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

OCT 0 7 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE RD ROXBORO, NC 27573

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Physician interview, and observation the facility failed to notify the Physician of the 4 day wait time	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 10/3/13

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 157	Continued From page 1 for an ordered diagnostic test for an acute change in condition for 1 of 1 (Resident #10) residents who had orders for diagnostic testing. Findings included: The record review indicated Resident #10 was admitted to the facility on 2/19/13. Admission diagnosis included muscle weakness disorder, chronic foot drop, upper gastrointestinal bleed, urinary tract infection that resulted in Encephalopathy. The most recent Minimum Data Set (MDS) quarterly review dated 5/24/13 indicated Resident #10 was moderately cognitively impaired with a short term memory problem. Resident #10 required extensive assistance of one person with activities of daily living (ADL). Resident #10 is incontinent of bowel and bladder. The record review of Resident #10's Care Plan dated 8/6/2013 indicated she had inventions in place for cognitive loss/dementia, potential for aspiration, at risk for falls related to her inability to walk, and at risk for impaired skin integrity. During an observation of incontinent care on 9/6/13 at 11:00 AM for Resident #10, the NA #13 noted Resident #10 had a large mass protruding from her pelvic area just above the pubic bone. Resident #10 was last changed at 8:00 AM and NA #13 stated the mass was not there before. Resident #10 had voided a small amount of dark colored urine in her brief. It was also noted there was a small amount light green tint drainage coming from the perineal area while NA #13 was cleansing the resident. NA #13 immediately	F 157	5. Compliance with all resident audits and education will be 10/23/2013.	10/23/2013

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F 157	Continued From page 2 called for the nurse to evaluate. Incontinent care was provided with proper technique. Resident #10 barely responded to NA #13. NA #13 stated this was unusual for Resident #10 because she is usually more alert and calls the NA by name. The resident was hard to arouse and slept through most of the care. At 11:10 AM on 9/6/13, Nurse #4 entered the resident's room. NA#13 showed her the mass on the resident's abdomen. Nurse #4 felt of the mass and attempted to ask Resident #10 if it hurt, there was no response from the resident. Nurse #4 left the room to contact the Physician and stated the resident was recently diagnosed with a urinary tract infection and the Physician was changing her medication from Cipro by mouth to Rocephin through intravenous access. She stated she would send a fax to the Physician to communicate this acute onset of change in condition. Upon reaching the nurses station Nurse #4 stated she would call the Physician instead. At 11:20 AM Nurse #4 called the Physician and received orders for an ultrasound of the abdomen for Resident #10. At 2:00 PM on 9/6/13 an interview with Nurse #4 revealed Resident #10 was not going for her ultrasound till 9/10/13. Nurse #4 shrugged her shoulders and went back to providing care to other residents. At 2:05 PM on 9/6/13 an interview with Resident #10's responsible party was conducted. She stated she was aware of the change in Resident #10's condition and that it would take several days for the ultrasound to be done. The responsible party indicated she would like it done sooner since it was a new condition and came on	F 157		

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F 157	Continued From page 3 so quick. An interview with NA#7 on 9/6/2013 at 2:15 PM indicated NA#7 had taken care of Resident #10 on 9/5/2013. NA#7 stated Resident #10 did not have a mass in her pelvic area on 9/6/13. NA#7 stated Resident #10 did cry out a lot on 9/5/2013 especially when she was being provided incontinent care. She stated securing the tabs on Resident #10's brief over her abdomen caused her to cry out. NA#7 stated she made the nurse aware. At 2:20 PM on 9/6/2013 an interview with Resident #10's Physician revealed he was not aware of the delay in diagnostic testing for Resident #10. He stated his expectation would have been to be notified that the ultrasound could not be done till Tuesday of the following week. If he had been notified he would have ordered a different test to find out the problem with the resident's new condition. The Physician indicated that he would take care of the situation today. At 2:35 PM on 9/6/2013 an interview was conducted with Nurse #2. Nurse #2 indicated that she had cared for Resident #10 on 9/5/13. Nurse #2 stated she did medicate Resident #10 with pain medicine. She stated she didn't call the Physician because Resident #10 quieted down and had no pain indications after she was medicated. At 2:45 PM on 9/6/2013 an interview was conducted with Nurse #4. Nurse #4 stated she did not call the Physician back to let him know of the ultrasound delay because the Physician didn't say to do the test immediately or seem that concerned about the mass. She stated she didn't	F 157		

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F 157	Continued From page 4 think it was something needing to be followed up on. At 3:00 PM on 9/6/2013 an interview with the Administrator was conducted. The Administrator stated her expectation would have been acute changes in a resident would be communicated to the Physician immediately and any orders followed up on. The Administrator stated she expected Nurse #4 to have called the Physician back to make him aware of the delay in the ultrasound so Resident #10 could have been treated in a timely manner for the acute change that was noted. At 4:00 PM on 9/6/2013 the Physician gave new orders for Resident #10 and a urinary catheter was placed for Resident #10. There was a large amount of white to yellow colored return in the urinary catheter tube and collection bag. There was no noted change in the size of the mass in Resident #10's pelvic area. At 6:15 PM on 9/6/2013, Resident #10 was taken to ultrasound. 483.15(a)	F 157		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to serve seven of 17	F 241		

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F 241	Continued From page 5 dependent and cognitively impaired residents close to the same time as the independent resident in the main dining room (Residents #7, 14, 16, 18, 41, 50 and 81). The findings included: Review of the Resident Council Minutes (RCM) dated 5/28/13 indicated there were dietary concerns, but the concerns were not specific. The RCM dated 6/2/13 and 7/30/13 identified that residents were not receiving breakfast on time and the 8/26/13 RCM indicated that there were dietary concerns but it was not specific. Review of the dietary test tray and cart delivery documents revealed the last test tray was documented on 8/24/13 and there were inconsistent temperatures of the meals and delivery of carts to the unit. Review of the undated meal service schedule revealed the first cart would be delivered to the dining room at 7:45 A.M., north hall at 7:55 A.M., east hall at 8:05 A.M. and south hall and dining room at 8:25 A.M. During a breakfast observation on 9/5/13 at 8:30 A.M, ten residents were seated around various tables in the dining room eating after set-up or being fed by the three staff assigned to the dining room. The remaining seven residents (Resident #7, 14, 16, 18, 41, 50 and 81) were also seated at various tables without food or beverages while they waited for their food to be served. The three assigned staff was unable to assist the residents that were currently eating and needed either cueing or direct hands-on assistance because they were feeding individual residents. The staff	F 241	1. 100% resident audit of the level of assistance required with meals. Dining preferences reviewed and accommodated. Dining table seating arrangement implemented to ensure proper delivery of food trays one table at a time to ensure no resident was seated without food or drink at a table. Independent residents and then residents requiring assistance to be served and then those that require total assistance to ensure adequate temperatures of food and beverages and staff present to assist with tasks. Staff assignments are designated upon onset of shift and administrative staff will be assigned to enable prompt assistance to residents and deliverance of meals. 2. Meal cart delivery to the ECU will be monitored by the Unit Clerk and/or Charge Nurse. This will occur by documenting time of delivery for each dietary cart and announcing via ECU paging system to ensure staff awareness and preparedness on the unit. 3. Dietary Manager has indicated new equipment ordered that is necessary to maintain food and beverage temperatures after leaving the dietary kitchen. Dietary staff educating and training ongoing. Dietary Manager to perform test tray check 3 times a week to ensure proper temperatures for Breakfast, Lunch, and Dinner.	10/23/2013

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F 241	Continued From page 6 in the dining room began to clear residents' meals trays without providing assistance or determining whether the residents were finished with the meal. Many of the residents did not finish the meal. The meal cart for the seven remaining residents arrived in the dining room at 8:30A.M. There was several hall staff that entered and exited the dining room to remove trays from the cart for residents that were on the hall. The seven remaining residents' trays did not get set-up or served until 8:50 A.M. to 9:15 A.M. Resident #18 became agitated during the wait verbalizing inappropriate language and stating " I'm hungry. " The last resident received a tray at 9:15 A.M. and all seven residents needed some form of assistance with the meal. At the completion of the last meal being set-up, a test tray was done with the Dietary Manager (DM) on 9/5/13 at 8:50 A.M. The hot foods were served cold and the cold juice was served warm. She stated that the temperatures for the bacon, eggs, apples were cold and the orange juice was served warm. She added that the residents should not have to wait 20 minutes or longer to get their meal once the cart was delivered to the unit. During an interview on 9/15/13 at 9:00 A.M., NA#13 and NA#16 indicated that there was no specific program for feeding in the dining room other than the restorative residents get set-up first around 7:45 A.M., because they could feed themselves. NA#13 indicated that on average there were six to seven residents at a time in the dining room that needed assistance, but there may be only one to two NAs to feed and they did the best they could. The NA said most of the residents in the dining room have some verbal	F 241	Continued from 3. Extended Care Unit employees educated on resident rights, delivering services with dignity, and dining protocol which will be included with orientation and annual training. 4. Administrative staff assigned to dining room will ensure proper protocol and update ECU QA Committee times 6 months. 5. Compliance with audits and education will be 10/23/2013.	10/23/2013

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F 241	Continued From page 7	F 241		

limitation with communication where they would not be able to say whether the temperature of the food was good or bad, but residents on the hall have reported concerns with cold food. NA# 16 confirmed concerns of cold food on the hall and lack of concern in the dining room due to limited cognition/communication capabilities.

During a follow-up interview on 9/5/13 at 10:50A.M., the DM (dietary manager) indicated that she was currently working on a system to monitor the kitchen, food temperatures and delivery of meals.

During an interview on 9/5/13 at 4:24 P.M., the Administrator indicated that she was aware of resident's concerns regarding cold food but was not aware of the resolution to the concerns. She added that there was no system in place to address the delivery of meals or dignity of the residents in the dining room. She added that administrative staff would be expected to assist the nursing assistant with feeding. She further added that no residents should be sitting and waiting for meals while other residents are eating more than five minutes of the arrival of the meal cart. She indicated there was no effective meal time delivery for residents in the dining room verses those on the hall. Staff could heat the meal in the dining room; however that did not help the residents on the hall since the staff would have to leave the hall to go to the dining room to re-heat the food. She would be re-evaluating the dining program with dietary.

During an interview on 9/6/13 at 11:28 AM, the registered dietitian (RD) indicated that she was aware residents complained of cold food, late trays and the length of time resident's waited for

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F 241	Continued From page 8 trays in the dining room and on the halls. She was also informed by individual residents and the coordinator of the resident council of the concerns and this was discussed with the dietary manager. The RD indicated she was unaware of the resolution process. She indicated the DM was responsible for ensuring the meal trays arrive on time and the food temps were correct. The residents should not have to wait for extended periods to receive their meal.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and review of resident council minutes, the facility failed to resolve ongoing group grievances for 2 of 4 residents (Resident # 3, and #42) with concerns regarding cold food and cold water temperatures during showers. The findings included: The facility identified these residents as alert and oriented. During an interview on 9/4/13 at 2:12 pm, Resident #3 revealed the water temperature in the facility had been a reoccurring concern	F 244	1. Resident Council general concerns reviewed for the past 3 months to ensure follow up. Activity Coordinator will inform Administrator and /or DON on resident council concerns to ensure proper and appropriate department resolution. 2. Resident Council monthly minutes form revised to include follow up to previous months concerns. Activity Coordinator will report concerns to Administrator promptly after resident council meeting to ensure proper resolution. Dietary issues and food delivery addressed with new dining protocol and monitoring. Maintenance is addressing the water temperatures with 2 plumbing companies for resolution. 3. Department managers educated on importance of resolution process and follow up with Resident Council. Activity Coordinator will ensure attendance of specific department manager to the following month's Resident Council meeting if requested by the Council.	10/23/2013

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F 244	Continued From page 9 addressed with resident council and staff. The resident indicated that he is able to perform his own daily hygiene at his sink. Showers were not being given due to the cold temperature of the water. Resident #3 stated that cold food times had also been an issue that was discussed in resident council meetings. Resident #3 stated the facility continued to communicate they were working on the concern. During an interview on 9/5/13 at 3:13PM, the Activity Director (AD), indicated that she was responsible for assisting the residents with the resident council meetings. She reviewed the resident council meeting minutes for the month of 5/28/13, 6/25/13, 7/30/13 and 8/26/13 and confirmed there had been some concerns regarding dietary and that they were not identified within the resident council minutes and she was uncertain whether the issues were resolved. She further added there had been complaints of cold food about two months ago that she did not document the concern from the group but had spoken with dietary regarding the issue. She was unaware of whether the concern was resolved. She further stated that she only worked the dining room periodically. There was no system in place that she was aware of to check on the resolution. During an interview on 9/5/13 at 4:20 pm, Resident #42 indicated the concern regarding cold water had been brought to the attention of more than one staff member in the building and discussed at more than one resident council meeting. The resident revealed the water in the facility had been an ongoing concern. During an interview on 9/5/13 at 4:24PM, the Administrator indicated that the department	F 244	4. Activity Director will monitor for timely responses to general concerns and present findings to Resident Council Meeting Findings weekly to IDT and monthly to ECU QA Committee. 5. Compliance with timely resolution of general unresolved concerns 10/23/13.	10/23/2013

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heads were responsible for resolving group grievances when they were brought to their attention at the morning meeting by the Activity Director. She indicated that there was no current system in place to identify the individual or group concerns based on the process of the current resident council. She added that she was aware of resident concerns regarding cold food but was not aware of the resolution to the concerns. She would be re-evaluating the dining program with dietary and resident council.

During a follow-up interview on 9/5/13 at 4:39 pm, the Administrator indicated she was aware the water in resident rooms was less than 100 degrees, both shower rooms and sinks were too cold. She added the expectation would be staff would go to another resident room or another location in the unit to warm the water prior to bathing a resident. In addition, the director of plant operations and plumbers were looking into it resolving the water problem.

During an interview on 9/6/13 at 11:28AM, RD indicated that she was aware of resident's complaints of cold food, late trays and the length of time a residents waited for trays in dining room and on halls. She was also informed by individual residents and the coordinator of resident council, and this was discussed with the dietary manager. The RD indicated she was unaware of the resolution process. She indicated the DM was responsible for ensuring the meal trays arrive on time and the food temps were correct. The residents should not have to wait for extended periods to receive their meal.

Review of Resident council minutes for May 28, 2013, August 26,, 2013, and July 30, 2013

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F 244	Continued From page 11	F 244		

revealed unresolved grievances. Resident council minutes dated May 28, 2013, indicated there were dietary concerns that were not clearly identified, but noted the concerns would be directed to the dietician and the physician. There was no resolution presented from the resident council department response form to address the May 28,2013 concerns. Resident council minutes dated July 30, 2013, revealed dietary concerns continued to be discussed with 1 identified concern that breakfast was not being served on time. There was no resident council department response form to indicate the concern was being addressed or resolved. Resident council minutes dated August 26, 2013, revealed the residents had concerns with the lack of hot water when taking showers. In addition, one side of the hospital had hot water but the (ECU) extended care unit had short supply of hot water. The concern was presented to the maintenance supervisor and noted that the hot water concern was being looking into it and a contracting company had not identified the problem. The resident council department response form dated 9/3/13, indicated the plant operations had been working on the extended care unit (ECU) for a number of weeks. They were not able to resolve the issue and some locations were not getting the require hot water temperatures.

During an interview on 9/6/13 at 8:54pm, Director of Plant Operations indicated he was aware the water was too cool in the ECU area, and had been on going for a couple of months. An outside contractor was hired and came for a month to diagnosis the problem. There were no blue prints to indicate where the circulating pumps were located. Another contractor was to look at the issue. The ECU was the only area affected.

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F 244	Continued From page 12 There was no alternative plan to provide comfortable water for showering to the unit.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff, family and resident interviews and record review the facility failed to provide comfortable water temperatures in 2 of 2 shower rooms and on 2 of 4 halls. Findings included: Review of the Resident Council Meeting minutes dated 8/26/13, revealed concerns about the hot water, not being hot enough to take their showers. Review of the Resident Council Department Response Form dated 9/3/13, indicated the plant operations had been working on the extended care unit (ECU) for a number of weeks. They were not able to resolve the issue and some locations were not getting the require hot water temperatures. Resident #28 Review of the Minimum Data Set (MDS) revealed, she had good long and short term memory and was able to make decision for her daily care. During interview on 9/3/13 at 12:27 pm, Resident #28 who was indentified by the facility as alert and oriented and cognitivly intact, indicated the water in her sink and the shower	F 253	1. Resident #28 did receive shower after maintenance increased water temperature slightly more to 96 degrees and increased shower room temperature. Resident #26 refused shower with the temporary correction and would wait for discharge. Bed bath given and warmer water brought from other area of unit. Discharged to home 9/23/13. Resident #9 not on Resident Roster. 2. Maintenance Director has coordinated 2 plumbing companies to diagnose and repair hot water issues on the ECU. Progress report thus far are repairs made by installing new pipe line from current hot water piping to the shower room on ECU. Installed new check valve on the main facility hot water heaters. Installed new mixing valve on the facility hot water heaters. Installed a new larger hot water circulating pump in the basement crawl space. Located and corrected 17 cold to hot water cross connects in the facility. Traced and located all water mains coming into the facility with assistance from the City of Roxboro Division of Water. Areas still reading 94-96 degrees Fahrenheit. In process to replace patient room shower mixing valves that cross over cold to the hot water side. Install new main shut off valves that are not holding, 3 in total. Install check valves on all Dietary kitchen sink water spraying units.	

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F 253	Continued From page 13 room was too cold to take a shower or a bath. She indicted the staff was well aware of the lack of hot water and she would love to take a shower. She stated she was given a quick wipe with a cold cloth. Resident #28 requested the hot water to be turned on during the interview. It was turned on and left to run during the interview. The water felt cool and the temperature did not get warmer during the 20 minute interview. During an interview on 09/04/2013 2:38 pm, Resident #26 who was indentified by the facility as alert and oriented and cognitivly intact, indicated the water was cold, all the time morning, noon and night. During an interview on 9/5/13 at 8:45am, Resident #9 indicated the water in the facility was not hot, it was usually cold. He doesn't remember a time in which the water was a comfortable temperature. He bathed in his room at the sink. During an interview on 9/5/13 at 10:15 am, Nurse #2 indicated for three months; the water was too cold for bathing. The problem had been reported to the administrator months ago. During an interview on 9/5/13 at 10:19 am, Aide #7 indicated the water was too cold, it wasn't even luke warm. The residents were not taking showers. She reported it to the nurses as she was instructed to do. The water has been a problem for over two weeks. The administrator was aware. During an interview on 9/5/13 at 1:42 pm, a family member indicated that the water in the residents	F 253	Install zone isolation valves on ECU. Replace current facility hot water heating system 2014. 3. Employees have been educated on electronic submission of any work order to maintenance. Maintenance will respond to work order requests appropriately and on priority level. Work order tracking maintained by maintenance. 4. Administrator performs random weekly water temperature audits in resident care areas and document appropriately Any discrepancies are reported immediately to Maintenance via work order or phone call and copy of findings given to Maintenance Director. Maintenance will include water temperature monitoring as part of PM and communicate results monthly to ECU QA Committee and Environment of Care Committee. 5. Compliance for repairs to ECU hot water temperatures 10/23/13.	10/23/2013

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F 253	Continued From page 14 sink is always cold. She stated Resident #28 always complained the water was cold. During an interview on 9/5/13 at 2:00 pm, Resident #28 indicated she washed her face with a cold rag this morning. She would love a hot shower before her doctor's appointment today. During an interview on 9/5/13 at 2:18 pm, maintenance worker (MW) # 1 indicated the hospital maintenance was aware of the cold temperatures in the ECU. He indicated they thought it was a circulation pump. He indicated water temperatures were not taken regularly on the ECU. During an interview on 9/5/13 at 2:26 pm, MW#2 indicated the nurses take the temperatures for the ECU. He indicated water temperatures were not taken regularly by maintenance on the ECU. Observation of water temperatures was conducted on 9/5/13 at 2:29 pm, with MW#1 and MW #2 in random rooms and shower room temperatures, the thermometer was calibrated with ice water to 33.6 degree Fahrenheit, 1.6 degrees was adjusted to equal 32 degrees Fahrenheit. There was no other thermometer available. There was no documentation of previous water temperatures to show water temperatures were adjusted to resident satisfaction in the ECU. Random ECU Temperatures were: • room 204 105.1 degrees Fahrenheit • shower room 228 85.8 degrees Fahrenheit • room 226 87.4 degrees Fahrenheit • shower room 211 83.8 degrees Fahrenheit	F 253		

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- room 260 98 degrees Fahrenheit
- room 248 100.7 degrees Fahrenheit
- room 250 111.7 degrees Fahrenheit
- room 244 98 degrees Fahrenheit

During an interview on 9/5/13 at 2:48 pm, MDS nurse indicated the water temperature on the one end of the facility had been a continuous problem. It was resolved and now was cold again. The aide should be getting hot water from other sinks to do bathing.
During an interview on 9/5/13 at 2:56pm, Aide #8 indicated the residents complained the water was too cold . She indicated until the water was fixed, she would wipe residents off at their sink.

During an interview on 9/5/13 at 3:00 pm, Aide #7 indicated she Residents were not showered because of the cold water.

During an interview on 9/5/13 at 3:58pm, Aide #12 indicated the water had been icy cold for about two weeks. The residents were not getting any showers. The water at the sink was better then in the shower. The residents were washed from their sink. Aide #12 had reported it to the nurse and the administrator. She would use the hygiene wipes to do a bath if she needed too.

During an interview on 9/5/13 at 4:39 pm, Administrator indicated she was aware the water in both shower rooms was too cold, and some of the water in the sinks was too cold. In rooms where the water was less then 100 degrees she expected the Aides to go to another room to get warmer water. She was told by the Director of

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F 253	Continued From page 16 Plant Operations, plumbers were looking into it. Residents were currently getting bed baths. The range of water was 100-116 degrees Fahrenheit, for comfortable bathing. Some aides had asked to microwave the water, which was not permitted. She indicated she was not aware if the maintenance department monitored the water temperatures on the ECU regularly. During an interview on 9/5/13 at 5:06 pm, Aide #10 indicated the water was too cold. The water had to run a long time before it was warm. If the showers were too cold, residents had a bed bath. She had gone to different sinks and got warm water. She had reported the cold water to the secretary and she called maintenance. Aide #10 indicated they don't enter work orders into the computer. During an interview on 9/6/13 at 8:44am, MW#3 indicated the cold water in ECU had been a problem for months. The administrator had been working on it for months. During an interview on 9/6/13 at 8:54pm, Director of Plant Operations indicated he was aware the water was too cool in the ECU area, and had been on going for a couple of months. An outside contractor was hired and came for a month to diagnosis the problem. There were no blue prints to indicate where the circulating pumps were located. Another contractor was to look at the issue. The ECU was the only area affected. He suggested the residents be taken to another shower room for showers, in another area of the hospital. There was not alternate plan to provide hot water to the residents in the ECU. He indicated the maintenance staff had not routinely check the water temperatures on the ECU floor.	F 253		

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F 309	Continued From page 20 hours or of the light green drainage from Resident #10's perineal area. Nurse #4 felt of the mass and attempted to ask Resident #10 if it hurt, there was no response from the resident. Nurse #4 did not ask NA #13 any further questions. Nurse #4 left the room to contact the Physician and stated the resident was recently diagnosed with a urinary tract infection and the Physician had written an order on 9/6/13 to change her medication from Cipro by mouth to Rocephin through intravenous access. She stated she would send a fax to the Physician to communicate this acute onset of change in condition. Upon reaching the nurses station Nurse #4 stated she would call the Doctor instead. At 11:20 AM Nurse #4 called the Doctor and made him aware of the pelvic mass that Resident #10 had. Nurse #4 did not offer any further information. The Physician gave orders for an ultrasound of abdomen to be done. At 2:00 PM on 9/6/13 an interview with Nurse #4 revealed Resident #10 was not going for her ultrasound till 9/10/13. Nurse #4 indicated that she was unaware of how serious Resident #10 condition was. At 2:05 PM on 9/6/13 an interview with Resident #10's responsible party was conducted. She stated she was aware of the change in Resident #10's condition and that the ultrasound would take several days to be done. The responsible party indicated she would like it done sooner since it was a new condition and came on so quick. An interview with NA#7 on 9/6/2013 at 2:15 PM indicated NA#7 had taken care of Resident #10 on 9/5/2013. NA#7 stated Resident #10 did not	F 309	5. Compliance with be reached 10/23/13.	

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F 309	Continued From page 21 have a mass in her pelvic area on 9/5/13. NA#7 stated Resident #10 did cry out a lot on 9/5/2013 especially when she was being provided incontinent care. She stated securing the tabs on Resident #10's brief over her abdomen caused her to cry out. NA#7 stated she made the nurse aware. At 2:20 PM on 9/6/2013 an interview was done with Resident #10's Physician. The Physician was made aware of the residents change in cognition, scant amount of urine in brief for 3 hours, slight green drainage observed during incontinent care, the time frame the mass appeared, the change of alertness, and the delay in diagnostic testing for Resident #10. The Physician indicated that he was not aware of the other changes in condition and the delay in diagnostic testing for Resident #10. He stated his expectation would have been to be notified that the ultrasound could not be done till Tuesday of next week and that the nurse whom he communicated with about Resident #10 would have told him of the other changes that had occurred. If he had been notified he would have ordered a different test to find out the problem with the resident ' s new condition. The Physician indicated he would take care of this problem today. At 2:35 PM on 9/6/2013 an interview was conducted with Nurse #2. Nurse #2 indicated that she had cared for Resident #10 on 9/5/13. Nurse #2 stated she did medicate Resident #10 with pain medicine. She stated she didn't call the Physician because Resident #10 quieted down and had no pain indications after she was medicated.	F 309		

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F 309	Continued From page 22 At 2:45 PM on 9/6/2013 an interview with Nurse #4 was conducted. Nurse #4 stated she did not call the Physician back to let him know of the ultrasound delay because the Physician didn't indicate he wanted the test done today. Nurse #4 indicated the Physician didn't seem concerned about the mass. She stated she didn't think it was something needing to be followed up on. At 3:00 PM on 9/6/2013 an interview with the Administrator was conducted. The Administrator stated she expected Nurse #4 to have called the Doctor back to make him aware of the delay in the ultrasound. The Administrators expectation was that nurses would do a thorough assessment of residents when there is a change in condition and if not sure about what to look for, to have them seek out other nurses or nurse managers on the unit for help. At 4:00 PM on 9/6/13 Nurse #4 approached and stated she had received new orders from the Physician. She stated a urinary catheter was placed and returned 300 cc's of milky, white fluid. Observation of the catheter collection bag on 9/6/13 at 4:05 PM revealed a urinary catheter bag that contained 300 cc's of a white to yellowish fluid. At 6:15 PM on 9/6/13, Resident #10 was observed going to ultrasound for her diagnostic test.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		

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F 318	Continued From page 23 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview and family interviews, the facility failed to apply hand splints as ordered for 3 of 4 sampled residents (Resident #2, #3 and Resident #7) who were observed with contractures. Findings include: 1. Resident #2 was admitted to the facility on 12/7/07. Cumulative diagnoses included right cerebrovascular accident with left hemiparsesis, and contractures of joint (hands). The quarterly Minimum Data Set (MDS) dated 5/28/13, revealed that Resident #2 had short term and long term memory and decision making problems and required total and extensive assistance with all activities of daily living. The most recent quarterly Minimum Data Set assessment of 5/28/13 indicated Resident#2 needed extensive assistance with activities of daily living. In the restorative nursing section of this assessment, there was no indication that the resident had received passive range of motion (PROM), active range of motion (AROM). A physician's telephone order of 08/9/12 indicated Resident #2 was to receive occupational therapy (OT) 5 times weekly for therapeutic exercises and to improve access to palm for hygiene and wear the palmer splint up to 8 hours a day without skin irritation.	F 318	1. Resident #2 splint order clarified and resident wears l hand splint 8 hours per day and documented in Treatment Record Book by licensed nurses. PROM and AROM also documented in Treatment Record Book by licensed nurses who ensure PROM and AROM are performed. OT has evaluated and treated and recommendations communicated to nursing. Resident #7 evaluated by OT and soft splint applied temporarily awaiting new splint that was ordered on 9/9/13. Splint was delivered and applied 9/23/13. Resident does communicate to staff when to remove and put splint on. OT following resident #2. Resident #1 was reevaluated by OT to ensure proper device for contractures. Recommendation for RHS and may tolerate splint for 2 to 3 hours a day. Remains on OT caseload and then will change to restorative or maintenance program. 2. 100% audit completed on all residents regarding contractures by PT and OT. MDS to capture assessments of contractures on admission and refer to therapy as required to ensure proper services. Review quarterly and annual assessments with PT or OT screening. 3. Staff educated on proper application of splints and PROM or AROM proper documentation. Nurses aware of Treatment Administration record documentation, Nursing Assistants refer to Kardex and ADL Record. Therapy Department to assist with regular training on new devices with nursing staff and general training annually and with new orientees.	10/223/2013

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F 318	Continued From page 24 Review of the OT (occupational therapy) discharge evaluation dated 12/10/12, revealed Resident #2 tolerated the left roll splint up to 8 hours without signs and symptoms of irritation and staff demonstrated proficiency at PROM left digits (fingers) and wrist and application of left palm roll each day. Review of the most recent restorative mobility documentation dated April 2013, revealed the diagnosis as joint stiffness and pain left upper extremities and the equipment was the left functional hand splint. The goal included Resident #2 would tolerate left hand splint 6 hours daily and tolerate ROM (range of motion) to left upper extremity. The document revealed Resident #2 only wore the splint 13 days in the month April. There was no other documentation prior to or after April 2013 to indicate resident had been consistently wearing the splint. During an initial tour observation on 9/3/13 at 11:00AM, Resident #2 was lying in bed with a sign posted above that indicated palm splint should be place in hand after bath. Resident#2 was nicely groomed and dressed in clean hospital gown. There was no splint in the left hand. The splint was lying on table beside storage bins across the room near the television. During an observation on 9/3/13 at 11:30AM, the resident was lying in bed with no hand splint/roll in place. The splint remained on the table beside the storage bin near the television. During observations on 9/4/13 at 8:30AM, 10:21AM, 11:00AM and 3:29PM, Resident #2 left hand contracture had no splint in place but the splint was on the night stand.	F 318	4. IDT will review process for splint application and PROM/AROM weekly in Medicare/Casemix meeting and document appropriately. DON will audit Treatment Administration Record to ensure proper documentation of splints and AROM or PROM. Findings will be reported to ECU QA Committee monthly times 6 months and to the Clinical Care Committee. 5. Compliance will be 10/23/13.	10/23/2013

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F 318	Continued From page 25 During an interview on 9/6/13 at 8:30AM, the administrator indicated there was no current restorative program in place to ensure the residents that needed splints were having the splints applied consistently. During an interview on 9/6/13 at 9:00AM, nurse #15 indicated there was no person in charge of ensuring that splints were applied consistently as ordered. She added that there had not been any consistent monitoring on the application by nursing or nursing assistants. During an interview on 9/6/13 at 9:13AM, the occupational therapist (OT) indicated that Resident #2 was discharged from therapy on 12/10/12 with orders for a palm roll to the left hand for up to 8 hours a day. Resident #2 was referred to the restorative program in 2012 with the plan for Resident #2 to receive passive range of motion to left fingers and wrist and tolerate left hand splint 6 hrs daily as well as tolerate range of motion to left upper extremities. During an interview on 9/6/13 at 9:59AM, NA#14 indicated that Resident #2 had contracture of the left hand and wore a soft hand splint. The resident was suppose to wear the splint at least 4 hours a day. NA#14 indicated Resident #2 received a bath in the morning and the splint should be applied per the sign over bed. There was no system in place to document when the splint was applied and when it was removed. The restorative mobility documentation form stopped around Jan 2013. She indicated that she was the person formerly responsible for the restorative program. Resident #2's splint was expected to be applied after baths. She was uncertain	F 318		

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F 318	Continued From page 26 whether the resident wore the splint consistently. During an interview on 9/6/13 at 10:19AM, NA#13 indicated the expectation was that Resident #2's splint should be applied to the left hand in the mornings. She added there was once a restorative aide that did the daily application of the splints. There was no current system in place to document when the splint was applied. She added that she worked with the resident and had not applied the splint consistently due to other work responsibilities. 2. Resident #7 was admitted to the facility on 8/1/13. Cumulative diagnoses included cerebrovascular accident, wrist fracture and rheumatoid arthritis. The quarterly Minimum Data Set (MDS) dated 8/16/13, revealed that Resident #7 required total and extensive assistance with all activities of daily living. The most recent quarterly Minimum Data Set assessment of 8/23/13 indicated Resident #7 needed extensive assistance with activities of daily living. In the restorative nursing section of this assessment, there was no indication that the resident had received passive range of motion (PROM), active range of motion (AROM) or splint assistance. Review of the occupational evaluation dated 9/1/13, revealed the Resident#7 had contractures of left hand, wrist and fingers. Resident#7could benefit from skilled OT to provided orthotic fitting to address left hand contractors. Resident#7 was able to tolerated rolled washed cloth to left hand and nursing educated on application of left palmer roll each day with passive range of motion.	F 318		

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F 318	Continued From page 27 Review of occupational treatment plan dated 9/1/13, revealed that Resident#7 would tolerate wearing left upper extremity hand splint 8 hours per day when staff applied correctly 100% of time and after passive range of motion to left hand each 3 times a week for 8 weeks. During an observation on 9/3/13 at 10:30AM, Resident #7 was seated in hallway with peers and left hand contracted and there was no washcloth or hand roll in place. During an observation on 9/4/13 at 8:30AM, nurse #15 was providing Resident #7 with morning treatment. After completion of treatment Resident #7 was rolled to another location, Nurse#15 did not apply washcloth or apply hand roll to Resident #7 hands. During an observation on 9/4/13 at 9:30AM, 10:30AM, 11:00AM, 12:00PM and 3:00PM, Resident #7 was in the dining room with her peers and still did not have a washcloth or hand roll in place. During an interview on 9/4/13 at 3:30PM, nurse#15 observed Resident #7 was seated in dining room with peers and Resident #7 did not have the hand roll in place. She indicated that she had put the roll in the resident hand earlier in the day and she did not know what happened. She indicated that she had spoken with therapy staff about the splint earlier and they were waiting on splint evaluation. NA#14 was assigned to Resident #7 During an interview on 9/4/13 at 3:45PM, the ST(speech therapist) indicated that she had	F 318		

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F 318	Continued From page 28 spoken with Nurse#15 about the splint, but she was unaware the resident should have had the hand roll until the OT evaluation was reviewed dated 8/26/13. The expectation would be the palm pillow to be applied to hand daily. During and interview on 9/6/13 at 9:20AM, family member indicated that Resident #7 was evaluated last month for recurrent falls He indicated that Resident #7 had not had a hand roll or wash cloth in her hand in the past. He added on a visit this week was the first time was when he saw the blue brace Resident#7. During an interview on 9/6/13 at 10:03AM, NA#14 indicated that Resident#7 had not been wearing a hand roll, unsure when the use of the hand roll was started and was not aware that she should be wearing one. She indicated that she had worked with resident over the weekend (8/29/13-30/13) and resident did not wear or have hand roll. During an interview on 9/6/13 at 10:19AM, NA#13 indicated that Resident#7 was not wearing any splints or hand washcloths in the past or present she had not put any in resident hand but resident did have contractures. NA#13 indicated that when a resident was suppose to wear splints or hand rolls nursing staff would let the NA know when a resident needed splints, hand rolls etc after they spoke with therapy. 3. Resident # 1 was admitted on 6/22/09 with a cumulative diagnosis which included hypertension, rheumatoid arthritis, dementia, paralysis of left arm and left leg, osteoporosis, and bilateral contractures of left and right hands. Review of the Occupational Therapist screen	F 318		

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dated 8/8/12 indicated Resident #1 demonstrated discomfort with bilateral passive range of motion secondary to severe contractures. The Occupational Therapy screen further included that hand cones would prevent further deformity and promote better skin integrity by keeping fingers/fingernails out of the patients palm which cold lead to skin breakdown, wounds, and infections. The Occupation Therapy screen further indicated Resident #1's cones had arrived.

Review of the rehab discontinuation summary dated 8/15/12 concluded resident #1 was able to tolerate bilateral splints 6 to 8 hours. Skilled Occupational Therapy was required for progressive Range of motion and splinting for bilateral hand contractures.

Restorative Mobility Documentation for the month of April 2013 indicated a goal that Resident #1 would tolerate bilateral hand cones for 6 hours daily to prevent further hand contracture. Equipment included right and left hand cone (located in patient room 1st dresser drawer). Special precautions indicated check patient ' s hands before and after for wounds, skin breakdown or bruises. The facility was unable to produce additional documentation regarding restorative service provided for resident #1 following April 2013.

Resident #1 was readmitted on 6/1/13. The latest Minimum Data Set Assessment dated 6/13/13 indicated that Resident #1 had short term and long term memory impairment and was severely cognitively impaired for daily decision making. Resident #1 was totally dependent on one staff member for all activities of daily living.

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F 318	Continued From page 30 Review of the care plan dated 12/16/12 and updated 6/13/13 revealed Resident #1 had impaired mobility and was at an increase of further complications of contractures. The care plan goal indicated existing contractures will not worsen through next review. Approaches to this problem included gentle range of motion during daily care as tolerated, observe for pain or increased stiffness, splinting devices applied as per MD order, and assess skin underneath splints and palms of hands daily. There was no physicians order located for bilateral splints. The care plan further indicated that Resident #1 was at risk for pain related to severe contractures. The approaches included gentle range of motion. There was no mention of bilateral splinting devices. During an observation on 9/3/13 at 11:30 am, Resident #1 was lying in bed with no splints noted to bilaterally contracted hands. During an observation on 9/4/13 at 8:30 am, no splints were noted to Resident #1's bilaterally contracted hands. During an observation on 9/4/13 at 8:47 am, no splints were noted to Resident #1's bilaterally contracted hands. During an observation on 9/4/13 at 2:24 pm, no splints were noted to Resident #1's bilaterally contracted hands. During an observation on 9/5/13 at 8:54 am, Nurse #3 indicated she had instructed Nurse #14 to place wash cloths in Resident #1's hands. When asked if Resident #1 received range of motion, Nurse #3 indicated range of motion was	F 318		

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to be done by gently moving resident's fingers. Nurse #3 was observed to place rolled washcloths in the resident's hands. Resident #1 did not have a regular range of motion schedule. Resident #1's treatment record did not indicate treatment for left and right bilateral hand contractures.

During an observation on 9/6/13 at 9:00 am no splints were noted to Resident #1's bilaterally contracted hands. A reddened area was observed to the left side Resident #1's left palm.

Interview on 9/6/13 at 9:07 am with Nurse #15 revealed she was aware of Resident #1's bilateral hand contractures. Nurse #15 indicated on 9/5/13 contractures became her focus with residents. Nurse #15 stated that while she provided Resident #1 with g-tube care on 9/5/13 she placed rolled washcloths in the resident's hands. Following g-tube care, Resident #1's Occupational therapy notes were reviewed by Nurse #15. Resident #1's hand rolls were looked for in the resident's room on 9/5/13. Nurse #15 indicated she could not locate resident #1's hand cones and attempted to locate something for splinting in therapy. Nurse #15 contacted the resident's hospice nurse to communicate concerns regarding the resident's bilateral contractures and determine if the resident could have an occupational therapy referral. Nurse #15 stated she would write an order for occupational therapy today, 9/6/13. Nurse #15 stated she was unaware of when the bilateral hand splints stopped and further indicated there had not been a restorative aide following the resident following the month of April 2013.

Interview on 9/6/13 at 9:10 am with Nurse Aide #

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F 318	Continued From page 32 14 stated at one time Resident #1 had huge roll cones that were used to prevent the resident from further contracture and pressure areas due to her level of contracture. Nurse # 14 indicated she was unaware of where resident #1's bilateral hand cones were. Nurse #14 revealed the last time she saw the cones was about a year ago when Nurse #14 was a restorative aide. Resident #1 had a long dresser at the time and her hand cones were placed in the top drawer. Nurse #14 stated that she recalled a therapist evaluating Resident #1 due to the hand cones being large and causing red areas on the resident's hands. The nurse aide revealed she recalled nursing staff being instructed to keep the cones out for about 2 weeks. Nurse #14 did not recall any other method of contracture prevention being put into place. Interview with a Hospice Worker on 9/6/13 at 10:35 am revealed services began for Resident #1 in August 2013. The Hospice worker indicated that her visit with the resident was on 9/5/13 and the resident did have rolled washcloths in her hands. She visits with the resident once weekly. The Hospice worker further revealed she was contacted on 9/5/13 by the facility in regards to resident splinting. Approval was provided to obtain a consult for an occupational therapy evaluation. Interview with Nurse Aide #13 on 9/6/13 at 10:49 am revealed she puts rolled washcloths in Resident #1' left hand. Nurse #13 was unaware of how long the roll was to stay in the resident's left hand. Nurse #13 had no recollection of any use of splinting for Resident #1. Interview with Nurse #3 on 9/6/13 at 11:00 am	F 318		

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F 318	Continued From page 33 revealed the resident did have hand cones at one time. Nurse #3 stated the resident had a long dresser in her bedroom although she could not locate the cones prior to the dresser being removed. Nurse #3 stated that she was unaware of how long the hand cones were missing or what was put into place following their disappearance. Interview with Nurse Aide on 9/6/13 at 4:41 pm revealed the cones were stopped due to the resident frequently moving her hands and hitting the top of them on the hand rails. The cones were really bulky for the resident. The cones at one time were in the resident's top drawer in her room. Nurse #16 stated that she would occasionally see a rolled cloth in her left hand only.	F 318		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on a meal observation, staff interviews and resident interviews, the facility failed to provide palliative foods and beverages for 1 of 1 dining room and 2 of 4 halls to resident preferences. The findings included Review of Resident #28's admission Minimum	F 364		

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F 364	Continued From page 34 Data Set(MDS) dated 6/24/13, revealed the ability to understand and be understood by others with intact cognition and identified by staff as alert and oriented. During an interview on 9/3/13 at 12:44PM, Resident #28 indicated that they ate meals in the dining or in their room. Resident #28 further stated the eggs were always cold at breakfast when served. Resident #28 further stated they ate the meal even when it was cold, because staff was too busy to reheat the meal. During an interview on 9/04/2013 at 11:06AM, Resident #5 indicated meals were eaten in the room and breakfast was cold. She doesn't ask to heat it up because its was too far for the nursing assistants to go back to dining to reheat the meal. During an interview on 9/04/2013 at 2:12PM, Resident #31 indicated meals were eaten in the dining and/or in room and the meals arrived late and cold. Resident #31 indicated when reported to staff nothing gets done. During an interview on 9/04/2013 at 2:40PM, Resident #26 indicated meals were eaten in room and breakfast was always cold and arrived late. Resident #26 indicated being tired of reporting food concerns with no change. During an interview on 9/5/13 at 8:45AM, Resident #9 indicated meals were eaten in the dining room and/or room and that breakfast was cold due to being late and it never came hot. During an observation on 9/5/13 at 8:27AM, the second cart left the kitchen and arrived in the dining room at 8:30AM. There were 10 residents	F 364	1. 100% resident audit of the level of assistance required with meals. Dining preferences reviewed and accommodated. Dining table seating arrangement implemented to ensure proper delivery of food trays one table at a time to ensure no resident was seated without food or drink at a table. Independent residents and then residents requiring assistance to be served and then those that require total assistance to ensure adequate temperatures of food and beverages and staff present to assist with tasks. Staff assignments are designated upon onset of shift and administrative staff will be assigned to enable prompt assistance to residents and deliverance of meals. 2. Meal cart delivery to the ECU will be monitored by the Unit Clerk and/or Charge Nurse. This will occur by documenting time of delivery for each dietary cart and announcing via ECU paging system to ensure staff awareness and preparedness on the unit. 3. Dietary Manager has indicated new equipment ordered that is necessary to maintain food and beverage temperatures after leaving the dietary kitchen. Dietary staff educating and training ongoing. Dietary Manager to perform test tray check 3 times a week to ensure proper temperatures for Breakfast, Lunch, and Dinner. Extended care staff educated on Resident right and providing services with dignity.	10/23/2013

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F 364	Continued From page 35 eating while 7 other residents waited and the cart with the test tray sat until the last resident was served at 8:50AM. Several of the meals on the cart were for other residents on the hall. Staff from the hall would come to the dining room to get trays from the cart for residents on the hall. The meal included grits, oatmeal, fried apples, bacon, eggs, toast, orange juice and coffee. Test tray was set-up by the dietary manager who declined to taste the food and proceeded to take temperature of food. The food was sampled with the following results: The DM (dietary manager) took the temperature of the following items grits were cool to taste, oatmeal was cool to taste, fried apples, eggs cold and rubbery/chewy, bacon cold and hard with a slimy film, toast hard and barely warm and 2 orange juices warm. During an interview on 9/5/13 at 9:00AM, NA#13 and NA#16 indicated that there was no specific program for feeding in the dining room other than the restorative residents get set-up 1st around 7:45AM, because they could feed themselves. NA#13 indicated that on average there were 6 to 7 residents at a time in the dining room that needed assistance but there may only be one or two NA's to feed and they do the best they could. NA#13 indicated many of the residents were unable to verbalize the temperature of the food, but the residents who eat meals on the hall have reported concerns with cold food. During a follow-up tour and interview on 9/5/13 at 7:50AM, the DM indicated that she was aware the tray warmer had not been working since May 2013 and aware that residents also had concerns with the temperature of the food. She added that	F 364	4. Administrative staff assigned to dining room will ensure proper protocol and update ECU QA Committee times 6 months. 5. Compliance with audits and education will be 10/23/2013.	10/23/2013

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F 371 SS=F	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, staff interviews, and record review, the facility failed to maintain sanitary conditions in the kitchen by ensuring opened and resealed food items in 2 of 2 walk in freezer were dated and labeled, clean floors of the freezer where trash and frozen food products was stored, remove fresh produce from rotten/spoiled produce in 1 of 1 vegetable refrigerator, remove ladles from dry storage bin, clean and ensure 2 of 2 cook/warming box and hot plate carts was clean, separate dented cans from ready to use food items, and remove rodent/insect traps found in container with dry food products and cover opened unlabeled dry food products in 1 of 1 dry storage area and staff clean food thermometer with proper sanitizer wipes. The findings included: 1. During an observation of the walk in freezer on 9/3/13 at 11:00AM, the following items were open on shelves unlabeled and undated; a 1/2 bag of barbeque chicken drumets, a 1/2 bag of chicken	F 371	1. All items in the freezer checked to be appropriately dated and labeled. Properly placed on shelves according to sanitation guidelines. Produce rotated and bad produce thrown out by DM. New process to ensure proper rotation and discarding of bad produce implemented by DM. Staff educated and monitoring tools in place. Ladles removed and appropriately stored. Dented cans removed and set aside for vendor to collect. Cleaning schedule revised for appropriate team member and implemented immediately. 2. 100% audit of kitchen protocol performed by DM. Training outline revised to correlate with proper dating/labeling of items in freezer, refrigerator, and dry storage. Kitchen cleaning schedule and duties revised to account for staff responsibilities and daily monitoring systems to ensure clean cook box area. 3. Staff duties outlined according to role as cook or food service aide. Training and educating staff on cleaning schedule, proper labeling, food storage, and rotation of food items is ongoing to comply with regulations and sanitation regulations. This will be part of orientation and annual training. 4. Dietary manager and Lead Food Service Aide will perform walk through audits daily and monitor compliance of schedules. Evening cook will complete closing checklist and all results will be reviewed by DM and presented monthly to ECU QA Committee and Environment of Care Committee times 6 months.	10/23/2013

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F 371	Continued From page 38 strips with freezer burns, 1 bag of freezer burned string beans, an opened silver tray of stuff green peppers and a opened freezer burned container of ice cream with no cover, an opened package of Italian bread and an opened freezer burned cheese. The floor of the freezer had several loose frozen items (meats/biscuits, ice cream) and trash (paper wrappings) under the shelving area. During an interview on 9/3/13 at 11:00AM, the Dietary Manager (DM) identified the products in the freezer and confirmed that the products should be labeled once they have been removed from the package and put into the container. DM indicated that the cook staff was responsible for labeling and dating all items that were open with the date item was open. The DM acknowledged that several of the items that were found should have a label and date. In addition the floors of the freezer/refrigerator should be cleaned daily and after deliveries by dietary staff. During a follow-up observation on 9/5/13 at 6:15AM, on the shelf was 2 bags of opened unsealed yellow/white cubed chunks cheese same pan of green stuff peppers opened/ unsealed, a package of an opened unlabeled/dated dough product and 1 large half wrapped package of meat turkey in a silver pan dated 9/3/13. During a follow-up tour and interview on 9/5/13 at 7:50AM, the DM did a follow-up tour of the vegetable cooler, freezer, milk/juice box and storage area an identified the opened and unsealed/unlabeled products and indicated that all opened items should be resealed properly. 2. During an observation on 9/3/13 at 11:05AM,	F 371	5. Compliance for proper storage and sanitation will be 10/23/2013.	10/23/2013

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	345004	A. BLDG. _____ B. WING _____	C 09/06/2013

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F 371	Continued From page 39 the vegetable refrigerator had a box of fresh cucumbers which contained cucumbers that were mushy and molded. Also observed in this refrigerator was a box of fresh tomatoes that contained tomatoes that were rotten. During an interview on 9/3/13 at 11:05AM, the DM identified the produce and stated the fresh produce should be rotated and checked daily to ensure there were no bad produce being stored with fresh produce in refrigerator. She added that she did not have a formalized system in place for checking the produce. During a follow-up observations on 9/5/13 at 6:15AM, the box of tomatoes remained in same spot with the rotten tomatoes. 3. During an observation on 9/3/13 at 11:00AM, a ladle lying face down in a large white container with what was identified by DM as brown sugar. DM indicated that ladle should not be directly on the product and should be kept in the ladle holder located on the top portion of the container. During a follow-up observation on 9/5/13 at 6:15AM, the ladle remained in the large white container in the brown sugar that had direct contact with the sugar. During a follow-up interview on 9/5/13 at 7:50AM, the DM indicated that the ladle should have been removed and returned to proper holder on top of container. 4. During an observation on 9/3/13 at 11:00AM, the cook box where ready to serve hot/cold food was stored in preparation for meal deliver and hot plate cart had large volumes of grimy grease,	F 371		

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F 371	Continued From page 40 dried food and liquid substance on the shelves/base of box. The hot plate cart on top and surrounding areas had dried food and liquids on the surfaces where the plates were stored. During an interview on 9/3/13 at 11:45AM, the DM indicated that cook staff was responsible for cleaning all the cook boxes and plate carts daily after the meals have been served. DM acknowledged the cook box/plate cart needed to be cleaned thoroughly. DM was unable to state when the surfaces were last cleaned. 5. During an observation on 9/5/13, at 6:45AM, the kitchen's dry storage area had the following items; 2 dented cans of applesauce, 1 dented can of sliced pineapples, 1 dented can of sliced apples, 1 dented can of baked beans, 1 dented can of mushrooms. In addition, 1 bag of opened unsealed pasta noodles, 1 opened/unsealed container of sugar, 1 container of vanilla wafer cookies, chocolate pudding snacks and animal crackers that had a steri-tech sticky pad insect monitor(mouse/rodent) stored in the container with the dry products. During a follow-up tour and interview on 9/5/13 at 7:50AM, the DM indicated that dented cans should be checked before they were stocked and removed to be returned to the vendor. DM added that opened dried foods should be stored in proper container with cover and no mouse traps should be stored with the dry foods. 6. During an observation on 9/5/13 at 7:25AM, the cook cleaned the thermometer with a dish cloth using a bucket full of water before performing food temperatures. The cook indicated that she did not have any alcohol wipes available and so	F 371		

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F 371	Continued From page 41 the sanitizer water from the main sink was the water she used to clean the thermometer. The cook also used the same dish cloth to clean the food preparation surfaces when foods or liquids were spilled. The cloth was used for all purposes of cleaning and temperature checks. During an interview on 9/5/13 at 7:50AM, the DM did follow-up tour of the kitchen and indicated that sanitizer wipes should be kept under the cook preparation tables and there was some available in her office. She went to her office to retrieve the wipes and gave them to the cook.	F 371		

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	345004	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE RD ROXBORO, NC 27573

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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 II(222) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	RECEIVED NOV 06 2013 CONSTRUCTION SECTION	11/21/13
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: A. On 10/18/2013 the fire doors located near the Nurses Station failed to close and latch upon activation of the fire alarm. 42 CFR 483.70 (a)	K 011	1. The fire doors at nurses station corrected to close and latch Upon fire alarm activation. Corrected by Fire alarm company Simplex Grinnell. 2. Maintenance checked all fire doors to close and latch upon fire alarms. Simplex Grinnel in to check all fire doors to close and latch upon fire alarm activation. Repairs completed as needed. 3. Maintenance to round weekly to ensure proper closing and latching on all fire doors and present findings monthly times 3 and then quarterly.to Extended care Unit QIPI Committee and Environment of Care Committee. 4. Compliance by November 21, 2013	
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	K 018		

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

LNHA | 11/1/13

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.

CD

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
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K 018	Continued From page 1 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: A. On 10/18/2013 the doors to rooms 259,240,205and 218 failed to latch when closed. 42 CFR 4883.70 (a)	K 018	11/21/13 1. Rroom doors 259, 240, 205, and 218 repaired to close and latch properly by Maintenance.. 2. Maintenance checked all doors to ensure proper closing and latching. Any door not properly closing and latching repaired by maintenance. 3. Maintenance to round weekly to ensure proper door Closing and latching and present findings monthly times 3 and then quarterly.to Extended care Unit QIPI Committee and Environment of Care Committee. 4. Compliance by November 21, 2013	
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:	K 029	11/21/13 1. The Soiled room door near room 230 repaired to close and latch properly. 2. Maintenance checked all doors to ensure proper closing and latching. Any door not properly closing and latching repaired by maintenance. 3. Maintenance to round weekly to ensure proper door Closing and latching and present findings monthly times 3 and then quarterly.to Extended care Unit QIPI Committee and Environment of Care Committee. 4. Compliance by November 21, 2013	

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K 029	Continued From page 2 A. The soiled room near room 230 failed to close and latch. 42 CFR 483.70 (a)	K 029	1. The dining room door into the stairwell corrected to release Within 15 seconds, alarm, and automatically lock by Simplex Grinnell. 2. Maintenance checked all delayed egress doors to ensure proper release and locking required by standard. Simplex Grinnel in to check all delayed egress for proper release, alarm, and automatic locking. Repairs completed as needed.	
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	3. Maintenance to round weekly to ensure proper release Of delayed egress and alarms. and present findings monthly times 3 and then quarterly.to Extended care Unit QIPI Committee and Environment of Care Committee. 4. Compliance by November 21, 2013	
	This STANDARD is not met as evidenced by: A. Based on observation on 10/18/2013 the delayed egress locked doors failed to release with in the 15 sec.(some went as high as 40 sec.), the door at the dining room failed to sound the alarm, and the door from the ding room into the stair well locked back automatically. 42 CFR 483.70 (a).			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard 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	K 056	11/21/13 1. Facility in process for proposal and plans to sprinkle unit to be 100% compliant with 42 CFR 483.70. Proposal acceptance from VSC (enclosed) 2. Facility in process to complete installation once drawings are completed and submitted to Construction Section and Fire Marshall for approval. Working diligently with State to ensure completed in 90 days as directed. 3. Progress to be updated weekly to CEO and to Construction Section to ensure compliance and Environment of Care Committee. 4. Compliance for dedsign approval and installation of sprinklers on the Extended Care Unit January 16, 2014.	

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 10/18/2013 the facility was not completly sprinkled, only the hazradous areas. The facilty was to be completly 100% sprinkled by 08/13/2013. 42 CFR 483.70 (a)	K 056	1. Plumbing company has been working on locating hot water piping for the ECU. Install new pipe line from current hot water piping to shower rooms. Install new mixing valves and check valves on main facility hot water heaters. Install new larger hot water circulating pump in basement crawl space. Repair 17 cold to hot cross connects in the facility. Install isolation valves on the ECU. 2. Hot and cold water temperatures will be monitored weekly by Maintenance and Administrator. Findings out of range of 100-116 degrees will be reported immediately for corrective action by Maintenance. Maintenance will check facility hot water temperature and adjust to temperature accordingly. 3. Findings will be reported to the Extended care Unit QIPI Committee and Environment of Care Committee monthly times 3 and then quarterly to ensure compliance. 4. Compliance by November 21, 2013.	11/21/13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. The hot water temperature was 130 degrees F in patient areas..	K 130		