will be reported to the quarterly Quality Assurance Process Improvement Committee.</p>		

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F 272	<p>Continued From page 4</p> <p>9/12/2017 at 11:42AM and revealed the resident resting in bed. The side rails were raised.</p> <p>An interview was conducted with the MDS Nurse on 9/13/2017 at 10:45 AM. The MDS nurse stated the basis for the information used for the restraint section of the MDS assessments came from someone at the state level several years ago. The MDS nurse indicated if the side rails were half, quarter, or grab bars, they were not coded as restraints. The MDS nurse indicated even if the rails were used for a safety intervention for falls, any rails half-length or less were not considered restraints, and did not need to be coded on the MDS.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated the facility did not code any rails as restraints because they thought only full rails were considered restraints. The DON reported the facility did use the half rails for safety to help prevent the residents from falling out of bed. The DON stated the expectation was all residents were accurately assessed and the MDS assessments contained correct information.</p> <p>4. A review of medical records revealed Resident #24 was admitted on 11/8/2015 with diagnoses of Pseudo Bulbar Affect (inappropriate laughing or crying due to a neurological disorder), insomnia, dementia without behaviors and depression.</p> <p>The Annual Minimum Data Set (MDS) dated 5/3/2017 noted Resident #24 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The MDS noted no restraints present.</p> <p>A review of the Weekly Nursing Summary from</p>	F 272			

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F 272	<p>Continued From page 5</p> <p>May 2 through September 12, 2017 noted the assessment for restraints to be upper half rails, when in bed, for safety.</p> <p>On 9/13/2017 at 2:15 PM, the Director of Nursing stated her expectation was all assessments would be complete and accurate.</p> <p>5. A review of medical records revealed Resident #28 was admitted 4/1/2014 with diagnoses of osteoarthritis, psychosis, GERD, delirium and depressive episodes.</p> <p>The Annual Minimum Data Set (MDS) dated 4/9/2017 noted Resident #28 to be severely impaired for cognition and needed total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The MDS noted no restraints were used.</p> <p>On 9/13/2017 at 2:15 PM, the Director of Nursing stated her expectation was all assessments would be complete and accurate.</p> <p>Contractures:</p> <p>1.A review of medical records revealed Resident #24 was admitted on 11/8/2015 with diagnoses of Pseudo Bulbar Affect (inappropriate laughing or crying due to a neurological disorder), insomnia, dementia without behaviors and depression.</p> <p>The Annual Minimum Data Set (MDS) dated 5/3/2017 noted Resident #24 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The MDS noted no impairment for</p>	F 272			

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F 272	Continued From page 6 functional range of motion in the upper or lower extremities. The care plan dated 5/30/2017 noted a focus of potential for further contractures with a notation the family denied therapy services for contractures, this notation was undated. The goal was to maintain skin integrity. The intervention was therapy to assess for contracture management. A review of the Weekly Nursing Assessments from 5/2/2017 through 9/12/2017 revealed no contractures in each weekly summary. On 9/14/2017 at 11:02 AM, in an interview, Nurse #1 walked into the room where Resident #24 was sitting in a chair. Nurse #1 stated Resident #24 did not have contractures, but would have contractures if nothing was done about her hands. Nurse #1 stated Resident #24 had only had this hand problem for about two weeks. A review of the therapy services screening form revealed Resident #24 had bilateral hand contractures and due to behaviors was not a candidate for therapy at that time. The form was dated 4/12/2017. On 9/14/2017 at 2:30 PM, the Administrator stated the expectation was that assessments would be accurate and comprehensive.	F 272			
F 280 SS=F	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		10/12/17	

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F 280	<p>Continued From page 7</p> <p>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.</p> <p>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to include a nursing assistant in care plan meetings for 14 of 14 residents (Resident #8, Resident #41, Resident #42, Resident #27,</p>	F 280	<p>Windsor Point Continuing Care proposes this plan of correction in order to maintain compliance with all applicable rules set forth by the Federal and State regulations.</p>		

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F 280	<p>Continued From page 9</p> <p>Resident #20, Resident #24, Resident #28, Resident #38, Resident #15, Resident 25, Resident #37, Resident 36, Resident #7, Resident #46).</p> <p>Findings included:</p> <p>1. Review of Resident #8 medical record indicated she was admitted in the skilled facility on 05/18/2017. Her diagnoses included Adult Failure to Thrive and Protein Calorie Malnutrition and Stage 4 sacral ulcer.</p> <p>Review of the resident's interdisciplinary care plan conference dated 08/30/2017 indicated there was no nursing assistant present for the conference.</p> <p>2. Review of Resident #41's medical record indicated he was admitted in the skilled facility on 03/22/2017. His diagnoses included Cerebral Infarction and T Cell Lymphoma.</p> <p>Review of the resident's quarterly interdisciplinary care plan conference dated 07/01/2017 indicated there was no nursing assistant present for the conference.</p> <p>3. Review of Resident #42's medical record indicated he was readmitted in the skilled facility on 06/20/2017 with diagnoses which included cerebral infarction and Vascular Dementia.</p> <p>Review of the resident's interdisciplinary care plan conference dated 07/02/2017 indicated there was no nursing assistant present for the conference.</p>	F 280	<p>We will continue to serve quality care to all of our residents. This plan of correction is submitted as our written allegation of compliance. Windsor Point's response to this statement of deficiencies does not constitute agreement with the deficiencies nor does it decree concurrence that any deficiency imposed an adverse effect upon the quality care that is delivered to our residents.</p> <p>Corrective action was accomplished for Resident #8, Resident #41, Resident #42, Resident #27, Resident #20, Resident #24, Resident #28, Resident #38, Resident #15, Resident #25, Resident #37, Resident #36, Resident #7 and Resident #46 by revising the Care Plan Conference Record Attendance form on 9/13/2017 to include the Certified Nursing Assistant.</p> <p>The procedure for implementing the plan of correction for all residents having the potential to be affected by the same deficiency will include ensuring that all Certified Nursing Assistants are aware of and understand that they will be attending care plan meetings for all residents assigned to them on the day of the care plan meetings as scheduled or rescheduled by the resident and/or family member. This will be accomplished by providing ongoing training for all new and current Certified Nursing Assistants and Nurses commencing on 9/13/2017 by the Director of Nursing.</p> <p>The monitoring procedure to ensure that</p>		

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F 280	<p>Continued From page 10</p> <p>4. Review of the Resident #27's medical record indicated he was admitted in the skilled facility on 07/28/2017 following a hospitalization for pneumonia.</p> <p>Review of the resident's interdisciplinary care plan conference dated 08/16/2017 indicated there was no nursing assistant present for the conference.</p> <p>5. Review of Resident #20 medical record indicated he was admitted in the skilled facility on 04/05/2017. His diagnoses included Congestive Heart Failure.</p> <p>Review of the resident's interdisciplinary care plan conference dated 04/15/2017 indicated there was no nursing assistant present for the conference.</p> <p>6. A review of medical records revealed Resident #24 was admitted 11/8/2015 with diagnoses which included Dementia without Behaviors and Major Depressive Disorder.</p> <p>A review of the resident's medical record revealed a care plan meeting was held for Resident #24 on 6/5/2017. There was no nursing assistant present at the meeting.</p> <p>7. A review of medical records revealed Resident #28 was admitted 4/1/2014 with diagnoses of psychosis, generalized edema, delirium and depressive episodes.</p>	F 280	<p>the plan of correction is effective and that C.N.A.s do attend care plan meetings in compliance with the regulatory requirements will include a performance improvement plan of all residents with scheduled care plans for each month. The Administrator will attend care plan meetings to ensure C.N.A.s are in attendance each Thursday for 3 months then weekly for one month. Any area for improvement will be addressed by the Administrator as needed and will be brought to the QAPI meeting for follow up.</p>		

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F 280	<p>Continued From page 11</p> <p>A care plan meeting was held on 4/10/2017 for Resident #28 and was attended by the Director of Nursing, Social Worker, Activities Director and Dietary Manager. No Nursing Assistant was present.</p> <p>8. Record review indicated Resident #38 was admitted to the facility on 8/22/2017 with cumulative diagnoses which included Anemia and Hypertension.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 8/23/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>9. Record review indicated Resident #15 was admitted to the facility on 4/12/2012 with cumulative diagnoses which included Hypertension and Osteoporosis.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 7/10/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>10. Record review indicated Resident #25 was admitted to the facility on 3/27/2015 with cumulative diagnoses which included Congestive Heart Failure and Chest Pain.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 9/16/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>11. Record review indicated Resident #37 was admitted to the facility on 3/15/2017 with cumulative diagnoses which included Diabetes and Dementia.</p> <p>Record review of the interdisciplinary Care Plan</p>	F 280			

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F 280	<p>Continued From page 12 meeting dated 9/27/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>12. Record review indicated Resident #36 was admitted to the facility on 9/2/2015 with cumulative diagnoses which included Alzheimer's disease and Hearing Loss.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 6/12/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>13. Record review indicated Resident #7 was admitted to the facility on 5/18/2017 with cumulative diagnoses which included Pneumonia and Hypertension.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 5/31/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>14. Record review indicated Resident #46 was admitted to the facility on 3/13/2017 with cumulative diagnoses which included Chronic Obstructive Pulmonary Disease and Dementia.</p> <p>Record review of the interdisciplinary Care Plan meeting dated 8/13/2017 revealed a Nursing Assistant was not present for the meeting.</p> <p>In an interview with the Director of Nursing (DON) on 09/14/2017 at 2:55 PM, she stated the Social Worker (SW) and the Minimum Data Set (MDS) Coordinator were responsible for scheduling care plan conferences. The DON also stated she heard of new changes regarding the meetings, but they were not implemented yet in the facility.</p> <p>In an interview with the facility SW on 09/14/2017</p>	F 280			

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F 280	Continued From page 13 at 3:00 PM, the SW stated it was part of her responsibility to coordinate and schedule care plan meetings. The SW also stated she was aware of the new changes, but they had not made the changes yet. In an interview with the MDS Nurse on 09/14/2017 at 3:05 PM, he stated he was partially responsible for implementing the new changes which required a nursing assistant to participate in care plan meetings, but this had not been implemented yet in the facility.	F 280			
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		10/12/17	

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F 323	<p>Continued From page 14</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff and family interviews, the facility failed to identify the use of loose side rails as an accident hazard for 5 of 23 residents reviewed for accidents which resulted in the risk for entrapment (Residents #15, #38, #36, #24 and #28).</p> <p>Findings included:</p> <p>1-Record review revealed Resident #15 was admitted to the facility on 4/12/2012 with diagnoses which included Insomnia, Osteoporosis, and Hypertension. The Quarterly Minimum Data Set (MDS) dated 7/5/2017 indicated the resident was severely cognitively impaired and required extensive assistance of 1 person with all activities of daily living (ADLs). The MDS indicated the resident did not have functional limitations in upper or lower extremities.</p> <p>An observation of Resident #15 on 9/12/2017 at 9:20 AM revealed the resident was lying in bed with half side rails raised on each side of the bed. The bed was observed with a concaved mattress with the sides of the mattress raised approximately 2 inches above the concave. There was a 3.5 to 4 inch gap observed between the side rails and the mattress. The side rails were loose on both sides of the bed. The resident was awake and moved her arms from the side of her body and rested them on her abdominal area during the observation.</p> <p>Observations were made of Resident #15 on 9/12/ at 2:50 PM, 9/13/2017 at 10:29 AM and 9/13/2017 at 2:10 PM. The resident was in bed during each observation, and the mattress and side rails were in the same position as the first</p>	F 323	<p>Windsor Point Continuing Care proposes this plan of correction in order to maintain compliance with all applicable rules set forth by the Federal and State regulations. We will continue to serve quality care to all of our residents. This plan of correction is submitted as our written allegation of compliance. Windsor Point's response to this statement of deficiencies does not constitute agreement with the deficiencies nor does it decree concurrence that any deficiency imposed an adverse effect upon the quality care that is delivered to our residents.</p> <p>Corrective action was accomplished for Resident #15, Resident #38, Resident #36, Resident #24, and Resident #28 when the side rails were either removed or repaired by the Maintenance Director as a result of the side rail assessment form on 9/13/2017. The raised perimeter mattress was removed from the bed of Resident #15 on 9/13/2017 by the MDS Nurse.</p> <p>All residents in skilled nursing were assessed for side rail usage on 9/13/2017 by the Interdisciplinary Team. All bilateral side rails were removed from all beds. If one side rail remained then it was repaired by the Maintenance Director on 9/14/2017 to ensure stability and no gaps.</p> <p>On 9/14/2017 all beds were audited by the</p>		

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F 323	<p>Continued From page 15</p> <p>observation on 9/12/2017 at 9:20 AM. An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated she was unaware of any possible side rail hazards in the facility. The DON accompanied this surveyor to Resident #15's room and observed the resident in bed with the side rails raised. The DON observed the rails to be loose and observed the 3 to 4 inch space between the rails and the mattress. The DON indicated the space was a possible safety hazard. The DON stated the expectation was for all side rails to fit securely with no space between the rails and the mattress.</p> <p>2-Record review revealed Resident #38 was admitted to the facility on 12/10/2015 with diagnoses which included Anemia and Hypertension. The most recent comprehensive MDS dated 9/11/2017 indicated the resident was severely cognitively impaired and required extensive to total assist of 1 person with all ADLs. The MDS indicated the resident had no impairment to upper or lower extremities. An observation of Resident #38 was made on 9/11/2017 at 2:45PM. The resident was observed in bed with half side rails raised on each side of the bed. Both of the side rails were loose and there was a 3 to 4 inch space between the mattress and the rail on the right side. No space was observed between the mattress and the rail on the left side. The resident was sleeping during the observation.</p> <p>On 9/12/2017 at 11:22AM an interview was conducted with the resident's family member. The family member was in the resident's room sitting with the resident. The resident was in a wheelchair. The family member reported the side rails on the resident's bed would loosen and the</p>	F 323	<p>Director of Nursing to ensure that raised perimeter mattresses were no longer used on the beds in skilled nursing. The new Supply Clerk was educated by the Administrator on 10/2/2017 and was made aware that raised perimeter mattresses were not to be ordered from our order guide.</p> <p>On 9/25/2017 45 new beds were ordered so that loose side rails will not provide any hazards to our residents. The beds will arrive in 30-45 days and will be observed immediately by the Administrator and the Maintenance Director for any hazards particularly related to the side rails. Any bed found to have a safety hazard will be removed, replaced and reported to the distributor Seneca Medical Mocksville.</p> <p>The monitoring procedure to ensure that the plan of correction is effective and that loose side rails and gaps no longer pose a threat to our residents will include a monitoring tool developed for our Maintenance Director to observe beds daily until the new beds arrive in 30-45 days from 9/25/2017. All monitoring tools will be reviewed during the next QAPI meeting by the Director of Nursing to ensure ongoing compliance.</p>		

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F 323	<p>Continued From page 16</p> <p>staff would tighten them. The family member reported the resident never sustained an injury due to the loose rails. The family member stated he never noticed a space between the rails and the mattress.</p> <p>An observation was made on 9/12/2017 at 4:10PM of Resident #38 lying in bed. The side rails were up on both sides and were loose. There was a 3 to 4 inch space between the right side rail and the mattress.</p> <p>On 9/13/2017 at 1:40PM an interview was conducted with the resident's family member. The family member was in the resident's room sitting with the resident. The resident was in bed. The family member reported the side rails on the resident's bed were often loose and the staff would tighten them. The family member reported the resident never sustained an injury due to the loose rails. The family member stated he never noticed a space between the rails and the mattress.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated she was unaware of any possible side rail hazards in the facility. The DON accompanied this surveyor to Resident #38's room and observed the resident in bed with the side rails raised. The DON observed the rails to be loose and observed the 3 to 4 inch space between the right rail and the mattress. The DON indicated the space was a possible safety hazard. The DON stated the expectation was for all side rails to fit securely with no space between the rails and the mattress.</p> <p>3-Record review revealed Resident #36 was admitted to the facility on 9/2/2015 with diagnoses which included abnormalities of gait and mobility and Parkinson's disease. The quarterly MDS</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>dated 6/3/2017 revealed the resident was rarely/never understood and required extensive to total assist of 1 to 2 people with all ADL's. An observation was conducted on 9/11/2017 at 3:31PM and revealed the resident to be resting in bed. There were half side rails on each side of the bed. Both rails were loose and there was a 3 to 4 inch space between the left rail and the mattress.</p> <p>An observation was conducted of the resident on 9/12/2017 at 11:42AM and revealed the resident to be resting in bed. The side rails were in the same condition as the day before.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/13/2017 at 2:15PM. The DON stated she was unaware of any possible side rail hazards in the facility. The DON stated the expectation was for all side rails to fit securely with no space between the rails and the mattress.</p> <p>4. A review of medical records revealed Resident #24 was admitted on 11/8/2015 with diagnoses of Pseudo Bulbar Affect (inappropriate laughing or crying due to a neurological disorder), insomnia, dementia without behaviors and depression. The Annual Minimum Data Set (MDS) dated 5/3/2017 noted Resident #24 to be severely impaired for cognition and needed extensive to total assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. The MDS noted no restraints present. On 9/12/2017 at 2:30 PM, Resident # 24 was observed lying in bed with side rails raised. There was a gap of three and one fourth inches between the side rail and the mattress. The side rail was loose and did not fit the bed.</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>A review of the Weekly Nursing Summary from May 2 through September 12, 2017 noted the assessment for restraints to be upper half rails, when in bed, for safety.</p> <p>On 9/13/2017 at 2:15 PM, the Director of Nursing stated her expectation was all side rails would fit the beds appropriately with no space between the mattress and the rail.</p> <p>5. A review of medical records revealed Resident #28 was admitted 4/1/2014 with diagnoses of osteoarthritis, psychosis, GERD, delirium and depressive episodes.</p> <p>The Annual Minimum Data Set (MDS) dated 4/9/2017 noted Resident #28 to be severely impaired for cognition and needed total assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The MDS noted no restraints were used.</p> <p>On 9/12/2017 at 11:44 AM Resident #28 was observed in bed with the half side rail raised. The side rail was very loose. The MDS nurse came into the room and tightened the rail with a knob located on the side of the bed rail.</p> <p>On 9/13/2017 at 2:15 PM, the Director of Nursing stated her expectation was all side rails would fit the beds appropriately with no space between the mattress and the rail.</p>	F 323			