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F 000	INITIAL COMMENTS There were no deficiences cited as a result of the complaint investigation survey of 12/28/15. Compliant Intake # NC00113107. Event ID # W1ZC11.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159		1/22/16

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

Electronically Signed | 01/25/2016

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F 159	Continued From page 1 The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on documentation and interviews, the facility failed to ensure account balances were within $200.00 of the eligibility limit for three of five resident fund accounts reviewed. (Resident #6, Resident #24 and Resident #25). The findings included: 1. Review of Resident #6's personal funds account for four months revealed: September, 2015 - $2,489.92 October, 2015- $2,514.92 November, 2015- $2,514.92 December, 2015- $1,999.92 During an interview on 12/31/15 at 12:17 PM, with the Business Office Manager and the Business Office Manager Assistant, the Business Office Manager stated the resident's liability was pulled late and rolled over to the next month. She revealed in December, Resident #6 had a little	F 159	Submission of this response and Plan of Correction is not a legal admission that a deficiency was correctly cited. It is not to be construed as an admission of interest against the facility, the Administrator Director of Nursing or any employee, agent or othe4r individuals who draft or may be discussed in the response or the Plan of Correction. In addition preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged nor the correction of any conclusions set forth in the allegation by the survey agency. For the defiencies cited during this survey, this survey, this facility has developed and implemented a facility-wide system to assure correction and continued compliance with the regulations. This facility will provide a complete copy of the	

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F 159	Continued From page 2 less than $2,000.00 in her account. She revealed her family member was told to buy clothes to keep the account under $2,000.00. She revealed that she did not have letters as documentation informing the family member about the need to keep Resident #6's account under $2,000.00. During an interview on 12/31/2015 at 2:06 PM, the Administrator revealed her expectation was to make sure when the resident's money was over $2,000.00, a certified letter would be sent to the family member/representative to make sure that they receive it. 2. Review of Resident #24's personal funds account for four months revealed: September, 2015- $4,501.03 October, 2015-$4,403.03 November,2015-$2,371.78 December,2015-$5,756.03 During an interview on 12/31/2015 at 1:20 PM the Business Office Manager stated Resident #24 was getting Social Security and Supplemental Security Income. She revealed last year they returned the money and spoke with someone at Social Security about it, however, Resident #24 continues to receive Supplemental Security Income. She stated she did not know why Resident #24 was getting the money. The Business Office Manager reported that they did not send letters to Social Security or family members about keeping Resident #24's account under $2,000.00. During an interview on 12/31/2015 at 2:06 PM,	F 159	deficiency list to the QAA Committee for review and appropriate actions. We would like you to accept this POC as our credible allegation of compliance. Credible Allegation of Compliance A. Residents #6, #24 and #25 have been reviewed and their accounts have been put back in compliance with the regulation. B. A comprehensive review will be completed on all other facility residents to ensure compliance. C. A written facility policy has been put into place to require a letter be sent to the resident/responsible party when the resident fund comes within $200 of the allowable $2,000 limit. This letter will be sent certified and a receipt will be kept on file. D. Incoming resident/ responsible parties will be informed of this policy as part of the admissions process (as well as all existing residents) E. Moving forward the Business office Manager , along with the facility Administrator , will monitor the resident fund account monthly to identify potential overages. F. The facility will be in substantial compliance by February 1, 2016.	

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F 159	Continued From page 3 the Administrator revealed her expectation was to make sure when the resident's money was over $2,000.00 a certified letter would be sent to a family member/representative to make sure that they receive it. 3. Review of Resident #25's personal funds account for four months revealed: September, 2015- $4,659.00 October, 2015-$4,890.00 November,2015-$5,129.00 December,2015-$2,525.62 During an interview on 12/31/2015 at 1:22 PM, the Business Office Manager stated Resident#25's family members had been handling his PML (Patient Monthly Liability). She revealed no letter had been sent to Resident #25's family members about keeping the resident's account under $2,000.00. During an interview on 12/31/2015 at 2:06 PM, the Administrator revealed her expectation was to make sure when the resident's money was over $2,000.00 a certified letter would be sent to a family member/representative to make sure that they receive it.	F 159		
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.	F 160		1/22/16

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F 160	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on documentation and interviews, the facility failed to forward the balance of expired resident's personal funds to the Clerk of Court for two of four resident personal fund accounts reviewed. (Resident #40 and Resident #108) The findings included: 1. Resident #108 expired on 6/6/15. On 6/9/15, the facility forwarded a check for $250.00 to a funeral home. During an interview on 12/31/15 at 11:31 AM, the Business Office Manager Assistant revealed the facility was not the payee for Resident #108's Social Security. She stated Resident #108's family member made deposits in her account for beauty shop appointments. She stated the family member also wrote a check for Resident #108's patient liability and the money was deposited into her account. The Business Office Manager Assistant revealed Resident #108's family member requested the balance of Resident #108's account be forwarded to the funeral home after she expired. During an interview on 12/31/15 at 10:14 AM, the Business Office Manager revealed Resident #108's family member wanted the money to be forwarded to the funeral home, however she knew the money should have been forwarded to the Clerk of Court. During an interview on 12/31/15 at 1:00 PM, the Administrator stated her expectation was the	F 160	A. A comprehensive review will be completed to ensure residents #8, #40 and all other facility residents are in compliance with regulation. B. A policy has been put in place to reflect all residents funds will be sent to the Clerk of the Court upon resident expiration. C. Resident/responsible parties will be notified of this policy during the admission process (as well as all existing residents). D. Facility Administrator, along with Business Officer Manager, will monitor monthly. E. The facility will be in substantial compliance by February 1, 2016.	

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F 160	Continued From page 5 money should be sent to the Clerk of Court. 2. Resident #40 expired on 11/7/15. Review of his personal fund account revealed $4,771.80 was withdrawn from his account and applied to his patient liability/room and board. During an interview on 12/31/15 at 10:14 AM, the facility Business Office Manager stated Resident #40 ' s family member wanted to clear her account before he expired. She revealed she thought the money was withdrawn from the account before Resident #40 expired instead of after he expired. During an interview on 12/31/2015 at 11:28 AM, the Business Office Manager Assistant revealed Resident #40 ' s family member requested that whatever Resident #40 owed the facility, it was supposed to be applied to his bill. She reported the resident still owed the facility $39.36. She revealed she was now aware the money should have been forwarded to the Clerk of Court. During an interview on 12/31/15 at 1:00 PM, the Administrator stated her expectation was the money should have been sent to the Clerk of Court.	F 160		
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	F 161		1/22/16

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F 161	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to provide a surety bond to protect resident funds for ninety two residents with personal fund accounts managed by the facility. The findings included: During an interview on 12/31/2015 at 10:10 AM the Administrator revealed she did not have a copy of the surety bond. She explained the corporate office kept the surety bond, but the corporate office was closed and would not reopen until Monday. During an interview on 12/31/15 at 10:30 AM, the Business Office Manager revealed the Business Office did not have copies of the surety bond and they had been trying to get the surety bond from the corporate office for the past couple of days. During another interview on 12/31/15 at 1:04 PM, the Administrator revealed the surety bond was out of her hands. She stated it would be easier if they had a copy of the surety bond in the facility.	F 161	A. A Surety Bond has been obtained from the Home Office in the amount of $80,000 to ensure the security of all resident funds kept by the facility. B. The Surety Bond will, moving forward , be maintained on site at the facility for review. C. The facility Administrator ,along with the Business Office Manager, Surety Bond is current and in an amount adequate to cover current resident fund balances. D. The facility will be substantial compliance by February 1, 2016.	
F 241 SS=D	483.15(a) 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 observations and staff interviews, the	F 241	A. Corrective action has been	1/22/16

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F 241	Continued From page 7 facility failed to ensure dignity by failing to serve three (3) dependent residents in the small dining room close to the same time during meals for four different meal observations. (Resident #36, Resident #16 and Resident #20). The findings included: 1. Resident #36 was originally admitted to the facility on 4/22/05, with diagnoses including Anemia, Hyperlipidemia, Dementia, and Cerebrovascular Accident. According to the most recent Quarterly Minimum Data Set (MDS) dated 9/29/15, Resident #36 was totally dependent in all areas of activities of daily living. During an observation on 12/28/15 at 12:55 PM, seven residents were observed in the small dining/activity room. One Nursing Assistant (NA) was observed feeding a resident in a geri chair separate from the dining table. At the dining table one NA was feeding two residents, and a family member was feeding a resident in a geri chair separate from the dining table. Two other residents were eating their meals independently. Resident #36 who was sitting in a geri chair near the television in the dining/activity room was not fed until 1:15 PM. During an observation on 12/30/15, at 8:44 AM, twelve residents were in the dining room waiting for breakfast. At 8:50 AM residents were served breakfast. Three staff were in the dining room feeding three dependent residents. One Nursing Assistant (NA) was feeding two residents at the dining table and two NAs were feeding two different residents in geri chairs separate from the dining table. Resident #36 who was sitting in a geri chair by a drink machine was not fed until	F 241	accomplished for those residents found to have been affected by the deficient practice as described in the following: Residents #36,#16 and #2 have been ident6ified as a dependent feeders and meal time schedules have been revised to ensure proper feeding times. B. The ADON and nursing staff have identified all dependent feeders. C. Meal times will be reviewed and revised by nursing. D. Residents identified as dependent feeders will be ensured appropriate feeding times. E. Meal times will be reviewed by the QA team. F. The facility will be in substantial compliance by February 1, 2016.	

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9:06 AM by a Nursing Assistant.

During an observation on 12/31/15 at 8:49 AM, ten residents were in the dining room. Three Nursing Assistants (NAs) were observed feeding three residents. One NA was observed feeding a resident in a geri chair next to a Christmas tree. One NA was feeding two residents at the dining table. One NA was feeding another resident in a geri chair. Resident #36 who was sitting in a geri chair next to a drink machine was not fed until 9:05 AM by a Nursing Assistant.

During an interview on 12/31/15 at 9:19 AM Nursing Assistant #1 revealed they needed more help in the dining room. She revealed they do the best they can with four staff. She stated she was scheduled off today, but she came in to help out. She revealed there was a problem feeding residents at the same time every day.

During an interview on 12/31/15 at 9:25 AM, Nursing Assistant #2, stated they do not have enough staff to feed each resident in the dining room and on the halls. She revealed sometimes they fed two residents at a time so they would not be waiting so long to eat. NA#2 said the problem with not being able to feed residents at the same time happened every day. She revealed she had not reported it to anyone. She said they just do it. She revealed they need more help in the dining room.

During an interview on 12/31/2015 at 9:31 AM, Nursing Assistant (NA) #3, revealed they had four Nursing Assistants. She said one NA was assigned to the kitchen during mealtimes, one NA had to feed residents on the hall and that only left two NAs for the small dining room, unless they

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had an extra person. NA#3 said an NA was needed to monitor the halls, but that was hard to do. She further stated they had five aides at one time but they were cut back due to the census.

During an interview on 12/31/2015 at 9:52 AM, Staff Nurse #1 said staff usually brought residents to the dining room that were able to feed themselves first and then they got the residents that had to be fed by staff. She revealed there might have been a few minutes between the time staff were able to feed a resident. She stated they needed more aides.

During an interview on 12/31/2015 at 12:31 PM the Director of Nursing (DON) revealed four staff were assigned in the dining room during mealtime. She explained one Nursing Assistant (NA) went to the big dining room, and one NA remained on the hall. She revealed her expectation was to have enough staff to feed all residents. The DON said some residents would have to wait until someone was available to feed them. She revealed she did not know there was a problem with residents not being fed at the same time as other residents in the dining room.

During an interview on 12/31/2015 at 2:19 PM the Nurse Supervisor stated she did not know there was a concern about residents waiting to be fed. She stated her expectation would be to have enough staff in the dining rooms so residents would not have to wait to be fed.

During an interview on 12/31/2015 at 12:57 PM, the Administrator revealed she did not know there was a problem with residents not being fed at the same time during meals. She stated if she knew about it she would have found someone else to

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help with feeding. She stated no one told her about it.

2. Resident #16 was originally admitted to the facility on 8/31/13 with diagnoses including Hypertension, Cerebrovascular Disease, and Dementia. According to the most recent Quarterly Minimum Data Set (MDS) dated 10/20/15, Resident #16 required extensive to total assistance in most areas of activities of daily living.

During an observation on 12/29/15 at 8:20 AM, nine residents were in the dining room waiting for breakfast. At 8:30 AM, breakfast was served and two staff were feeding two dependent residents in geri chairs separate from the dining table. Resident #16 who was sitting at the dining table was not served and fed until 8:47 AM.

During an interview on 12/31/15 at 9:19 AM Nursing Assistant #1 revealed they needed more help in the dining room. She revealed they do the best they can with four staff. She stated she was scheduled off today, but she came in to help out. She revealed there was a problem feeding residents at the same time every day.

During an interview on 12/31/15 at 9:25 AM, Nursing Assistant #2, stated they do not have enough staff to feed each resident in the dining room and on the halls. She revealed sometimes they fed two residents at a time so they would not be waiting so long to eat. NA#2 said the problem with not being able to feed residents at the same time happened every day. She revealed she had not reported it to anyone. She said they just do it. NA#2 stated they need more help in the dining room.

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During an interview on 12/31/2015 at 9:31 AM, Nursing Assistant (NA) #3, revealed they had four Nursing Assistants. She explained one NA was assigned to the kitchen during mealtimes, one NA had to feed residents on the hall and that only left two NAs for the small dining room, unless they had an extra person. NA#3 said an NA was needed to monitor the halls, but that was hard to do. She further stated they had five aides at one time but they were cut back due to the census.

During an interview on 12/31/2015 at 9:52 AM, Staff Nurse #1 said staff usually brought residents to the dining room that were able to feed themselves first and then they got the residents that had to be fed by staff. She revealed there might have been a few minutes between the time staff were able to feed a resident. She stated they needed more aides.

During an interview on 12/31/2015 at 12:31 PM the Director of Nursing revealed four staff were assigned in the dining room during mealtime. She explained one Nursing Assistant (NA) went to the big dining room, and one NA remained on the hall. She stated her expectation was to have enough staff to feed all residents. The DON stated some residents would have to wait until someone was available to feed them. She revealed she did not know there was a problem with residents not being fed at the same time as other residents in the dining room.

During an interview on 12/31/2015 at 2:19 PM the Nurse Supervisor stated she did not know there was a concern about residents waiting to be fed. She stated her expectation would be to have enough staff in the dining rooms so residents

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would not have to wait to be fed.

During an interview on 12/31/2015 at 12:57 PM, the Administrator revealed she did not know there was a problem with residents not being fed at the same time during meals. She stated if she knew about it she would have found someone else to help with feeding. She stated no one told her about it.

3. Resident #20 was originally admitted to the facility on 8/1/13, with diagnoses including Anemia, Cerebral Palsy and Hemiplegia. According to the most recent Quarterly Minimum Data Set (MDS) dated 12/1/15, Resident #20 was totally dependent in all areas of activities of daily living.

During an observation on 12/29/15 at 8:20 AM, nine residents were in the dining room waiting for breakfast. At 8:30 AM, breakfast was served and two staff were feeding two dependent residents in geri chairs separate from the dining table. Resident #20 who was sitting at the dining table was not served and fed until 8:43 AM.

During an interview on 12/31/15 at 9:19 AM Nursing Assistant (NA#1) revealed they needed more help in the dining room. She revealed they do the best they can with four staff. She stated she was scheduled off today, but she came in to help out. She revealed there was a problem feeding residents at the same time every day.

During an interview on 12/31/15 at 9:25 AM, Nursing Assistant #2, stated they do not have enough staff to feed each resident in the dining room and on the halls. She revealed sometimes they fed two residents at a time so they would not

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be waiting so long to eat. She said the problem with not being able to feed residents at the same time happened every day. NA#2 revealed she had not reported it to anyone. She said they just do it. NA #2 stated they need more help in the dining room.

During an interview on 12/31/2015 at 9:31 AM, Nursing Assistant (NA) #3, revealed they had four Nursing Assistants. She explained one NA was assigned to the kitchen during mealtimes, one NA had to feed residents on the hall and that only left two NAs for the small dining room, unless they had an extra person. She said an NA was needed to monitor the halls, but that was hard to do. She further stated they had five aides at one time but they were cut back due to the census.

During an interview on 12/31/2015 at 9:52 AM, Staff Nurse #1 said staff usually brought residents to the dining room that were able to feed themselves first and then they got the residents that had to be fed by staff. She revealed there might have been a few minutes between the time staff were able to feed a resident. She stated they needed more aides.

During an interview on 12/31/2015 at 12:31 PM the Director of Nursing revealed four staff were assigned in the dining room during mealtime. She explained one Nursing Assistant (NA) went to the big dining room, and one NA remained on the hall. She stated her expectation was to have enough staff to feed all residents. The DON revealed some residents would have to wait until someone was available to feed them. She stated she did not know there was a problem with residents not being fed at the same time as other residents in the dining room.

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F 241	Continued From page 14 During an interview on 12/31/2015 at 2:19 PM the Nurse Supervisor stated she did not know there was a concern about residents waiting to be fed. She stated her expectation would be to have enough staff in the dining rooms so residents would not have to wait to be fed. During an interview on 12/31/2015 at 12:57 PM, the Administrator revealed she did not know there was a problem with residents not being fed at the same time during meals. She stated if she knew about it she would have found someone else to help with feeding. She said no one told her about it.	F 241		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to refer a resident with long, thick toenails to a podiatrist within a timely manner. (Resident #11)	F 328	A. Corrective action has been accomplished for the resident found to have been affected by deficient practice as described in the following : 1. Resident #11 toenails were soaked and	1/22/16

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F 328	Continued From page 15 The findings included: Resident #11 was originally admitted to the facility on 6/16/10 with diagnoses including Diabetes Mellitus II. According to the most recent Quarterly Minimum Data Set dated 11/25/15, Resident #11 required minimal assistance in most areas of activities of daily living. Review of weekly skin assessments listed below revealed Resident#11 had long, thick toenails since October, 2015. Review of Resident #11 ' s weekly skin assessment dated 10/21/15, read in part, under other " condition of toenails: Checked: dry, thick, long. Resident refuses bath and nail care, Needs Podiatry Appt. " Review of Resident #11 ' s weekly skin assessment dated 11/19/15, read in part, under other " condition of toenails: Checked: dry, thick, long. " Review of Resident #11 ' s weekly skin assessment dated 11/30/15, read in part, under other " condition of toenails: Checked: dry, thick, long. " Review of Resident #11 ' s weekly skin assessment dated 11/30/15, read in part, under other " condition of toenails: Checked: dry, thick, long. " Review of Resident #11 ' s weekly skin assessment dated 12/17/15, read in part, under other " condition of toenails: Checked: dry, thick, long. Podiatry Appt.-Pending "	F 328	trimmed to an appropriate length not too close (per Physician's Order) ,. An appointment was made with the podiatrist for January 4, 2016. Resident was seen by the podiatrist - toenails were clipped and has a follow-up visit in 3 months (04-04-16 @ 11:00 am) Family requested that resident's toenails are not to be trimmed by nursing staff. B. All residents' toenails will be assessed by nursing staff. C. Staff will use existing tools which include weekly skin assessment and bath sheet. D. Re-in-service nursing staff on proper nail care. E. Resident assessment sheet will be monitored by the charge nurses. F. The facility will be in substantial compliance by February 1. 2016.	

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Review of Resident #11 ' s weekly skin assessment dated 12/24/15, read in part, under other " condition of toenails: Checked: dry, thick, long. "

Review of Resident #11 ' s weekly skin assessment dated 12/28/15, read in part, under other " condition of toenails: Checked: dry, thick, long. Continue to attempt Podiatry Appt. "

Review of a Nurse's note dated 12/28/15, read in part, " Resident on shower list today. Resident refuses to take a shower. Residents toe nails long. Podiatry appointment scheduled. Podiatry closed until 1/4/16. Family visiting. Note written by the Treatment Nurse.

During an interview on 12/29/2015 at 2:40 PM Nursing Assistant (NA) #4 revealed Resident #11 was able to do a lot for herself. She stated she helped Resident #11 with her baths and set up her meal tray during meals. NA#4 revealed Resident #11 went to the bathroom independently and she helped her when she had a toileting accident. In reference to nail care, NA #4 stated Resident #11 was diabetic and she was sent to the podiatrist when she needed to have her toenails cut. She stated she made sure Resident #11 ' s feet were washed clean. She revealed her toenails needed to be cut. NA#4 reported that she was in the facility on Sunday and the Nurse was informed Resident #11 needed to be referred to a podiatrist because of her long toenails. She revealed a Nurse wrote Resident #11 ' s name down to see a podiatrist.

During an interview on 12/28/15 at 3:27 PM, the Nurse Supervisor stated they had called everyone and no one could see her until January 9th. She

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revealed assessments were done once a week and they looked at them.

During an interview on 12/29/15 at 10:54 AM, Resident #11 ' s family member revealed she had observed Resident #11 ' s toenails and she was very concerned about the length of her toenails, and that the Podiatry office was closed until January 4th. She revealed she was not aware of the condition of Resident #11 ' s feet because no one had told her. She was also concerned that Resident #11 was diabetic and walking could have been difficult due to the condition of her feet.

On 12/29/2015 at 2:50 PM Resident #11 was observed lying in bed with beige non-skid socks on both feet. The resident said her feet did not hurt. Resident #11 agreed to the observation of her feet. The toe nail on the resident's left foot, big toe was thick, curled toward right over the toe and was about 1/2 of an inch long. The toe nail on the right foot, big toe was thick and was about a quarter inch long.

During another interview on 12/29/15 at 4:30 PM Resident #11's family member revealed she did not want Nursing Staff cutting Resident #11's toenails because she was diabetic and she preferred to have her seen by a Podiatrist in her area.

During an interview on 12/30/2015 at 9:22 AM, the Treatment Nurse stated Resident #11 refused to let her cut her toenails. She stated she could not verify whether or not Resident #11 was referred to the Podiatrist or not. She said she was not aware of an appointment. The Treatment Nurse stated the Social Worker would usually let

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transportation know about appointments. On Monday 1/8//16 she stated she spoke to Resident #11 ' s family member about the doctor ' s order to wash and soak Resident #11 ' s feet and for about thirty minutes, and trimming her toe nails not too close at an appropriate length. The Treatment Nurse stated it depended on Resident #11 ' s mood as to whether or not she would let her cut her toenails.

During an interview on 12/30/2015 at 3:57 PM, the facility Social Worker explained that usually Nurses made appointments and she might go behind them to see when the resident had the appointment scheduled. The Social Worker stated she completed Resident #11 ' s assessment in December. She revealed Resident #11 would refuse personal care and sometimes not allow staff to do anything for her. She stated Resident #11 ' s family member had agreed to go to the podiatrist with Resident #11.

During an observation on 12/30/2015 at 4:24 PM, Resident #11 was lying in bed with beige nonskid socks on her feet. She agreed to have her feet observed. The toenail on Resident #11's left foot big toenail was curved to the right over the toe. The toenail was long and thick and about 1/2 an inch long. The toenail on Resident #11' s right big toe was also thick and long a quarter inch long.

During an interview on 12/31/15 at 9:57 AM, the Nurse Supervisor revealed Resident #11 ' s family member came and got her when she saw Resident #11 ' s long toenails. She stated the Treatment Nurse cut Resident #11 ' s toenails and the aides cut toenails of residents that were not diabetic. The Nurse Supervisor said usually the aides would tell them if resident ' s toenails

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were long but she said she did not know about Resident #11 ' s toenails.

During an interview on 12/31/2015 at 12:21 PM, the Director of Nursing stated she was notified about Resident #11 ' s toenails on Monday, 12/28/15. She revealed Resident #11 ' s family member came to her office and discussed the concern about Resident #11 ' s toenails with her. The Director of Nursing explained that toenails were cut on an as needed basis. She stated she had not looked at Resident #11 ' s toenails because the resident refuses. The Director of Nursing revealed her expectation was that Resident #11 ' s nails were to be clipped as other residents. She stated Nurses could clip nails or refer nail clipping to the Treatment Nurse and if the Treatment Nurse was not able to resident ' s nails, the resident should be referred to the Podiatrist.

During an interview on 12/31/15 at 12:50 PM, the Administrator revealed her expectation was to make a referral to the Podiatrist. She revealed staff should tell the family member what happened and why Resident #11 was not referred to the Podiatrist. The Administrator stated the family member should be made aware when the resident refused to get her toenails cut and about doctor ' s appointments and referrals.

During an interview on 12/31/15 at 2:11 PM, the Nurse Supervisor revealed staff were supposed to make a referral. She stated she did not know why the referral was not done. She explained that a transportation person made all the appointments. She revealed Nurses usually nails and she would also cut nails at any time. She stated her expectation was to make sure a

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F 328	Continued From page 20 resident had a podiatry appointment if their toenails were too long.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent food borne illness by failing to clean four of four sheet pans, clean one of one steam tables and failed to clean the convection oven. The finding included: A review of the undated Healthcare Services PM Cook, under Assignment, reads; " Clean DR (dining room) Steam table, Degrease Conventional Oven. " 1.During the initial kitchen tour with the dietary manager on 12/28/15 at 9:27 AM the convection oven was observed. Four sheet pans stacked on top of the convection oven were observed with black food residual 1/8th inch thick baked onto the outer edges of the pans. A second observation on 12/30/15 at 8:47 AM two sheet pans stacked on top of the convection oven	F 371	A. The facility Dietary Manager, along with dietary staff, have thoroughly cleaned the steam table, the convention oven and the 4 sheet pans noted in the survey. B. The Regional Manager , along with the Dietary Manager, from the contract provider of food services for the facility have conducted a comprehensive inspection of the kitchen to ensure all other areas meet the standard of the regulation. C. Cleaning schedule covering all areas of the kitchen operation are in placed to ensure moving forward sanitation guidelines are met. D. Q.A. Committee members, along with the Dietary Manager and Regional	1/22/16

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F 371	Continued From page 21 were observed with black food residual 1/8th inch thick baked onto the outer edges of the pans. A third observation on 12/20/15 at 10:05 AM four sheet pans stacked on top of the convection oven were observed with black food residual 1/8th inch thick baked onto the outer edges of the pans. 2. During a kitchen observation on 12/29/15 at 4:04 PM the 4 foot underside of the steam table shelf was observed covered with dark dried food particles. The four foot wooden steam table shelf attached to the steam table had a 1/2 inch gap that was observed with dried food particles on the inner edges of the shelf. A second observation on 12/30/15 at 8:47 AM the 4 foot underside of the steam table shelf was observed covered with dark dried food particles. The four foot wooden table top shelf attached to the steam table had a 1/2 inch gap that was observed with dried food particles on the inner edges of the shelf. During a third observation on 12/31/15 at 10:12 AM the steam table was observed to be in the same condition. 3 .During the initial kitchen tour with the dietary manager on 12/28/15 at 9:27 AM the convection oven was observed. The front right lower shelf inside the convection oven was observed with black greasy buildup of charred food residual 2 inches wide and deep. A second observation on 12/31/15 at 10:12 AM the convection oven was observed. The front right lower shelf inside the convection oven was observed with black greasy buildup of charred food residual 2 inches wide and deep. In an interview with the Dietary Manager on 12/31/15 at 10:08 AM he revealed that first thing in the morning he does a walk thru of the kitchen, then verbally tells his staff what needs cleaning. He stated that he had worked on cleaning the sheet pans and that he would add that onto the	F 371	Manager, will monitor with weekly /monthly inspections of department to ensure compliance. E. The facility will be in substantial compliance by February 1, 2016.	

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F 371	Continued From page 22 cleaning schedule. The Dietary Manager stated that the convection oven was cleaned weekly but it had not been cleaned this week. He stated that he had a cleaning schedule but had not been using it lately and he did not keep a record of what had been cleaned.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		1/22/16

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F 431	Continued From page 23 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to remove expired insulin from 2 of 4 medication carts. The findings include: The 2006 American Society of Consultant Pharmacists and MED-PASS, Inc. Appendix 29: Medications with Shortened Expiration Dates stated vials of Novolog Insulin should be discarded 28 days after being punctured. 1a. On 12/31/15 at 9:45AM, an observation of the medication cart for residents in rooms 55-76 was made with Med (Medication) Tech (Technician) #1. There were 2 bottles of Novolog Insulin with the names of 2 separate residents and both were dated as being opened on 11/23/15. The Med Tech stated that both residents were still in the facility and both residents had current orders for Novolog Insulin. The Med Tech stated the nurses gave the insulin and were supposed to check the expiration dates prior to giving the insulin. The Director of Nursing (DON) stated in an interview on 12/13/15 at 12:46PM the nurses give the insulin and should look at the date and if past the 28 days after opened should remove the Insulin from the medication cart and get a new vial of insulin. 1b. On 12/31/15 at 10:15AM, an observation of the medication cart for residents in rooms 1 through 17 was made with Nurse #1. There was one bottle of Novolog Insulin dated as opened on 11/3/15. Nurse #1 stated the resident whose name was on the bottle was still in the facility and	F 431	A. The facility will provide storage and dispose of expired medication. 1. Director of Nursing and nursing staff will ensure no insulin is outdated. 2. Policy will be reviewed and revised to ensure compliance of regulation. 3. All Nurses will be in serviced on opening and dating of insulin. 4. Insulin dates will be monitored by 11-7 charge nurse/designee. B. The facility will be in substantial compliance by February 1, 2016.	

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F 431	Continued From page 24 had a current order for Novolog Insulin. A second bottle of Novolog Insulin was observed on the cart with another resident ' s name and was dated as opened on 11/17/15. Nurse #1 stated the resident was still in the facility and had a current order for Novolog Insulin. The Director of Nursing (DON) stated in an interview on 12/13/15 at 12:46PM the nurses give the insulin and should look at the date and if past the 28 days after opened should remove the Insulin from the medication cart and get a new vial of insulin.	F 431		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to provide a pest free dining experience for one of two dining rooms with flies. The findings included: On 12/29/15 at 8:37 AM in the small dining room, five residents were observed sitting at the dining table eating breakfast. During the observation three flies were flying over and on the table. A fly landed on the rim of Resident #7 ' s plate. The resident swatted the fly away with her hand. Another fly buzzed around Resident #7 ' s head and one landed again on the rim of her plate.	F 469	A. The facility immediately contacted our contracted provider of pest control services to implement additional interventions to reduce the fly issue in the dining area. B. Additional "fly traps" and recommendations for exterior spraying of dumpster areas, etc. have been put into place to significantly reduce the ongoing and surveillance by the contracted pest control provider has been increased as well. C. Compliance will be monitored by the	1/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 12/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 469	Continued From page 25 On 12/30/15 at 8:50 AM three or more flies were on the dining table, one fly landed on Resident #48 ' s plate cover. A fly landed on Resident #20 ' s tray while being fed by a Nursing Assistant. On 12/30/15 at 8:59 AM observed Resident #7 swatting a fly away from her food. Flies were observed on the dining table and plate tops. On 12/30/15 at 9:15 AM, observed a fly on Resident # 22 ' s finger. On 12/31/2015 at 8:54 AM a Nursing Assistant swatted a fly from Resident #20 ' s tray. On 12/31/2015 at 8:55 AM observed a fly landing on Resident # 7 ' s food. Two flies were observed landing on coffee cups on the table in front of Resident #56. On 12/31/15 at 8:59 AM observed a fly on Resident #22 ' s cup. On 12/31/15 at 9:07 AM observed a fly on Resident #7 ' s food and tray. On 12/31/15 at 9:08 AM a Nursing Assistant swatted away a fly while feeding Resident #20. On 12/31/15, at 9:10 AM observed a fly on Resident #36 ' s forehead while a Nursing Assistant was feeding the resident. The Nursing Assistant swatted the fly away. On 12/31/15 at 9:12 AM observed a fly on a plate top in front of Resident #20 ' s tray.	F 469	Dietary Manager and Q.A. Committee for effectiveness with results communicated to the contracted pest control provider for possible additional recommendations. D. The facility will be in substantial compliance by February 1, 2016.	

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F 469	Continued From page 26 During an interview on 12/29/15 at 9:04 AM Resident #95, who was identified by the facility as alert and oriented said there were a lot of flies in the facility flying around resident ' s food while they were eating. He revealed this had been a problem for about five months. During an interview on 12/31/2015 at 9:19 AM, Nursing Assistant (NA) #1 revealed the flies were real bad and roaches too. She stated she had reported the flies in the dining room but it had not gotten any better. She stated a company came in once a month to spray but it had not gotten any better. NA #1 revealed there were problems with flies every day. During an interview on 12/31/2015 at 9:25 AM, NA #2 revealed flies were kind of a problem every day. She revealed she had reported the problem with flies in the dining room but there had not been any improvement. During an interview on 12/31/2015 at 9:31 AM, NA #3 revealed there had been a problem with flies and when it was hot outside it was bad. She stated there had been some flies in the dining room and staff would usually call maintenance when there was a problem. She stated she had reported the problem to the Administrator a while back. She revealed some residents had complained about the flies. During an interview on 12/31/2015 at 9:52 AM, Staff Nurse #1 stated she had seen some flies but she did not know whether or not it had been reported. She stated staff would usually call maintenance when there was a problem. She stated there was not a problem with flies all the time. She revealed it happened when the doors	F 469		

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F 469	Continued From page 27	F 469		

were open and there was a change in the weather.

During an interview on 12/31/2015 at 12:27 PM, the Director of Nursing stated no one had reported anything to her about flies in the dining room. She revealed her expectation was for staff to keep flies away from the residents and to get fly swatters at this point. She said staff should report the problem with flies in the dining room to maintenance.

During an interview on 12/31/2015 at 1:43 PM, the Maintenance Director stated no one reported anything to him about flies in the dining room. He revealed there was a sweet potato company in the area which might have contributed to the fly problem. The Maintenance Director said the pest control company came to the facility once a month and sometimes twice a month. He revealed the facility was limited in terms of what they could do. The Maintenance Director revealed purple fluorescent lights with glue boards were located up and down hallways. He said the lights were in the dining room, the kitchen, one on the rehabilitation hall and one was on the outside of the small dining room. The Maintenance Director reported that the pest control company placed the fly devices in the best locations. He revealed the process for reporting pests was to write them on a clipboard including the location and the room number.

During an interview on 12/31/2015 at 2:17 PM the Nurse Supervisor stated she was not aware of the flies in the dining room. She stated staff should call maintenance if they saw flies.

During an interview on 12/31/2015 at 12:54 PM,

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F 469	Continued From page 28 the Administrator stated there had been flies the last couple of days. She revealed the maintenance man said a light device would zap the flies. She revealed her expectation would be to get more devices to prevent flies from coming into the dining room.	F 469		