MAY 17 2013
accepted

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345417	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

(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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to update a resident ' s care plan with documented weight loss. This was evident for 1 of 2 resident reviewed for weight loss. (Resident # 60) The findings Resident # 60 was readmitted to the facility on11/16/11with cumulative diagnosis of Alzheimer ' s dementia and chronic kidney disease. According to the minimum data set dated 2/7/13; Resident #60 was dependent for all activities of daily living including feeding.	F 280	F280 1. The corrective action will be accomplished for this resident in the following manner; Resident #60 had their care plan updated to include interventions for weight loss including nutritional supplements. 2. The corrective action for residents having the potential to be affected will be accomplished by having care plans reviewed for current residents with significant weight loss in order to identify appropriate interventions. This will be done by the MDS Coordinator or assistant. Care plans would be updated with recommended dietary interventions 3. This system will be put into place by having monthly and weekly weights monitored by the MDS Coordinator and assistant and reviewed at the weekly care plan meeting to ensure interventions will be implemented as indicated. Current licensed nursing staff has been inserviced by DON or SDC on updating resident care plans when orders are received.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bill [signature] 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.

KDB

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F 280	Continued From page 1 A review of the physician ' s monthly note dated 04/04/13 revealed " Geriatric Syndromes: weight notes: weight loss expected as dementia progresses. The findings included: Resident # 60 was readmitted to the facility on11/16/11 with cumulative diagnoses of Alzheimer ' s dementia and chronic kidney disease. According to the minimum data set dated 2/7/13; Resident #60 was dependent on staff for all activities of daily living including feeding. According to the weight records, the resident weight was 173.5 pounds in October, 2012 and 157.5 pounds in November of 2012. This constituted a significant weight loss of 9% in one month. A review of the physician ' s orders dated 11/2/12 DIETARY RECOMMENDATION: increase Med Pass to 4OZ (ounces) qid (four times a day). A review of the 11/08/12 note revealed " observation of resident pocketing food in mouth before swallowing. Med pass increased to 4 oz QID 11/21/12. A review of the notes on 11/12/12 revealed " placed on weekly weights. " According to the weight records, the resident weight was 158.6 pounds in January, 2013 and 136.4 pounds in February of 2013. This constituted a significant weight loss of 13% in one	F 280	4. This system will be monitored using a quality assurance tool to ensure that care plans are updated weekly to ensure that appropriate interventions are documented for weight loss and that care plans are reviewed for current residents with significant weight loss to identify interventionsWe will monitor the system daily until100% compliance is achieved and then weekly until 100% complianceis achieved again and then quarterly thereafter by the QA nurse, and Unit Manager 5. The completion date for this plan of correction will be May 23 2013.	5/23/13

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F 280	Continued From page 2 month and 13% in three months. The Nutritional Care Plan Review dated 02/13 revealed the resident was at nutritional risk for decline due to weight loss, dehydration and aspiration related to: poor appetite, swallowing difficulty, diagnosis of Alzheimer's, COPD (Chronic Obstructive Pulmonary Disease), HTN (Hypertension), GERD (Gastroesophageal reflux disease), Depression. The resident was on a puree NAS (no added salt) diet. A dietary assessment dated 02/07/13 revealed " Eats meals served in dining room fed by staff, po (food intake by mouth) intake poor. Refuses most meals, eats 25% meals. She drinks 360cc (cubic centimeters)-480cc or more per day. The family comes frequently during meal time to assist with feeding. Weight 136# (pounds), significant weight loss in past 60-180 days. She receives vanilla mighty shake at lunch and dinner, fruit smoothie at lunch and dinner med pass 2.0 4 ounces QID (four times a day) for added calories and help prevent weight loss. On weekly weights. She receives Remeron to help stimulate her appetite. " I moved up to make it chronological A review of the physician ' s order dated 02/19/13 revealed " DIETARY RECOMMENDATION: Add Mighty Shake at breakfast and Fruit Smoothie, D/C (discontinue) pureed fruit at 2 PM and give magic cup r/t (related to) weight loss with poor po. " A review of the physician ' s monthly note dated 04/04/13 revealed " Geriatric Syndromes: weight	F 280		

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F 280	Continued From page 3 notes: weight loss expected as dementia progresses " . A review of the physician ' s order dated 04/09/13 revealed " Prostat (protein supplement) 30 ml po QD (every day). " A review of the physician ' s order dated 04/19/13 revealed " Med pass 2.0 4 oz po TID for added nutritional intake. " A review of the physician ' s order dated 04/19/13 revealed " D/C (discontinue) Med pass TID keep previous order for med pass 2.0 4 oz QID " . A review of Medication Administration Record (MAR) for April 2013 revealed Resident # 60 was receiving Calcium 500 mg (milligram) po (by mouth) BID (twice a day), Vitamin C 500 mg 2 tabs (tablets) po BID, Remeron 15 mg po QHS (every evening), Mighty Shake and fruit smoothie were added at breakfast and at 2 pm snack was magic cup, Med pass 2.0 4oz (ounces) QID (four times a day) for added calories. The resident was fed a Pureed diet, NAS/C (no added or concentrated sweets), Nectar thick liquids. (started on 08/15/12). There was no indication of the percentage of med pass or nutritional supplements the resident drank. A review of Dietician ' s note dated 04/18/13 revealed that weight loss noted. The resident current weight was 132#. Resident triggered for weight loss. The resident was 66 inches and BMI (body mass index) was 26.3. Diet order was Pureed NAS. She refused 10 of the last 21 meals. PO intake was 25% per NA (nursing	F 280		

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F 280	Continued From page 4 assistant) flow sheet. Albumin was 3.3. The recommendation was to give the resident 4oz of med pass 2.0 TID secondary to weight loss and poor po intake. An interview with the minimum data set (MDS) coordinator on 04/35/13 at 2:30 PM revealed the resident ' s care plan can be updated by anyone. She further indicated the care plan should have included specific documentation regarding the need to measure and report the resident ' s refusal and intake of fluids and food due to her significant weight loss. She indicated there was documentation of the addition of the supplements but they were not accurate according to the physician ' s orders. The care plan was an indication of the care needs for the resident and this care plan was not accurate for the resident ' s care needs for nutrition. An interview with the Director of Nursing (DON) on 04/25/13 at 3:45 PM revealed her expectation was the care plan was to be updated quarterly, but anyone can add new interventions to the care plan. The staff would refer to the care plan if they had any questions regarding the resident ' s care.	F 280		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, Nurse Practitioner interview and record review, the facility failed to monitor a resident who was identified with weight loss by not documenting the amount of the nutritional supplemental ordered for this resident. This was evident in 1 of 2 residents reviewed for nutrition (Resident #60) The findings included: Resident # 60 was readmitted to the facility on11/16/11 with cumulative diagnoses of Alzheimer ' s dementia and chronic kidney disease. According to the minimum data set dated 2/7/13; Resident #60 was dependent on staff for all activities of daily living including feeding. According to the weight records, the resident weight was 173.5 pounds in October, 2012 and 157.5 pounds in November of 2012. This constituted a significant weight loss of 9% in one month. A review of the physician ' s orders dated 11/2/12 DIETARY RECOMMENDATION: increase Med Pass to 4OZ (ounces) qid (four times a day). A review of the 11/08/12 note revealed " observation of resident pocketing food in mouth before swallowing. Med pass increased to 4 oz QID 11/21/12.	F 325	F325 1. The corrective action will be accomplished for this resident in the following manner; Resident #60 is currently receiving nutritional supplements as ordered and the amount of the supplement consumed is recorded on the nourishment sheet to document intake. 2. The corrective action for residents having the potential to be affected will be accomplished by having current resident weights reviewed to identify significant weight loss and nutritional supplements will now be monitored and recorded to reflect percentages consumed.	

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F 325	Continued From page 6 A review of the notes on 11/12/12 revealed " placed on weekly weights. " According to the weight records, the resident weight was 158.6 pounds in January, 2013 and 136.4 pounds in February of 2013. This constituted a significant weight loss of 13% in one month and 13% in three months. The Nutritional Care Plan Review dated 02/13 revealed the resident was at nutritional risk for decline due to weight loss, dehydration and aspiration related to: poor appetite, swallowing difficulty, diagnosis of Alzheimer's, COPD (Chronic Obstructive Pulmonary Disease), HTN (Hypertension), GERD (Gastroesophageal reflux disease), Depression. The resident was on a puree NAS (no added salt) diet. A dietary assessment dated 02/07/13 revealed " Eats meals served in dining room fed by staff, po (food intake by mouth) intake poor. Refuses most meals, eats 25% meals. She drinks 360cc (cubic centimeters)-480cc or more per day. The family comes frequently during meal time to assist with feeding. Weight 136# (pounds), significant weight loss in past 60-180 days. She receives vanilla mighty shake at lunch and dinner, fruit smoothie at lunch and dinner med pass 2.0 4 ounces QID (four times a day) for added calories and help prevent weight loss. On weekly weights. She receives Remeron to help stimulate her appetite. " I moved up to make it chronological A review of the physician ' s order dated 02/19/13	F 325	3. This system will be put into place by creating a form for the CNA's to use to record the percentages of all supplements consumed. This form will be reviewed by the DON or Unit Mgr or SDC nurse or QA nurse to ensure that nutritional supplements are being provided and recorded. All nursing staff will be inserviced on recording nutritional supplement percentage. 4. This system will be monitored by the QA Nurse or DON or Unit Manager using a quality assurance tool to ensure that we will monitor these supplemenent consumption percentage sheets daily. We will monitor the system daily until 100% compliance is achieved and then weekly until 100% compliance is achieved again and then quarterly thereafter by the Staff Development Coordinator. 5. The completion date for this plan of correction will be May 23 2013.	5/23/13

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F 325	Continued From page 7 revealed " DIETARY RECOMMENDATION: Add Mighty Shake at breakfast and Fruit Smoothie, D/C (discontinue) pureed fruit at 2 PM and give magic cup r/t (related to) weight loss with poor po. " A review of the physician ' s monthly note dated 04/04/13 revealed " Geriatric Syndromes: weight notes: weight loss expected as dementia progresses " . A review of the physician ' s order dated 04/09/13 revealed " Prostat (protein supplement) 30 ml po QD (every day). " A review of the physician ' s order dated 04/19/13 revealed " Med pass 2.0 4 oz po TID for added nutritional intake. " A review of the physician ' s order dated 04/19/13 revealed " D/C (discontinue) Med pass TID keep previous order for med pass 2.0 4 oz QID " . A review of Medication Administration Record (MAR) for April 2013 revealed Resident # 60 was receiving Calcium 500 mg (milligram) po (by mouth) BID (twice a day), Vitamin C 500 mg 2 tabs (tablets) po BID, Remeron 15 mg po QHS (every evening), Mighty Shake and fruit smoothie were added at breakfast and at 2 pm snack was magic cup, Med pass 2.0 4oz (ounces) QID (four times a day) for added calories. The resident was fed a Pureed diet, NAS/C (no added or concentrated sweets), Nectar thick liquids. (started on 08/15/12). There was no indication of the percentage of med pass or nutritional supplements the resident drank.	F 325		

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F 325	Continued From page 8 A review of Dietician ' s note dated 04/18/13 revealed that weight loss noted. The resident current weight was 132#. Resident triggered for weight loss. The resident was 66 inches and BMI (body mass index) was 26.3. Diet order was Pureed NAS. She refused 10 of the last 21 meals. PO intake was 25% per NA (nursing assistant) flow sheet. Albumin was 3.3. The recommendation was to give the resident 4oz of med pass 2.0 TID secondary to weight loss and poor po intake. An observation on 04/23/13 at 8:45 AM revealed the resident was sitting in the dining room with breakfast tray. The tray was removed by staff with mighty shake and fruit smoothie unopened. An interview with NA #1 on 04/23/13 at 9:00 AM revealed the resident refused the mighty shake and fruit smoothie. An observation of resident #60 ' s meal tray on the cart to be returned to the kitchen on 04/24/13 at 8:30 AM revealed the container of mighty shake and fruit smoothie were unopened on the resident ' s meal tray. A review of the dinning sheet for the resident revealed Resident # 60 ' s breakfast for 04/24/13 intake was 25% and 120 cc of fluid drank. An observation on 04/25/13 at 8:36 AM revealed a NA encouraging the resident to eat her breakfast and drink her nutritional supplements from her breakfast tray. The resident drank 75% of her mighty shake and 50% of her fruit smoothie.	F 325		

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F 325	Continued From page 9 An interview with NA#2 on 04/25/13 at 8:38 AM revealed she was instructed to sit with the resident and encourage her to eat and drink her supplements. A review of the Supplement Sheet (this sheet was provided by the kitchen for documentation of the resident ' s percentage of intake of the ordered nutritional supplements and snacks) for 04/24/13 revealed resident #60 was to receive a magic cup at 2 pm. There was no documentation of the percentage or amount of the mighty shake or fruit smoothie the resident ate or drank. An interview with NA#1 on 04/24/13 at 11:11 AM revealed usually on the resident's breakfast tray, she would have pureed eggs, sausage, grits and or oatmeal, strawberry smoothie (120cc) and 1-2 thicken liquid (120 each) and a Mighty shake (120cc) . This AM (04/24/13) she drank 120cc and only ate 25% of breakfast, if there was a problem where she did not take in all the fluid and only ate 25% " we (NA) would tell the Nurse. " NA #2 who was in the dining room would look at each tray and documented the information on the meal percentage sheets An interview with NA#2 on 04/24/13 at 11:15 AM stated " I do not remember which fluid she (resident #60) drank yesterday or this morning; she usually only drinks small amount of her drinks. It is the NAs responsibility to encourage Resident #60 to drink the supplements and also to tell the nurse and I did not tell the Nurse " . She continued we (NAs) are to record the amount of fluids the resident drinks after each meal on the	F 325		

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F 325	Continued From page 10 fluid intake log. We (NAs) were not told to document the supplements she (Resident #60) drank separately on the log. An interview with Unit Manager on 04/23/13 at 10:40 AM revealed the nursing assistants (NA) use the supplemental sheets to document the percentage of supplements the resident takes. The mighty shake and fruit smoothies should be on the log like the 2pm magic cup was. He further indicated with a resident who has had weight loss the NA should be specific in documenting the amount of supplements that the resident had drank. If the resident did not drink the supplements this should be reported to the floor nurse. An interview with the dietary manager (DM) on 04/23/13 at 11:52 AM revealed the NA were expected to record the information (the amount and type of supplement the resident drank) on the work sheet and put it in the fluid intake log. She continued, it was her responsibility to make sure the supplements ordered were on the resident ' s trays before going out to the residents. She was also responsible to follow up with the NA to make sure the resident was drinking the supplements ordered for the resident and then she would document that information in the resident's nutritional note. After reviewing her notes; she indicated she documented the supplements were given in February 2013 but there was no indication of what type of fluids she has had since February 2013. She reviewed the RD note for April 2013 and revealed the resident had lost 18# and stated "that is not acceptable." (referring to	F 325		

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F 325	Continued From page 11 the amount of weight loss). She continued that her responsibility was to keep her (Resident #60) weight stable. She also indicated she was responsible to being aware of the resident ' s refusal of meals, percentage of supplements the resident drank and weekly weight loss and reporting this information to the dietician and the physician. She was unable to indicate why this was not done for the resident. She stated " there were a lot of things put into place for her (referring to supplements) and I guess the interventions in place have not been effective An interview with Nurse#1 on 04/23/13 at 11:22 AM revealed the resident drank the entire med pass and the nurse did not document the percentage on the MAR. Nurse #1 indicated the nurses followed up with the resident ' s supplements by taking the information from the NA supplement documentation, meal and fluid intake documentation and they would bring it to the Unit Manager or Nurse Practitioner and they would review this information and make recommendation with the DM or RD to address the weight loss. She continued, when it comes to food intake the DM was supposed to go through the resident's weight for the month or week to follow the trends and contact the RD if necessary. She further indicated Resident #60 was holding the food and fluid in her mouth and then letting it drool out of her mouth and not swallowing her food or drinks. The NAs were supposed to assist her to eat and drink at each meal and her family often comes in to assist with her meals too. The staff was also to document if the supplement snacks and fluids were taken and notify the nurse if they were not. She stated " no one had told me the resident was not taking her supplements or	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12 snacks " . An interview with the RD on 04/23/13 at 11:40 AM revealed it was her understanding that her dementia was taking over and she was allowing food to drain out of her mouth. She continued that she also had refused 10 of the 21 meals in the past week. She indicated that the staff was unable to do anything about this due to her advancing dementia. She stated the family and the doctor were aware of her weight loss. She further indicated her weight loss was due to the advancing dementia diagnosis. She continued she felt more specific documentation of the resident's enjoying the strawberry shake for breakfast would be helpful so she would recommend adding more strawberry shakes with additional protein for the resident. She indicated she depends on the DM to have documented the resident ' s weight loss and refusal of the supplements so she could make recommendations when she reviewed the resident ' s chart when she was in the facility. She was unaware that the resident was not taking the snacks or supplements ordered each day. She could have made different recommendations if she had had this information. A telephone interview with the Nurse Practitioner on 04/25/13 at 12:08PM revealed the resident ' s intake of the supplements should be documented after each meal. Her responsibility was to look at the resident ' s continued weights loss. She indicated she had not received reports that Resident #60 was refusing the supplements. She continued the family was aware of the weight loss, they all felt it was part of the dementia process. She stated she was remiss that she had	F 325		

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	345417	A. BUILDING ______ B. WING ______	04/25/2013

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F 325	Continued From page 13 not looked at the chart because she was taking the word of the staff and not specifically checking to see if the resident was taking in the nutritional supplements ordered to help prevent her weight loss. She indicated the supplements should be documented after each meal. She stated she had looked at fluid intake but never considered that the supplements were not being taken by the resident. She finally stated I will look at this more closely now. An interview with the Director of Nursing (DON) on 04/24/13 at 2:40 PM revealed her expectation was the NA would document the food and fluid intake of each resident after each meal or snack on the fluid intake logs. The NAs would report to the nurses if the resident refused their meals or supplements or snacks. The nurse would review the logs daily and follow up with the unit manager and the DM. She continued she would expect the DM to do dietary reviews weekly along with the weekly or monthly weights. The DM was supposed to initiate the Significant Weight Loss Assessment if she identified a resident at risk for weight loss and notify the nurse who intern would notify the NAs. The nurse was required to complete the assessment, contact the doctor, and implement possible new orders from the physician. She would then inform the NAs as to what new orders were placed for the resident. She further indicated she was aware that Resident #60 required to be fed, so the staff or family would feed her too. The NA was supposed to document the meal percentage and intake, specifically the supplements. She added the Unit Manager would also have a list of resident ' s identified with weight loss and he would be responsible to follow up with the nurse to ensure	F 325		

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F 325	Continued From page 14 the resident was receiving the supplements ordered or if the resident were refusing them. She would also expect the unit manager would notify the physician and dietician. She indicated obviously the interventions in place did not meet the resident's needs. She stated " we do not have a weight committee that tracks or reviews weight issues for the residents. The unit manager was expected to track this information and address it. " She continued she was not aware of a specific place where all this communication was documented.	F 325		
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 observations of the Kitchen/Food Service, the facility failed to store potentially hazardous foods (cold cuts:(Salami, bologna, and ham),cheese, fresh produce(green peppers and onions), and sugar and flour in a manner to prevent contamination. The facility also failed to store canned goods (Pineapple tidbits) in non-dented cans. Findings include: Review of the facility policy entitled Dietary Policy	F 371	F371 1. The corrective action has been to inspect all potentially hazardous foods to ensure they have been stored in a manner to prevent contamination. All leftover foods, packages and boxes have been wrapped and labeled with name of product and and Todays date. All such foods have been verified to be within shelf life date. All produce has been inspected to ensure that any bad pieces have been discarded. The flour and sugar bins have been dated and any cans with a dent in them have been removed from inventory.	

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F 371	Continued From page 15 and Procedures dated May 2005, indicated All leftover foods, opened packages, boxes must be wrapped and labeled with: Name of the Product and Today's Date. Check product for shelf life -Refrigerator left over food not used within 3-days of preparation must be discarded, to prevent any food borne illness. Processed Meats are used by Use by Date. Leftover Meat must be used within 48 hours. All other leftover foods not used within 72 hours must be discarded. Kitchen/Food Service observations were conducted on 4/22/13 at 11:00 AM. The Walk-In Refrigerator was observed at 38 degrees. In the Walk-In Refrigerator, the following items were observed : A one-fourth pound of bologna was observed not labeled, wrapped loosely, and not sealed. The product was opened to air. The bologna had an opened date of 4/18/13. Two packages, two pounds each, of Salami were observed loosely wrapped and not sealed. One of the two pound packages had broken seals on both ends, and the salami was exposed to air. On one end, the salami was discolored and was brown. The other two pound package of Salami was observed unsealed on one end. The product was exposed to air, and had a brown color. A seven pound Buffet Ham was observed not sealed. It was observed loosely wrapped with plastic wrap, and exposed to air. The product had no opened date. One pound of sliced cheddar cheese was observed loosely wrapped with plastic wrap and was not sealed. The product was exposed to air and had an opened date of 4/2213. A three pound box of onions was observed stored with one rotten bell pepper. The juices of the rotten bell pepper were observed seeping under and touching the onions. A box	F 371	2. The corrective action for residents having the potential to be affected will be accomplished by inspecting all cans for dents upon delivery and ensure that all dented cans are returned to the vendor for credit. All opened refrigerated products will be placed in a air-tight ziploc bag or stored in the original sealed container. All boxed produce will be stored in a clear see through plastic bin and inspected every other day for spoiled product which would be discarded. Flour and sugar will be stored in original bags and then place in a ziploc bag with name and date label when opened. 3. This system will be put into place by having all cans inspected upon delivery and dented cans removed from inventory to be returned. See through ziploc bags for opened product have been ordered and are being used to	

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F 371	Continued From page 16 containing 48 Bell peppers was observed. In the box, 25 bell peppers were observed still fresh and hard to the touch. The 25 fresh bell peppers were observed mixed in with 23 rotten and mushy bell peppers. The juices from the rotten bell peppers were observed seeping on the fresh bell peppers. The flour and sugar bins were observed not dated with the date the product was put into the bins. A staff interview was conducted on 4//22/12 at 11:30 AM with the Dietary Supervisor who does the ordering. The Dietary Supervisor stated the Deli Sandwich Meats(Bologna and the Ham) were received at the facility from the vendor on 4/18/13. The Salami was delivered to the facility on 12/04/12. When asked about when the green peppers had been received, the Dietary Supervisor who does the ordering, indicated, " The green peppers came in on 4/5/13. I look through when I do the orders twice a week. The staff cut salads everyday and should be discarding the bad ones. Someone got careless and left the green pepper in the onions. We order the peppers every two weeks, and the onions every week. The Dietary Supervisor indicated there was approximately 25 pounds of product stored in the sugar and flour bins. The Dietary Supervisor was not aware when the sugar and flour were put into the bins." Observations in the dry storage room were conducted on 4/22/13 at 11:40 AM. A six pound can of pineapple tidbits was observed dented on one side of the can. A staff interview with the Dietary Manager was conducted on 4/22/13 at 11:50 AM regarding the reason the dented can remained in the can rack.	F 371	ensure a tight seal. See through plastic bins have been ordered and are being used for produce so that quality can be observed. Produce will be checked for spoilage by staff every other day. 4. This system will be monitored using a quality assurance tool to ensure that dented cans are not in stock and that refigerated produce is identified and discarded. This monitor will also ensure that flour and sugar are stored properly and dated and that all leftover food is wrapped and labeled with name and date. We will monitor the system daily until.100% compliance is achieved and then weekly until 100% compliance is achieved again and then quarterly thereafter by the Dietary Manager. 5. The completion date for this plan of correction will be May 23 2013.	5/23/13

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F 371	Continued From page 17 The Dietary Manager indicated, "Dented cans should have been discarded when it was noticed, but I'm not sure if it was noticed, because usually they bring it to the office when they see it. When asked about the Policy for discarding fresh produce, the Dietary Manager indicated, "If it's brown, wilted, soft, or mushy, they should be thrown out, because we use it on a daily basis for salads." A second observation was conducted in the Kitchen on 4/24/13 at 12:00 Noon. In the Walk-in Refrigerator, The Salami, bologna, ham, and cheese had been sealed in plastic bags and labeled and dated with Use- By dates. The rotten green peppers and the contaminated onions from the initial observation on 4/22/13 had been discarded. The flour and sugar bins were observed still not dated with the date the product was added to the bins.	F 371		

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

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	345417	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/30/2013

JUN 18 2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE NURSING CENTER OF WAK	968 EAST WAIT AVENUE WAKE FOREST, NC 27587

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K 000	INITIAL COMMENTS Based on observation on 05/30/2013 the following was noted: 1) The facility at this time is not 100% sprinklered. All Long Term Care and Skilled Nursing facilities federall certified by CMS will have to be 100% sprinklered by 8/13/2013. The facility has 32 rooms with closets that do not have sprinkler coverage.	K 000	K029 1. The corrective action taken by the facility to correct the deficient practice consists of replacing and adjusting the hinges on the laundry room doors so that these doors will close and latch while the dryers are running. 2. We will identify other life safety issues having the potential to affect residents by the same deficient practice by inspecting all doors to both laundry rooms to ensure that they will close and latch while the dryers are running. 3.The measures we are putting into place to ensure the same deficient practice does not recur will be to inspect the laundry room doors on a monthly basis to ensure they will close and latch while the dryers are running. 4.We will monitor the corrective action by using a quality assurance tool weekly to monitor compliance until 100% is achieved and then monthly thereafter. 5. The date of correction will be by June 28 2013	6/28/13
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 05/30/2013 the doors to the laundry main and the spark unit failed to close and latch with the dryers runing. 42 CFR 483.70 (a)	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/14/13

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

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	345417	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/30/2013

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K 050	Continued From page 1 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation on05/30/2013 the staff interviewed did not know the fire drill procedure. 42 CFr 483.70 (a)	K 050	K050 1. The corrective action taken by the facility to correct the deficient practice consists of educating all staff on the fire drill procedure. This will be accomplished through inservices conducted by the maintenance director along with additional fire alarm procedure drills. 2. . Other life safety issues having the potential to affect residents by the same deficient practice be addressed by conducting inservices by the maintenance director along with additional fire alarm procedure drills. 3. The measures we are putting into place to ensure the same deficient practice does not recur will be to conduct regular fire drills so that staff will be familiar with the procedure 4. We will monitor the corrective action by using a quality assurance tool to drill and review with employees the correct procedures so that they can verbalize these procedures at any given time. 5. The date of correction will be by June 28 2013.	6/28/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2013 there were unsecured 02 in the 02 storage room near room 111. 42 CFR 483.70 (a)	K 076		

K076

1. The corrective action taken by the facility to correct the deficient practice consists of securing or removing any unsecured O2 tanks in the storage room near room 111. This was accomplished on May 30 2013

2. We will identify other life safety issues having the potential to affect residents by the same deficient practice by reviewing all oxygen storage rooms to ensure that there are no unsecured O2 tanks. Any unsecured tanks will be appropriately secured.

3.The measures we are putting into place to ensure the same deficient practice does not recur will be to review the proper procedure for storing O2 tanks with the nursing staff and to post signs in the O2 storage locations as reminders as to the proper storage procedure.

4.We will monitor the corrective action by using a quality assurance tool weekly to monitor compliance until 100% is achieved and then monthly thereafter.

5. The date of correction will be by June 28 2013.

6/28/13