| 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 11/27/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Windsor Point Continuing Care | | STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Broad Street Fuquay Varina, NC 27526 | |

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 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234<br><br>Based on observations, record review, and interviews with staff and resident representative, the facility failed to provide personal privacy when a resident's door to the room was left open during incontinent care allowing the resident to be visible from the hallway for 1 of 2 residents (Resident #16) reviewed for privacy. A reasonable person has an expectation of privacy during care and would have experienced feelings such as embarrassment.<br><br>The findings included:<br><br>Resident #16 was admitted to the facility on [DATE] with diagnoses including dementia, anxiety disorder, glaucoma, and age-related physical debility.<br><br>Resident #16's Minimum Data Set (MDS) dated [DATE] indicated the resident had severe cognitive impairment, was always incontinent of bowel and bladder, and was totally dependent on staff for toilet hygiene.<br><br>Observation on 11/25/24 at 10:38 a.m. revealed Resident #16's room was close to the nurses' station at the beginning of the hallway.<br><br>A continuous observation on 11/27/24 from 5:01 a.m. through 5:06 a.m. revealed Resident #16's room door was open approximately 12 inches and Nursing Assistant (NA) #8 was in the room. Resident #16 resided in a room without a roommate. NA #8 was putting a brief onto the resident, who slept in the bed by the door, and the resident's legs and the brief were in view. If the brief was not being put on the resident, her private areas would have been in view. NA #8 had not pulled a privacy curtain. NA #9 walked down the hall, stopped by Resident #16's room, spoke to NA #8, then grabbed the trash bag outside of the room.<br><br>In an interview on 11/27/24 at 5:06 a.m., NA #8 said that she must have left the door open when she had to get the nurse to change the resident's dressing. She said she should have shut it for privacy when she finished providing care.<br><br>In an interview on 11/27/24 at 9:15 a.m., Resident #16's representative said she was a very private person who kept to herself.<br><br>In an interview on 11/27/24 at 11:12 a.m., the Director of Nursing (DON) said NA #8 should have closed the door and pulled the curtain to provide privacy during care. |

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 |
|---|---|---|

| 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 11/27/2024 |
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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234<br><br>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Gradual Dose Reduction (Residents #16 and #13) and Restraints (Resident #8) for 3 of 12 residents reviewed.<br><br>Findings included:<br><br>1. Resident #13 was admitted on [DATE] with diagnoses including dementia and major depressive disorder.<br><br>A psychiatric Nurse Practitioner progress note dated 10/03/24 recorded Resident #13 was to continue taking quetiapine (an antipsychotic medication used to treat mental health conditions) 25 milligrams (mg) and apriprazole 2.5 mg. Her medications were reviewed for possible Gradual Dose Reduction (GDR- to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and it was noted a GDR was not recommended at that time.<br><br>Review of Resident #13's October 2024 Medication Administration Record revealed she had received quetiapine and aripiprazole daily.<br><br>Resident #13's significant change MDS assessment dated [DATE] indicated she had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. The date when a GDR review was completed and not recommended was blank.<br><br>In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said the information provided by the psychiatric Nurse Practitioner should have been used in the MDS and it was an error to not indicate a GDR review was done and to leave the date it was done blank.<br><br>2. Resident #16 was admitted on [DATE] with diagnoses including dementia and bipolar disorder.<br><br>A psychiatric Nurse Practitioner progress note dated 10/22/24 recorded Resident #16 was to continue taking apriprazole (an antipsychotic medication used to treat mental health conditions) 5 milligrams (mg) in the morning and 2 mg at bedtime. Her medications were reviewed for possible Gradual Dose Reduction (GDR to reduce the dose or discontinue the medication) of psychotropics (includes several classifications of medications used to treat mental illness), and it was noted a GDR was not recommended at that time.<br><br>Review of Resident #16's October 2024 Medication Administration Record revealed she had received aripiprazole twice daily.<br><br>Resident #16's quarterly MDS assessment dated [DATE] indicated she had received antipsychotic medication routinely and a GDR had not been documented by a physician as clinically contraindicated. The date when a GDR review was completed and not recommended was blank.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said the information provided by the psychiatric Nurse Practitioner should have been used in the MDS and it was an error to not indicate a GDR review was done and to leave the date it was done blank.<br><br>3. Resident # 8 was admitted to the facility on [DATE] with diagnoses including depression and heart failure.<br><br>Resident #8's annual Minimum Data Set (MDS) dated [DATE] indicated he was cognitively intact, had no behaviors, and needed assistance with bed mobility and transfers. The MDS also documented that Resident #8 had bed rails used as a physical restraint daily during the observation period.<br><br>Review of Resident #8's physician's orders from 7/1/24-11/27/24 did not reveal an order for bed rails as a restraint.<br><br>Review of Resident #8's progress notes from 7/1/24-11/27/24 did not reveal notes that he had any behaviors or any indications of a need for a restraint. The notes did not document that a restraint was used.<br><br>In an interview on 11/27/24 12:30 PM, MDS Nurse #1 said Resident #8 did not use bed rails as a restraint and the MDS was coded in error. She said Resident #8 used his bed rails for mobility and assistance for bed mobility and transfers.<br><br>In an interview on 11/27/24 at 8:50 AM, the Director of Nurses (DON) said Resident #8 did not use his bed rails as a restraint and the MDS was coded incorrectly. |

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159

Based on record review and staff interviews, the facility failed to develop comprehensive care plans for the care areas of use of anticoagulant medication {medications that prevent or treat blood clots in the heart and blood vessels} (Resident #22), the use of antipsychotic medications {a class of drugs used to treat symptoms of psychosis, such as hallucinations, delusions, and disordered thinking} (Resident #14), and for the care area of respiratory care (Resident #5) for 3 of 14 residents whose comprehensive care plan were reviewed.

Findings included:

1. Resident #22 was admitted to the facility on [DATE]. Her diagnoses included heart failure (a condition where the heart is unable to pump enough oxygen-rich blood to the body) atrial fibrillation (a heart condition that causes an irregular and often fast heartbeat), and deep vein thrombosis or DVT (a condition that occurs when a blood clot forms in a vein deep within the body, usually in the lower extremities).

Resident #22's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact and was coded for anticoagulant use (a substance or medication that prevents or treats blood clots in the heart and blood vessels).

Review of Resident #22's medication administration record (MAR) dated August 2024 revealed she was receiving an anticoagulant medication.

Review of Resident #22's care plan dated 9/9/24 and revised on 9/24/24 revealed she did not have a care plan for anticoagulants.

An interview was conducted on 11/27/24 at 12:25 PM with MDS Nurse #1. She stated she was an interim MDS nurse and was responsible for care plans. She stated this resident should have been care planned for anticoagulants. She was unable to offer a reason why Resident #22 did not have a care plan for anticoagulants.

An interview was conducted on 11/27/24 at 12:33 PM with the Director of Nursing (DON). She stated she expected Resident #22 would have an anticoagulant care plan.

41387

2. Resident #14 was admitted to the facility on [DATE] with diagnoses including dementia.

Physician orders dated 9/3/2024 included Quetiapine Fumarate (an antipsychotic medication) half of a 25 milligram tablet twice a day for dementia with agitation.

The quarterly Minimal Data Set (MDS) assessment dated [DATE] indicated Resident #14 was severely cognitively impaired and was receiving antipsychotics on a routine basis.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #14's care plan last reviewed 9/25/2024 did not include a focus for the use of antipsychotic medications.

A review of Resident #14's Medication Administration Record from 9/3/2024 to 11/26/2024 recorded Resident #14 received Quetiapine Fumarate half of a 25 milligram tablet twice a day.

In a phone interview with the MDS Nurse #1 on 11/27/2024 at 12:14 pm, she explained she worked part-time on weekends and she had been working as the MDS nurse since the last full time MDS Nurse left the facility in September 2024. She stated as the MDS Nurse, she was responsible for developing the initial care plan and updating residents' care plan quarterly. She stated Resident #14's Quetiapine Fumarate medication was an antipsychotic and Resident #14 was scheduled to receive daily. She stated Resident #14's care plan should have included the use of antipsychotics. She explained with her only working weekends, she had been trying to keep care plans up-to-date and did not know why Resident #14's care plan did not include a focus for the use of antipsychotics.

In an interview with the Director of Nursing on 11/27/2024 at 11:17 am, she stated residents' care plans were updated quarterly by the MDS nurse. She explained Resident #14 was receiving Quetiapine Fumarate, an antipsychotic, and should have been care planned for the use of antipsychotics.

In an interview with the Administrator on 11/27/2024 at 3:28 pm, she explained the MDS Nurse, who worked part-time, had access to Resident #14's electronic medical records to gather information to care plan for the use of antipsychotic medications when ordered. She stated Resident #14 should have been care planned for the use of antipsychotics.

50234

3. Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia and respiratory failure.

Resident #5's physician's orders revealed an order dated 9/4/24 for oxygen supplementation as needed for shortness of breath, hypoxia, and comfort at 2 liters per minute (Lpm) by nasal canula as needed to maintain oxygen saturation levels above 90%.

Resident #5's Minimum Data Set (MDS) dated [DATE] indicated the resident had severe cognitive impairment, had shortness of breath or trouble breathing with exertion, while sitting at rest, and while lying flat. The MDS indicated she used oxygen therapy and received hospice services.

Resident #5's care plan last reviewed 10/22/2024 did not include a focus for the use of oxygen.

Observation on 11/25/24 at 10:06 a.m. revealed Resident #5 asleep in low bed. She had a nasal cannula on and oxygen was running from her concentrator at 2 Lpm.

Observation on 11/26/24 at 11:40 a.m. revealed Resident #5 in bed. She had removed her nasal cannula, but the oxygen concentrator was running at 2 Lpm.

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a phone interview with the MDS Nurse #1 on 11/27/2024 at 12:14 pm, she explained she worked part-time on weekends and she had been working as the MDS nurse since the last full time MDS Nurse left the facility in September 2024. She stated as the MDS Nurse, she was responsible for developing the initial care plan and updating residents' care plan quarterly. She stated if Resident #8 was using oxygen, there should be a focused care plan for the use and care of her oxygen.<br><br>In an interview with the Director of Nursing on 11/27/2024 at 11:50 am, she stated Resident #8 should have had a care plan for the use of oxygen.<br><br>In an interview with the Administrator on 11/27/2024 at 3:10 pm, she said Resident #8 had a care plan for the use of oxygen and provided a copy of the hospice agency's care plan for pulmonary/dyspnea (shortness of breath), which included instructing the patient and patient caregiver in safe oxygen use. The care plan provided did not include interventions and goals for oxygen usage. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50234<br><br>Based on observations, interviews with staff, and record review, the facility failed to ensure an oxygen filter was clean of dust and debris for 1 of 2 residents (Resident #5) reviewed for oxygen use.<br><br>The findings included:<br><br>Resident #5 was admitted to the facility on [DATE] with diagnoses including dementia and respiratory failure.<br><br>Resident #5's physician's orders revealed an order dated 9/4/24 for oxygen supplementation as needed for shortness of breath, hypoxia, and comfort at 2 liters per minute (Lpm) by nasal canula as needed to maintain oxygen saturation levels above 90%.<br><br>Resident #5's Minimum Data Set (MDS) dated [DATE] indicated the resident had severe cognitive impairment, had shortness of breath or trouble breathing with exertion, while sitting at rest, and while lying flat. The MDS indicated she used oxygen therapy.<br><br>Observation on 11/25/24 at 10:06 a.m. revealed Resident #5 asleep in low bed. She had a nasal cannula on and oxygen was running from her concentrator at 2 Lpm. The external air filter had a buildup of dust-like gray and white particles.<br><br>Observation on 11/26/24 at 11:40 a.m. revealed Resident #5 in bed. She had removed her nasal cannula, but the oxygen concentrator was running at 2 Lpm. The external air filter had a build-up of dust-like gray and white particles.<br><br>In an interview on 11/26/24 at 11:42 a.m., Nurse #10 said that the night shift nurse was normally supposed to change and clean the oxygen filters. When Nurse #10 saw the filter, she said it was extremely dirty and took the filter off to clean it.<br><br>In an interview on 11/27/24 at 5:15 a.m., the nurse on the night shift, Nurse #11 said she never thought about checking and cleaning the filter when she changed the oxygen tubing.<br><br>In an interview on 11/27/24 at 11:12 a.m., the Director of Nursing (DON) said the nurses should be monitoring and cleaning the oxygen concentrator filters when they were dirty. |

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| F 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>49159<br><br>Based on record review and staff interviews, the facility failed to ensure 2 of 5 staff reviewed who were assigned nurse aide tasks met the minimum qualifications for working as a nurse aide when Staff #1 and Staff #2 were performing nurse aide tasks without having completed a training and competency evaluation program, or a competency evaluation program approved by the State and were not in a state approved training and competency evaluation program.<br><br>The findings included:<br><br>The North Carolina (NC) Department of Health and Human Services (DHHS) Health Care Personnel Education and Credentialing Section's website indicated under the section of Nurse Aide I, last updated 1/24/24, that in accordance with federal law, a facility may employ a nurse aide (NA) for a period of up to 4 months under the following conditions:<br><br>-During the 4-month grace period, an individual must be deemed competent to provide nursing or nursing-related services by a Registered Nurse and work toward meeting the training and testing requirements by participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program.<br><br>The website clarified that the individual must be actively participating in a state-approved Nurse Aide I training and competency evaluation program during the 4-month grace period. It further indicated the NC Nurse Aide I Registry was a registry of all people who met the state and federal training and testing requirements to perform Nurse Aide I tasks.<br><br>a. Review of the facility records revealed Staff #1 was hired on 10/23/24.<br><br>Review of Staff #1's human resource file revealed there was no evidence she had completed a state approved NA training and competency evaluation program, or a competency evaluation program approved by the State.<br><br>Review of the nursing schedule dated 11/25/24 through 11/29/24 revealed Staff #1 was scheduled to work 8-hour shifts and was assigned NA tasks on 11/25/24, 11/26/24, 11/27/24, and 11/28/24.<br><br>During an interview on 11/26/24 at 2:19 PM Staff #1 stated she moved to the United States (US) from another country. She further stated while in that other country, she worked as a certified NA. She stated she planned to apply to take the CNA certification test here as a challenge, as North Carolina (NC) did not recognize her certification from her country of origin. She verified she had not completed a state-approved nurse aide training and competency evaluation program or competency evaluation program and that she was not participating in a state approved training and competency evaluation program.<br><br>b. Review of the facility records revealed Staff #2 was hired on 9/16/24.<br><br>(continued on next page) |

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| F 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Staff #2's human resource file revealed there was no evidence she had completed a state approved NA training and competency evaluation program, or a competency evaluation program approved by the State.<br><br>Review of the nursing schedule dated 11/25/24 through 11/29/24 revealed Staff #2 was scheduled to work 8-hour shifts and was assigned NA tasks on 11/25/24, 11/26/24, 11/27/24, and 11/28/24.<br><br>During an interview on 11/26/24 at 3:25 PM with Staff #2 he stated he moved to the US from another country. He stated he worked in a hospital in his country of origin as a caregiver, providing direct patient care. He further stated he is registered to begin a CNA certification program in December 2024. He verified he had not completed a state-approved nurse aide training and competency evaluation program or competency evaluation program and that he was not participating in a state approved training and competency evaluation program.<br><br>An initial interview was conducted on 11/26/24 at 12:03 PM with the Business Administrator, who was also in charge of Human Resources. She stated she thought nurse aides could work if they were in competency skills training at the facility. In a subsequent interview on 11/26/24 at 3:33 PM she explained her role in the hiring process. This included checking the nurse aide registry for certification and placing the information in a folder. The Director of Nursing (DON) retrieves the folder and was responsible for following up on certification status.<br><br>An interview was conducted with the Director of Nursing (DON) on 11/26/24 at 3:44 PM. She indicated if a potential NA hire did not have a CNA certification, she talked to them about enrolling in CNA school. She stated she was aware Staff #1 and Staff #2 were not certified as CNAs, however she was aware Staff #1 planned to take a challenge exam and Staff #2 was registered to begin a CNA certification program in December 2024.<br><br>During an interview on 11/27/24 at 12:43 PM with the Administrator she stated if an NA did not have certification, the facility informed them they needed to register for a class within the 4-month period from date of hire. She further stated if they did not complete the class or get their certification within 4 months the employee was let go. She indicated she was unaware the regulation required an NA who had not completed a state-approved training and competency evaluation program and/or competency evaluation program to be actively participating in a state-approved Nurse Aide I training and competency evaluation program or a state-approved competency evaluation program. |