STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	**116 LANE DRIVE TRINITY, NC 27370**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 10/23/14. Event ID# UQP511.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		11/17/14

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

Electronically Signed | 11/16/2014

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 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility	F 156		

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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview with staff, interview with a family member and record review the facility failed to provide a list of services and items that would or not be charged for under the Medicaid program. This was evident in 1 of 1 resident sampled who payment source was Medicaid. (Resident #139) Findings included: Review of the Resident Census and Conditions of Residents completed during this survey of 10/23/14 revealed there were 79 residents residing in the facility which had Medicaid coverage as a source of payment. Interview on 10/21/14 at 11:27 am with the family member of Resident #139 revealed the facility had not provided a list of items and services that would and would not be covered under the Medicaid program. Interview on 10/23/14 at 10 am with the admission coordinator and the business office manager was held. The business office manager revealed Resident #139 was approved for Medicaid coverage on 10/13/13. Review of the DMA-5002 form approval notice for Medicaid	F 156	1. On 11/12/14, the identified resident and responsible party of the resident, were provided a list of services and items that would or would not be charged for under the Medicaid program. 2. By 11/17/14, all residents currently receiving Medicaid benefits will be notified by mail of the services and items that would or would not be charged for under the Medicaid program. 3. The facility will include a list of services and items that would or would not be charged for under the Medicaid program in the admission packet. An acknowledgement form will also be included in the admission packet for any new admission of the facility to ensure the facility can demonstrate that newly admitted residents know of services and items that would or would not be charged for under the Medicaid program. Furthermore, the facility will post a list of services and items that would or would not be charged for under the Medicaid program in a prominent location within the facility. This newly implemented procedure will be effective as of 11/17/14. 4. The Director of Admissions will be	

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F 156	Continued From page 3 confirmed the approval date. Continued interview with the business office manager revealed the business office responsibility was to notify the resident or the responsible party of the Medicaid approval. The admission coordinator and the business office manager indicated they were unaware of who was responsible for informing individuals about Medicaid coverage or non coverage. The admission coordinator indicated she had not discussed Medicaid coverage with residents in the facility. Interview on 10/23/14 at 11:00 am with the administrator revealed he was unsure of who was responsible in the facility to inform residents or responsible parties of covered or non covered Medicaid items.	F 156	responsible for providing residents, before or at the time of admission, a list of services and items that would or would not be charged for under the Medicaid program. The Director of Social Work will inform residents of the list of services and items that would or would not be charged for under the Medicaid program, when the Medicaid application is made. The residents making Medicaid applications will be tracked on a Medicaid Application QA Tool maintained by the Director of Social Work. This will be monitored by the Nursing Home Administrator each month. At the direction of the Nursing Home Administrator, the Admissions Coordinator and Director of Social Work will report their activity, including any adjustments, for review by the Executive QA Quarterly Meeting Committee. The next Executive QA Quarterly Committee meeting is scheduled for January 20, 2015. This QA initiative will continue for a minimum of the next 6 months.	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview with staff and review of the	F 160	1. Refunds were disbursed to the two	11/7/14

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F 160	Continued From page 4 financial record, the facility failed to convey expired resident ' s personal funds to the executor of the state or probate jurisdiction administering the resident ' s estate for 2 of 3 resident funds accounts reviewed. (Residents # 49 and #178) Findings included: 1. Resident # 49 expired on 7/6/14 and a check for $1201.68 was forwarded to the executor of the estate on 8/14/14. 2. Resident # 178 expired on 5/10/14 and a check for $230.99 was forwarded to the clerk of courts on 6/18/14. Interview on 10/23/14 at 11:06 am with the concierge responsible for the conveyance of funds revealed she was on vacation when the residents expired and there was no other person in the facility covering her duties. The concierge indicated the funds should be conveyed within 30 days of expiration. Interview on 10/23/14 at 3 pm with the administrator revealed he expected the funds to convey within 30 days of the residents ' expiration.	F 160	resident□s estates identified prior to the annual survey. The dates of the refunds were on 6/18/14 and 8/14/14. 2. On 11/7/14, the facility completed an audit of any resident with a trust fund who had expired in the previous 12-month period. No other residents were identified to have refunds issued outside of the 30-day time frame. An in-service was completed by the Business Office Manager with all Business Office staff to ensure compliance with trust fund refunds within 30 days of discharge. This was completed on 11/7/14 and will be an annual in-service for the Business Office Staff members moving forward. 3. A procedure has been created to ensure that resident fund refunds are completed within 30 days of discharge. The Concierge will monitor trust fund refunds weekly for residents discharged within 30 days. The Business Office Manager will monitor trust fund refunds for residents discharged within 30 days, on a semi-monthly basis as well to ensure compliance. 4. A QA team, The Conveyance of Personal Funds Upon Death QA Team, was developed to monitor the progress of trust fund refunds and to ensure refunds are completed within 30 days. The QA team consists of the Chief Operating Officer, Nursing Home Administrator and the Business Office Manager. This QA team will meet monthly for 12 months and will report monitoring efforts and results at the Executive QA Quarterly Committee Meeting. The next Executive QA Quarterly Committee meeting is	

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F 160	Continued From page 5	F 160	scheduled for January 20, 2015.	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility failed to maintain the temperature at a comfortable level in the dining room for 1 of 14 residents interviewed (Resident #129). Findings include: On 10/23/14 at 1:34pm an interview with resident #129 revealed it was cold in the dining room. Resident #129 stated she sits next to the wall unit providing heat/air condition and it is cold. Further discussion revealed that the wall unit read 68 degrees Fahrenheit. Resident #129 stated when staff were told it was cold she was told to put a sweater on. On 10/23/14 at 1:43pm a tour of the dining room reveled there were 4 wall units providing heat/air condition to the dining room. On the left side of the dining room there was a wall unit located in the front of the dining room near the door to the kitchen the temperature was registered at 65 degrees Fahrenheit. The unit located at the back of the dining room near the entrance to the dining room registered 71 degrees Fahrenheit. On the	F 257	1. The thermostats in the affected area were adjusted by the Director of Maintenance on 10/23/14 to correct the temperature at the time it was identified. 2. All thermostats in common areas within the facility have been labeled reminding staff, residents, and visitors to not adjust the temperature setting. A desired temperature range of 71-81 degrees is also listed on the heating/cooling units. This was completed on 10/23/14 as well. 3. To help ensure a comfortable environmental temperature, an in-service has been provided to all Nursing Home staff regarding the procedural change(s) and the posted thermostat reminders. The Maintenance Director, Maintenance Assistant, or designee will round daily to ensure thermostat readings are within desired ranges. To account for any changes in the external temperature of the facility, the facility reserves the right to adjust thermostats as needed to ensure an appropriate temperature range is maintained for our residents.	11/19/14

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F 257	Continued From page 6 right side of the dining room the unit located near the entrance to the kitchen registered 68 degrees Fahrenheit. The unit located at the back of the dining room located near the entrance to the dining room registered 69 degrees Fahrenheit. 10/23/14 at 1:47pm an interview with the maintenance director revealed that he usually sets the wall heat/air units at 72 degrees Fahrenheit. Further discussion revealed that anyone (residents, family members or staff) can change the temperature setting in the dining room. He indicated some residents have complained to him and he would adjust the settings to their liking either up or down. The maintenance director indicated that he does not check the units routinely to maintain a comfortable temperature for all residents.	F 257	4. The Maintenance Director will utilize the Room Temperature Audit QA Tool to record room temperatures in common areas within the facility. This QA tool has been created to log temperatures and corrective interventions to help ensure compliance. The tool will be completed weekly for six months by the Maintenance staff. Results will be reviewed in the Executive QA Quarterly Committee Meeting successively, for six months at a minimum. The next Executive QA Quarterly Committee meeting is scheduled for January 20, 2015.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to consistently	F 325	1. Resident #135 had corrections made to the monitoring of fluid restrictions	11/21/14

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F 325	Continued From page 7 monitor the amount of fluids provided (including nutritional supplements) and implement a fluid restriction as prescribed for 1 of 1 sampled residents (Resident # 135) receiving a fluid restricted diet. The findings included: Resident #135 was re-admitted to the facility on 7/23/14. The resident's cumulative diagnoses included diabetes, protein-calorie malnutrition, and End Stage Renal Disease (ESRD) with hemodialysis. A review of Resident #135's medical records revealed her admission orders included 30 cubic centimeters (cc) ProSource (a high protein liquid nutritional supplement) given twice a day (initiated 7/23/14). Resident #135's prescribed diet order was: No Concentrated Sweets, No Added Salt, and No Fried Food. The resident's most recent Minimum Data Set (MDS) assessment dated 7/29/14 reflected a significant change in status. The MDS indicated that Resident #135 had intact cognitive skills for daily decision making. There were no behaviors nor rejection of care reported. The resident required limited assistance with eating. A review of Resident #135's medical record revealed a Telephone Order was received on 8/20/14 from the Dialysis Center where she received her treatments. The order indicated that a 1000 cc fluid restriction was added to the resident ' s diet prescription. A review of the resident's Diet Order Form dated 8/20/14 included notations which indicated that 8 ounces (240 cc) fluid would be sent on each of the	F 325	(including nutritional supplements) on 10/24/2014. 2. All residents on a fluid restricted diet were reviewed by the Director of Nursing and the Certified Dietary Manager on 10/24/14. These residents were reviewed to ensure the monitoring and recording tools were in place and that the expectations were clearly communicated to the staff. 3. To ensure compliance, the Director of Nursing created and started an in-service for 100% of the nursing and dietary department(s) regarding compliance with fluid restrictions. This in-service will be completed no later than 11/21/2014. 4. Effective 11/6/2014, The facility formed a QA Team, The Fluid Restriction Monitoring QA Team, to direct and monitor efforts specific to fluid restrictions and documentation efforts. Team members consist of the DON, Dietary Manager, MDS Coordinator, SDC/QA nurse and Restorative Aide. Additional team members can be added as needed. Moving forward, the Director of Nursing, or designee, will complete weekly audits of fluid restricted residents (including newly admitted residents and residents with changes to their fluid restrictions) using a newly created Fluid Restriction QA tool. The Fluid Restriction Intake Record QA tool will be used to ensure that nursing is able to accurately and consistently monitor the amount of fluids provided, including nutritional supplements. The Fluid Restriction Monitoring QA team will meet during the existing QI Nursing meeting each week unless otherwise	

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F 325	Continued From page 8 resident's three meal trays daily; and 4 ounces (120 cc) of fluid would be allotted for each of 3 medication passes provided by nursing staff. Based on this information, the dietary fluid allowance equaled 720 cc per day and the nursing fluid allowance equaled 360 cc per day. The sum total of the daily fluid allowance calculated for Resident #135 was 1080 cc per day. A review of Resident #135's fluid intake records from 8/21/14 through 10/9/14 was conducted. The fluid intake records consisted of two parts: 1) An Intake Record Sheet completed by the hall nurse each shift and kept inside of the Medication Administration Record (MAR) book; and 2) Fluid Intake documentation completed by the Nursing Assistant (NA) each shift and kept inside the NA's Flow Book. Results of the two fluid intake records for 8/21/14 through 8/31/14 revealed that the sum total of fluid intake documented on the two records exceeded 1000 cc daily on at least 9 days during this period of time (8/21 through 8/29); 5 entries were missing on the fluid intake records reviewed. Results of the two fluid intake records for 9/1/14 through 9/30/14 revealed that the sum total of fluid intake documented on the two records exceeded 1000 cc daily on at least 28 days during this period of time (including each day reviewed with the exception of 9/20 and 9/26); 27 entries were missing on the fluid intake records reviewed. Results of the two fluid intake records for 10/1/14 through 10/9/14 revealed that the sum total of fluid intake documented on the two records	F 325	indicated, with a minimum of 6 months of continuous weekly meetings. The team will summarize and report their findings at the Executive QA Quarterly Committee Meeting. The next Executive QA Quarterly Committee meeting is scheduled for January 20, 2015.	

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exceeded 1000 cc daily on at least 3 days during this period of time (10/7/14, 10/8/14, and 10/9/14); 5 entries were missing on the fluid intake records reviewed.

A review of Resident #135's medical record revealed that on 10/10/14, the Dialysis Center provided results of the resident ' s October 2014 monthly lab work. The labs included: albumin = 3.4 (normal range 3.5 - 5.5), which reflected a decrease from the previous month's albumin level of 3.5. A hand-written notation on the lab report read, "Protein supplement please." An additional communication form sent from the Dialysis Center to the facility was dated 10/10/14 and included a notation to provide a protein supplement three times daily between meals and at bedtime. Further review of the medical record revealed a 10/10/14 Physician's Order was written for 30 cc ProSource three times daily and at bedtime. A clarification order was also received on 10/10/14 which reinstated the initial order for ProSource to be given as 30 cc twice daily. This clarification order initiated Sugar-Free Med Pass (a high calorie, high protein nutritional supplement) to be given as 4 ounces (120 cc) by mouth three times daily between meals and at bedtime. The nutritional supplements, as ordered, provided a total of 540 cc fluid daily (60 cc per day from ProSource and 480 cc per day from the Sugar-Free Med Pass).

A review of Resident #135's fluid intake records from 10/10/14 through the date of review on 10/21/14 was conducted. The fluid intake records consisted of two parts: 1) An Intake Record Sheet completed by the hall nurse each shift and kept inside of the Medication Administration Record (MAR) book; and 2) Fluid

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Intake documentation completed by the NA each shift and kept inside the NA ' s Flow Book. Results of the two fluid intake records for 10/10/14 through the date of review on 10/21/14 revealed that the sum total of fluid intake documented on the two records exceeded 1000 cc daily on at least 7 days during this period of time (10/10, 10/13, 10/14, 10/15, 10/17, 10/20, 10/21); 2 entries were missing on the fluid intake records reviewed.

An interview was conducted on 10/22/14 at 9:35 AM with Nursing Assistant (NA) #4. NA #4 was assigned to care for Resident #135. The NA reported she worked fulltime and was typically assigned to Resident #135's hall. During the interview, NA #4 reviewed the procedure followed in documenting the resident's fluid intake. The NA reported that she recorded the fluids consumed from the resident's meal trays on the Intake Form kept in the NA Flow Book. Upon inquiry, the NA stated that Resident #135 did "super" with her food and fluid intake and indicated the resident was compliant with the fluid restriction.

An interview was conducted with the facility's consultant Registered Dietitian (RD) on 10/22/14 at 10:45 AM. The consultant RD reported that residents on dialysis typically received an order from the dialysis center which indicated what their individual fluid restriction was. The RD reported that the designated amount of fluid was divided between dietary and nursing. Upon inquiry, the RD reported that she understood nutritional supplements provided to a dialysis resident were not counted as part of the prescribed fluid restriction. After reviewing the September 2014 fluid intake records, the RD indicated that it

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appeared Resident #135 received more than the prescribed fluid allotment.

An interview was conducted with the facility's Certified Dietary Manager (CDM) on 10/22/14 at 10:57 AM. During the interview, the CDM reported that based on past communication with the Dialysis Center, nutritional supplements provided to a dialysis resident were not counted as part of a prescribed fluid restriction.

An interview was conducted with Nurse #1 on 10/22/14 at 11:10 AM. During the interview, Nurse #1 reported that nutritional supplements (Med Pass and ProSource) were counted as part of the nursing fluid allowance for Resident #135. Nurse #1 reported that she typically told the NA assigned to the resident how much of the nutritional supplements she gave to Resident #135 so that this amount would be included in the total amount recorded for the shift.

An interview was conducted with the Staff Development Nurse (SD Nurse) on 10/22/14 at 3:00 PM. The SD Nurse discussed the process and staff responsibilities of recording fluid intakes for Resident #135. The SD Nurse reported that the NA ' s Flow Book was used to document how much fluid the resident consumed at mealtime and that the hall nurse was responsible to review that information. The SD Nurse also noted that the hall nurse had a separate sheet (kept in the MAR book) where she recorded the amount of fluids provided during medication pass and the total fluid intake for the shift. The SD Nurse reported that the hall nurse included Med Pass (and other nutritional supplements given to the resident) in the amount of fluid intake documented.

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An interview was conducted with Nurse #2 on 10/23/14 at 7:45 AM. During the interview, Nurse #2 reported that she was informed earlier that morning (on 10/23/14) that the fluid intake from nutritional supplements did not count as part of a resident ' s fluid restriction. Prior to this, Nurse #2 reported that she thought Med Pass and other nutritional supplements did count as part of the fluid restriction and that dietary was already taking it into account in calculating the nursing allotment. Nurse #2 described the record keeping responsibilities for documenting a resident ' s fluid intake. The nurse indicated that the NAs monitored the fluid intake from meal trays and recorded this information on the fluid intake record kept in the NA ' s binder (the NA Flow Book). She also reported that the hall nurse was responsible to keep a separate record of any fluids provided during medication passes. Nurse #2 reported that that fluid intake documented by the nurse was not included in the fluid intake documented by the NA. The two fluid intake records needed to be added together to obtain the resident ' s total fluid intake for the day.

An interview was conducted with Dialysis Center RD #1 on 10/23/14 at 2:32 PM. RD #1 was identified by the facility's CDM as the contact person at the Dialysis Center. RD #1 reported that although she did not provide direct care for Resident #135, she recommended counting the free fluid portion of all nutritional supplements as part of a dialysis patient ' s prescribed fluid restriction. She noted that the free fluid portion of a specific nutritional supplement would be calculated based on the manufacturer's information (typically 65-85% of the total volume of the supplement).

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An interview was conducted with Dialysis Center RD #2 on 10/23/14 at 2:40 PM. RD #2 assumed responsibility for the nutritional care of Resident #135 at the Dialysis Center. During the interview, RD #2 stated nutritional supplements should be included in a resident ' s prescribed fluid restriction. She stated, "They (the facility) need to adhere to the total fluid restriction allowance and include the nutritional supplements."

An interview was conducted with Resident #135's Physician Assistant (PA) on 10/23/14 at 1:36PM. Upon inquiry, the PA stated, "I would imagine any fluids, including the nutritional supplements, would be incorporated into the fluid restriction unless otherwise stated (in the order)."

An interview was conducted with the Director of Nursing (DON) on 10/23/14 at 1:46 PM. During the interview, the DON reported that approximately 2-3 weeks ago the facility noticed some inconsistencies in the process of recording the fluid intakes of residents. In discussing the procedures employed, the DON reported that the NA's Flow Book record only included documentation of what fluids were sent out on a resident's meal trays (plus any extra fluids personally given to the resident or observed as consumed by the NA). The DON reported that the NA Flow Book record did not include any fluids provided by the nurses during medication pass. The DON also reported that there was a separate fluid intake record kept on the MAR by the hall nurse, but that a discrepancy had been found with this documentation. While some nurses recorded only the fluids given to a resident during medication pass on this record, other nurses included the fluids a resident consumed at

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F 325	Continued From page 14 mealtime as well. The DON noted that the nurses were recently instructed to record only the fluid that they personally gave to the resident, and were educated not to include any nutritional supplements as part of this fluid intake. The DON reiterated that her expectation was for the hall nurse to include only the free fluids given to the resident and not to include Med Pass (or other nutritional supplements) in the fluid intake recorded. The DON acknowledged that the 540 cc of nutritional supplements prescribed for Resident #135 would have been provided in addition to the resident's 1000 cc fluid allowance. The DON stated her expectation was that the fluid intake record in the NA Flow Book would reflect the dietary's fluid allowance, while the hall nurse's fluid intake record would reflect the nursing allowance from the resident's fluid restriction. The DON also indicated that the two fluid intake records, when added together, should provide the resident's total fluid intake for the day. A follow-up interview was conducted with the DON on 10/23/14 at 3:20PM. During this interview, the DON stated, "We were working on getting it fixed (referring to the process of monitoring fluid intake), but we didn't fix it as well as we could have."	F 325		
F 364 SS=D	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.	F 364		11/17/14

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F 364	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on a meal observation, staff interviews and resident interviews, the facility failed to provide palatable foods for 2 of 14 residents interviewed regarding food quality. (Resident #123 and #92) Findings include: An interview with Resident #92 on 10/21/14 at 1:41pm revealed the supper meal was cold. An interview with Resident #123 on 10/21/14 at 2:58pm revealed that breakfast was not warm. I eat in my room and it does not taste good. On 10/23/14 a test tray was requested from the server on the steam table. A regular tray was placed on an open cart to be taken to the East Hall. The tray had scrambled eggs, a bowl of oatmeal, 2 pieces of bacon, a biscuit, a glass of orange juice and a cup of coffee. The tray arrived on the East Hall at 8:14am and remained on the cart until the last tray was served to a resident at 8:38am. The corporate dietary manager removed the tray from the open cart and placed it on the counter at the nursing station. The surveyor tasted the meal on the test tray along with the corporate dietary manager. The scrambled eggs had a rubbery texture to them. The oatmeal was warm, the bacon was luke warm and the coffee was warm. The corporate dietary manager stated the scrambled eggs had a denseness, the oatmeal was warm, the bacon was luke warm, and the coffee was warm.	F 364	1. Corrective actions were taken at the time they were identified for all residents identified during the survey process. These residents have also been re-interviewed by the Certified Dietary Manager since the conclusion of the survey. Resident # 92 reports that meals have been hot and the taste good. Resident #123 reports that the meal taste has improved and are being served hot. 2. Meal temperatures for all resident meals have been recorded since 11/7/14 and are in an acceptable range prior to being served. Recipes are available and utilized by the cooks for daily meal preparation. 3. On 11/13/14, The Certified Dietary Manager and Executive Chef completed an in-service on with all cooks who are responsible for serving meals. Cooks were re-educated on thermometer calibration, keeping food on the steam line above the required holding temperature and following the approved recipes. Digital thermometers were ordered and issued to cooks to improve the accuracy of food temperature monitoring. Also, effective 11/13/2014 the facility has altered the cooking process for eggs to allow for a more palatable product. 4. The Certified Dietary Manager, Executive Chef, Administrator, and/or Line Cooks will check meal quality (daily) for appetizing taste, texture, and temperature prior to serving meals. The results will be documented on a Meal Quality Monitoring QA Tool starting on 11/17/14. Daily meal	

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F 364	Continued From page 16	F 364	quality will be monitored and recorded to help ensure proper temperature, taste and palatability. Concerns with meals will be addressed as reported/identified and at the monthly Resident Council meetings. The Executive Chef, as part of the Meal Preparation and Delivery QA Team, (along with the Nursing Home Administrator and Certified Dietary Manager) will be responsible for addressing the concerns. The efforts of the Meal Preparation and Delivery QA Team will be reported at the Executive QA Quarterly Committee Meeting for the next 6 months. The next Executive QA Quarterly Committee meeting is scheduled for January 20, 2015.	
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, record review, and staff interview the facility failed to ' keep pureed eggs, pureed turkey, fried bacon, chopped turkey, and thick sliced turkey at 135 degrees Fahrenheit during operation of the tray-line, failed to clean	F 371	1. Food items noted under the acceptable temperature range were reheated and corrected during the surveyor process. The incorrectly calibrated thermometer was also	11/17/14

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F 371	Continued From page 17 convection oven after use for 1 of 1 kitchen, and failed to label food items belonging to residents stored in the refrigerators located in the nourishment room for 1 of 3 nourishment rooms.. Findings include: 1. On 10/23/14 at 7:22am cook #1 calibrated a thermometer to take the temperatures of the breakfast items being held on the steam table. The thermometer was calibrated to between 32 and 0 degrees Fahrenheit. The cook placed the thermometer in the pureed eggs which registered at 120 degrees Fahrenheit; the pureed turkey registered 100 degrees Fahrenheit; the chopped turkey registered 90 degrees Fahrenheit; the scrambled eggs registered 140 degrees Fahrenheit; the oatmeal registered 160 degrees Fahrenheit; the fried bacon registered at 88 degrees Fahrenheit; the thick sliced turkey registered at 82 degrees Fahrenheit; boiled pasteurized eggs registered at 140 degrees Fahrenheit and the coffee registered at 140 degrees Fahrenheit. On 10/23/14 at 7:32am the cook was asked what the temperatures of the hot food was, he looked up on the temperature log hanging from the top of the steam table and stated it was to be held at 135 degrees Fahrenheit. On 10/23/14 at 7:32am the corporate dietary manager arrived and she instructed the cook to re-heat the food. On 10/23/14 at 7:50am the corporate dietary manager questioned the cook ' s calibration of the thermometer and had a staff member get her another thermometer. She calibrated the	F 371	corrected during the survey observation. The oven was cleaned after an initial observation on 10/22/2014 to correct the identified concern. The unlabeled items belonging to a resident in the nourishment room refrigerator were discarded as well. 2. The cook observed to have incorrectly calibrated the thermometer was in-serviced for recording proper temperatures and thermometer calibration on 11/12/14. Effective 11/17/14, all temperatures are recorded on a QA temperature log prior to serving meals. The oven was cleaned on 10/22/2014 and all nourishment room refrigerators were checked to ensure no unlabeled food items intended for specific residents were stored. 3. Under the direction of the Meal Preparation and Delivery QA Team, adjustments were made to the temperature log, cooks are now required to sign temperatures of each food item and what time the first cart leaves the kitchen. Cooks are now required to place food on the steam line no earlier than 30 minutes prior to serving the meal. If necessary, food is kept in a warm oven until it is ready to be served. The CDM and Executive Chef have altered the cleaning schedule to ensure there is a system of accountability in place to make sure dietary equipment is kept clean. The Director of Housekeeping Services, or a designee, now completes daily rounds to ensure no food items belonging to residents are stored without a resident name and date. A sign has been posted to notify family members that any unlabeled,	

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F 371	Continued From page 18 thermometer at 32 degrees Fahrenheit. The food with low temperatures had been removed from the steam table; there were trays on an open cart ready for delivery to the halls. The trays had warmed plates with a bottom and top insulated cover. The dietary manager pulled a tray and took temperatures of the following food items. The pureed eggs registered at 110 degrees Fahrenheit; the pureed meat registered at 113 degrees Fahrenheit. On 10/23/14 at 8:56am an interview with the cook revealed that he had taken the temperatures of the food items when they were placed on the steam table; however "they were behind and he did not log them on the temperature log". He stated "I know I am suppose to". On 10/23/14 at 7:43am the cook re-took the temperatures of the food he had re-heated and they were; Pureed eggs 155 degrees Fahrenheit; Pureed Turkey 149 degrees Fahrenheit; Chopped Turkey 141 degrees Fahrenheit; Bacon 100 degrees Fahrenheit; and the thick sliced turkey was 97 degrees Fahrenheit. 2. On 10/20/14 at 10:48am and on 10/22/14 at 2:50pm the convection oven had black brown substance on the sides and on the back. Located at the base where the convection oven is affixed is a ledge 1/2 inches wide was an accumulation of dust and debris. The top of the convection oven had a layer of accumulated grease and debris. On 10/22/14 at 2:55pm the chef/dietary manager confirmed the convection oven had black brown substance on the sides and on the back. Located at the base where the convection oven is affixed	F 371	undated, or out of date food items will be discarded. Specific staff including the housekeeping staff, the Director of Maintenance, and QA nurse have been in-serviced to discard unlabeled, undated, or out of date food items belonging to residents. 4. The Food Preparation and Delivery QA Team was formed to monitor and ensure compliance with this plan of correction. The team will consist of the Administrator, Certified Dietary Manager, Executive Chef, and Registered Dietician (when available). The team will meet weekly x 4, monthly x 3, and quarterly thereafter. The QA team will report their activity to the Executive QA Committee on the next scheduled meeting, which is January 20, 2015.	

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was a ledge 1/2 inches wide was an accumulation of dust and debris. The top of the convection oven had a layer of accumulated grease and debris. At 2:58pm the dietary aide that was assigned the cleaning of the oven stated he did not clean the back, sides or top of the oven.

3. On 10/22/2014 at 3:56:05 PM on the area called 'Cooper River Neighborhood' in the refrigerator located in the nourishment room 1 container yogurt, and three 3.75oz. (Ounce) containers of diced peaches was observed to have no name on it identifying who it belonged to. An 8oz Styrofoam cup with a plastic lid of cranberry juice was observed with no date as to when it was poured.

On 10/23/14 at 10:16am an interview with Nurse #1 revealed the yogurt and the peaches belonged to specific residents. Further discussion revealed whoever takes the food items a family or resident brings are to date them and place the residents ' name on them. She indicated that she had no idea who those food items belonged to.

On 10/23/14 at 10:18am the corporate dietary manager stated the dietary staff stocks all the refrigerators located in the nourishment rooms. The nurses, housekeepers and the dietary staff are responsible to check for expired items. Further discussion revealed the kitchen does not stock yogurt nor the cups of diced peaches.

On 10/23/14 10:19am an interview with NA (nurse ' s aide) #2 revealed that when families bring in food items she would ask the nurse if that resident was allowed to have the item and then if the nurse says the resident can have the food

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F 371	Continued From page 20 item "I would put the residents name on it. " On 10/23/14 at 10:23am NA#3 stated the staff on the hall was responsible for items brought in by family; they are to put the date and resident names on items. The dietary staff are responsible for stocking refrigerators.	F 371		