SEP 0 4 2013

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

PRINTED: 08/22/2013
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
	345181	A. BUILDING _____ B. WING _____	08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2678 WEST 5TH STREET GREENVILLE, NC 27834

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep tuna salad and slaw made with mayonnaise/dressing at or below 41 degrees during operation of the trayline, failed to air dry kitchenware before stacking it in storage, failed to remove cracked kitchenware from stock being used at meals, and failed to label and date opened food items in storage. Findings included: 1. At 12:25 PM on 08/12/13 a calibrated thermometer was used to check the temperature of tuna salad which was being kept over ice in a steam well which was turned off on the steam table. The thermometer registered 46 degrees Fahrenheit. The tuna salad was in a full tray pan, and was about six inches in depth. The tray pan of tuna salad was placed over another tray pan of melting ice. At this time the dietary manager (DM) stated the tuna salad was assembled the day before, and had been stored in the large tray pan in the walk-in refrigerator until approximately 11:45 AM on 08/12/13 when the trayline began operation. She also reported the tuna salad was made in the facility using tuna, pickle relish, and	F 371	1. Dietary staff will label and date all food items upon opening and discard per policy, to ensure foods are served/stored in a safe and sanitary manner. Dietary staff have been reeducated (8/27/13 Label and Date In service) to the policy of dating/labeling of food items as well policy of discarding outdated food items. 9-3-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

L.N.H.A. 8-28-13

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 371	Continued From page 1 mayonnaise. At 5:00 PM on 08/14/13 a calibrated thermometer was used to check the temperature of Cole slaw which was being kept over ice in individual plastic cups which were stacked in a large plastic tub sitting on a cart. The thermometer registered 50 degrees Fahrenheit. The tub of cups containing slaw was placed over another tub with ice in it. At this time the DM reported the slaw was assembled the day before, and had been stored in the cups in the walk-in refrigerator until approximately 4:45 PM when the trayline began operation. She also reported the slaw, which was prepared in the facility, contained cabbage, carrots, and Cole slaw dressing. At 9:58 AM on 08/15/13 the DM stated when chilled salads containing mayonnaise were being served as part of a cold plate, they were prepared the day before, stored in the walk-in refrigerator in a tray pan, and brought out of storage right before the trayline began operation. She reported the staff was supposed to use 4-inch deep tray pans instead of 6-inch deep tray pans for storing these chilled salads. According to the DM, once the trayline began operation, the tray pans of chilled salads were to be stored over ice in a steam well which had been turned off. The DM explained if chilled salads made with mayonnaise were served as a side dish, the salads were still prepared the day before being served and stored in the walk-in refrigerator. However, she stated the day the salads were to be served they were spooned out into china bowls which were kept on trays in meal carts in the walk-in refrigerator. Once the trayline began operation, the DM reported only one tray of the salads at a time were to be brought out of refrigerated storage.	F 371	2. Dietary staff will not stack wet dishes to ensure a safe/sanitary environment. Dietary staff have been reeducated (8/27/13 Wet Dish In service) on proper dishwashing procedures to prevent stacking of wet dishes. 3. Dietary staff will not use cracked/chipped/broken dishware. All dishware has been evaluated and discarded as needed, with replacements in place. Dietary staff have been reeducated (8/27/13 Dish Replacement In service) on identifying cracked/chipped/broken dishware and procedures for discarding/replacement. 9-3-13	

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F 371	Continued From page 2 At 10:38 AM on 08/15/13 the AM cook's description of preparing chilled salads with mayonnaise for cold plates matched the DM's expectations except that the cook reported she did not realize she was supposed to use the more shallow tray pans to store the salads in. The cook's description of preparing chilled salads containing mayonnaise for side dishes matched the DM's expectations except the cook reported the salads were supposed to be spooned into small plastic containers which were kept on ice in large tubs. 2. During initial tour, beginning at 10:23 AM on 08/12/13, 2 of 5 tray pans were stacked on top of one another with moisture inside of them. At 9:58 AM on 08/15/13 the dietary manager (DM) stated before stacking kitchenware into storage it was to be air dried. She reported the tray pans found stacked wet on 08/12/13 were placed in storage by her PM staff. She explained the staff member responsible was relatively new, and did not know better. According to the DM, stacking pieces of kitchenware on top of one another with moisture trapped in between posed an infection control risk. She reported the PM staff had to exit the kitchen by 8:00 PM in the evenings, and if kitchenware was still wet, it was to be left open to air on the draining board of the three-compartment sink or left open to air on the drying rack. At 10:38 AM on 08/15/13 the AM cook confirmed that the tray pans found stacked wet on 08/12/13 were placed in storage by the PM dietary staff. She commented that moisture caught between pieces of kitchenware overnight could cause the	F 371	4. Dietary staff will check all temperatures to ensure food items are held and served at the appropriate temperatures in appropriate dishware. Dietary staff has been reeducated (8/27/13 Temperature In service) on cold food preparation /planting and storage to validate foods are served in a safe and sanitary manner.	9-3-13

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F 371	Continued From page 3 formation of harmful bacteria. 3. At 9:30 AM on 08/14/13 8 of 18 sectional plates (44% of the sectional plates observed) had cracks in the dividing walls or the bottoms of the plates. These cracks extended through to the back side of the plates. At 9:58 AM on 08/15/13 the dietary manager (DM) stated cracked or chipped kitchenware was supposed to be pulled out of circulation by those dietary staff running the dish machine, brought to her office for inventory, and was eventually replaced by reordered kitchenware. She reported that the continued use of compromised kitchenware could pose infection control risks when food and beverage were still being placed in it. At 10:38 AM on 08/15/13 the AM cook confirmed the DM's expectations regarding the disposal of chipped and cracked kitchenware. She added that she also tried to remove compromised kitchenware when she was plating food at the trayline. 4. During initial tour, beginning at 10:23 AM on 08/12/13, opened food items were found in the reach-in refrigerator without labels and dates. These items included a gallon container of ranch dressing, two plastic bags containing sliced cheese, a five pound bag of shredded cheese, a gallon container of light mayonnaise, and a gallon container of Cole slaw dressing. Opened food items were found in the dry storage room including a 15-ounce box of raisins and a pound container of wheat farina. The dates on an opened pound bag of potato chips and a bag of cake mix were not readable. Opened food items	F 371	5. Daily audits will be performed by CDM/RD and/or designee x 30 days, then three times per week x 30 days, then random audits will be continued with results reported to Administration and QI committee monthly. Any trends identified will be addressed by then Administration/QI committee for direction as necessary.	9-3-13

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F 371	Continued From page 4 were also found in the walk-in freezer. These items included a bag of carrots, a bag of mixed vegetables, a bag of hash brown cubes, and a bag of shredded hash browns. During a follow-up tour of the kitchen, beginning at 9:16 AM on 08/14/13, an opened gallon container of ranch dressing in the reach-in refrigerator and an opened bag containing corn on the cob in the walk-in freezer were without labels and dates. At 9:58 AM on 08/15/13 the dietary manager (DM) stated opened food items, food items removed from original packaging, and leftover food items should have labels and dates on them. She reported the dietary employees who opened food items or placed leftovers in storage were responsible for placing labels and dates on them, but she commented when she was not engaged in clinical responsibilities, she also monitored the storage areas for appropriate labeling and dating. In addition, she stated her assistant DM conducted rounds of the storage areas when she arrived each morning. At 10:38 AM on 08/15/13 the AM cook stated all opened food items and leftovers should be labeled and dated by the dietary employees placing them in storage. She commented that the DM monitored the storage areas to make sure food items were labeled and dated per facility protocol.	F 371		

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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 III construction, one story, with a partial automatic sprinkler system for hazardous areas only. The census of the day was 110 beds. The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following building construction type was non-compliant, specific findings include; A. Penetration in the corridor wall, above the laundry room door, does not meet the required fire resistance rating. B. Penetration in the roof ceiling assembly, in the main electrical room, from the new electrical panel. C. Penetration in the roof ceiling assembly in the west wing pantry. D. Penetrations in the 100 hall fire wall around the new sprinkler pipe installation. E. Penetrations in the 700 hall fire wall around the new sprinkler pipe installation.	K012	RECEIVED SEP 30 2013 CONSTRUCTION SECTION 1. A. Caulking and ceiling tile will be repaired/replaced. B. Ceiling tile has been replaced. C. Ceiling tile has been replaced. D. Fire caulking will be repaired around 100 fire wall. E. Fire caulking will be repaired around 700 fire wall. 2. Fire sprinkler system to be complete by 10-27-13. Century Fire Protection Co. and Maintenance Director to do a visual check before completing project. 3. Upon completion of installing new sprinkler system all penetrators will be repaired. 4. -Daily rounds will be completed to ensure all ceiling tiles are in place. -Fire caulking in the roof will be inspected every 6 months indefinitely to ensure the deficient practice does not occur. 5. All negative findings will be reported in the monthly QA meeting.	10-27-13

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L.N.H.A. 9-27-13

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following corridor doors were non-compliant, specific findings include; A. Door to room 307 did not close and latch tightly in it's frame. B. Door to room 311 did not close and latch tightly in it's frame. C. Door to room 105 sticks and did not close and latch tightly in it's frame.	K 018	1. A. 307 door will be repaired to close and latch properly. B. 311 door will be repaired to close and latch properly. C. 105 will be repaired not to stick and will latch properly. 2. All doors in facility have been assessed to close and latch properly. 3. All doors have been assessed and will be monitored on a monthly basis to ensure the deficient practice does not re occur. 4. All doors will be monitored on a monthly basis indefinitely. 5. All negative findings will be reported in the monthly QA meeting	10-27-13
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029	1. A. Wedge has been removed and not used. B. Door will be sanded to close and latch properly. C. Door will sanded to close and latch properly. D. Soiled linen room all 3 carts removed.	10-27-13

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K 029	Continued From page 2 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: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following hazardous areas were non-compliant, specific findings include; A. The door to the laundry room was wedged open. B. The door to the east wing soiled linen room did not close and latch tightly in it's frame. The door scrubs the floor, impairing its momentum to close. C. The door to the west wing soiled linen room did not close and latch tightly in it's frame. The door scrubs the floor, impairing its momentum to close. D. There were three double carts of trash/soiled linen stored in the east wing spa. The room is not sprinklered nor one hour rated for soiled linen.	K 029	2. All doors in facility have been assessed to close timely and latch properly. 3. All doors will be assessed on a monthly basis to ensure they are latching tightly with proper momentum. 4. Doors will be checked monthly indefinitely to ensure the deficient practice does not re occur. 5. All negative finding will be brought to the monthly QA meeting and discussed.	10-27-13
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	1. A & B. Some type of lighting will be installed.	10-27-13

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K 038	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following exit access was non-compliant, specific findings include; A. Exit access from walk in cooler was not readily accessible with loss of power. B. Exit access from freezer was not readily accessible with loss of power.		2. All exit accesses will be assessed for proper lighting. 3. All exit accesses will be assessed for proper lighting on a monthly basis. 4. Exit accesses will be assessed on a monthly basis indefinitely for proper lighting to ensure the deficient practice does not re-occur. 5. All negative finding will be in the monthly QA meeting and discussed.	
K 045 SS=E	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: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following exit discharge illumination was non-compliant, specific findings include; lighting was not available between the 200 hall and 300 hall exit paths. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	1. Lighting has be arranged and put in place between 200 hall and 300 hall. 2. All outside areas have been assessed for proper lighting. 3. All outdoor exits and lighting will be assessed on a monthly basis.	10-27-13 10-27-13

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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 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: 42 CFR 483.70(a) By document review on 9/12/13 at approximately noon the following fire drills were non-compliant:, specific findings include; A. The last four fire drills on third shift for 2013 & 2012 were held between 5:45 AM and 6:45 AM only. Fire drills are to be held at unexpected times. B. Documentation indicated less than the required number of drills were held on second shift of 4th quarter 2012.	K 050	4. Outdoor lighting will be assessed on a monthly basis indefinitely to ensure the deficient practice does not re-occur. 5. All negative finding will be brought to the monthly QA meeting and discussed. K 050 1. A. Any negative finding will be brought to the monthly QA meeting and discussed. B. All fire drills will be conducted in a timely manner per regulation K050. 2. All fire drills in Maintenance books have been assessed to current. 3. Maintenance Director or designee will bring Fire Drill paperwork to LNHA upon completion of back fire drill per month. 4. LNHA or designee will monitor the book on a monthly basis indefinitely to ensure the practice does not re-occur. 5. All negative finding will be brought to the monthly QA meeting and discussed.	10-27-13 10-27-13 10-27-13 10-27-13
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4			

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following fire alarm system components were non-compliant, specific findings include; A. Smoke detector #25 located in the corridor near the west wing nurses station was covered with tape. B. The heat detector in the staff dining area was covered with tape.	K 052	1. A. Some detector #25 has been uncovered. B. Heat detector in staff dining are has been uncovered. 2. All smoke detectors will remain uncovered upon completion of installing the new Fire Sprinkler System. 3. All smoke detectors will be assessed visually on a monthly basis to ensure not covered. 4. Smoke detectors will be visually assessed on a monthly basis indefinitely to ensure the deficient practice does not re-occur. 5. All negative finding will be brought to the monthly QA meeting and discussed.	10-27-13
K 053 SS=D	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following smoke detector was non-compliant, specific findings include; smoke detector in room 211 was missing from it's base.	K 053	1. Smoke detector has been replaced in room 211. 2. All resident rooms and common have been assessed for smoke detectors.	10-27-13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST 5TH STREET GREENVILLE, NC 27834

(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 056	Continued From page 6 for the installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following automatic sprinkler system was non-compliant, specific findings include; there was not a complete automatic sprinkler system installed.	K 056	3. On a monthly basis all smoke detectors will be checked visually. 4. Smoke detectors will be visually assessed on a monthly basis indefinitely. 5. All negative finding will be brought to the monthly QA meeting and discussed. 1. Automatic fire sprinkler system will be installed and working properly. 2. The fire sprinkler system will be working properly for the entire building. 3. The fire sprinkler system will not be taken out until building closes or no longer operation. 4. Any negative findings with fire sprinkler system, system will go into alarm quarterly. Fire Sprinkler test will be completed as scheduled. 5. Any negative findings will be brought to the monthly QA meeting.	10-27-13 10-27-13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.			

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	345181	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2013

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K 066	Continued From page 7 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following smoking regulation was non-compliant, specific findings include; a metal container with a self-closing cover into which ashtrays can be emptied in the employee smoking area per paragraph 4 above was not provided.	K 066	1. 2 self-closing covered containers have been ordered. 2. Only 2 smoking areas. - Resident/staff courtyard - Staff outdoor patio. 3. Will keep Red self-closing containers in the 2 smoking areas. 4. Smoking areas will be checked on a weekly basis to ensure closed containers are there and being used properly. 5. Any negative findings will be brought to the monthly QA meeting and discussed.	10-27-13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/12/13 at approximately noon the following electrical code items were non-compliant, specific findings include; A. The fire alarm panels located at both nurses stations were not labeled as to breaker and panel served. B. The electrical panel "B" located in the main	K 147	1. A. Fire alarm panels have been labeled @ both nurses' station. B. Electrical panel B has been labeled as to circuits served. C. GFCI has been replaced in beauty shop. 2. No other electrical issues have been identified.	10-27-13

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	345181	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2013

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K 147	Continued From page 8 electrical room was not labeled as to circuits served. C. The ground fault circuit interrupter (GFCI) to the right of the sink in the beauty shop showed a reverse polarity when tested.	K 147	3. GFCI tester has been purchased to test other receptacles in facility. 4. Will test 10 receptacles on a monthly basis, indefinitely to ensure the deficient practice does not re-occur. 5. Any negative findings will be brought to the monthly QA meeting.	10-27-13