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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [ROOM NUMBER] on 05/20/24 at 4:00 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 [ROOM NUMBER] 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 [ROOM NUMBER] 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 [AGE] 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. (continued on next page)

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.

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

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007 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 [DATE] with diagnoses of unspecified dementia and hallucinations. Resident #44's most recent Minimum Data Set (MDS) dated [DATE] 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 [DATE] with diagnoses of Alzheimer's dementia and orthostatic hypotension. Resident #13's quarterly MDS assessment dated [DATE] revealed she was moderately cognitively 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An observation on 5/20/24 at 10:50 am of Resident #13 showed approximately 1/2 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 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 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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.