STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility received a medication error rate greater than 5% as evidenced by 3 medication errors out of 57 opportunities, resulting in a medication error rate of 5.26% for 3 of 10 sampled residents (Resident #66, #14, and #68) observed during medication pass. Findings include: 1. During medication pass observation on 04/06/11 at 8:20 AM, Nurse #1 was observed to place Zyprexa Zydis (antipsychotic medication) 5 mg (milligram) tablet on Resident #66's tongue to dissolve. Review of Resident #66's physician order sheet for March 2011 indicated an order for Zyprexa Zydis 5 mg dissolve ½ tab (tablet) (2.5mg) on tongue qd (every day) "discard remainder." In an interview with Nurse #1 on 04/06/11 at 3:20 PM, Nurse #1 reviewed Resident #66's physician's order sheet, Medication Administration Record (MAR), and medication package for Resident #66. Nurse #1 stated she should have broken the tablet in half before she administered it to Resident #66. In an interview with the Director of Nurses (DON) on 04/07/11 at 1:30 PM, the DON said it was her	F 332	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 date(s) indicated. **F332** **4/29/2011** **Corrective Action – affected resident(s)** DON Contacted physician regarding dosage of Zyprexa on 4/7/11 for Resident #66 and medication error of administering 5.0mg instead of 2.5mg. She received order to increase dosage from 2.5mg QD to 5.0mg p.o. QD. (See attached copy of Physician Telephone order (attachment A) and Medication Error Report (Attachment B) Resident #14 has received Theragran-M daily since 4/7/11. Resident #68 has received Therems-M daily since 4/7/11. Nurse #1 received re-training on "The 5 R's of Medication Administration" and 1:1 counseling by DON 4/7/11. (See Attached TIP documentation (Attachment C)).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
RN/LNHA	Administrator	4/21/11

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.

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	345404	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

(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 332	Continued From page 1 expectation for nurses to administer medications according to each resident's MAR and follow the 5 R's of medication administration. (Right dose, right patient, right time, right route, and right medication) 2. During medication pass observation on 04/06/11 at 8:30 AM, Nurse #1 was observed passing medications to Resident #14. Nurse #1 completed the medication pass for the resident and moved on to her next assigned resident. She did not administer Theragran-M to Resident #14. A review of Resident #14's physician orders revealed an order on 03/10/11 for Theragran-M 1 po (by mouth) daily (house stock). In an interview with Nurse #1 on 04/06/11 at 3:20 PM, Nurse #1 said she thought she had administered the medication but must have missed it. In an interview with the Director of Nurses (DON) on 04/07/11 at 1:30 PM, the DON said it was her expectation for nurses to administer medications according to each resident's MAR and follow the 5 R's of medication administration. (Right dose, right patient, right time, right route, and right medication) 3. During medication pass observation on 04/06/11 at 8:40 AM, Nurse #1 was observed passing medications to Resident #68. Nurse #1 completed the medication pass for the resident and moved on to her next assigned resident. She did not administer Therems-M to Resident #68. A review of Resident #68's physician's order sheet for April 2011 revealed an order for	F 332	**Corrective Action – potential resident(s)** All Licensed Nurses received retraining on "The 5 R's of Medication Administration" by 4/8/11. (Attachment K) DON will complete "Medication Administration Observation" of each Licensed nurse by 4/29/11 using Form CMS-20055. (Attachment D). The audit will be completed on each licensed nurse monthly x 2 months and results reviewed in monthly Quality of life meeting (Attachment E). **Systemic Changes to prevent recurrence** DON or designee will complete random monthly audits using "Medication Administration Observation" CMS-20055 (Attachment D) on 2 licensed nurses monthly varying nurse and med pass time until next annual recertification survey. **Evaluation of Plan / Monitoring** Findings of the Individual audits as well as random monthly audits will be reviewed in Monthly Quality of Life meetings (Attachment E). Concerns will be addressed immediately through 1:1 retraining and staff inservices as indicated by audit findings.	4/29/2011

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F 332	Continued From page 2 Therems-M tablet 1 tab (tablet) po (by mouth) qd (daily) generic Multivits. In an interview with Nurse #1 on 04/06/11 at 3:20 PM, Nurse #1 said she thought she had administered the medication but must have missed it. In an interview with the Director of Nurses.(DON) on 04/07/11 at 1:30 PM, the DON said it was her expectation for nurses to administer medications according to each resident's MAR and follow the 5 R's of medication administration. (Right dose, right patient, right time, right route, and right medication)	F 332	**F371** **Corrective Action – affected resident(s)** No residents were adversely affected by the cited deficiencies. Staff was immediately inserviced on proper sanitation of food preparation surfaces (Attachment F). Potato salad was immediately removed from tray line and alternate served. Damaged kitchenware was removed, discarded and replaced. (Attachment J). Unlabeled items were removed and discarded immediately. **Corrective Action – potential resident(s)** All dietary staff received re-training on "Cleaning and Sanitizing", "Monitoring Temperatures", "Preparing & Serving Cold TCS Foods", and "Food Safety- Proper Food Storage" using Powerpoint Presentations prepared by Ellen Anderson, RD, CDG, LDN. (Attachment G) **Systemic Changes to prevent recurrence** Dietary Manager completed a "Plan of Action for Preparation of Cold Foods" (Attachment H). Cold salads and foods will be prepared on the evening shift prior to date on menu, and then correctly labeled for storage in walk-in cooler until served. **Evaluation of Plan / Monitoring** Dietary Manager will complete an audit of kitchen practices at random times and shifts using Form CMS-20055 (Attachment I) at least once monthly until next annual recertification survey. Results of Audit as well as Temp Logs will be reviewed during Monthly Quality of Life, with re-training completed as indicated.	04/22/2011
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to sanitize food preparation surfaces and kitchen carts between usage, failed to keep a cold salad made with mayonnaise at 41 degrees Fahrenheit or below during the operation of the trayline, failed to discard damaged kitchenware, and failed to label and date food items in storage which were opened. Findings include:	F 371		

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

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F 371	Continued From page 3 1. At 8:30 AM on 04/06/11 there was a box which contained frozen biscuit dough and a box which contained turkey sausage sitting on the food preparation counter. The cook was pouring barbecue sauce over cooked chicken in a tray pan. A knife and a pair of tongs were sitting directly on the food preparation counter. At 8:50 AM on 04/06/11 the cook sprayed and wiped down a kitchen cart with a degreasing solution, and placed pots and tray pans on the cart which she had run through the dish machine. At 8:57 AM on 04/06/11 the cook removed a strainer, which previously contained cooked chicken, from the sink in the food preparation area, and set it on the food preparation counter. At 9:05 AM on 04/06/11 a box of frozen cookie dough was sitting on the food preparation counter. At 9:13 AM on 04/06/11 the cook ran a rag under hot water, and used the rag to wipe off the food preparation counter. At 9:25 AM on 04/06/11 the cook poured cooked potatoes into a large bowl, and set a spoodle directly on the food preparation counter. At 9:38 AM on 04/06/11 another box of frozen cookie dough was sitting on the food preparation counter. At 9:47 AM on 04/06/11 oven mitts were placed on the food preparation counter. At 9:52 AM on 04/06/11 a dietary employee	F 371		

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F 371	Continued From page 4 removed dirty dishes and trays from a kitchen cart, sprayed and wiped down the cart with a degreasing solution, and placed resident snacks on the cart. At 9:58 AM on 04/06/11 a box of plastic wrap was sitting on the food preparation counter. At 10:15 AM on 04/06/11 the cook placed jars of mayonnaise and pickle relish and a plastic container of mustard packets on the food preparation counter. At 10:20 AM on 04/06/11 another spoodle was sitting on the food preparation counter. Between 8:30 AM and 10:20 AM on 04/06/11 no sanitizing solution was used to wipe down the food preparation counter even though utensils were placed directly on the counter where boxes, a strainer used in the preparation of chicken, plastic wrap, oven mitts, and jars of food were placed. At 8:52 AM on 04/07/11 the Dietary Manager (DM) stated spray bottles of commercially prepared quaternary sanitizer were to be used to sanitize counters between food preparation tasks and to sanitize carts which were returned from dining rooms/resident halls or which were used in the kitchen to transport food or kitchenware. She reported dietary staff was trained to use cutting boards as much as possible during food preparation tasks and to place utensils on parchment paper rather than setting them directly on food preparation surfaces. The DM explained the degreasing solution was to be used only when trying to remove built-up deposits of food from kitchenware, and this solution did not have any	F 371		

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F 371	Continued From page 5 sanitizing properties. At 9:20 AM on 04/07/11 the AM Cook reported the dietary staff was trained to use spray bottles of commercially prepared quaternary sanitizer to sanitize food preparation counters/tables, carts, and kitchen equipment. 2. At 8:28 AM on 04/06/11 potatoes were cooking on the stove in the kitchen. At 9:25 AM on 04/06/11 potatoes were cooling in a large bowl on the food preparation counter. At 10:23 AM on 04/06/11 the cook mixed mayonnaise, pickle relish, mustard, and sugar into the cooked potatoes. At 10:34 AM on 04/06/11 the cook placed a tray pan of potato salad, approximately 12 x 12 x 8 inches, into the walk-in refrigerator. At 11:52 AM on 04/06/11 this tray pan of potato salad was observed sitting in a well of the steam table which was filled with ice. At 12:25 PM on 04/06/11 a digital thermometer inserted into the potato salad at the trayline registered 60.5 degrees Fahrenheit (adjusted to 58 degrees Fahrenheit due to a calibration error discovered when the thermometer was placed in a slurry of ice and water). At his time the cook reported the 12 x 12 x 8 tray pan of potato salad was transferred from the walk-in refrigerator to the walk-in freezer where it spent thirty minutes chilling prior to being removed at approximately 11:40 AM to be placed in a steam table well of ice. Review of the trayline temperature log revealed there was no temperature recorded for	F 371		

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	345404	A. BUILDING _____ B. WING _____	04/07/2011

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

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F 371	Continued From page 6 the potato salad. However, the cook stated a temperature was taken on the potato salad before the trayline started up, and she thought that the temperature was approximately 46 degrees Fahrenheit. After surveyor intervention, the potato salad was removed from the steam table. The ice in the steam table well where the potato salad was being stored had melted considerably. At 8:52 AM on 04/07/11 the Dietary Manager (DM) stated the preferable method of making cold salads which contained mayonnaise was to have the PM Cook prepare/assemble the salads the day before they were to be served. She commented the staff was encouraged to use chilled ingredients such as mayonnaise, pickle relish, and boiled eggs in the preparation of cold salads. Once prepared, the DM reported these cold salads were to be stored in the walk-in refrigerator. The DM commented dietary staff was trained to place cold salads containing mayonnaise on ice at the trayline. According to the DM, the temperature of all hot and cold foods was to be recorded in the trayline temperature log. She reported the cooks were trained to take food temperatures at the start of the trayline, but temperatures were not taken again, once the trayline was in operation, since it only took 20 -25 minutes to complete the entire trayline operation for a meal. At 9:20 AM on 04/07/11 the AM Cook stated the facility served Cole slaw, potato salad, chicken salad, and tuna salad, but most of the time these salads were bought commercially prepared. According to the AM Cook, the PM Cook did not prepare any potato salad on 04/05/11 because she was expecting the commercially prepared salad to arrive on the truck during food delivery	F 371		

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	345404	A. BUILDING _____ B. WING _____	04/07/2011

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F 371	Continued From page 7 the morning of 04/06/11. The AM Cook reported she did not prepare potato salad when she first arrived on the morning of 04/06/11 for the same reason. However, she commented when the delivery truck arrived later on the morning of 04/06/11, she realized no potato salad was ordered. The AM Cook reported the dietary staff was trained, if they prepared a cold salad with mayonnaise from scratch, to prepare it the day before serving and store it overnight in the walk-in refrigerator. She commented the salad was stored in ice at the steam table during operation of the trayline. She reported the temperatures of both hot and cold foods were recorded on the facility's trayline temperature log. According to the DM, cold foods were to be kept at 40 degrees or below during the entire operation of the trayline. 3. During the inspection of kitchenware on 04/06/11, beginning at 11:34 AM, 6 of 18 sectional plates were cracked. The cracks were in the dividing walls or the bottom of the plates, and the cracks were visible when examining both the front serving surface and the back side of the plates. The interior serving surface of 6 of 17 plastic soup/cereal bowls was abraded and rough to the touch. In addition, 2 of 17 knives in a holder were touching the kitchen wall. At 8:52 AM on 04/07/11 the Dietary Manager (DM) stated dietary staff was trained to dispose of damaged kitchenware with cracks, chips, and abrasions, and to inform the DM in case she needed to order replacements. The DM commented such damages posed an increase risk of harming the health of residents. She explained the cooks monitored the kitchenware for damages as they used it daily. According to	F 371		

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	345404	A. BUILDING _____ B. WING _____	04/07/2011

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F 371	Continued From page 8 the DM, this monitoring was completed by visual observation, and no monitoring forms were utilized. She reported once a month the cook checked plates for chips and cracks. The DM stated direct care staff often asked for individual serving size cans of soup to heat up in the microwave for residents. She explained this practice might be partly responsible for the abraded surface of the soup bowls. The DM commented either she or the cooks checked the plastic kitchenware such as soup/cereal bowls, dessert bowls, and coffee mugs weekly for damages. At 9:20 AM on 04/07/11 the AM Cook stated it was the responsibility of all dietary employees to check kitchenware for damages, especially the employees working at the dish machine who were placing sanitized kitchenware into storage. She reported chipped, cracked, or abraded kitchenware could cut residents and increase the chance bacteria could make residents sick. According to the AM Cook, damaged kitchenware was to be thrown away, and the DM was to be notified about what type and how many pieces of kitchenware were disposed of. 4. During the initial tour of the kitchen on 04/04/11, beginning at 10:30 AM, there was no open date on a gallon container of mayonnaise in the walk-in refrigerator. Two thirds of the container was used. In the walk-in freezer bags of chicken tenders, meatballs, steak fries, and cookie dough, which had been opened, did not have labels of open dates on them. In the dry storage room one bag of enriched macaroni noodles, which had been opened, did not have a label or date on it. In storage bins in the kitchen three bags of pasta, which had been opened, did	F 371		

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	345404	A. BUILDING _____ B. WING _____	04/07/2011

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F 371	Continued From page 9 not have a label or date on them. Under the food preparation table a pouch of chicken gravy mix, which had been opened, did not have a label or date on it. At 8:52 AM on 04/07/11 the Dietary Manager (DM) stated she did a visual inspection of all storage areas when she arrived each morning, checking to make sure food items were labeled and dated. She commented all opened food items, leftovers, and food items removed from their original packaging should have labels and dates on them. The DM reported the cooks also checked for labeling and dating daily as they went about their food preparation tasks. At 9:20 AM on 04/07/11 the AM Cook stated all dietary staff was responsible to make sure food items in storage were labeled and dated. She commented this visual inspection was to be conducted in the refrigerators, freezers, and dry storage area daily as staff went about their dietary tasks. She explained all opened food items, leftovers, and food items removed from their original packaging were to be labeled and dated.	F 371		

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	345404	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2011

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 5/3/11 between 9:30 AM and 12:30 PM the following was noted. 1) The kitchen corridor door located in the service corridor did not close latch and seal when checked. 42 CFR 483.70(a)	K 029	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 date(s) indicated. **K029** **Corrective Action** Determined make-up air system motor was not functioning properly, thus creating negative air flow in kitchen when vent hood was on. System was repaired after part received on May 20, 2011. (see Attachment A) Make-up air system is now functioning correctly. All doors leading into/out of kitchen now self-close, latch and seal. **Identifying Further Potential Effects and Correction** All self-closing doors were inspected to insure they close, latch and seal easily. Any door found not to close easily was adjusted. **Systemic Changes** All doors will be inspected by Plant Operations Manager monthly to assure proper close, latch and seal. **Monitoring** Plant Operations manager will complete a "Self-Closing Door Audit" monthly to be reviewed in monthly quality of life. (See Attachment B)	05/20/2011
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 5/3/11 between 9:30 AM and 12:30 PM the following	K 061		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Pinkley | TITLE: NW/CNHA | (X6) DATE: 5/20/11

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.

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	345404	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2011

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DR WINDSOR, NC 27983

(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
K 061	Continued From page 1 was noted. 1)The accelerator line to the dry side of the sprinkler riser has a valve when closed will affect the operation of the system is not equipped with electronically supervised tamper alarm. 42 CFR 483.70(a)	K 061	K061 **Corrective Action** An electronically supervised tamper alarm was installed on the accelerator line to the dry side of the sprinkler riser by Williams Fire Sprinkler Company on 5/10/11. (See Attachment C) **Identifying Further Potential Effects and Correction** Reviewed all life safety regulations regarding the sprinkler system with the technician from Williams Fire Sprinkler Company to assure all are being met in our facility 5/10/11 **Systemic Changes** No systemic changes were indicated related to the finding of this deficient practice as it was resolved by installing the tamper alarm. **Monitoring** Continued monitoring of fire and sprinkler systems with monthly fire drills. Continued quarterly inspections of entire sprinkler system by Williams Fire Sprinkler Company as required by regulations. Next inspection due June, 2011	05/10/11