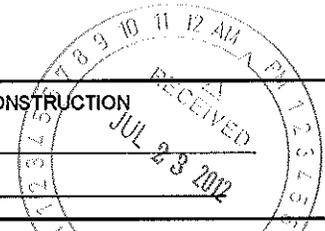


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER CROSS CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885
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(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 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide grooming services to 3 of 6 sampled residents (Resident #60, #62, and #63) who were extensively to totally dependent on staff for their personal hygiene needs. The facility failed to cut and clean fingernails for Resident #60 and #63, and failed to shave Resident #62. Findings include:</p> <p>1. Resident #60 was admitted to the facility on 08/05/11. The resident's documented diagnoses included Down's syndrome.</p> <p>On 08/05/11 the resident's care plan identified, "I require assistance with ADLs (activities of daily living) and am at risk for complications related to dependence." as a problem. Interventions included, "If I become resistant to care than attempt to determine the cause and address, maintain safety and leave and approach me later."</p> <p>Resident #60's 03/23/12 Quarterly Minimum Data Set (MDS) documented the resident had short and long term memory impairment, was severely impaired in decision making, did not reject care,</p>	F 312	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>F 312 SS=D</p> <p>Corrective Action for Resident Affected Resident # 60 and Resident #63 had their fingernails cleaned and trimmed on 6/20/12. Resident # 62 was shaved on 6/20/12.</p> <p>Corrective Action for Resident Potentially Affected All residents who are unable to carry out grooming activities without assistance have the</p>	7/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Inaedin Weatherly RN, RN</i>	TITLE Administrator	(X6) DATE 7/19/12
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ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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 312	<p>Continued From page 1 and was extensively dependent on a staff member for personal hygiene and bathing.</p> <p>At 3:30 PM on 06/18/12 Resident #60's fingernails were long with brown matter underneath some of the nails. The nails extended 1/4 to 3/8 of an inch beyond the fingertips on some fingers.</p> <p>At 10:15 AM on 06/19/12 Resident #60's fingernails were long with brown matter underneath some of the nails. The nails extended 1/4 to 3/8 of an inch beyond the fingertips on some fingers.</p> <p>At 4:20 PM on 06/19/12 Resident #60's fingernails were long with brown matter underneath some of the nails. The nails extended 1/4 to 3/8 of an inch beyond the fingertips on some fingers.</p> <p>At 12:18 PM on 06/20/12 Resident #60's fingernails were long with brown matter underneath some of the nails. The nails extended 1/4 to 3/8 of an inch beyond the fingertips on some fingers.</p> <p>At 12:40 PM on 06/20/12 Nurse #2 stated sometimes Resident #60 resisted bathing and hygiene tasks if he was being cared for by male staff. However, she reported if female staff were brought in to assist the resident with these same tasks, the resident stopped any resistance to care. According to the nurse, the nursing assistants (NAs) checked and cut resident fingernails as they bathed and showered the residents. However, she explained it was also the responsibility of the nursing staff to cut and</p>	F 312	<p>potential to be affected by this alleged deficient practice. Fingernails of all residents dependent for grooming were visually inspected by the Director of Nursing on 6/22/12 and fingernails were cleaned and trimmed as deemed necessary. All residents that are dependent for shaving were visually inspected by the Director of Nursing on 6/21/12 and were clean shaven.</p> <p>Systemic Changes An in-service was conducted on 0709/12 by the Director of Nursing. All Certified Nursing Assistants, FT, PT, and PRN employed by this facility have completed the in-service. Hospice providers were not included because they do not utilize the facility electronic documentation records. The in-service topics included:</p> <ol style="list-style-type: none"> 1) Proper documentation of nail care and shaving in the Smart Charting electronic nursing assistant records, Activities of Daily Living Section 	

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F 312	<p>Continued From page 2</p> <p>clean any resident fingernails which the NAs missed. She commented nails were not cut on a mandatory basis at specified intervals, and the cutting of nails was not documented electronically or on paper.</p> <p>At 12:45 PM on 06/20/12 the Director of Nursing (DON) stated she expected NAs to check resident fingernails daily as the bathed and showered residents. She reported the staff were to cut and clean fingernails immediately as problems were observed.</p> <p>At 1:01 PM the DON observed Resident #60's fingernails, and reported they definitely needed to be cut and cleaned. The resident also stated he would let the staff cut and clean his nails.</p> <p>At 1:58 PM on 06/20/12 the DON stated a family member had been cutting Resident #60's fingernails at one time. She reported she thought maybe the staff had stopped monitoring the resident's fingernails as closely since the family member had taken on that responsibility.</p> <p>At 2:17 PM on 06/20/12 NA #2 stated Resident #60 did not always want to allow staff to complete his care involving personal hygiene. However, the NA explained he learned that if he left the resident alone after the resident refused hygiene care, and reapproached at a later time, most of the time the resident would allow staff to perform their duties. The NA reported he thought the last time he cut Resident #60's fingernails toward the latter part of May 2012, the resident let him complete the care without incident. However, NA #2 commented the time before that Resident #60 only allowed him to cut the nails on</p>	F 312	<p>2) Nail care and shaving are to be provided on the scheduled shower days. Refusals are to be reported to the Nurse on duty and documented electronically.</p> <p>3) Issues with grooming supplies are to be reported to the Director of Nursing for resolution.</p> <p>4) This information has been integrated into the standard orientation training for all certified nursing assistants and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</p> <p>Quality Assurance The Director of Nursing or MDS Coordinator will monitor this issue using the "Daily Clinical Rounds" QA Tool. The monitoring will include verifying that fingernails are clean and trimmed as needed and residents are clean shaven.</p>	

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F 312	<p>Continued From page 3</p> <p>a couple of fingers, and then he had to ask a family member to finish providing the nail care.</p> <p>At 4:02 PM on 06/20/12 NA #3 stated Resident #60 would sometimes resist/refuse baths and showers. The NA reported, however, he had not attempted to cut the resident's fingernails because the NAs on first shift did that. In working with the resident, NA #3 commented he had learned that the resident worked and cooperated better with female staff. In addition, the NA stated when Resident #60 refused any care/services he also learned that if he went to a relative of the resident who resided in the facility, this relative could usually talk the resident into cooperating.</p> <p>2. Resident #63 was admitted on 10/20/11. The resident's documented diagnoses included seizure disorder, Alzheimer's dementia, and frequent falls with ataxia.</p> <p>On 11/01/11 the resident's care plan identified, "I require assistance with ADLs (activities of daily living) and am at risk for complications related to dependence." as a problem. Interventions included, "If I become resistant to care than attempt to determine the cause and address, maintain safety and leave and approach me later."</p> <p>Resident #63's 06/05/12 Quarterly Minimum Data Set (MDS) documented the resident had short and long term memory impairment, was severely impaired in decision making, did not reject care, and was totally dependent on a staff member for personal hygiene and bathing.</p>	F 312	<p>See attached monitoring tool. Results will be reported daily to the QOL/QA committee and corrective action initiated as appropriate.</p> <p>This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager.</p>	

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F 312	<p>Continued From page 4</p> <p>At 3:28 PM on 06/18/12 Resident #63's fingernails were long with brown matter underneath some of the nails, especially on the left hand. The nails extended about a 1/8 to a 1/4 of an inch beyond the fingertips on some fingers.</p> <p>At 10:12 AM on 06/19/12 Resident #63's fingernails were long with brown matter underneath some of the nails, especially on the left hand. The nails extended about a 1/8 to a 1/4 of an inch beyond the fingertips on some fingers.</p> <p>At 4:16 PM on 06/19/12 Resident #63's fingernails were long with brown matter underneath some of the nails, especially on the left hand. The nails extended about a 1/8 to a 1/4 of an inch beyond the fingertips on some fingers.</p> <p>At 12:13 PM on 06/20/12 Resident #63's fingernails were long with brown matter underneath some of the nails, especially on the left hand. The nails extended about a 1/8 to a 1/4 of an inch beyond the fingertips on some fingers.</p> <p>At 12:40 PM on 06/20/12 Nurse #2 stated she never had any problems with Resident #63 resisting care. The nurse reported since the resident had advanced dementia staff just needed to approach the resident slowly, tell him what they wanted to do, explain the steps involved, and the resident was very cooperative. According to Nurse #2, the nursing assistants (NAs) checked and cut resident fingernails as</p>	F 312		

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F 312	<p>Continued From page 5</p> <p>they bathed and showered the residents. However, she explained it was also the responsibility of the nursing staff to cut and clean any resident fingernails which the NAs missed. She commented nails were not cut on a mandatory basis at specified intervals, and the cutting of nails was not documented electronically or on paper.</p> <p>At 12:45 PM on 06/20/12 the Director of Nursing (DON) stated she expected NAs to check resident fingernails daily as the bathed and showered residents. She reported the staff were to cut and clean fingernails immediately as problems were observed.</p> <p>At 2:00 PM the DON observed Resident #63's fingernails, and reported they definitely needed to be cut and cleaned, especially on the left hand.</p> <p>At 2:17 PM on 06/20/12 NA #2 stated Resident #63 was dependent on the staff for all his ADL needs. He reported this resident was "one of the easiest to care for" on his assignment. The NA explained the resident was not resistant to care, but had to be approached slowly and offered an explanation of the care to be rendered because of his advanced dementia. According to the NA, he always tried to feed the resident immediately when his tray was delivered because the resident had a tendency to play in his food otherwise.</p> <p>At 4:02 PM on 06/20/12 NA #3 stated Resident #63 would sometimes resist care in the evenings due to his dementia. However, he reported if you reapproached the resident slowly at a later time and explained the importance of providing the care, the resident was usually receptive and</p>	F 312		

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F 312	<p>Continued From page 6</p> <p>cooperative. NA #3 reported he had not attempted to cut Resident #63's fingernails because the NAs on first shift did that.</p> <p>3. Resident #62 was admitted to the facility on 09/30/11 with diagnosis of Alzheimer's disease.</p> <p>A quarterly Minimum Data Set (MDS), dated 06/15/12, documented Resident #62 as having short term and long term memory problems and severe cognitive impairment for daily decision making. Resident # 62 was documented as having no behaviors and did not reject any care. Resident #62 needed extensive assistance of one staff member for hygiene and bathing.</p> <p>Review of the resident shower book revealed Resident #62 was scheduled for a shower on Tuesday and Fridays on the day shift.</p> <p>An observation made 06/18/12 at 3:01 PM revealed what appeared to be several days' facial hair growth on Resident #62's face and neck area.</p> <p>Review of an electronic printout from the nurse aide documentation system documented Resident #62 had been given a bed bath by Nurse Aide (NA) #1 on 06/19/12. There was no entry that Resident #62 had been shaved.</p> <p>Observations made on 06/19/12 at 12:00 noon and 3:55 PM of Resident #62 revealed what</p>	F 312		

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F 312	<p>Continued From page 7</p> <p>appeared to be several days' facial hair on his face and neck.</p> <p>Observations made on 06/20/12 at 8:55 AM and at 11:24 AM revealed Resident #62 still had not been shaved.</p> <p>In an interview with the Director of Nurses (DON) on 06/20/12 at 12:40 PM, the DON said it had been her expectation that male residents were shaved at least two times weekly on their scheduled shower days. An observation was made of Resident #62 and the DON said it looked like it had been awhile since Resident #62 had been shaved.</p> <p>During an interview with NA #1 on 06/20/12 at 2:15 PM, NA #1 said it had been about 1 week since she had shaved Resident #62.</p> <p>In an interview with Nurse #1 on 06/20/12 at 2:50 PM, Nurse #1 said she had not been aware of any facility policy regarding shaving male residents. Nurse #1 said her expectation was male residents should be shaved as needed as hair grows different in each individual and some residents needed to be shaved more often than others.</p>	F 312		
F 329 SS=D	<p>483.25(j) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose</p>	F 329		

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F 329	<p>Continued From page 8 should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to effectively monitor the Dilantin level for 1 of 10 sampled residents (Resident #63) reviewed for unnecessary medications, who experienced active seizures and a change in Dilantin dosage. Findings include:</p> <p>Resident #63 was admitted on 10/20/11. The resident's documented diagnoses included seizure disorder, Alzheimer's dementia, and frequent falls with ataxia.</p> <p>A 02/10/12 physician order began Resident #63 on Dilantin 300 milligrams (mg) nightly.</p> <p>A 04/18/12 Nurse's Note and physician order documented Resident #63's Dilantin level was to</p>	F 329	<p>F 329 SS=D</p> <p>Corrective Action for Resident Affected Resident # 63- Dilantin level was redrawn on 6/21/12.</p> <p>Corrective Action for Resident Potentially Affected All residents residing in the facility with physician ordered Dilantin levels have potential to be affected by this alleged deficient practice. All residents with Dilantin orders were reviewed by the Director of Nursing on and it was verified that all Dilantin levels were received and proper procedure for disposition was followed.</p> <p>Systemic Changes An in-service was conducted on 07/15/12 by the Director of Nursing. All RNs and LPNs, FT, PT, and PRN employed by this facility have completed the in-service. Hospice providers were not included because they are not involved in the provision of lab services at the facility.</p>	7/19/12

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F 329	<p>Continued From page 9 be checked now and every six months following.</p> <p>A 04/26/12 laboratory report documented Resident #63's Dilantin level was low at 8 micrograms per deciliter (ug/mL) with the normal range being 10 - 20 ug/mL.</p> <p>A 05/19/12 Nurse's Note and physician order documented Resident #63's new physician wanted the resident's Dilantin dosage decreased to 200 mg nightly x five nights, then decreased to 100 mg x five nights, and then to be discontinued.</p> <p>A 05/28/12 3:53 PM Nurse's Note documented at 7:45 AM that morning Resident #63 was, "observed lying on floor in room. Resident observed with muscle stiffness for a couple of seconds and then convulsions. Resident then went into a deep sleep with labored pursed mouth breathing...Resident with new orders Dilantin 600 mg now and then restart Dilantin 300 mg q hs (nightly) on 05/29/12."</p> <p>A 05/29/12 11:40 PM Nurse's Note documented Resident #63 may have experienced some questionable seizure activity as evidenced by some jerking and fixed eyes.</p> <p>On 05/29/12 Resident #63's care plan identified, "I am at risk for injury related to seizure disorder, I'm on Dilantin." as a problem. Interventions to this problem included, "Blood draws to check my levels and notify MD (physician) with abnormal results."</p> <p>A 06/03/12 physician's order documented a Dilantin level was to be determined for Resident</p>	F 329	<p>The in-service topics included:</p> <ol style="list-style-type: none"> 1) Laboratory Protocols (see attached) 2) Proper documentation of review and follow-up of laboratory results on the log. See attached log. 3) This information has been integrated into the standard orientation training for all licensed staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. <p>Quality Assurance The monitoring will include verifying that all laboratory specimens are obtained as ordered and protocols are followed. This will be done weekly by the Director of Nursing. Reports will be given during the daily QOL and corrective action initiated as appropriate. This will be done weekly for three months or until resolved by QOL/QA committee.</p>	

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(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 329	<p>Continued From page 10 #63 at the next lab draw.</p> <p>Resident #63's Quarterly 06/05/12 Minimum Data Set (MDS) documented he had short and long term memory impairment, and was severely impaired in decision making.</p> <p>A 06/07/12 laboratory report documented, "This sample was rejected for analysis due to specimen submission in a gel barrier tube...Please submit specimen in red-stopper tubes."</p> <p>A 06/09/12 Nurse's Note documented at approximately 10:10 AM that morning Resident #63 was found laying on his right side, and was not able to get up on his own.</p> <p>A 06/14/12 Nurse's Note documented on 06/13/12 at 11:00 PM Resident #63 was found sitting up on the floor in another resident's room, very sleepy and barely able to keep his eyes open.</p> <p>Resident #63's care plan was updated on 06/13/12 to reflect that the resident's 06/13/12 fall may have involved possible seizure activity, and he was to be assisted to bed by 10:00 PM.</p> <p>A 06/15/12 Nurse's Note documented at 5:40 AM that morning Resident #63 was found laying on the floor beside his bed.</p> <p>Record review revealed no laboratory reports dated after 06/07/12, when Resident #63's sample was rejected for analysis, which documented the resident's Dilantin level.</p>	F 329	<p>Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager.</p>	

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

PRINTED: 07/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/21/2012
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F 329	<p>Continued From page 11</p> <p>At 4:25 PM on 06/20/12 the MDS Nurse stated she updated Resident #63's care plan to reflect his 06/13/12 fall may have involved possible seizure activity because the resident was still having some jerky movements, and he seemed very sleepy and lethargic at the time of that fall. The nurse explained this sleepiness and lethargy was not usual for the resident, and presented themselves in some of his earlier documented seizure activity.</p> <p>At 10:22 AM on 06/21/12 the Director of Nursing (DON) stated the nursing staff should approach the physician for an order to check Dilantin levels when a resident experienced active seizures or experienced a change in Dilantin dosage. She reported it was very important to monitor the Dilantin level in order to help prevent future seizure activity. According to the DON, it was facility practice to redraw specimens at the next lab draw date when specimens were rejected for analysis. She commented lab draws were completed on Tuesday and Thursday evenings. The DON stated the nurse documented she faxed the 06/07/12 laboratory report to Resident #63's physician. Instead, the DON explained the nurse should have called the physician for a lab redraw order since the sample which was submitted was not usable.</p> <p>At 11:56 AM on 06/21/12 the DON reported she could find no evidence of a lab draw to determine Resident #63's Dilantin level after the 06/07/12 report documented the sample which was submitted was rejected.</p>	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 12</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview the facility failed to sanitize food preparation surfaces between food preparation tasks and failed to wash/sanitize meal carts returned from the dining room and resident halls before placing sanitized meal trays in them. Findings include:</p> <p>1. During food preparation observation on 06/20/12 the cook placed a box of frozen pork cutlets on the right ledge of the two-compartment sink at 9:07 AM.</p> <p>Beginning at 10:12 AM on 06/20/12 the cook mixed up cornbread in a bowl on the right ledge of the two-compartment sink.</p> <p>At 10:23 AM on 06/20/12 the cook retrieved a cloth from the detergent water of the three-compartment sink, where kitchenware had been soaking and had been washed, rung the cloth out, and used it to wipe down the right ledge and right sink in the two-compartment sink system.</p> <p>At 10:32 AM on 06/20/12 the cook placed a bowl</p>	F 371	<p>F 371 SS=E</p> <p>Corrective Action for Resident Affected No specific resident is identified.</p> <p>Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be effected. All meal carts are cleaned and sanitized after each meal service beginning 6/21/12. Food prep areas were cleaned and sanitized according to facility protocols.</p> <p>Systemic Changes An in-service was conducted on 07/02/12 by the Dietary Services Director. All cooks and dietary aides, FT, PT, and PRN employed by this facility have completed the in-service. See attached. The in-service included:</p> <ol style="list-style-type: none"> 1) General cleaning and sanitizing of the dietary department 2) Proper cleaning and sanitizing of meal carts 	7/11/12
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F 371	<p>Continued From page 13</p> <p>of lettuce, a bag of carrots, a bag of grated cheese, a container of boiled eggs, a cucumber, and several tomatoes on the right ledge of or in the right sink of the two-compartment sink system. The cook used a knife to peel the cucumber. When she was finished peeling it, she set the knife down flush on the right ledge of the two-compartment sink (where the box of frozen pork cutlets had been placed previously).</p> <p>At 10:35 AM on 06/20/12, as the cook retrieved the same knife to begin slicing the tomatoes, the surveyor stopped the food preparation process. At this time the cook stated the facility had a red bucket of quaternary sanitizing solution made up and stored in the food preparation area. However, the cook acknowledged that she had not been utilizing this solution to wipe down food preparation surfaces.</p> <p>At 3:18 PM on 06/21/12 the Dietary Manager (DM) stated the dietary staff had been in-serviced to wash and sanitize all food preparation surfaces between all food preparation tasks. She reported staff were instructed to use quaternary sanitizer, obtained from the three-compartment sink dispensing system, to sanitize with. The DM commented the quaternary solution was made up and stored in a red bucket and in a spray bottle.</p> <p>At 3:23 PM on 06/21/12 the PM cook stated sanitizing food preparation surfaces was covered in recent dietary in-services. She reported the staff was told to use a cloth in the red bucket of quaternary sanitizer to wipe down food preparation surfaces between performing food preparation tasks on them.</p>	F 371	<p>3) Proper cleaning and sanitizing of food prep areas.</p> <p>Quality Assurance</p> <p>The Dietary Manager or Cook will monitor this issue using the "Dietary Services QA Checklist" and general observation. The monitoring will include verifying that all sanitation procedures are followed. See attached monitoring tool.</p> <p>This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager.</p>	

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F 371	<p>Continued From page 14</p> <p>2. At 8:56 AM on 06/20/12 a dietary aide finished unloading a cart which was returned from the dining room or resident halls with breakfast dishes. As soon as the cart was unloaded the aide immediately took sanitized meal trays and loaded them back into the cart. The aide did not wash or sanitize the cart between unloading and reloading it.</p> <p>At 9:13 AM on 06/20/12 a dietary aide finished unloading a second cart which was returned from the dining room or resident halls with breakfast dishes. As soon as the cart was unloaded the aide immediately took sanitized meal trays and loaded them back into the cart. The aide did not wash or sanitize the cart between unloading and reloading it.</p> <p>At 9:27 AM on 06/20/12 a dietary aide finished unloading a third cart which was returned from the dining room or resident halls with breakfast dishes. As soon as the cart was unloaded the aide immediately took sanitized meal trays and loaded them back into the cart. The aide did not wash or sanitize the cart between unloading and reloading it.</p> <p>At 3:18 PM on 06/21/12 the Dietary Manager (DM) stated since holding her present position no in-servicing had been presented to dietary employees about care of carts between meals. However, she reported in discussion with the corporate dietitian, the dietitian reported the staff should be at least washing down the meal carts each time they were returned from the dining room or resident halls, before being reloaded with sanitized kitchenware.</p>	F 371		

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

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F 371	Continued From page 15 At 3:25 PM on 06/21/12 a PM dietary aide stated she always tried to wash down meal carts which were returned from the dining room or resident halls with detergent water from the three-compartment sink system before reloading them with kitchenware that had been run through the dish machine.	F 371		

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		A. BUILDING 01 - MAIN BUILDING	
		B. WING	

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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 08/01/2012 the staff did not know about the master release switch for the locked doors (switch located at the nurses station). 42 CFR 483.70 (a)</p>	K 038	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>K 038 SS=D</p> <p>Corrective Action Staff present on 8/1/12 was instructed on the use and location of the Master Release Switch for the Magnetic Door Lock System</p>	8/24/12
K 050 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 08/01/2012 the staff interviewed did not know the fire drill procedure. 42 CFR 483.70 (a)</p>	K 050	<p>Identification of related safety hazards potentially affecting Residents All Staff have been instructed in the location and use of the Magnetic Door Lock System (Nurses Station)</p> <p>Systemic Changes In-services were conducted on 08/01/12-08/02/12 by the Environmental Services Director. All Staff, FT, PT, and PRN employed by this facility have completed the In-service. The In-service topics included:</p> <ol style="list-style-type: none"> 1) Location of the Master Release Switch for the Magnetic Door Lock System (Nurses Station) 2) How and when to utilize the Master Release Switch for the Magnetic Door Lock System 3) This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained 	
K 061 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm</p>	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Waterhouse</i>	TITLE Administrator	(X6) DATE 8/24/12
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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			<p>K 038 (continued)</p> <p>Quality Assurance The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the weekly Fire Safety Check List. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager</p>	

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K 061	Continued From page 1 will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 08/01/2012 the valve for the high and low air pressure switch was not supervised. 42 CFR 483.70 (a)	K 061	K 060 SS=D Corrective Action The new staff member interviewed was re-educated on the fire drill procedure on 8/1/12 Identification of related safety hazards potentially affecting Residents Fire Drills are conducted once each shift each quarter. These drills are critiqued with the staff present and instruction provided as needed. Systemic Changes In-services were conducted on 08/21/12-08/24/12 by the Environmental Services Director. All Staff, FT, PT, and PRN employed by this facility have completed the in-service. The in-service topics included: 1) How to activate the fire alarm system 2) Fire Alert emergency code 3) Fire Alarm Panel Messages 4) Evacuation procedures during a fire 5) Chain of command during a fire 6) Location of pull stations 7) This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained Quality Assurance The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the weekly Fire Safety Check List. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager	8/24/12

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			<p>K 061 SS=D</p> <p>Corrective Action The High/ Low air pressure switch alarm will be integrated into the existing Fire Alarm Panel on 8/29/12</p> <p>Identification of related safety hazards potentially affecting Residents The High/Low air pressure switch alarm will be integrated into the Fire Alarm Panel which is supervised 24 hours per day on 8/29/12</p> <p>Systemic Changes In-services will be conducted 8/29/12-9/7/12 by the Environmental Services Director. All Staff, FT, PT, and PRN employed by this facility will complete the in-service. The in-service topics will include:</p> <ol style="list-style-type: none"> 1) High/low air pressure switch alarm indicator on the fire alarm panel 2) Action to be taken when high/low air pressure alarm is indicated on the fire alarm panel 3) This information has been integrated into the standard orientation training for all staff and will be reviewed by the Quality Assurance Process to verify that the change has been sustained <p>Quality Assurance The monitoring is included in the TELS System Preventative Maintenance Schedule as part of the weekly Fire Safety Check List. Reports will be given during the daily stand-up meetings and the Monthly Quality of Life- QA committee and corrective action initiated as appropriate</p>	9/7/12