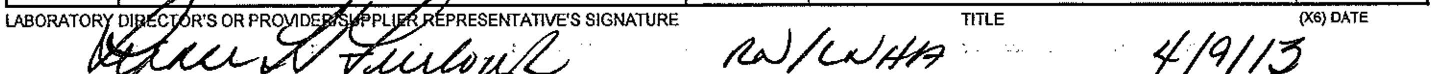
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	C 03/13/2013

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 000	INITIAL COMMENTS No deficiencies were cited as a result of a complaint investigation conducted 03/10/13 to 02/13/13. Event ID# S1M111	F 000	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.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	**F272** **Corrective Action – affected resident(s)** Resident #13 was reassessed for wounds by N Roberson, RN/DON on 3/14/2013. New Weekly Wound Review was completed on 4 areas. Left and Right heels were both unstageable r/t presence of slough. Newly noted darkened areas right lateral heel and foot assessed as probable deep tissue injury. (Attachment 1) Received MD orders to d/c multi-podus boots and start soft boots to bilateral feet and dress new areas with Kerlix.(Attachment 2) Resident was discharged 3/17/2013 to hospital. **Corrective Action – potential resident(s)** J Roberson, RN/DON assumed responsibility for Three Rivers' wound program effective 3/13/13. She reassessed all current wounds in the facility 3/14 and 3/15 (Attachment 3) and communicated any concerns for updated (cont)	4/11/2013



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE RN/LNHA — (X6) DATE 4/9/13

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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to identify a skin impairment on a 1 (Resident #13) of 1 sampled resident ' s with skin impairment, and the facility failed to correctly identify a Stage IV pressure ulcer that developed from a deep tissue injury (an injury to underlying tissue below the skin ' s surface that results from prolonged pressure in an area of the body) for 1 (Resident #13) of 1 sampled resident with a deep tissue injury.. Findings included: Resident #13 was admitted to the facility on 12/18/12 with diagnoses to include Diabetes Mellitus Type II, paralysis, and general muscle weakness. 1) An Admission Minimum Data Set (MDS) assessment of 12/25/12 indicated the resident required extensive assistance of 2 or more person physical assistance for bed mobility. The resident was assessed as having had no unhealed pressure ulcers and no deep tissue injuries. The assessment indicated the resident was at risk for pressure ulcers. Review of a 14-day MDS assessment of 1/1/13 revealed the resident was assessed as having	F 272	(con't) orders with respective physicians. No further discrepancies were noted with wound staging. J Roberson will continue to follow wound policies and procedures and complete wound assessments and measurements no less frequently than weekly on all in-house wounds. **Systemic Changes to prevent recurrence** J Roberson, RN/DON assumed responsibility for Three Rivers' wound program effective 3/13/13. An RN will oversee the wound program at all times going forward. All nursing staff will receive training regarding notification of new wounds on 4/11/2013 Training will also include skin assessment specifically in regard to pressure area using . (Attachment 4) Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Evaluation of Plan / Monitoring** Weekly Wound Log will be presented by J Roberson, RN/DON and reviewed during Weekly QA Meeting and coordinated with MDSs completed during that week for accuracy. (Attachment 5) This will be done weekly times three months or until resolved by QOL/QA (con't)	

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F 272	Continued From page 2 had 2 deep tissue injuries. The resident required the same amount of assistance for bed mobility. The resident ' s Care Plan of 12/18/12 documented a problem identified as: I have a pressure ulcer on my heels. I am also at risk for further breakdown of skin problems. An additional problem was documented as: I am at risk for pressure ulcers related to decreased mobility, recent hospitalization and incontinence. The goal for the problem was written as: I will maintain skin integrity through next review on 3/18/13. Review of a facility " Weekly Wound Review " of 12/20/12 revealed the resident ' s right heel was assessed as a deep tissue injury and measured 2.8 cm (cubic centimeters) by 2.4 cm. The resident ' s left heel was assessed as a deep tissue injury and measured 3 cm by 2.6 cm. Review of the most " Weekly Wound Review " of 3/7/13 revealed the resident had a right heel deep tissue injury that measured 1 cm x 1.2 cm and a left heel deep tissue injury that measured 1.7 cm x 2.5 cm. A physician ' s order of 2/8/13 was given to cleanse the left heel with wound cleanser apply santyl (chemical debriding agent), cover with a dry dressing twice daily, cleanse the right heel with wound cleanser and apply hydrogel (a moisturizing agent) and cover with a dry dressing twice daily. An observation was made of the resident's heels during a dressing change on 3/13/13 at 11:30 AM with Nurse #1. The dressing that was removed	F 272	(con't) committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly or Monthly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads	

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F 272	Continued From page 3 from the resident ' s left heel had a moderate amount of serous sanguineous drainage. After the wound was cleaned, the wound was covered with stringy slough and the wound bed was not visible. The nurse reported the slough on the left heel had been there so long, she wanted to ask the physician for a change in treatment. Observation of the right heel remained revealed the area had a small open area and was mushy, During an interview with Nurse #1 on 3/13/13 at 12:55 pm, the nurse reported the resident ' s left heel was open and no longer a deep tissue injury. The right heel has a small open area and mushy. During an interview with the Director of Nursing (DON) on 3/13/13 at 2:20 PM, the DON stated once the deep tissue injuries had opened, they should have been reassessed and staged. The DON stated the wounds should have had an RN oversight to assess the wounds. 2) An Admission MDS assessment of 12/25/12 indicated the resident required extensive assistance of 2 or more person physical assistance for bed mobility. The resident was assessed as having had no unhealed pressure ulcers and no deep tissue injuries. The assessment indicated the resident was at risk for pressure ulcers. Review of a 14-day MDS assessment of 1/1/13 for Resident #13 revealed the resident was assessed as having had 2 deep tissue injuries. No other wound or pressure areas were documented.	F 272		

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A dressing change observation was made of Resident #13 right heel on 3/13/13 at 11:30 AM. An area on the outer right heel was observed that was purplish blue and slightly raised from the base of the skin. The nurse reported the area was present on admission and the physician did not want to treat it at that time.

The resident ' s Care Plan of 12/18/12 documented a problem identified as: I have a pressure ulcer on my heels. I am also at risk for further breakdown of skin problems. An additional problem was documented as: I am at risk for pressure ulcers related to decreased mobility, recent hospitalization and incontinence. The goal for the problem was written as: I will maintain skin integrity through next review on 3/18/13.

Review of a facility " Weekly Wound Review " of 12/20/12 revealed the resident was assessed as having had 2 deep tissue injuries, one on each heel. No documentation was provided for any additional wounds.

Review of the most " Weekly Wound Review " of 3/7/13 revealed the resident had a left and right heel deep tissue injury. No documentation was provided for any additional wounds.

During the observation of the right heel dressing change on 3/13/13 at 11:30 AM, an area on the outer right heel was observed that was purplish blue and slightly raised from the base of the skin, The nurse reported the area was present on admission and the physician did not want to treat it at that time.

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F 272	Continued From page 5 During an interview with Nurse #1 on 3/13/13 at 5:01 PM revealed she hadn't done wound care for the resident until today and saw the purplish area. When the resident was admitted, she remembered the area as discolored. If she had found the area between the resident ' s admission and at the time of the dressing change, she would have documented the area on a wound assessment, called the physician and Responsible Party, and notify them of the change in the area. During an interview with the Director of Nursing (DON) on 3/13/13 at 2:20 PM, the DON stated she expected the purple/blue area on the resident ' s right heel was documented and monitored weekly for changes. The DON stated the area should have had an RN oversight to assess the wounds.	F 272	F364 **Corrective Action – Affected Residents** No residents were known to be affected by this deficient practice. **Corrective Action – Potential Residents** New practice of holding milk and cold foods in walk-in cooler until trays are being served was instituted during survey 3/12/13. All Dietary Staff received training by Registered Dietician on 4/3/2013 regarding Safe Storage and Serving of Foods. (Attachment #6) **Systemic Changes** Temperatures are checked on sample of milk and all cold foods immediately prior to serving trays with each meal. Milk is kept in walk-in cooler until trays are sent out of kitchen for serving. Milk temperature is checked upon delivery into walk-in cooler. **Monitoring** Dietary staff will complete temperature checks on sample of all cold foods and milk immediately prior to serving trays and record on Dietary QA Audit daily. Dietary QA Audits will be reviewed during Weekly QA Meeting with any concerns addressed immediately.	4/3/2013
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and an interview with the Dietary Manager, the facility failed to maintain milk, peaches, and pudding at the proper temperatures on the tray line for 2 of 2 observations. Findings included:	F 364		

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F 364	Continued From page 6 A temperature check of pudding on a food tray to be served for lunch on 3/12/13 at 11:55 AM revealed the pudding temperature was 52 degrees and two separate containers of diced peaches were 52 degrees. On 3/13/13 at 11:35 AM, a test temperature of 2 cartons of milk to be served for lunch was tested by the Dietary Manager. Each carton temperature was tested at 45 degrees. A temperature check of the walk in refrigerator, where the milk was stored, was at 38 degrees, and a milk carton stored in the refrigerator was tested at 40 degrees. During an interview with the Dietary Manager on 3/13/13 at 11:45 AM, the Manager stated cold foods were expected to be at 41 degrees or less when ready to be served. An interview was conducted with the Administrator on 3/313/13 at 4:15 PM. The Administrator stated she expected foods on the tray line to be at the proper temperatures.	F 364	**F371** **Corrective Action – Affected Residents** No residents were known to be affected by the deficient practice. **Corrective Action – Potential Residents** Undated food items were immediately removed from walk-in cooler and discarded. Styrofoam cup was immediately removed from storage bin containing thickener. Wet pans were immediately removed from rack and rewashed then allowed to air dry. Personal items were removed from kitchen immediately. All storage racks in kitchen were pressure washed 3/14/2013. Dietary Staff received training on 4/3/2013 on Dietary Sanitation Regulations and cleaning schedules.	4/3/2013
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	F 371	**Systemic Changes** Dietary Staff and Plant Operations Manager have established a Dietary Cleaning Schedule (Attachment #8) to assure all racks and surfaces in the kitchen are properly cleaned and sanitized. Dietary Staff will complete Dietary QA Audit II daily to inspect specific areas of sanitation concern cited during survey. (Attachment #9) **Monitoring** Dietary Cleaning Schedule and Dietary Audit II will be reviewed during Weekly QA meeting with any concerns addressed immediately.	

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This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to store 2 packages of cheese and one package of sliced deli ham with no opened or use by date in the walk in refrigerator; the facility failed to use a scoop with a handle for the sugar container and left a Styrofoam cup in the sugar; the facility failed to store 6 of 6 wet stainless steel holding pans in a dry manner; the facility failed to maintain storage shelving free of dust and debris; the facility failed to store four drying racks of servingware away from a hand wash sink used by staff; and the facility failed to maintain 1 of 1 refrigerators in the medication room in clean condition.

Findings included:

An observation of the facility ' s walk in refrigerator on 3/10/13 at 4:15 PM revealed an opened package of sliced smoked ham placed in plastic zippered bag with no opened or use by date, Two inches of sliced yellow cheese was placed in a zippered bag with no opened or use by date. An opened bag three quarters full of shredded yellow was stored in its original bag and had no open or use by date.

An interview was conducted with Dietary Aide #1 on 3/13/13 at 4:00 PM. The aide reported deli meats and cheeses were to be stored in zip lock bags and dated when they were opened before they were stored in the refrigerator. The aide stated dietary staff washed their hands at the sink and pointed at the sink where the clean plastic dishware was stored.

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An interview was conducted with the Dietary Manager on 3/13/13 at 12:05 PM. The Manager reported staff were expected to put opened packages of deli meat and cheeses in zip lock bags and date them for the date they were opened before storing in the refrigerator.

An observation was made on 3/10/13 at 4:24 PM of a Styrofoam cup stored in a small countertop storage container of sugar. The Lead Cook reported they did not have a scoop for the sugar and the cup should not have been in the sugar. During an interview with the Dietary Manager on 3/13/13 at 12:10 AM, the Manager reported the Styrofoam cup should not have been used or left in the sugar container and staff were expected to use a scoop with a handle.

On 3/10/13 at 4:20 PM, an observation was made of 3 stacks of stainless steel holding pans on a storage rack that were stacked 2 deep. The inside of the top pans were wet and the outside of the bottom pans were wet. There was a thick layer of dust and debris on both ends of 5 shelves of a storage rack for the stainless steel holding pans. A coat was observed on the second shelf from the bottom rack. During an interview with the Lead Cook, she reported that the clean storage rack was not on a cleaning schedule. During an interview with the Dietary Manager on 3/13/13 at 12:15 PM, the Manager stated she expected staff to air dry the stainless pans. The DM reported staff had an area to store their personal belongings and the coat was not expected to be on a storage rack for the holding pans.

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F 371	Continued From page 9 An observation was made of the hand wash sink in the kitchen on 3/12/13 at 12:10 PM. The observation revealed 2 stacked rows of servingware were stored beside the sink with 1 foot between the racks and the sink. During an observation of the hand sink with the Dietary Manager on 3/13/13 at 11:45 AM, revealed 2 rows of stacked servingware were stored 1 foot from the hand wash sink. The Dietary Manager reported the dishware could be affected when staff washed their hands at the sink and should not have been stored beside the sink. During an observation of a small refrigerator inside the medication room on 3/12/13 at 2:20 PM, the back wall of the refrigerator was covered with a 1-inch thickened wall of ice. There was no thermometer in the refrigerator, and the bottom shelf and side walls of the refrigerator had splattered yellowed-thickened matter. The refrigerator stored nutritional supplements, applesauce, and thickened liquids. During the observation with the Minimum Data Set (MDS) nurse, the nurse reported there was no thermometer in the refrigerator, it needed defrosted, and cleaned. The MDS nurse stated she thought housekeeping was responsible for cleaning the refrigerator. During an observation of the medication room refrigerator with the Administrator and Maintenance Director on 3/12/13 at 2:39 PM, the Administrator looked in the refrigerator and stated that the refrigerator needed cleaned, defrosted, and a thermometer. The Maintenance Director reported he usually cleaned the refrigerator about the beginning of the month, but did not document	F 371		

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F 371	Continued From page 10 anywhere when it was cleaned. An interview was conducted with the Administrator on 3/313/13 at 4:15 PM. The Administrator stated her expectations were that servingware in the kitchen were stored in an area away from the hand sink, the stainless pans were stored dry, deli meats and cheeses were stored in zippered bags with opened dates, storage racks were clean, a scoop with a handle was used in the sugar container, staff were expected to store their coats in the area provided, the medication room refrigerator was clean, and temperatures were recorded daily.	F 371		

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FORM APPROVED
OMB NO. 0938-0391

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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
K 000	INITIAL COMMENTS	K 000	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.	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: A. Based on observation on 04/09/2013 the exit discharge path from the 200 Hall to a public way was not lighted as required. 42 CFr 483.70 (a)	K 045	K045 **Corrective Action** Electrical contractor was contacted and installed a total of 14 exterior double-bulb light fixtures all of which are directly wired to generator/emergency current. With the installation there is now greater than the required amount of 1 candle foot of light around the entire perimeter of the building and the asphalt walkway around the facility is well-lit. **Identifying Further Potential Effects and Correction** Plant Operations Manager and Administrator walked perimeter of building following installation after sunset to assure perimeter was well-lit. **Systemic Changes** No further systemic changes indicated **Monitoring** Plant Operations manager will complete perimeter inspection for lighting monthly after sunset and report during Monthly QA meeting (con't next page)	04/12/2013
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 04/09/2013 the facility did not have documentation showing that the five (5) year obstruction test had been preformed on the dry sprinkler system. 42 CFR 483.70 (a)	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: [signature] (X6) DATE: 4/30/13

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.

(con't from page 1)

K062 04/10/2013

<u>Corrective Action</u>
An Obstruction Test / 5 year sprinkler inspection was completed by Williams Fire Sprinkler on 4/10/2013 (attachment 2)

<u>Identifying Further Potential Effects and Correction</u>
System passed Obstruction Test without concerns – no further potential effects noted at present.

<u>Systemic Changes</u>
Williams Fire Sprinkler has placed our facility on a 5 year schedule to repeat the Obstruction Test no less than every 5 years with scheduled maintenance of sprinkler system.

<u>Monitoring</u>
QIC Committee will review Plant Operations Preventive Maintenance to assure 5 year Obstruction Test is on file and updated no less frequently than every 5 years.