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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041073	A. BUILDING: _____ B. WING _____	R 06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTCHESTER HARBOUR	630 WHITTIER AVENUE HIGH POINT, NC 27262

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 05/31/23 through 06/01/23.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure physician follow-up was completed for 1 of 5 sampled residents (#1) who had an order for daily weights with parameters for notifying the doctor. The findings are: Review of Resident #1's current FL2 dated 05/11/22 revealed: -Diagnoses included hypertension, atrial fibrillation, type 2 diabetes mellitus, and dementia. -There was an order to check weight weekly. Review of Resident #1's physician's order dated 07/27/22 revealed an order to check weight daily and notify the primary care provider (PCP) of weight gain 3 pounds or greater in 1 day. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for check weight daily and notify the PCP of weight gain 3 pounds or greater in 1 day scheduled daily from 7:00am to 9:30am. -Resident #1's weight increased from 191.8 pounds on 04/07/23 to 195.4 pounds on 04/08/23	D 273	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency 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 and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: RCD completed a record review of affected resident's chart. RCD notified PCP due to weight gain, physician advised to continue plan of care and place resident on log to be assessed next day in facility. 2. Identification of other residents having the potential to be affected was accomplished by: RCD identified 8 residents who could potentially be affected by the deficient practice by pulling the weight trend report and physician orders. Upon review of reports no further weight gain/losses to be reported. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: RCD has reviewed the facility weight protocol and established a schedule to obtain weights outside of routine monthly weights, eg. Weekly, bi-weekly, etc. Weights will be audited weekly by MCC, RCD, and or designee to assess compliance in reporting changes to the physician as per parameters. RCD/designee will provide in-service education to Medtechs regarding the notification to physicians as directed by physician orders for weights and identification of signs/ symptoms of CHF.	6/30/23

Reviewed and Acknowledged Keisha Banks 06/30/2023

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D 273	Continued From page 1 which was a 3.6-pound weight gain. -Resident #1's weight increased from 195.4 pounds on 04/08/23 to 198.4 pounds on 04/09/23 which was a 3.0-pound weight gain. -Resident #1's weight increased from 191.8 pounds on 04/11/23 to 196.0 pounds on 04/12/23 which was a 4.2-pound weight gain. -Resident #1's weight increased from 194.4 pounds on 04/13/23 to 198.4 pounds on 04/14/23 which was a 4.0-pound weight gain. -There was no documentation that the PCP was notified about the weight gain of 3 or more pounds on 04/08/23, 04/09/23, 04/12/23 or 04/14/23. Review of Resident #1's May 2023 eMAR revealed: -There was an entry for check weight daily and notify the PCP of weight gain 3 pounds or greater in 1 day scheduled daily from 7:00am to 9:30am. -Resident #1's weight increased from 189.6 pounds on 05/03/23 to 193.0 pounds on 05/04/23 which was a 3.4-pound weight gain. -Resident #1's weight increased from 190.0 pounds on 05/11/23 to 194.4 pounds on 05/12/23 which was a 4.4-pound weight gain. -Resident #1's weight increased from 185.6 pounds on 05/15/23 to 191.0 pounds on 05/16/23 which was a 5.4-pound weight gain. -Resident #1's weight increased from 185.6 pounds on 05/19/23 to 188.6 pounds on 05/20/23 which was a 3.0-pound weight gain. -There was no documentation that the PCP was notified about the weight gain of 3 or more pounds on 05/04/23, 05/12/23, 05/16/23 or 05/20/23. Review of Resident #1's Progress Notes revealed there was no documentation the PCP was notified about Resident #1's weight gain of 3 or	D 273	4. How the corrective action(s) will be monitored to ensure the practice will not recur: RCD/MCC will review charts of residents with physician orders for weight parameters weekly x 4 weeks, then bi- weekly x 4 weeks, and then monthly x 4 months. A summary of the indicated residents will be reviewed by the Quality Assurance Committee quarterly for at least 2 months and if consistent substantial compliance has been achieved as determined by the committee at that time will be resolved.	

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D 273	Continued From page 2 more pounds on 04/08/23, 04/09/23, 04/12/23, 04/14/23, 05/04/23, 05/12/23, 05/16/23 or 05/20/23. Review of Resident #1's PCP Progress Note dated 04/19/23 revealed: -Resident #1 had a diagnosis of congestive heart failure (CHF) with weight gain. -She assessed Resident #1 on 04/19/23 due to a notification she received from the home health nurse regarding Resident #1 having weight gain and increased edema (swelling) to her bilateral lower legs. -Resident #1 had complaints of shortness of breath with exertion but responded well over the previous two days to the increased dose of diuretic she had ordered. -Resident #1 had 2+ edema to her bilateral lower legs and her compression wraps were in place. -Resident #1 was to continue taking her daily diuretic and she ordered a temporary diuretic medication to take for three days in a row, then twice a week ongoing to help with fluid removal. -There was no documentation she had been updated on Resident #1's weight gain of 3 or more pounds on 04/08/23, 04/09/23, 04/12/23, or 04/14/23. Review of Resident #1's Home Health Nurse (HHN) progress notes revealed: -On 04/10/23, there was documentation Resident #1's bilateral lower extremities had no edema or skin breakdown, but her left foot had 1+ pitting edema so compression wraps were applied as ordered. -On 04/17/23, there was documentation that Resident #1's bilateral lower extremities were free from skin breakdown and compression wraps were applied to manage edema. -On 05/17/23, there was documentation Resident	D 273		

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D 273	Continued From page 3 #1's bilateral lower extremities had no edema but there was some puffiness above the wraps and on her feet. -On 05/26/23, there was documentation Resident #1's bilateral lower extremities had no edema and her compression hose were in place. Observation of Resident #1 on 06/01/23 at 12:50pm revealed she was sitting in her wheelchair in her room, her compression hose were on her legs, and there was no edema observed. Telephone interview with Resident #1's PCP on 06/01/23 at 11:30am revealed: -She reviewed Resident #1's daily weights whenever she was at the facility to see Resident #1. -She saw Resident #1 at least once or twice per month. -She had not received any notification from the facility regarding Resident #1 gaining 3 or more pounds on 04/08/23, 04/09/23, 04/12/23, 04/14/23, 05/04/23, 05/12/23, 05/16/23 or 05/20/23. -When Resident #1 had weight gains that she was aware of, she prescribed short-term doses or dose increases of diuretic medication. -She expected the facility to contact her as ordered if Resident #1 gained 3 or more pounds from the day prior. -When Resident #1 gained weight due to her CHF she sometimes experienced increased swelling to her legs or shortness of breath. -If she was aware that Resident #1 had gained 3 to 4 pounds, she would have wanted to know if Resident #1 was experiencing any symptoms such as increased edema or shortness of breath, and she might have ordered a dose increase of her diuretic.	D 273		

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D 273	Continued From page 4 -If she was aware that Resident #1 had gained 5 or more pounds, she would have adjusted her prescriptions or increased her dose of diuretic. Telephone interview with Resident #1's power of attorney (POA) on 06/01/23 at 12:20pm revealed: -Resident #1 went through cycles of retaining fluid and having her legs swell. -The facility let him know if Resident #1's prescriptions changed but did not contact him if she gained 3 or more pounds, so he was not sure if Resident #1 had gained weight -Resident #1 was occasionally short of breath but never to the point of needing oxygen. -He had not noticed Resident #1 having worsening edema in the previous two months. Interview with a medication aide (MA) on 06/01/23 at 12:30pm revealed: -The personal care aides (PCA) obtained Resident #1's weight every day and reported the weight to the MA. -The PCAs weighed Resident #1 on the wheelchair scale and were all trained how to weigh the wheelchair and subtract that weight from the total weight with Resident #1 in the chair. -If Resident #1's weight had increased 3 or more pounds, the MAs were supposed to call and notify the PCP's office, document which nurse they spoke to at the PCP's office, then fill out a PCP communication form for the PCP to review the next time she was at the facility. Interview with the Resident Care Director (RCD) on 06/01/23 at 12:37pm revealed: -The MA who had documented each of Resident #1's weight gains of 3 or more pounds no longer worked at the facility. -She completed audits of the eMARs every month	D 273		

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D 273	Continued From page 5 but had not been auditing the orders with parameters to ensure the MAs followed the parameters. -She was not aware that Resident #1 had documented weight gains of 3 or more pounds and the PCP had not been notified. -The MA who documented the increased weights for Resident #1 had not given her a PCP communication form for the doctor to review. -Resident #1 did sometimes have increased swelling to her legs or increased shortness of breath but the PCP was aware because she had adjusted her diuretic medication in April 2023. -The PCP saw Resident #1 and reviewed her daily weights at least twice per month. -The MAs were expected to follow orders as written on the eMAR. Interview with a PCA on 06/01/23 at 12:45pm revealed: -She obtained Resident #1's weights on most days. -She weighed Resident #1 the same way every time she weighed her by using the wheelchair scale and subtracting the weight of the wheelchair from Resident #1's weight. -If there was a discrepancy in Resident #1's weight from the day prior, the MA usually had her recheck the weight. -Resident #1 occasionally had shortness of breath or increased edema but she could not remember if those symptoms occurred on the same days that her weight was increased 3 or more pounds. Telephone interview with a representative from Resident #1's home health office revealed: -They saw Resident #1 for her diagnoses of CHF, edema, and diabetes. -They monitored Resident #1's weight at each of	D 273		

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D 273	Continued From page 6 their weekly visits. -Their parameters were to notify the PCP if Resident #1's weight was greater than 192 pounds. -Resident #1's edema fluctuated from visit to visit but had been well controlled over the previous month or two. Interview with the Administrator on 06/01/23 at 1:40pm revealed: -He was not aware that Resident #1 had weight gains of 3 or more pounds 4 times in April 2023 and 4 times in May 2023 and the PCP had not been notified as ordered. -He expected the MAs to follow PCP's orders which included completing notifications if values fell outside of set parameters. -If the MA completed a notification to the PCP, they were expected to document the notification in a progress note. Attempted interview with the MA who documented each of Resident #1's weight gains of 3 or more pounds on 06/01/23 was unsuccessful. Based on observation, record review and attempted interview it was determined that Resident #1 was not interviewable.	D 273		