STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345090	A. BUILDING _____ B. WING _____	C 05/23/2024

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/20/24 through 5/23/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RC9V11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/20/24 through 5/23/24 Event ID# RC9V11. The following intakes were investigated NC00216565 and NC00208757. 2 of the 3 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/10/24

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

Electronically Signed | 06/10/2024

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and maintenance audit and repair review the facility failed to maintain walls (Rooms 501 A, 509, and 601 B) and red plastic electrical outlet plate (Room 603 B) in good repair for 4 of 20 rooms (Rooms 501, 509, 601, and 603) on the 500 and 600 halls reviewed for environment. Findings included: a. Observations of room 501 A on 05/20/24 at 3:48 PM and on 05/21/24 at 10:56 AM revealed horizontal areas of gouged drywall behind the head of the bed and 10 reddish-brown spots on the ceiling near the doorway. b. Observations of room 509 on 05/20/24 at 4:00	F 584	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts allegded or conclusions set forth on the statement of deficiencies. Corrective action will be accomplished by touch up painting in rooms 501A, 509, and 601B and replacing the red plastic electrical outlet cover in room 603B This was completed on 6/09/24. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:	

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F 584	Continued From page 2 PM and on 05/21/24 at 10:33 AM revealed gouged drywall behind the visitors' chairs on the left side of the room. c. Observations of room 601 B on 05/20/24 at 4:15 PM and on 05/23/24 at 3:00 PM revealed black marks around the perimeter of the room approximately 3 feet from the floor. d. Observations of room 603 B on 05/20/24 at 4:15 PM and on 05/21/24 at 11:19 AM revealed a broken red plastic electrical outlet plate on the wall behind the head of the bed. During an interview and room observations with the Maintenance Director on 05/23/24 at 3:00 PM he stated he had been the Maintenance Director for 15 years for the entire facility complex. He further stated facility staff notified him of repairs that were needed in residents' rooms. He explained staff could enter work orders into an online system and he could access the orders from a database. The Maintenance Director shared he was aware that there were many areas in the facility that needed repairs, and they are prioritizing the areas as they identify concerns. He explained he prioritized repairs by working on those which impacted resident safety first. He added two maintenance employees recently quit and he was working with a recruiting agency to find skilled maintenance assistants. During the observation round with the Maintenance Director, he stated he had repaired many of the concerns found during the survey and the others were on a list to be completed within the week. He displayed a list of the rooms he had audited and the repairs that had been completed.	F 584	Painters were contracted and provided touch up painting for all resident rooms. This was completed on 6/9/24. Administrator completed a room check for all resident rooms on 6/10/24. Rounds included monitoring for painting needs and need for replacement of outlet covers. Any items found were placed in the TELS system for maintenance. Measures will be put in place or systemic changes made to ensure that the deficient practice does not reoccur: Education was provided to staff regarding reporting issues in the Tels system. Information also has been posted as a reminder on how to use the TELS system. If immediate need, staff educated to contact the maintenance supervisor or on call maintenance team member via phone. If unable to reach maintenance, staff were educated to call the administrator. Indicate how the facility will monitor so issues do not reoccur: Administrative staff will conduct monthly rounds on their assigned rooms and provide a list of any issues to the administrator. These items will be entered into the TELS system. The administrator or designee will conduct weekly rounds of all rooms x 4 weeks, then monthly rounds of all rooms ongoing and as needed. Results will be presented to the Quality Assurance Team for recommendations and follow up for six months.	

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F 584	Continued From page 3 On 05/23/24 at 5:20 PM an interview was conducted with the Administrator, and she stated she expected the Maintenance Director to complete repairs that impacted resident safety first and then attend to cosmetic repairs. She stated the Maintenance Director had completed an audit of needed room repairs and had initiated or completed many of the repairs. She stated a process will be put in place for department leaders to make rounds on a consistent basis to identify areas of concern. The Administrator added nurses on the hall should submit work orders in the online system. She said training on entering work orders will be part of process that will be put in place. She stated staff are expected to report identified needs in the electronic system or to report concerns directly to her or the Maintenance Director.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		6/11/24

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F 600	Continued From page 4 Based on observations, record review, staff and nurse practitioner interviews the facility failed to protect a resident's right to be free from abuse (Resident #13) when another resident (Resident #44) pulled out a section of hair from Resident #13. This deficient practice occurred for 1 of 3 residents reviewed for physical abuse. The reasonable person concept was applied for Resident #13 due to a reasonable person would feel pain and emotional distress having his or her hair pulled out of their head by another person. Findings included: Resident #44 was admitted to the facility on 10/9/2021 with diagnoses of unspecified dementia and hallucinations. Resident #44's most recent Minimum Data Set (MDS) dated 3/7/24 showed her to be cognitively intact, required moderate staff assistance to complete activities of daily living, and she used a wheelchair to propel herself. Resident #44's care plan showed she had been care planned for physical behaviors on 4/23/24 which included hitting, scratching, and throwing objects at staff during care. Interventions included removing resident from triggering behavior, approach resident warmly and softly, and allow resident time to de-escalate when agitated. Resident #13 was admitted to the facility on 5/10/2022 with diagnoses of Alzheimer's dementia and orthostatic hypotension. Resident #13's quarterly MDS assessment dated 2/5/24 revealed she was moderately cognitively	F 600	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that immediate jeopardy exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response. Immediate action(s) taken for the resident(s) found to have been affected include: The facility self-reported F600 cited incident at the time of occurrence on 4/30/24. Complaint survey reviewed incident as part of an intake investigation on 5-20-24 through 5-23-24. At time of event residents #14 and #44 were immediately separated and 1:1 initiated with resident #44 until ambulance transport arrived to take the resident for an evaluation at the hospital. Resident #14 was assessed at time of event for distress/injury and again the following day, 5/1/2024. Staff 1:1 with resident #44 continued since the incident on an as needed basis when resident #44 was exhibiting agitated behaviors. Facility Nurse Practitioner assessed the resident #44 on 5/1/2024 rounds, facility psych Nurse Practitioner was called on 5/1/2024, resident transferred to ER for evaluation at another hospital, 5/7/24 facility psych NP assessed resident in person, and on 5/16/24 Psychotherapy visit provided at the facility. Continuous 1:1 implemented for resident #44 on 6/5/2024.	

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F 600	Continued From page 5 impaired, and she used a wheelchair to propel herself. A review of a facility reported incident revealed that on 4/30/24 at around 4:00 pm, Resident #44 was seen sitting in her wheelchair behind Resident #13, who was also in her wheelchair, in the common area in front of the nurse's station on the 400 hall. Resident #44 was observed to be holding a moderate amount of hair in her hand by Nurse Aide #1. The report stated that both residents were immediately separated and 1:1 supervision immediately began for Resident #44 until a psychiatric evaluation was obtained. Resident #13 was immediately assessed, and an approximately two-inch reddened area was noted to her back hairline near her neck. Resident #13 voiced no complaints at that time. The nurse practitioner was made aware of the incident and both responsible parties were notified. An interview with Resident #44 was attempted on 5/20/24 at 10:32 am. Resident #44 was noted to be oriented to self only. When asked if she had any recollection of an incident with Resident #13, she became agitated, and the interview ceased. An observation on 5/20/24 at 10:50 am of Resident #13 showed approximately ½ inch of new hair growth where the hair had been pulled out near her neckline. There was no redness noted. Resident #13's hair was fairly thin and most of it was curled toward the top. She had very little near the bottom and around her neckline where it was thinner. An interview with Resident #13 on 5/20/24 at 10:50 am revealed that she had no memory of the incident and denied any past or current issues	F 600	Identification of Residents Affected or Likely to be Affected: Facility was aware of residents affected at the time of event occurrence on 4/30/24. The DON completed a review of residents on Quality Measures report for time range of 3/4/24-6/4/24 that were identified as having behavior symptoms that affected others. The DON completed an audit of residents with current behavior care plans for all residents currently residing in the facility. Both audits were crossed referenced to obtain a list of residents to review for potential to be affected or identified as risk for being a perpetrator. Social workers reviewed and updated all resident care plans identified by DON audit. MDS coordinators performed a review of CNA behavior monitoring tasks and updated residents who were identified with behaviors for daily charting parameters. Resident #44 care plan was included in all audits, reviews, and updated. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from	

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F 600	Continued From page 6 with staff or other residents. During an interview with Nurse Aide #1 (NA#1) on 5/22/24 at 2:58 pm, she stated that she saw both residents sitting in the common area on the 400-hall watching television. She stated that when she came back to the common area a few minutes later, she saw Resident #44 had propelled herself over to Resident #13 and was holding some of Resident #13's hair in her hand. She stated that she did not hear Resident #13 yell out in pain. NA#1 stated that Resident #13 did not complain of any pain when asked and only stated that "she wanted her hair back". NA#1 stated that Resident #13 had about a 2-inch reddened area where her hair was at her neckline. She stated that she immediately separated the two residents, and the Director of Nursing (DON) was made aware of the incident. During an interview with the Social Worker on 5/22/24 at 12:13 pm she stated that Resident #13 had no memory of the incident and was seen smiling at her within minutes of the incident occurring. The social worker stated that Resident #44 had become combative with staff and increasingly agitated since she realized she could not propel her wheelchair as easily as she could before even with rehabilitation services. The social worker stated this was the first time she had touched a resident. She added that the facility is trying new interventions with Resident #44 such as taking her on walks when it's nice outside and spending more time doing one-on-one activities. During an interview with the DON on 5/22/24 at 3:30 pm, she stated that she was made aware of the incident as soon as it occurred. She stated	F 600	reoccurring. Abuse policies were reviewed/updated to include all sources of abuse, including resident to resident. Abuse investigation procedure and documentation process were reviewed. Staff development nurse, DON, and nurse supervisors educated all staff on changes regarding facility abuse polices, identification of abuse, and documentation related to resident behaviors and how to report them at meetings held on 6/8/24-6/11/24. Behavior documentation will be monitored by the Social Workers, DON, and MDS coordinator. Care plans will be updated as indicated by the IDT. Staff will be informed of new interventions either verbally or in written form by the DON, nurse supervisor, and/or designee. The need for psych services at the facility has been assessed for any resident with a behavior care plan trigger. In the event of any future resident to resident altercation that is deemed abuse, the perpetrating resident will immediately have 1:1 supervision until primary care, nursing, and psych evaluations can be complete. The outcome of these evaluations will result in continued 1:1 supervision until the resident is no longer	

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F 600	Continued From page 7 that Resident #44 was immediately put on 1:1 until they were able to get her to the hospital for a psychiatric evaluation. She stated that she reviewed the incident via camera footage of the 400-hall common area. She saw Resident #44 propel herself a couple feet over to Resident #13, reach out and pull out a section of Resident #13's hair. She stated she saw staff intervene within seconds of it occurring and separating the two. She stated she was immediately notified of the incident. The DON stated that Resident #44 had been displaying behaviors over the last month such as kicking and spitting on staff and throwing her food at staff members. She stated that they have done bloodwork and radiology scans to see if there is a metabolic reason for her behavior change and they have not found one. The DON did state that she was recently treated for a urinary tract infection, and she also had COVID infection. Per psychiatry recommendation, they are keeping her on 1:1 supervision for the foreseeable future. Camera footage of the 400-hall common area for the incident was not downloaded and saved by the facility. It was not available for review during the investigation. During an interview with the psychiatric Nurse Practitioner on 5/23/24 at 3:20 pm, she stated that she has spent a lot of time with both residents. She stated that Resident #44 has become very agitated over the last month or two and had recently started exhibiting behaviors such as kicking and spitting on staff, including her. She stated she has seen her twice since the incident, changing medication dosages each time. She added that she feels like this is a progression of her dementia following two	F 600	deemed by evaluating providers to be a threat to harm another resident, or the initiation of discharge planning to a facility with a focus on behavior management will be assessed. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON will audit CNA behavior documentation three times weekly to identify new trends in any resident behaviors that could indicate a potential for aggression or abuse toward another resident. If a resident identified for a risk, facility will perform an update of care plan, initiate psych services if not already in place, notify the facility provider, and family of change at the time of identification. The administrator will complete random audits of three resident care plans on a weekly basis X 12 weeks, then a review of 6 resident records monthly for 3 additional months. A weekly resident behavior meeting will be held with IDT members every week for 6 months. After the 6-month period the facility will assess frequency for appropriateness and adjust meeting schedule. The corrective action will be reviewed monthly at the QAPI meeting for a period of 6 months.	

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F 600	Continued From page 8 significant infections and that the staff are doing all they can to redirect her when she becomes agitated and keeping her on 1:1 supervision while they are adjusting her medications so that no further incidents occur. During an interview with the Administrator on 5/23/24 at 3:45 pm, she stated she has reached out to both responsible parties to discuss the incident. She stated that she has spoken with Resident #44's daughter at length regarding her change in behavior and the possibility of her having to eventually have constant 1:1 supervision to keep others safe. She stated that Resident #44's daughter is open to any help the facility can provide.	F 600	The staff education nurse will provide quarterly education to staff regarding behavior monitoring, abuse prevention, and identification of abuse for a period of 1 year.	