MAY 28 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to monitor and manage a resident's low heart rate as an adverse consequence of the medication regimen for 1 of 3 (Resident #41) sampled residents who were receiving digoxin; and failed to monitor a laboratory test in a timely manner as ordered by the physician for 1 of 10 (Resident #49) residents reviewed for	F 329	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	5/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlene B. Palmer — TITLE: Administrator — (X6) DATE: 5/17/13

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 329	Continued From page 1 unnecessary medications. The findings included: 1. Resident #41 was admitted to the facility on 9/20/12 and re-admitted to the facility from the hospital on 12/27/12. The resident's cumulative diagnoses included atrial fibrillation (a specific type of irregular heartbeat). Admission medications ordered on 12/28/12 included digoxin (an antiarrhythmic medication used to control the heart rate in atrial fibrillation) 0.25 mg (milligrams) tablet with instructions to give one tablet by mouth daily. The order also indicated, "Hold for HR (heart rate) less than 60 **Check pulse**." A normal resting heart rate for adults may range from 60 to 100 beats a minute. Review of Resident #41's medical record revealed his last digoxin level (a lab value) = 0.8 ng/ml (nanograms per milliliter) was drawn on 10/20/12. Therapeutic range noted by the reporting lab was = 0.9 - 2.0 ng/ml. Lab reports from 1/25/13 included: Potassium = 3.8 mmol/L (millimoles per liter) with the normal range = 3.5-5.2 mmol/L; Calcium = 8.5 mg/dl (milligrams per deciliter) with the normal range = 8.6-10.2 mg/dl; BUN (blood urea nitrogen) = 12 mg/dl (milligrams per deciliter) with the normal range = 3-36 mg/dl; and creatinine = 0.86 mg/dl with the normal range = 0.76-1.27 mg/dl. A review of the facility's Routine Laboratory Determinations schedule (undated) indicated the following routine lab work would be completed every 6 months for a resident receiving digoxin: digoxin level, electrolytes (sodium, potassium, chloride and bicarbonate), BUN and serum creatinine.	F 329	**F 329** **A) On 4/24/13 Resident #41's physician was notified of the digoxin being held due to the resident's low heart rate. An order was received to give digoxin 0.125mg. one tablet by mouth every other day and to monitor the resident's heart rate and hold digoxin if the heart rate was less than 60 beats per minute. A digoxin level was drawn on 5/2/13 and results were reported to the physician.** **On 4/3/13 Resident #49's digoxin order was changed to digoxin 0.125mg. by mouth daily (hold for pulse below 60). On 4/19/13 a digoxin level was drawn and the results were within normal range.** **B) On 5/8/13 the pharmacy consultant performed a 100% audit of labs and medications to include digoxin monitoring and medications held. The Director of Nursing and Assistant Director of Nursing notified residents' physicians of the pharmacy recommendations.**	**5/23/13**

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F 329	Continued From page 2 Review of the January 2013 Medication Administration Record (MAR) revealed Resident #41's digoxin was held 4 days (1/15, 1/22, 1/23, and 1/25) due to a HR less than 60. The MAR also indicated digoxin was given on 3 days without documentation of the resident's HR. Eleven heart rates less than 60 beats per minute were recorded in the resident ' s electronic record for January 2013, with the lowest recorded heart rate noted as 45 beats per minute. There was no documentation indicating the resident's physician was notified of either the resident's low HR or the digoxin being held. Review of the February 2013 Medication Administration Record (MAR) revealed Resident #41's digoxin was held 6 days (2/2, 2/6, 2/12, 2/14, 2/16 and 2/21) due to a HR less than 60. The MAR also indicated digoxin was given on 1 day without documentation of the resident's HR. There was no documentation indicating the resident's physician was notified of either the resident's low HR or the digoxin being held. Review of the March 2013 Medication Administration Record (MAR) revealed Resident #41's digoxin was held 8 days (3/1, 3/3, 3/12, 3/13, 3/14, 3/18, 3/26, and 3/28) due to a HR less than 60. The MAR also indicated digoxin was given on 2 days without documentation of the resident's HR. There was no documentation indicating the resident's physician was notified of either the resident's low HR or the digoxin being held. Review of the April 2013 Medication Administration Record (MAR) through 4/24/13	F 329	**F329 (continued)** **A 100% audit of labs to ensure compliance was completed by the Director of Nursing and Administrator on 5/15/13.** **On 5/14/13 the Director of Nursing completed a 100% audit of all residents taking digoxin to ensure correct transcription of digoxin orders, notification of the physician if digoxin held 2 or more days due to heart rates below 60, timeliness of labs (digoxin level, electrolytes, BUN and serum creatinine) and physician notification of lab results.** **All new admission or readmission orders are being reviewed by the Administrative Nurses in the daily clinical meetings to ensure they are accurate. New telephone orders are also being reviewed daily in the clinical meetings.**	**5/23/13**

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F 329	Continued From page 3 revealed Resident #41's digoxin was held 14 days (4/2, 4/4, 4/5, 4/6, 4/7, 4/8, 4/11, 4/13, 4/14, 4/15, 4/17, 4/20, 4/21 and 4/23) due to a HR less than 60. The MAR also indicated digoxin was administered to the resident on 2 occasions (4/12/13 and 4/19/13) when his HR was recorded as less than 60 beats per minute. There was no documentation indicating the resident's physician was notified of either the resident ' s low HR or the digoxin being held. During an interview on 4/24/13 at 3:14 PM, Nurse #1 indicated that it would be a "judgment call" as to when a nurse would notify the resident's physician for a low heart rate or a medication being held multiple times. Nurse #1 was not aware of the facility having a policy which addressed this. An interview was conducted on 4/24/13 at 3:45 PM with the Director of Nursing (DON). The DON stated her expectation, "If I was a nurse passing this medication (digoxin) and it was held one day and indicated to be held the next day, I would pick up the phone and call the doctor to ask if the dose needed to be adjusted." During a follow-up interview with the DON on 4/24/13 at 4:15 PM, the DON stated she had just consulted with the resident's physician by telephone. The physician changed the order to: digoxin 0.125 mg tablet with instructions to give one tablet by mouth every other day. The order also included instructions to monitor the resident's heart rate and hold the digoxin if the HR was less than 60 beats per minute. The DON re-stated that she would have expected a nurse to make the judgment call and check with the	F 329	F329 (continued) C) On 5/13/13 to 5/16/13 the Director of Nursing conducted inservices for all licensed nurses regarding the procedure for transcribing lab orders and obtaining labs timely, the procedure for transcribing and verifying admission/readmission orders for accuracy, and the procedure for notifying physicians of medications held 2 or more times. D) New admission and readmission orders will be reviewed by two administrative nurses (DON, ADON, or QI Nurse) during the morning clinical meetings to ensure accurate transcription and physician verification of all orders. Also, all new telephone orders will be reviewed in the morning clinical meetings. The Director of Nursing, or Assistant Director of Nursing, will monitor residents' Medication Administration Records 3 x a week x 4 weeks then monthly x 3 and quarterly x 3 for medications being held 2 or more times and timely notification of physican. Results will be reviewed by the Executive QI Committee monthly x 3 then quarterly x 3 to identify trends and the need for further monitoring.	5/23/13

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F 329	Continued From page 4 physician on the dose of digoxin if it had been indicated the medication be held two days in a row. She indicated there was not a facility policy in place regarding when to contact a physician if a medication is held multiple times. On 4/24/13 at 4:55 PM an interview was conducted with Resident #41's physician. The physician did not provide instruction or guidance as to when he wished to be notified of a medication (such as digoxin) being held. The physician indicated he was most comfortable decreasing the resident's digoxin dosing at this time and rechecking the digoxin level in one week. 2. Resident #49 was readmitted on 03/20/13 with diagnoses of congestive heart failure, hypertension, chronic obstructive pulmonary disease, coronary artery disease, and cerebral vascular accident. Review of Resident #49's Medication Reconciliation Discharge Order form, signed 03/21/13, documented Digoxin 0.125 mg (milligrams) to be given by mouth once daily. Review of Resident #49's Physician's Orders sheet completed by Nurse #1 on 03/21/13 and reviewed by Nurse #2 on 03/21/13 listed Digoxin 0.125 mg BID (twice a day) with meals and to hold if pulse was below 60. Review of a laboratory test on Resident #49 on 03/22/13 documented a Digoxin level of 2.1 ng/ml (nanograms/milliliters) (normal range 0.9-to 2.0 ng/ml).	F 329	**F329 (continued)** **The Director of Nursing, or Assistant Director of Nursing, will complete a Lab QI monitoring tool monthly x 3 then quarterly x 3. Results will be reviewed by the Executive QI Committee monthly x 3 then quarterly x 3 to identify trends and the need for continued monitoring.**	**5/23/13**

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F 329	Continued From page 5 Review of Resident #49's Medication Administration Record (MAR) for March 2013 and April 2013 listed Digoxin 0.125 mg BID (twice daily) hold for pulse < (below) 60 with times entered as 7:30 AM and 5:30 PM. Initials were present in both boxes (indication medication was given) for 03/22/13, 03/23/13, and 03/26/13. The rest of the days had one box circled (indication medication was held) for pulse rate that ranged 53 to 58 when the dose had been held. The facility's Consultant Pharmacist report on 04/03/12 for Resident #49 noted a medication error Digoxin 0.125 mg BID was suppose to be od (once daily). A physician's telephone order form on Resident #49 ordered to change Digoxin to 0.125 mg po (by mouth) daily (hold for pulse below 60) and to send a Digoxin level today. Review of laboratory results on Resident #49 documented the Digoxin level had not been drawn until 04/19/13 at which time the results were within normal range. In an interview with the Director of Nurses (DON) on 04/23/13 at 4:40 PM, the DON said she had been notified of the transcription error on 04/03/13 and a medication error form had been filled out, and the physician had been notified by the Assistant Director of Nurses (ADON) who obtained the order for a Digoxin level to be drawn. The DON said she was not sure why the lab was not drawn until 04/19/13. The DON said it was her expectation that the Digoxin level had been drawn immediately after the error had been identified per the physician's	F 329		

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F 329	Continued From page 6 order. In an interview with the ADON on 04/25/13 at 8:40 AM, she said after the medication error had been reported by the consultant pharmacist, she had notified Resident #49's physician and wrote the telephone order for the corrected medication and Digoxin level to be drawn 04/03/13. The ADON said she had told the nurse on the unit verbally to draw the Digoxin level and the nurse had added it to Resident #49's monthly lab work that had been drawn on 04/19/13 instead of doing it right away. The ADON said the Digoxin level should have been drawn 04/03/13 as ordered by the physician.	F 329	**F 333** **A) On 4/3/13 Resident #49's digoxin order was changed to digoxin 0.125mg. by mouth daily (hold for pulse below 60). On 4/19/13 a digoxin level was drawn and the results were within normal range.** **B) On 5/8/13 the pharmacy consultant performed a 100% audit of medication orders to include digoxin.** **On 5/14/13 the Director of Nursing completed a 100% audit of all residents taking digoxin to ensure correct transcription of digoxin orders.** **All new admission or readmission orders are being reviewed by the Administrative Nurses in the daily clinical meetings to ensure they are accurate. New telephone orders are also being reviewed daily in the clinical meetings.**	**5/23/13**
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent a transcription medication error resulting in a resident receiving three additional doses of Digoxin (medication used to treat heart failure) for 1 of 10 (Resident #49) residents reviewed for unnecessary medications. Findings include: Resident #49 was readmitted on 03/20/13 with diagnoses of congestive heart failure, hypertension, chronic obstructive pulmonary disease, coronary artery disease, and cerebral vascular accident.	F 333		

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F 333	Continued From page 7 Review of Resident #49's Medication Reconciliation Discharge Order form, signed 03/21/13, documented Digoxin 0.125 mg (milligrams) to be given by mouth once daily. Review of Resident #49's Physician's Orders sheet completed by Nurse #1 on 03/21/13 and reviewed by Nurse #2 on 03/21/13 listed Digoxin 0.125 mg BID (twice a day) with meals and to hold if pulse is below 60. Review of a laboratory test on Resident #49 on 03/22/13 documented a Digoxin level of 2.1 ng/ml (nanograms/milliliters) (normal range 0.9-to 2.0 ng/ml). Review of Resident #49's Medication Administration Record (MAR) for March 2013 and April 2013 listed Digoxin 0.125 mg BID hold for pulse < (below) 60 with times entered as 7:30 AM and 5:30 PM. Initials were present in both boxes (indication medication was given) for 03/22/13, 03/23/13, and 03/26/13. The rest of the days had one box circled (indication medication was held) for pulse rate that ranged 53 to 58 when the dose had been held. The facility's Consultant Pharmacist report on 04/03/12 for Resident #49 noted a medication error Digoxin 0.125 mg BID was suppose to be od (once daily). A physician's telephone order form on Resident #49 ordered to change Digoxin to 0.125 mg po (by mouth) daily (hold for pulse below 60) and to send a Digoxin level today. A review of a Medication Error Form, dated	F 333	**F 333** **C) On 5/13/13 to 5/16/13 the Director of Nursing conducted inservices for all licensed nurses regarding the procedure for accurately transcribing and verifying admission/readmission orders . Two nurses will be required to review the orders for accuracy and then the physician will be contacted verify the orders. If the pharmacist questions an order, the nurse must contact the physician for clarification.** **D) New admission and readmission orders will be reviewed for accurate transcription by two administrative nurses (DON, ADON or QI Nurse) during the morning clinical meetings. Review of the orders will be recorded on a monthly log sheet. Also, all new telephone orders will be reviewed in the morning clinical meetings.** **Results of the reviews will be shared with the Executive QI Committee monthly x 6 to identify trends and the need for continued monitoring.**	**5/23/13**

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F 333	Continued From page 8 04/03/13, signed by Nurse #2 documented a transcription error was made on Resident #49's Digoxin and should have been once daily instead of twice daily. Review of laboratory results on Resident #49 documented the Digoxin level had not been drawn until 04/19/13 at which time the results were within normal range. In an interview with the Director of Nurses (DON) on 04/23/13 at 4:40 PM, the DON said she had been notified of the transcription error on 04/03/13 and a medication error form had been filled out, and the physician had been notified by the Assistant Director of Nurses (ADON) who obtained the order for a Digoxin level to be drawn. The DON said she was not sure why the lab was not drawn until 04/19/13. In another interview with the DON on 04/25/13 at 9:15 AM, the DON said it was her expectation that two nurses check the physician's order sheets against the hospital reconciliation sheets for accuracy. The DON said Nurse #2 had mistakenly transcribed the Digoxin with the directions from the medication listed on the sheet above it. The DON said it was her expectation that the second nurse who reviewed it would have picked up the error. The DON said she was not aware if the provider pharmacy had questioned the order. In a telephone interview with the provider Pharmacist on 04/25/13 at 10:10 AM, the pharmacist said he would question an order for Digoxin to be given twice daily due to the potential side effects and toxicity of too much medication	F 333		

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F 333	Continued From page 9 being given. The Pharmacist pulled Resident #49's record and said the pharmacist had called the facility on 03/21/13 at 10:41 PM and verified the frequency with Nurse #2 as being correct. The DON spoke with the provider pharmacist on the telephone. The DON said she would have expected Nurse #2 to check the hospital discharge orders and verify with the physician if there had been any questions. In an interview with Nurse #2 on 04/25/13 at 10:32 AM, she said she had made a mistake when she had transcribed Resident #49's when he had been admitted on 03/21/13. Nurse #2 said she transcribed the Digoxin 0125 mg to be given twice daily instead of once per day. Nurse #2 said the potential danger of giving the medication more frequently could cause a drop in a resident's heart rate and could cause toxicity. Nurse #2 said she had not recalled the pharmacist calling her to verify the frequency of the Digoxin for Resident #49. In an interview with Nurse # 3 on 04/25/13 at 10:53 AM, Nurse #3 said she had verified the admission orders on Resident #49 for Nurse #2 against the hospital discharge Medication Reconciliation form and she told Nurse #2 that the order for Digoxin had been missing. Nurse #3 said she had not gone back to verify if Nurse #2 had transcribed the Digoxin order correctly. Nurse #3 said she had not talked to anyone in the pharmacy regarding the frequency of the medication. Nurse #3 said the effects of too much Digoxin could cause a resident's heart rate to go down and cause toxicity.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 10 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 temperature of a cold salad made with sour cream at or below 41 degrees Fahrenheit during operation of the trayline. The facility also failed to prevent cross contamination at the dish machine, and failed to follow facility guidelines for the storage of foods and kitchenware. Findings include: 1. At 5:15 PM on 04/22/13 an announcement was made over the intercom that trays were being served in main dining room. At 5:27 PM on 04/22/13 the temperature of the "five-cup" salad was checked during operation of the trayline using a calibrated thermometer. The regular salad registered 52.2 degrees Fahrenheit, and the puree salad registered 47.7 degrees. At 5:32 PM on 04/22/13 the cook stated regular "five-cup" salad contained pineapple, oranges, sour cream, marshmallows, and coconut while the sugar-free version was without the marshmallows and coconut. According to the	F 371	**F371** **A) As of 4/23/13, cold food temperatures are being taken and found to be at or below 41 degrees during operation of the trayline for every meal. Also, all cold items are being placed on ice during operation of the trayline. Hot food temperatures are being recorded on all hot items and found to be at or above 135 degrees during operation of the trayline.** **On 4/22/13, the dietary cook and dietary aide were inserviced by the Administrator regarding proper food temperatures, testing the temperatures of all food items during prep time and during operation of the trayline, labeling and dating foods, and practice good handwashing after handling dirty dishes and before handling sanitized dishes.** **As of 4/23/13, all expired leftovers and food items without labels/dates were discarded by the Dietary Manager.**	**5/23/13**

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
	345226	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

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F 371	Continued From page 11 cook, she completed assembling the "five-cup" salad around 11:00 AM on 04/22/13, and it was stored in refrigeration until between 3:00 PM and 4:00 PM. She explained she then dished it up, and placed the dishes in a rack until the tray line started shortly after 5:00 PM. The cook stated because the dietary staff was running behind schedule she did not take food temperatures as the trayline began operation. At 5:37 PM on 04/22/13 the dietary manager (DM) stated the "five-cup" cup salad should be kept below 40 degrees during operation of the trayline since it contained sour cream. She explained cold salads were usually made up the day before being served, but a dietary aide called out so the staff was running behind in its food preparation. At 9:37 AM on 04/25/13 the DM stated it was necessary to take temperatures on all hot and cold foods as the trayline began operation at each meal. She reported after cold salads were assembled the day before being served they were placed in the refrigerator, and sometimes even the freezer, to chill them down to 40 degrees Fahrenheit or below. The DM commented cold salads were supposed to be kept on ice during the operation of the trayline. At 9:50 AM on 04/25/13 a cook/dietary aide stated she was supposed to take the temperature of all hot and cold foods as the trayline began operation. She reported she was trained to prepare cold salads the morning before being served and to place them in the freezer and then refrigerator. Once the trayline began operation, she explained these cold salads were to be kept	F 371	**F371 (continued)** **On 4/23/13, the Dietary Cook Rewashed the wet tray pan and let it air dry. The Dietary Cook also washed the utensils, storage container lid, and the storage shelving.** **B) On 4/29/13 the Dietary Manager Conducted a 100% sanitation audit of the following:** **Food storage in the dry storage area, refrigerators and freezer- to include labeling/dating food.** **Kitchenware storage.** **Food temperatures during operation of the tray line.** **Proper handwashing when going from dirty to sanitized kitchenware** **C) On 4/30/13, 5/1/13 and 5/2/13, the Administrator inserviced the dietary staff regarding proper storage (to include labeling and dating food), preparation, distribution and serving food under sanitary conditions.** **This addressed food temperatures when preparing, serving and storing food. Also, addressed was proper handwashing when going from dirty to clean areas to avoid cross contamination. Washing, air drying and proper storage of kitchenware was discussed.**	**5/23/13**

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	345226	A. BUILDING ______ B. WING ______	04/25/2013

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F 371	Continued From page 12 on ice. 2. At 2:55 PM on 04/23/13 the only dietary employee operating the dish machine placed dirty silverware in pre-wash solution, and retrieved racks off the floor to place other dirty kitchenware in. However, the employee failed to wash her hands before removing several dishes from a rack of sanitized kitchenware, and placing them in storage. In addition, at 3:02 PM on 04/23/13 the employee handled several cups that had been sanitized, and at 3:03 PM on 04/23/13 handled several coffee mugs which had been sanitized without washing her hands. At 9:37 AM on 04/25/13 the dietary manager (DM) stated it was common practice for only one dietary employee to run the dish machine. However, she reported the dietary staff was trained to wash their hands everytime they went between the dirty and sanitized ends of the dish machine. She commented if this practic was not followed, the sanitized kitchenware could be contaminated. At 9:50 AM on 04/25/13 a cook/dietary aide stated because of a staffing shortage only one person usually operated the dish machine. She reported all dietary staff were trained to wash their hands everytime between handling dirty and sanitized kitchenware. 3. During initial tour of the kitchen on 04/22/13, beginning at 8:30 AM, storage containers of leftover food were found in the reach-in refrigerator. The leftovers included cooked	F 371	**F371 (continued)** **D) The Dietary Manager will perform a Food Sanitation audit 4 x a week for 4 weeks then monthly x 3 then quarterly x 3.** **The Dietary Manager will perform random temperature audits at the beginning of the tray line and then toward the end of the tray line 3 x a week for 4 weeks then monthly x 3 then quarterly x 3.** **The Dietary Manager will perform audits of staff handwashing while operating the dish machine and audits of kitchenware sanitation/storage weekly x 4 then monthly x 3 then quarterly x3.**	**5/23/13**

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	345226	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 13 chicken placed in storage on 04/18/13, cooked potatoes placed in storage on 04/16/13, bean soup and chicken soup placed in storage on 04/17/13, tuna salad placed in storage on 04/16/13, prunes placed in storage on 04/11/13 with a discard date of 04/18/13, two containers of tea placed in storage on 04/18/13 with a discard date of 04/19/13, tomato soup placed in storage on 04/14/13 with a discard date of 04/17/13, egg salad placed in storage on 04/18/13, pineapple placed in storage on 04/13/13 with a discard date of 04/18/13, a salad plate containing fruit and cottage cheese placed in storage on 04/15/13, and a plate of four chicken salad sandwiches cut in half placed in storage on 04/17/13. In the walk-in freezer bags of tater tots and squash were opened without labels and dates. 1 of 6 tray pans stacked on top of one another in storage were wet inside. Utensils were being stored on top of a storage container lid which was contaminated by food crumbs and stored on top of dusty storage shelving. During a follow-up tour of the kitchen on 04/23/13, beginning at 3:15 PM, a plate of four chicken salad sandwiches cut in half and dated 04/17/13 were still in the reach-in refrigerator. 1 of 10 tray pans stacked on top of one another in storage were wet inside. At 9:37 AM on 04/25/13 the dietary manager (DM) stated she monitored all storage areas daily checking to make sure leftovers were disposed of in a timely manner, food items were labeled and dated as necessary, and opened food items were resealed. She reported three days was the maximum amount of time cooked leftovers or foods containing protein such as mayonnaise	F 371		

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F 371	Continued From page 14 should remain in storage. She also commented more shelf stable items such as leftover fruit should be disposed of after five days of storage. According to the DM, the dietary staff was trained to place two dates on the food storage labels, one date representing when the food was placed in storage and the other date representing when the food was to be removed from storage. The DM commented all opened food items, leftovers, and food items removed from their original packaging were supposed to be labeled and dated when placed in storage. She stated kitchenware should be completely dry before stacking it in storage. The DM also reported utensils were to be stored hanging or inside a plastic container with a lid in place. At 9:50 AM on 04/25/13 a cook/dietary aide stated all dietary employees who entered the storage areas were supposed to monitor leftovers and labeling/dating. She commented that all opened food items, leftovers, and food items removed from their original packaging were supposed to be labeled and dated when placed in storage. She stated after three days of refrigerated storage cooked leftovers and salads made with mayonnaise were to be disposed of, and after five days of refrigerated storage leftover fruit was to be disposed of. According to the cook/dietary aide, utensils were to be hung or stored inside a plastic container. She stated all kitchenware was to be dry before being stacked in storage.	F 371		

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

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	345226	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/22/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (111)) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	7/6/13
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: A. Based on observation on 05/22/2013 the door to the soiled linen room failed to close and latch. 42 CFR 483.70 a)	K 029		
K 038 SS=D	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. 19.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlene B. Palmer
TITLE: Administrator
(X6) DATE: 6/6/13

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.

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
	345228	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 05/22/2013 the staff interviewed did not know about the master door release switch located at the nurses station. B. Based on observation on 05/22/2013 the door release switches located at the door were too high above the floor, these switches must be between 34 and 48 inches above finioshed floor. 42 CFR 483.70 (a)	K 038	K 029 A) A vent is scheduled to be installed no later than 7/6/13 in the laundry (soiled linen) room to decrease pressure in the room resulting from the exhaust fan. This will enable the laundry room door to close and latch on its own. B) On 6/6/13 the Maintenance Supervisor and the Assistant Maintenance Supervisor completed an audit of all doors with closers to ensure they were self-closing and latching. C) As of 6/6/13 the Staff Development Coordinator inserviced all staff and contract staff to inform them all doors with closers must be closed and latched at all times. On 6/4/13 the Administrator inserviced the Maintenance Department and Housekeeping Supervisor that all doors with closers must be closed and latched at all times.	7/6/13

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

PRINTED: 05/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING 01 - MAIN BUILDING B. WING	05/22/2013

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		K 029	K 029 (continued) D) The Maintenance Supervisor and/or Assistant Maintenance Supervisor will perform an audit monthly x 3 and quarterly x 3 to ensure all doors with closers are self-closing and latching. Results will be reported to the QI Executive Committee and action taken if needed.	7/6/13
		K 038	K 038 A) As of 6/6/13 all employees and contract employees have been inserviced by the Staff Development Coordinator regarding the location of the master door release switches at the nurses stations and their purpose. The door release switches are scheduled to be relocated between 34 and 48 inches above the finished floor by 7/6/13.	7/6/13

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	345226	A. BUILDING 01 - MAIN BUILDING B. WING ______	05/22/2013

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		K 038	**K 038 (continued)** **B) All new employees and new contract employees will be inserviced upon hire by the Staff Development Coordinator regarding the locations of the master door release switches at the nurses stations and their purpose.** **Yearly inservices, regarding the locations of the master door release switches and their purpose, will be given to all employees, including contract employees.** **On 6/4/13 the Maintenance Supervisor and Assistant Maintenance Supervisor were inserviced by the Administrator regarding the NFPA 101 Life Safety Code Standard requirement of door release switches being between 34 and 48 inches above the finished floor.** **C) All employees, including contract employees, will be inserviced yearly and more often if necessary by the Staff Development Coordinator regarding the locations of the master door release switches at the nurses stations and their purpose.** **All new maintenance employees will be inserviced during the orientation period regarding the master door release switch locations and their purpose, as well as the requirement for door release switches, located at the doors, being 34 and 48 inches above the finished floor.**	**7/6/13**

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	345228	A. BUILDING 01 - MAIN BUILDING B. WING ______	05/22/2013

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		K 038	K 038 (continued) D) A random audit of staff, regarding the location of the master door switches at each nurses station and their purpose, will be conducted by the Staff Development Coordinator through questioning of staff monthly x 3 then quarterly x 3. Results will be reported to the QI Executive Committee and further action taken if necessary. The Maintenance Supervisor has a list with locations of all door release switches and will oversee the relocation of all door release switches to ensure they are between 34 and 48 inches above the finished floors. The list will be updated to confirm all door release switches have been relocated between 34 and 48 inches above the finished floors.	7/6/13

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

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	345226	A. BUILDING 02 - BUILDING 02 B. WING ______	05/22/2013

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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: A. Based on observation on 05/22/2013 there were residents rooms being used for storage rooms. The doors did not have closers on them. (the rooms were covered by the sprinkler system) 42 CFr 483.70 (a)	K 029	**K 029** **A) On 5/24/13 the Maintenance Supervisor and Assistant Maintenance Supervisor installed closers on the doors to rooms 501 and 503 that were being used for storage.** **B) On 6/6/13 the Maintenance Supervisor and Assistant Maintenance Supervisor completed an audit of all areas used for storage to ensure closers were on all doors to those areas.** **C) The Maintenance staff and Housekeeping Supervisor were inserviced by the Administrator on 6/4/13 regarding the NFPA 101 Life Safety Code Standard requirement that all storage areas have ¾ hour fire-rated, self-closing doors and an approved automatic fire extinguishing system.** **D) A QI monitoring tool, regarding closers on doors to storage areas, will be completed by the Maintenance Supervisor or his assistant monthly X 3 and quarterly x 3. Results will be brought to the QI Executive Committee and further action taken if needed.**	7/6/13

RECEIVED
JUN 07 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Arlene B. Palmer	Administrator	6/6/13

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