STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide compression hose to 1 of 1 sampled residents (Resident # 166) as ordered by the physician in a timely manner. Findings include: Resident # 166 was admitted on 04/30/10 with cumulative diagnoses of hypertension, hyperlipidemia, deep vein thrombosis and Parkinson's disease. Orders received on 06/30/11 indicated Resident # 166's legs should be elevated in the afternoon and edema should be monitored. A Significant Change in Status Minimum Data Set (MDS) was completed on 07/05/11. Resident # 166 was coded as severely cognitively impaired. The resident had no behaviors and did not reject care. The MDS indicated the resident was totally dependent on staff for dressing and required extensive assistance for personal hygiene. The care plan, dated 07/08/11, indicated Resident # 166 had pain and edema in his lower	F 309	F309 1. 9/26/2011 – clarification order received for knee high TED hose on in AM off at HS. Resident #166 care plan was updated on 9/28/2011 with an approach for Knee high TED stocking on in AM off at HS. The order for Knee high TED hose on in AM off at HS was added to the MAR on 9/26/2011 to be checked by charge nurse daily. The CNA/ADL flow sheet was updated by the ward clerk on 10/21/2011 to show the intervention of TED hose. 2. 10/24/2011 – Audit performed by ADON and SDC of all residents that have an order for TED hose to verify intervention put into place on resident, CNA/ADL worksheet, and care plan. 3. 10/14/2011 an in-service for all nursing staff to discuss the procedure on taking an order and implementing the intervention of TED hose. A memo was posted for RNs/LPNs and CNA's to reinforce the procedure and importance on 10/24/2011. a. 10/24/2011 TED hose will be added	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/24/2011

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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F 309	Continued From page 1 extremities with a diagnosis of peripheral vascular disease. The goal of pain relief within 30 minutes of pain medication was to be accomplished by keeping his lower extremities elevated during the day as much as possible and attempting non-pharmacologic pain relief measures such as elevating lower extremities. There was no addition on the care plan for compression hose. Physician's orders were received on 07/21/11 for a stat venous Doppler (a test that shows the circulation of a leg) of Resident # 166's right leg. Findings of the Doppler study were negative for thrombus. The Physician's Progress Note dated 07/28/11 indicated Resident # 166 had 4 + edema (edema is measured in values from 1+ being slight to 4+ being the worse) in his extremities. The plan was to start compression hose from morning to bedtime. September 2011 Physician orders indicated compression hose were to be placed in the morning and removed at night. An order clarification dated 09/26/11, indicated Resident # 166 was to wear knee high compression hose that were to be placed in the morning and removed at bedtime. An observation was made on 09/27/11 at 3:00 PM. Resident # 166 was sitting in his wheelchair. His legs were not elevated. No compression hose were present. An observation of morning care was made on 9/28/11 at 10:23 AM. When Nursing Assistant	F 309	to CNA flow sheet as an item that is signed for each shift by the assigned CNA. 4. Random audits of residents with the intervention of TED hose will be performed by the DON, ADON, and SDC 2 x a week for 3 weeks, weekly for 3 weeks, then monthly for 2 months. 5. The audits for TED hose intervention will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	

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F 309	Continued From page 2 (NA) # 8 removed Resident # 166's socks, the imprint of the sock cuff was left on the resident's ankles. Resident # 166's feet and legs were edematous. After completion of the bath, NA # 8 applied regular socks to the resident's feet. She stated this was the same type sock the resident used on a daily basis. Upon transfer to the wheelchair, the NA elevated Resident # 166's feet on the wheelchair foot pedals. An interview was held with NA # 9 on 09/28/11 at 12:02 PM. She stated resident information was available for the NA's in the flow sheet book that was kept at the nurse's station. The information included diet, transfer needs and if the resident had special clothing needs such as compression hose. Review of the ADL Flow sheet on 09/28/11 at 12:20 PM, for Resident # 166, indicated he had bunny boots, but did not include an entry regarding compression hose. An interview was held with NA # 8 on 09/28/11 at 2:26 PM. NA # 8 stated information about residents was found on the ADL Flow Sheet or by asking the nurse. The flow sheet included information about transfers, compression hose or bunny boots. The NA stated only 1 resident in her assignment required compression hose. Resident # 166 was not the named resident. The NA stated she had not been told to put compression hose on Resident # 166 and added the resident had no compression hose in his room. She stated today was the first day she had heard about the compression hose. An interview was held with the Director of Nursing (DON) on 09/28/11 at 3:03 PM. When an order was received it was written on a telephone order.	F 309		

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F 309	Continued From page 3 The order was then faxed to the pharmacy, the pink copy of the order was sent to medical records and the was written in the nurse's notes. The DON stated orders were written on the Medication Administration Record (MAR) or the Treatment Record (Tx) as needed. The DON reviewed Resident # 166's physician's orders for 07/28/11, the physician's progress note from 07/21/11 and the re-clarification order from 09/26/11. She stated the order for the compression hose had not been noted. The DON added the compression hose helped to prevent a deep vein thrombosis in someone with edema and a diagnosis of peripheral vascular disease. She stated without the use of the hose as ordered, there could have potentially been a negative outcome for Resident # 166. An interview was held with Nurse # 5 on 09/28/11 at 3:25 PM. She stated she was unaware until today that Resident # 166 should have compression hose. Nurse # 5 was interviewed on 09/29/11 at 10:10 AM. She stated compression hose was needed for Resident # 166 for his lower extremity edema and was needed to improve circulation in his lower extremities. The nurse that noted the order for the compression hose was out of the facility and would not be available until sometime in October	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 4 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to change the bath water prior to providing perineal care for 1 of 3 sampled residents (Resident # 166) whose personal care was observed. Findings include: Resident # 166 was admitted on 04/30/10 with cumulative diagnoses of urinary tract infection, urinary retention, hypertension, chronic kidney disease,and Parkinson's disease. An Occupational Therapy (OT) note dated 11/08/10 indicated Resident # 166 stated he did not want to gain independent with activities of daily living (ADL's) and preferred to have assistance from nursing when needed. A Significant Change in Status Minimum Data Set (MDS) was completed on 07/05/11. Resident # 166 was coded as severely cognitively impaired. The resident had no behaviors and did not reject care. The MDS indicated the resident was totally dependent on staff for dressing and required extensive assistance for personal hygiene. The care plan, dated 07/08/11, indicated Resident # 166 had a self care deficit related to impaired mobility, decreased balance and weakness. The goal was the resident would wash his face and lift his extremities into his clothing. Approaches included assisting him to complete his bath. The approaches also included	F 312	**F312** 1. Bed bath performance checklist was completed with CNA #8 on 10/14/2011. CNA #8 demonstrated correct procedure on performing a complete bed bath, adhering to all policies and procedures 2. Instruction and teaching was given to the RNs/LPNs and CNAs on 10/14/2011 on the policy and procedure for a complete bed bath – or (full sponge bath). 3. Skills reviews will be completed for all new CNA's and annually thereafter for all CNA's. 4. Random CNA competency skills checklist audits will be completed by DON, ADON, and SDC 2 x a week for 3 weeks, weekly for 3 weeks, then monthly for 2 months. 5. The competency audits for ADL care will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	

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F 312	Continued From page 5 setting the resident up for oral care, hair care and shaving and assisting to complete these tasks. An observation of Resident # 166 receiving care was made on 9/28/11 at 10:23 AM. Nursing Assistant (NA) # 8 washed the resident's face and upper body. She then rinsed him and dried his body. The NA then removed the resident's socks and washed his feet and legs. Resident # 166 turned to right side. After loosening the resident's brief, the NA changed gloves and washed her hands. Perineal care was provided with the same bath water the NA had used for the resident's upper body, feet and legs. The bath was completed, Resident # 166 was dressed and assisted to his wheelchair. An interview was held with NA # 8 on 09/28/11 at 2:26 PM. The NA stated she was taught to change the bath water prior to washing a resident's perineal area. The NA stated she did not change the bath water before washing Resident # 166's perineal area. She stated sometimes she would change the bath water before washing a resident's perineal area, but not all the time. NA # 8 stated the danger of not changing the water could be the transmission of an infection. An interview was held with the Director of Nursing (DON) on 09/28/11 at 3:03 PM. Bath water should be changed as the NA washed the resident from dirty to clean and as needed. The expectation was to change the water before washing the perineal area. The water needed to be changed before washing the perineal area so the contaminated water would not be introduced into the urinary system and potentially causing an	F 312		

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F 312	Continued From page 6 infection.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to implement interventions for 2 of 3 (Resident # 175 and Resident # 170) sampled residents reviewed for accidents. Findings include: 1. Resident # 175 was admitted to the facility on 9/16/10 with cumulative diagnoses of dementia and muscle weakness. Resident #175's quarterly Minimum Data Set (MDS) dated 8/30/11 indicated that Resident #175 was moderately impaired in cognition. Resident #175 did not reject care. Resident #175 was independent in bed mobility and locomotion on and off the unit. Resident #175 needed supervision with transfers. Resident #175 was not steady but was able to stabilize without human assistance when moving from a sitting to a standing position and while walking. A review of the Morse Fall Scale dated 9/16/10 and 9/29/11 indicated that Resident #175 was a	F 323	F232 1. 9/29/2011 – residents #175 and #170's CNA ADL flow sheet and care plan were updated with the required intervention of a pad/tab alarm. Alarm put into place on both resident #175 and #170. 2. 10/24/2011 – Audit performed by ADON and SDC of all residents that have a pad/tab alarm to verify intervention put into place on resident, CNA/ADL worksheet and care plan. 3. An in-service performed on 10-25-2011 for all nursing staff to educate on the tab/pad alarm policy. 4. 10/24/2011 all residents upon admission, quarterly, upon significant change in resident's condition and immediately after every fall, a Fall Risk Assessment will be completed so that a causative factor can be identified and a tab/pad alarm can be implemented if appropriate. The licensed nurse will add to the MAR each shift that the tab/pad alarm has been implemented to insure the alarm is on the resident. The licensed nurse will notify the ward clerk that a tab/pad alarm has	

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F 323	Continued From page 7 fall risk. A review of the September 2011 Flow Sheet used by the Nursing Assistants (NA) to provide care for the residents showed that Resident #175 needed a bed/chair pad alarm. A review of the September Alarm Check List used by the nurses to monitor residents who needed alarms did not contain Resident #175's name. A review of Resident #175's Care Plan (CP) updated 9/7/11 showed a problem of decreased balance, weakness, cognitive losses and impaired mobility with potential for falls. The onset date was 9/23/10. The interventions were listed as: Nurse to check proper functioning of alarms each shift and change batteries as needed, mats at bedside, bed in lowest position, and bed/chair pad alarm to remind resident not to get up without assistance and to alert staff if resident did get up. A review of the Nurses Notes dated 9/14/11 at 1:45 AM indicated that Resident #175 was found sitting on the floor beside the bed. There were no injuries noted. On 9/27/11 at 3:37 PM Resident #175 was observed lying in a low bed. There were no alarms noted on the wheelchair or the bed. There was a fall mat on the left side of the bed. Resident #175's call bell was in reach. On 9/28/11 at 9:50 AM Resident #175 was lying in a low bed. There was a fall mat on the left side of the bed. There were no alarms on the bed or	F 323	been issued to the resident, so that she can add the alarm to the ADL worksheet which will be signed on each shift by the assigned CNA. The licensed nurse will add to the care plan that an alarm has been implemented for fall intervention. 10/24/2011 memo posted for RNs/LPNs and CNA's to reinforce the importance of the policy. 10/24/2011 the resident care coordinator will perform daily checks to all residents that have pad/tab alarms and record documentation on the Resident Alarm check sheet. 5. Random audits of the MAR, CNA/ADL worksheet, and care plan will be performed by the DON/ADON/SDC 2 x a week for 3 weeks, weekly for 3 weeks, then monthly for 2 months to insure that all residents that have been identified as fall risks have an alarm in place and updated on the master alarm list. 6. The audits for fall prevention will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	

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F 323	Continued From page 8 wheelchair. On 9/28/11 at 10:37 AM Resident #175 was sitting in the wheelchair at the side of the bed. No alarms were noted to the wheelchair or the bed. Resident #175 stated that he had slipped to the floor but had not been injured when asked about the fall on 9/14/11. In an interview on 9/28/11 at 2:20 PM with Nursing Assistant (NA) #4 he indicated that the aides found out what residents needed by looking in the flow sheet book. He stated that Resident #175 had a floor mat and was supposed to call for assistance to get up. He indicated that Resident #175 did not have any alarms but did have a low bed. On 9/28/11 at 2:27 PM Resident #175 was sitting in a wheelchair in the dining room. There was no alarm on his chair. In an interview on 9/28/11 at 3:53 with NA #5, she indicated that on 9/14/11 she went to see what Resident #175 needed after the call light was put on. She stated there were no alarms sounding. She indicated that Resident #175 was sitting on the floor and that she went to get the nurse. In an interview on 9/28/11 at 4:30 PM with nurse #3, she stated that she was called to Resident #175's room by the NA. She found the resident sitting on the floor with no injuries. There were no alarms sounding. On 9/29/11 at 8:10 AM Resident #175 was in a wheelchair eating breakfast. There were no alarms noted on the bed or in the wheelchair.	F 323		

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F 323	Continued From page 9 In an interview on 9/29/11 at 8:45 AM with NA #4, he was shown the flow sheet that listed that Resident #175 should have bed/chair alarms. He stated that Resident #175 did not have alarms and walked to the resident's room to look. He confirmed that there were no alarms. He indicated that he had worked with Resident #175 for two months and in that time Resident #175 had not had any alarms. In an interview on 9/29/11 at 9:40 AM with MDS Nurse #1, she indicated that the interventions listed on Resident #175's CP were pertinent and needed. She stated that the floor nurses were responsible for putting interventions in place immediately after a fall and for updating the CP's. She indicated that it was the responsibility of the Unit Clerk to add residents to the alarms list. In an interview on 9/29/11 at 10:12 AM with nurse #4, she indicated that she looked at the residents to see what they needed. She stated that she also looked at the CP. She indicated that she was not aware that Resident #175 should have had pad alarms and did not have any alarms at that time. She stated that she had been caring for Resident #175 for two months and that Resident #175 had not had any alarms during that time. In an interview on 9/29/11 at 10:30 AM with Unit Clerk #1, she indicated that she had been working in her position in September of 2010 when the alarm interventions were put in place. She stated she had never placed Resident #175 on the alarm monitoring list. She indicated that if she had been informed that Resident #175 needed alarms she would have added the name	F 323		

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F 323	Continued From page 10 to the alarm monitoring list. On 9/29/11 at 11:02 AM Resident #175 was lying on a low bed. There was a fall mat in place on the left side of the bed. The wheelchair was next to the bed. There were no alarms on the bed or in the wheelchair. In an interview on 9/29/11 at 1:43 PM with the Director of Nursing (DON) she indicated that she would expect the interventions listed on the CP to be in place at all times. 2. Resident #170 was admitted to the facility on 06/17/10 with diagnoses of chronic obstructive pulmonary disease, lung cancer, diabetes, and hypertension. A fall risk assessment completed on Resident #170 on 03/09/11 scored 75 (score >60 is at risk for falls). An annual Minimum Data Set (MDS) assessment completed on 08/23/11 identified Resident #170 as having severe cognitive impairment and needing limited assistance of one staff member for transfers, ambulation, and toileting. Resident #170 was documented as having impaired functional range of motion on one side of the upper and lower extremities. The assessment indicated Resident #170 ' s balance was not steady and was only able to stabilize with human assistance with transfers, ambulation, and	F 323		

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F 323	Continued From page 11 moving on and off the toilet. Resident #170 was documented as having had one fall without injury since his last assessment completed on 06/01/11. A review of Resident #170's Care Area Assessment (CAA's) completed 08/26/11triggered for falls. Documentation included interventions added for a chair and bed pad alarm to be in place. Review of Resident #170's care plan, updated 08/31/11, identified Resident #170 as having impaired mobility, decreased balance with potential for falls. Interventions listed on the care plan included a bed and chair pad alarm to alert staff if Resident #170 attempted to get up unassisted. Review of Resident #170's Nurse's Notes revealed Resident #170 sustained falls on 05/09/11, 05/17/11, 08/16/11, and 09/12/11. Review of September 2011 nurse aide flow sheets (used by nurse's aides to direct care) for Resident #170 under the alarm section indicated he was to have a bed pad alarm and a chair pad alarm. An observation was made on 09/28/11 at 10:20 AM with Restorative Nurse's Aide (RNA) #1 of Resident #170. RNA #1 assisted Resident #170 to a standing position with a gait belt and walker. Resident #170 was observed to be unsteady and shaky while standing. There was no alarm present on the wheelchair. In an interview with Resident #170 and his family	F 323		

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F 323	Continued From page 12 member on 09/28/11 at 10:30 AM, they said there had been an alarm but neither knew what happened to it or why it had no longer been there. In an interview with Nurse Aide (NA) #1 on 09/28/11 at 2:40 PM, NA #1 said if a resident needed any alarms, the information would be found on the nurse aide flow sheets under the alarm section. NA #1 said Resident #170's balance had declined over the past month and he had some recent falls. NA #1 said the only interventions that had been put in place for Resident #170 were for assistance to the bathroom and reminders to call staff for help. NA #1 said Resident #170 did not have any other safety measures in place. During an interview with Nurse #2 on 09/28/11 at 4:20 PM, Nurse #2 said if a resident was identified at risk for falls alarms were put in place as an intervention to alert staff if a resident attempted to get up on their own unassisted. Nurse #2 said if alarms were to be used; the information would be on the resident's care plan and nurse aide flow sheet. After review of Resident #170's care plan and flow sheets, Nurse #2 said Resident #170 was supposed to have chair pad and bed pad alarm in place. An observation was made with Nurse #2 and NA #2 on 04/28/11 at 4:30 PM of Resident #170. NA #2 stood Resident #170 up to transfer him in the bathroom. NA #2 said there was no alarm present on the wheelchair. Nurse #2 checked Resident #170's bed and said there was no alarm present in the room. In an interview with NA #3 on 09/28/11 at 4:50	F 323		

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F 323	Continued From page 13 PM, NA #3 said Resident #170 was able to wheel his chair into the bathroom by himself but needed assistance for transfers as he was very unsteady. NA #3 said Resident #170 would try to transfer without assistance. NA #3 said Resident #170 had alarms but they were no longer there. In an interview with the Director of Nurses (DON) on 09/29/11 at 1:40 PM, the DON said if a resident had been assessed and identified at risk for falls and interventions of alarms had been care planned, it was her expectation the alarms would be in place.	F 323		
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 maintain the final rinse temperature at the dish machine at or above 180 degree Fahrenheit, failed to maintain a cold salad made with protein at or below 41 degrees Fahrenheit during operation of the trayline, failed to remove build-up from the back panel of the ice machine, failed to stack tray pans clean and dry, and failed to remove dairy products past their	F 371	F371 1. 9/29/2011 -The dish machine procedure was verified on how to properly operate and to assure that the appropriate temperature of 180 degrees Fahrenheit was reached during the final rinse cycle on each dish rack. Upon review of the procedure the dish machine has to complete the final rinse cycle on each rack before the boost will bring the temperature back up to or above 180 degrees Fahrenheit. The DM and	

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F 371	Continued From page 14 use-by from refrigerated storage areas. Findings include: 1. During observation of the dish machine operation on 09/28/11 from 9:17 AM until 9:47 AM, a cart would be unloaded, the dirty kitchenware would be loaded into racks, and the racks from that cart would be run through the dish machine one after another. The dish machine gauges were monitored from 9:48 AM through 10:05 AM. At 9:48 AM the final rinse temperature registered 186 degrees Fahrenheit, but from 9:49 AM through 10:05 AM, as additional racks were run through, the final rinse temperatures ranged from 168 to 172 degree Fahrenheit. During this time period the dietary employee loading dirty kitchenware into the dish machine did not monitor the gauges, but she reported the final rinse temperature should always be at least 180 degrees Fahrenheit. She stated she recorded the final rinse temperature once on a temperature log during operation of the dish machine, approximately five minutes after the machine was started around 9:30 AM. She commented she was not aware in the past of there being a problem with final rinse temperatures. Examination of the September 2011 dish machine log revealed the AM final rinse temperature was recorded as 180 degrees Fahrenheit daily. At 9:34 AM on 09/29/11 the Dietary Manager (DM) stated the final rinse temperature at the dish machine should remain at 180 degrees Fahrenheit as racks were run through it. She reported the staff had not been in-serviced recently on the operation of the dish machine	F 371	Maintenance director reviewed the procedure and quality checked the dish machine and found the dish machine to be functioning properly at or above the 180 degree mark. 2. 10/17/2011- An in-service was held for all dietary staff to educate all associates on the proper procedure and process on operating the dish machine. The DM will conduct in-services with all new associates and annually thereafter to all associates on our policy and procedure regarding proper use of the dish machine. 3. 10-24-2011 – Dish Washer Temperature Log will be required to be filled out by operator after the first rack of dishes and last rack of dishes after each meal daily. 4. 10/24/2011 – The DM or Assistant DM will perform random audits using the DM/Assistant DM QA sheet to ensure proper procedures are being followed on the dish machine and temperature is reaching 180 degrees Fahrenheit. Audits will be performed 2 x week for 3 weeks, then weekly x 3 5	

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F 371	Continued From page 15 because she was unaware that there were any problems with the dish machine temperatures. At 9:44 AM on 09/29/11 a dietary employee stated dietary in-services were held monthly, but she could not remember a recent one about the correct way to operate the dish machine. She reported the gauges on the dish machine had to be monitored so that employees could make sure kitchenware was sanitized during the final rinse at temperatures of 180 degrees Fahrenheit or higher. 2. Beginning at 5:25 PM on 09/28/11 the temperature of cold salads was taken at the trayline. A calibrated thermometer inserted in the egg salad filling of sandwiches registered 52 degrees Fahrenheit. At the time the temperature was taken the sandwiches were being stored in a tray pan in a well of the steam table. The tray pan wall still half full of sandwiches. The Dietary Manager reported there was ice in the steam table wells, and the trayline started operation at 4:55 PM. She also stated the actual egg salad was prepared the day before and assembled into sandwiches earlier today. She explained the egg salad was stored in the walk-in refrigerator, and after it was placed on bread, the sandwiches were placed back in the walk-in refrigerator. At 5:29 PM on 09/28/11 a new tray pan of egg salad sandwiches was removed from the walk-in refrigerator. When a calibrated thermometer was inserted in the filling of the sandwiches, the egg salad registered 38 degrees Fahrenheit. At 9:34 AM on 09/29/11 the Dietary Manager (DM) stated she educated staff that cold foods	F 371	weeks then monthly x 2 months. 6. The audits of the dish machine will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee. 1. 9/28/2011 – All egg salad that was above the temperature of 41 degrees Fahrenheit was discarded immediately and not used for the remainder of the tray line. 2. Temperatures were taken from the other egg salad container and found to be below 41 degrees Fahrenheit. The remainder of the egg salad was used during the dinner try line on 9/28/2011. An in-service was held on 10/17/2011 to educate all dietary staff on the importance of having cold plate food item temperatures at or below 41 degrees Fahrenheit. 3. 10/24/2011 – The DM will conduct in-services with all new employees on the process of cold plate food temperatures at or below 41 degrees Fahrenheit and annually thereafter to all dietary staff. 10/24/2011 – Before serving any cold plate food item the cook	

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F 371	Continued From page 16 should remain at or below 40 degrees Fahrenheit during the entire operation of the trayline. She reported she suggested for staff to place cold foods in the walk-in freezer for about 30 minutes before they were placed on the trayline. The DM commented all cold salads were supposed to be prepared the day before they were to be served. Review of the trayline temperature log for 09/29/11 revealed the temperature of the egg salad filling in the sandwiches was not recorded as the trayline began operation. At 9:44 AM on 09/29/11 a dietary employee stated she thought cold foods were supposed to be kept at 30 degrees or below during operation of the trayline. She reported when she was responsible for preparing a cold salad containing protein, she completed the prep work the day before the salad was to be served, stored the salad in the walk-in refrigerator, and placed the salad on ice in a larger container outside of the steam table wells as the trayline began operation. At 9:49 AM on 09/29/11 the DM stated a temperature was not taken on the egg salad filling in the sandwiches as the trayline operation began, but instead, a temperature was obtained for a small tray pan of egg salad reserved for those residents who did not want the bread available in a sandwich. 3. During initial tour of the kitchen, beginning at 11:18 AM on 09/26/11, there was a brown/gray film on the back panel of the ice machine. The ice in the machine did not make contact with the back panel, but condensation was dripping off the back panel onto the ice.	F 371	in charge for the meal will check the temperature of the food item and log it on the Cold Food Temperature log. Each portion/pan of a cold plate food item that is brought out of the cooler to be use on the line will go through the same procedure. 4. The DM or Assistant DM will perform random audits to ensure all cold plate food items are served at or below 41 degrees Fahrenheit. The audits will be recorded on the Dietary Manager/Assistant Manager QA sheet 2 x weeks for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. 5. The audits of the cold plate food temperatures will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee. 1. Ice machine was cleaned inside and outside (including the back panel) on 9/29/2011 to remove any brown/gray pre mold film/build up. 2. After review of the cleaning schedule and proper procedure to clean the ice machine a cleaning schedule will be performed daily on the inside and outside	

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F 371	Continued From page 17 During a follow-up inspection of the kitchen, at 9:30 AM on 09/28/11, there was a brown/gray film on the back panel of the ice machine. The ice in the machine did not make contact with the back panel, but condensation was dripping off the back panel onto the ice. At 9:34 AM on 09/29/11 the Dietary Manager (DM) stated the ice machine was on the cleaning schedule for the kitchen, and the assigned employee wiped down the outside and inside of the ice machine weekly. She explained this prevented any mold or pre-mold accumulation on and in the ice machine. At 9:43 AM on 09/29/11 the DM applied a paper towel to the brown/gray film on the back panel of the ice machine. Most of the film was removed, and it left a slimy residue on the paper towel. At 9:44 AM on 09/29/11 a dietary employee stated the ice machine appeared on the kitchen cleaning schedule. She reported this meant the ice machine was wiped down outside and inside from every other day to once a week. She commented this should prevent any film or mold build-up from developing inside the ice machine. 4. During initial tour of the kitchen, beginning at 11:18 AM on 09/26/11, 12 of 17 tray pans which were stacked on top of one another in storage, below a food preparation table, were wet inside. 5 of 17 tray pans had dried food particles in them. Two of these tray pans had dried white debris inside of them, one had dried tan residue resembling oatmeal inside, one had dried yellow	F 371	(including the back panel). The dietary employee that performs the daily cleaning will log date and time on the Daily Cleaning Schedule worksheet. 3. 10/17/2011 – an in-service was held to educate all dietary staff of the proper cleaning schedule for the ice machine. A demonstration was held during the in-service by the Maintenance director on the proper way to clean the ice machine. 10/24/2011 – quarterly preventative maintenance will be performed by the maintenance department. Monthly cleaning of the filters, and quarterly servicing/cleaning of the ice machine. 10/24/2011 – all new associates will be in-serviced on the proper procedure to clean the ice machine and all associates will be in-serviced annually. 4. The DM or Assistant DM will perform random audits to ensure the proper cleaning procedures and daily schedule completion of the ice machine. They will log their findings on the Dietary Manager/Assistant Manger QA worksheet. Audits will be performed 2 x week for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. 5. The audits for proper cleaning and prevention of pre mold build up for the ice machine will be	

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F 371	Continued From page 18 residue resembling eggs inside, and one had red/brown debris inside of it. A dietary employee stated she thought most of the wet tray pans were used at the breakfast meal, but she was not sure about all of them. During a follow-up inspection of the kitchen, at 10:31 AM on 09/28/11, 1 of 11 tray pans which were stacked on top of one another in storage, below a food preparation table, was wet inside. A dietary employee stated that this tray pan may have been used and washed the night before. At 9:34 AM on 09/29/11 the Dietary Manager (DM) stated dietary staff were trained to make sure tray pans were dry and clean before stacking them in storage. She explained there were areas in the kitchen designated for air-drying kitchenware before it was placed in final storage. At 9:44 AM on 09/29/11 a dietary employee stated tray pans were to be checked to make sure they were dry and there were no food particles on them before stacking them in storage. 5. During initial tour of the kitchen, beginning at 11:18 AM on 09/26/11, there were two four-ounce containers of yogurt with a use-by date of 09/24/11 among resident snacks on a tray in the reach-in refrigerator. In the walk-in refrigerator there was a box containing ten four-ounce containers of yogurt with a use-by date of 09/24/11. At 9:34 AM on 09/29/11 the Dietary Manager (DM) stated the facility did not provide any of its	F 371	reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee. 1. 9/29/2011 – All wet and or soiled pans where rewashed and placed on the blue drying racks and allowed to air dry before being stored. 2. A further review was completed by the DM and found that all pans where properly dried and stored. An in-service was conducted on 10/17/2011 for all dietary staff to educate them on our policy and the importance that all pans need to be free from food particles and completely dry before storing. 3. The DM will conduct in-services with all new associates and annually thereafter to all associates on our policies regarding stacking try pans clean and dry. 4. The DM and Assistant DM will perform random audits and record their findings on the Dietary/Assistant Manger QA sheet for wet pan quality checks to ensure all stored tray pans are free from food particles and dry. Audits will be performed 2 x week	

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F 371	Continued From page 19 residents with dairy products which were past their use-by dates. She reported she monitored the use-by dates of products in refrigerated storage on Mondays when putting up stock, and pulled those items past their use-by dates so that they were not available for staff to provide to residents. However, she commented all dietary staff was supposed to check for labeling/dating and monitor use-by dates daily as they retrieved food items from refrigerated storage. At 9:44 AM on 09/29/11 a dietary employee stated all employees were supposed to check the use-by dates on dairy products before providing them to residents or utilizing them in the preparation of resident foods. She reported the facility did not use any dairy products past their use-by dates.	F 371	for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. 5. The audits for stacking tray pans clean and dry will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee. 1. 9/26/2011 – All dairy products that where past the use-by date listed on the product where discarded immediately. 2. A further review was completed by the DM and found all other dairy products to be in compliance with the use-by date listed on each item. An in-service for all dietary staff was completed on 10/17/2011 to educate on the procedure for checking use-by dates on dairy products in refrigerated storage. 10/24/2011 – daily checks will be performed by an assigned dietary staff member and signed off on the cook/aide QA sheet. 3. The DM will conduct in-services with all new associates and annually thereafter to all associates on our policies regarding expired use-by dates on dairy products. 4. The DM or Assistant DM will perform random audits to ensure	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 20 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of records the facility failed to change gloves and wash hands between soiled tasks and clean tasks during 1 of 3 observations of personal care. Findings include: The un-dated facility policy indicated the facility regarded hand washing as the single most important means of preventing the spread of infection. An observation was made of Resident # 30 receiving incontinent care from Nursing Assistants (NA) # 6 and # 7 on 09/27/11 at 2:20 PM. The resident had soiled herself with stool. After removing the stool, NA # 6 rolled the soiled	F 441	5. all dairy products are not past the use-by date. Audits will be performed 2 x week for 3 weeks, then weekly x 3 weeks, then monthly x 2 months. 6. The audits of dairy products past their use-by date will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee. **F441** 1. 10/13/2011 and 10/18/2011 Instruction and teaching was given on proper infection control practices, hand washing techniques, handling of linens, and changing of gloves between soiled and clean tasks to CNA #6 and CNA #7. 2. 10/14/2011 RN's, LPN's and CNA's were provided educational in-service on infection control practices, hand washing techniques, handling of linens, and changing of gloves between soiled and clean tasks. 3. Skills reviews will be completed for all new CNA's and annually thereafter for all CNA's. 4. Random CNA skills checklists on infection control and peri care will be performed by DON, ADON, and SDC 2 x week for 3 weeks, 5.	

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F 441	Continued From page 21 brief up with the soiled part in the center. While the resident was lying on her left side, and without changing gloves or washing her hands, NA # 6 placed the clean brief on top of the rolled soiled brief. The resident was then rolled to her right side and the soiled brief removed by the NA # 7. Each NA taped her side of the resident's brief securely. NA # 6 continued to handle the resident's clothing, touched her skin and completed the task without changing gloves or washing her hands. On 09/27/11 at 2:34 PM, an interview was held with NA # 6. The NA stated she was taught to change gloves and wash her hands after providing direct patient care. Additionally, she was taught to change gloves and wash hands between handling soiled and clean items. The NA stated she did not change gloves between handling the soiled items and handling the clean items. The reason was she was trying to get care for the resident completed. An interview was held with the Director of Nursing (DON) in the absence of the Infection Control nurse on 09/28/11 at 2:50 PM. Hand washing compliance and compliance with changing gloves was monitored by the unit managers and charge nurses. The DON stated she observed NA's providing care on a daily basis. The DON added hand washing was expected before care, after care and in between glove changes, between residents, between handling dirty and clean items such as linen or food. As the DON, the expectation was for the NA to wash her hands prior to donning the gloves, provide the incontinent care, and while the soiled gloves were on the soiled brief and/or linens would be	F 441	weekly for 3 weeks, then monthly for 2 months. 6. The audits for proper infection control during incontinent care will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 441	Continued From page 22 removed and secured in a plastic bag. After disposing of the soiled items, the DON stated she expected the NA to wash her hands and don clean gloves before clean briefs/clothes and linens were applied. The DON stated not changing gloves and washing hands during incontinent care could increase the chance of a urinary tract infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING 04 - W.R WINSLOW MEMORIA B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: residents bedroom door 307 and 313 did not close for smoke tight seal. Gap greater than 1/4 inched at top of door. 42 CFR 483.70(a)	K 018	K018 1. 10-26-2011 Resident room's 307 and 313 were found to be noncompliant, specific findings include bedroom doors not closing for a smoke tight seal. Gap greater than ¼ inch at top of door on both rooms. Room 307's door is being replaced with new door that is on order and will be installed on or before December 10, 2011. Resident Room 313's gap is being fixed with fabricated sheet metal that is attached to the door frame to create a gap of less than ¼ inch to create an appropriate tight seal smoke barrier. The fabricated sheet metal will be in place on or before December 10, 2011. 2. 10-27-2011 Maintenance department performed audit to identify any other doors with a greater than ¼ inch gap and found all other doors to be in compliance with Life Safety regulations. 3. 12-10-2011 all doors will be checked monthly for one year, then quarterly by the Maintenance department for appropriate seal for a tight smoke barrier. These	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to Supply storage/Oxygen room would not close and latch because cardboard	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-12-2011

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.

GW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING 04 - W.R WINSLOW MEMORIA B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 038	Continued From page 1 was use to block door from latching. Also door in PT were oxygen was stored would not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 038	findings will be recorded on the Smoke Barrier Audit Checklist. 4. The audits for seal tight smoke barriers on all doors will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056	**K038** 1. (a) 10-26-2011 door to supply storage/Oxygen room on neighborhood would not latch due to cardboard used to block open door. 10-27-2011 an in-service was held for all housekeeping on procedure and purpose of not preventing any door from closing or latching. (b) 10-26-2011 door in PT where Oxygen is stored would not close and latch for smoke tight seal. 11-11-2011 hinges to door in PT adjusted and automatic door closure installed by maintenance department. 2. (a) 11-14-2011 keys will be given to all appropriate staff providing access to supply storage/oxygen rooms on each neighborhood. 11-10-2011 in-service conducted for all staff on procedure and purpose of not preventing any	
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: valves on accelerator are not electrical supervised. 42 CFR 483.70(a)			
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed	K 067		

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	345036	A. BUILDING 04 - W.R WINSLOW MEMORIA B. WING _____	10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 067	Continued From page 2 in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: fire /smoke dampers in return vents have large amounts of lent/dust build up(this is facility wide). 42 CFR 483.70(a)	K 067	door from closing or latching. (b) 10-27-2011 Maintenance department performed audit to identify any other doors that failed to close or latch for a smoke tight seal and found all other doors to be in compliance with Life Safety regulations. 3. (a) in-service will be provided for all new associates on the proper procedure and purpose of not preventing any door from closing or latching for a smoke tight seal and all associates will be in-serviced annually. 11-14-2011 random weekly audits will be performed by the Housekeeping director for compliance, audits will be performed weekly for 3 months (b) 11-14-2011Door in Pt for oxygen storage will be checked weekly for 3 months for purpose of maintaining closure and latching for a smoke tight seal. 4. Audits for Supply storage/oxygen room on neighborhoods and Pt oxygen storage door will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to	

the attention of the QA committee.

K056

1. 10-27-2011 Virginia Sprinkler was contacted in regards to the accelerator values in the riser room not being electronically supervised. 10-28-2011 VA Sprinkler was on sight to begin the quote for work to be performed on the installation of electronic monitoring on the accelerator values. Electronic monitoring devices will be installed on or before December 10, 2011 by an accredited sprinkler contractor.
2. Electronic monitoring will be audited by the maintenance department monthly for 3 months then quarterly. Audits will begin 12-13-2011.
3. The audits for electronic monitoring on the accelerator valves will be reported to the QA committee quarterly. Problematic areas will be addressed at the time of the findings and brought to the attention of the QA committee.

K067

1. 10-26-2011 fire/smoke dampers in return vents where found to have large amounts of lent/dust build up on all facility dampers. 10-27-2011 to 11-4-2011 all fire/smoke dampers in return vents where cleaned by the maintenance department and recorded on fire/smoke dampers audit sheet.
2. 10-27-2011 all fire/smoke dampers will be routinely checked and cleaned on a quarterly basis for one year, then every 6 months. PM schedule will be performed by members of the maintenance department and recorded on Fire/smoke dampers in return vent audit sheet.
3. Audits for fire/smoke dampers in the return vents will be reported to the QA committee quarterly. Problematic area's will be addressed at the time of the findings and brought to the attention of the QA committee.