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| EAST CAROLINA REHAB AND WELLNESS | 2575 W 5TH STREET GREENVILLE, NC 27834 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>There were no deficiencies cited as a result of this complaint investigation of 04/20/2016. Event ID #PUVM11. | F 000 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and record review, the facility failed to stop a treatment when the resident showed signs of pain for 1 of 1 sampled residents (Resident #64) whose pressure ulcer treatment was observed.<br><br>Findings included:<br><br>Resident #64 was readmitted to the facility on 2/1/16 with diagnoses that included multiple pressure ulcers.<br><br>A quarterly Minimum Data Set (MDS) with a date of 3/20/16 indicated Resident #64 was rarely understood and rarely able to understand. Staff assessed Resident #64 with short and long term memory impairment and moderately impaired cognitive skills for daily decision making. The MDS identified the resident as requiring extensive assistance with bed mobility, and totally | F 309 | 1. Once it was pointed out that the resident was experiencing pain, the treatment was stopped. The resident was given pain medication and then the treatment was finished once the pain medication had taken effect.<br><br>2. The treatment nurse and treatment aide were inserviced on what signs and symptoms to look for when performing treatments to ensure that the resident is not experiencing pain. The inservice also included checking with the floor nurse to see if the resident needs to receive any medications before treatment(s) are set to begin.<br><br>3. An audit will be performed by either the DON or designated nursing management to ensure that residents are not receiving | 5/18/16 |

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

Electronically Signed | 05/13/2016

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| F 309 | Continued From page 1<br>dependent on staff for toilet use, personal hygiene and extensive assistance with eating. Resident # 64 was coded with multiple Stage III, IV and unstageable pressure ulcers. The resident was coded as having received pain medication during the assessment period.<br><br>Resident #64's care plan, last reviewed on 4/1/16, indicated the resident had the possibility of pain due to multiple pressure ulcers. The goal of reporting signs and symptoms of pain relief after pain relief measures was to be achieved by assessing the characteristics of the pain including the location and severity of the pain, giving pain medications per orders, give pain medication before the pain become severe, observed for signs and symptoms of pain, discuss with the resident the need to request pain medication before the pain becomes severe, offer comfort measures such as music, rest and repositioning and notify the physician if the level or the frequency of pain increases or the use of as needed pain medication increases.<br><br>On 4/19/16 at 11:50 AM an observation was made of Resident #64 lying in bed. Wedges were used to position the resident on her right side. The resident was heard moaning.<br><br>A treatment observation began on 4/19/16 at 2:38 PM with the treatment nurse and the treatment aide. The treatment nurse and the treatment aide stated the resident had been pre-medicated. The resident was turned so her left hip was facing upward. The old dressing was removed and an unstageable pressure ulcer was visualized. The treatment aid began cleansing the wound at which time Resident #64 began moaning. At the insistence of the surveyor, the treatment aide | F 309 | continued treatment if they are showing signs and/or symptoms of pain. A minimum of 5 treatments will be observed on a weekly basis x 4 weeks and then monthly x 3 months to ensure that treatments are not being performed while the resident is experiencing pain.<br><br>4. The results of these audits will be brought to the facility's monthly Quality Assurance and Assessment Committee meeting (QA&A) to ensure that residents are not receiving treatments while they are experiencing pain. | |

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stopped the wound cleansing, the resident stopped moaning. The treatment nurse spoke with the medication nurse and reported Resident #64 had last been medicated for pain at 10:30 AM. The treatment nurse and the treatment aide both stated they thought the resident had been pre-medicated with a scheduled pain medication because she was on hospice. The treatment nurse stated when a resident was unable to verbalize pain, such as Resident #64, the resident sometimes moaned and groaned such as Resident #64 had when the treatment aide cleansed the wound on the left hip. The treatment aide gave no reason why she continued to irrigate the wound when the resident started moaning.

Nursing Assistant (NA) #3 was interviewed on 4/19/16 at 4:00 PM. She stated it seemed lately Resident #64 had experienced more pain since she had been yelling more than usual when turned; to the point he could hear the resident yelling in the hall

The Director of Nursing (DON) was interviewed on 4/20/16 at 8:35 am. The DON stated if any staff member noticed a resident having increased pain, by either verbalizations or hearing more moans and groans, the expectation was for that staff member to report their observations to a nurse. She added if a treatment was started and the resident exhibited signs of pain, such as moaning or groaning, the expectation would be for the treatment to stop and see if the resident required repositioning or needed pain medication. The DON added the treatment nurse and the treatment aide should have checked on when Resident #64 had last received her pain medication and assured she was pre-medicated

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prior to the dressing change. She stated she would have expected the treatment aide to stop the treatment when Resident #64 started moaning. The DON stated the resident was able to verbalize when she hurt, but also moaned when she was in pain.

Nurse #1 was interviewed on 4/20/16 at 9:56 AM. The nurse stated Resident #64 was confused at times, but usually able to communicate her needs. She stated she had seen hospice staff bathing the resident and heard Resident #64 moaning and groaning. At that time, Nurse #1 stated she stopped the hospice aide and gave the resident pain medication. Nurse #1 added the resident had scheduled pain medication, but also had pain medication she took as needed. She stated she had told the treatment nurse to let her know at least 30 minutes before dressing changes so she could give Resident #64 pain medication and this morning she had pre-medicated Resident #64. She stated Resident #64 had had an overall decline in condition and an increase in the number of pressure ulcers. She stated staff had not reported increased pain during care or sensitivity to the bath water.

The treatment nurse was interviewed on 4/20/16 1:53 PM. The nurse stated over the last 2 months Resident #64 had declined and the number of pressure ulcers had increased. The treatment nurse stated during the wound observation, the treatment aide should have stopped the treatment when Resident #64 started moaning. The treatment nurse added she was disappointed with herself that she did not stop the treatment.

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| F 309 | Continued From page 4<br><br>The Social Worker (SW) was interviewed on 4/20/16 at 2:30. She stated during the quarterly MDS review, she chose to do the staff assessment for cognition because Resident #64 was in so much pain with all her pressure ulcers, she did not want to be bothered. The SW added while Resident #64 did not verbalize pain, she could tell she was in pain because of her lack of response to questions. She added she had not reported Resident #64 ' s pain to staff because she felt the nursing staff already knew.<br><br>NA #4 was interviewed on 4/20/16 at 2:45 PM. She stated she had worked with Resident #64 at least once a week. The NA stated it had seemed in the last few weeks she had noticed Resident #64 moaned and groaned more during her bath. The NA stated she had reported the pain to the nurse on the hall. | F 309 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the | F 315 | 1. The missing lab for resident #81 from | 5/18/16 |

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| F 315 | Continued From page 5<br>facility failed to collect a urine sample for a urinalysis, culture, and sensitivity for one of five residents reviewed for laboratory results, Resident #81, who had a history of urinary tract infections. Findings included:<br><br>A review of the annual assessment dated 03/20/16 revealed Resident # 81 had an altered level of consciousness, was frequently incontinent of bladder and bowel, and displayed no overall behavioral symptoms or rejection of care.<br><br>The nursing care plan initiated on 03/21/16 revealed there were goals and interventions in place to address Resident # 81's risk for urinary tract infections and pressure ulcers related to her bowel incontinence and her frequent bladder incontinence. One of the interventions included on the nursing care plan was to provide perineal care after her incontinent episodes.<br><br>A physician's progress note dated 02/18/16 documented Resident #81 had experienced daytime sleepiness and some confusion. The same progress note indicated Resident #81 had a recent urinary tract infection that had been treated with a round of antibiotics. In addition, the progress note documented the physician was going to order a urinalysis with a culture and sensitivity to determine whether Resident #81 had a urinary tract infection.<br><br>A review of the physician's orders revealed an order dated 02/18/16 for a urinalysis with culture and sensitivity due to sedation.<br><br>A review of Resident #81's laboratory results revealed there were no urinalysis or culture and | F 315 | 2-18-16 was d/c'ed and a new order was received for a UA with CNS, for sedation, on 4-21-16 with lab results to be called to the MD. The lab was collected on 4-22-16 and sent to the lab for analysis. The final results were faxed back to the facility on 4-24-16 and the results were called to the MD.<br><br>2. An audit was performed on all resident charts going back 30 days to ensure that all ordered labs were performed as ordered on the residents in the facility.<br><br>3. An audit will be performed by either the DON or designated nursing management to ensure that all new labs ordered are performed. This audit will be performed weekly x 4 weeks then monthly x 3 months to ensure that all labs are performed as they are ordered.<br><br>4. The results of these audits will be brought to the facility's monthly Quality Assurance & Assessment Committee meeting (QA&A) to ensure that all labs were performed as ordered. | |

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sensitivity results dated 02/18/16 or later present in the medical record.

A nurse's note dated 02/19/16 at 3:30 AM documented there was a new order for a urinalysis with a culture and sensitivity, and that if the urine specimen could not be obtained on that shift (11:00 PM to 7:00 AM shift), the new order would be communicated with the day nurse (7:00 AM to 3:00 PM) to obtain the urine specimen.

A nurse's note dated 02/19/16 documented Resident #81 displayed verbally abusive behavior toward a staff member that morning.

A nurse's note dated 02/20/16 at 6:00 AM documented that a 24 hour chart check was done and that there was a new order for a urinalysis with a culture and sensitivity. The same note indicated the resident was unable to void continently, and that the writer of the note would ask the day nurse (7:00 AM to 3:00 PM) to follow up and ask for a straight catheter order. (A straight catheter is a catheter that can be inserted into the resident's bladder briefly to obtain a urine sample.)

The next nurse's note was dated 02/20/16 at 11:50 PM and documented, "No new orders."

A review of all nurse's notes after 02/20/16 at 11:50 PM through 04/12/16 at 2:00 AM revealed there were no other notes regarding a urinalysis or culture and sensitivity for Resident #81.

The director of Nursing (DON) stated in an interview on 04/20/16 at 2:50 PM that she would have expected the nursing staff to follow up and obtain the urine sample for the urinalysis and

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| F 315 | Continued From page 7<br>culture and sensitivity as ordered by the physician on 02/18/16. The DON reviewed the nurse's notes and noted there was no refusal documented by the resident to provide a urine sample and that there was no indication that an order was obtained to get the urine sample via a straight catheterization. The DON stated she would contact the physician to report the order was not completed as ordered and to receive any further instruction. | F 315 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record reviews, the facility failed to maintain a safe water temperature on 1 of 5 hallways (200 short hallway, rooms #201/#203, #206/#208, and #207/#209, where the water temperature exceeded 116 Fahrenheit (F).<br><br>Findings included:<br><br>Record review of a facility policy entitled Water Temp Policy documented, "It is our policy to check the water temperatures a minimum of once a week. Various temperatures will be taken throughout the building to get an adequate picture | F 323 | 1. The water temperature was immediately adjusted so that it would register in the required temperature range.<br><br>2. The maintenance department staff were inserviced on the proper temperature range for water in the facility. The water temperature policy was also reviewed with the maintenance staff.<br><br>3. An audit will be performed by the environmental services director or designated maintenance staff member to | 5/18/16 |

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| F 323 | Continued From page 8<br>of whether or not the temperatures are consistently within the range necessary. Acceptable temperature ranges are within the range of 100 - 116 degrees for patient care areas including bathrooms, shower rooms, etc. The kitchen and laundry temperatures should be at least 140 degrees. If it is determined that the temperatures are not being maintained within the acceptable range, adjustments are made to the thermostat and should be monitored closely until the temperature stabilizes within the acceptable range. If temperatures do not come within a safe range quickly the water will be shut off and the hot water drained to a sufficient level to ensure that there is no risk of injury. Temperatures will be logged when taken to provide documentation of the temperatures at least weekly."<br><br>A temperature observation with the Maintenance Director (MD) on 04/19/16 at 12:21 PM on the short 200 resident hall (rooms #201/#203, #206/#208, and #207/#209), revealed the following room water temperatures in the shared residents' bathroom sinks with a calibrated thermometer: (Prior to sink water temperature checks, the MD placed the thermometer laser beam of the thermometer into an ice bath to calibrated it to 32F. After the thermometer was calibrated to 32F.) His immediate fix to lower the hot water temperatures, was to turn back down the water heater ' s thermostat (one click).<br><br>Rm 201/203 - 124 F<br>Rm 206/208 - 118 F and 122 F<br>Rm 207/209 - 123 F<br>Rm 211/213 - 119 F<br>Bath-B - not utilized<br>Bath-C - 113 F | F 323 | ensure that the water temperatures are within the appropriate range. These audits will be completed 1x/week ongoing to ensure that the water temperatures are within the required range.<br><br>4. The results of these audits will be brought to the facility's Quality Assurance & Assessment Committee meetings (QA&A) to ensure that the water temperatures are within the required range. | |

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An additional temperature observation with the Maintenance Director (MD) was done at 2:00 PM. Thermometer was calibrated with a cup of ice water to 32 F. He checked room 203, 206, 211 and 311. It revealed a temperature of 124 F in room 203, 118 F in room 206, and 123 F in room 209. The MD stated the water was still too hot; it should have been between 110 F-116 F. His additional fix was to flush out the hot water out of the water line leading from the 200 short hall water heater.

At 2:45 PM. on 04/19/16, the MD returned to the 200 short hallway with a calibrated thermometer. He took the temperature in the bathrooms serving rooms #201/#203, #206/#208, and #207/#209, Bath-B, and Bath-C. All temperature reading were between 102 F - 112 F, while being taken in running water.

In an interview with the MD on 04/19/16 at 2:25 pm, the MD stated he documented in a log weekly water temperatures. The MD stated that morning (04/19/16) the water temperatures down the 200 short hall were too cold; so, he adjusted up (one click) the 200 short hall water heater's thermostat, and failed to follow-up and re-check the water temperatures.

In an interview with the MD, he stated, "I check the water usually three times per week. I record it on my log sheets." The MD provided a policy for water temperatures.

Review of the temperature logs from 01/1/16 through 04/13/16 revealed no water temperatures greater than 116 F.

In an interview with the Administrator on 04/20/16

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at 11:15 AM, the Administrator stated if the water is too hot, the facility would adjust the water temperature until it was within range, and then the facility would stop the showers until the temperatures were back within safe range. The Administrator stated the hot water down the 200 short hall was too hot at 120 F on 04/19/16, and the Maintenance Director should have re-checked water temperatures after adjusting the water temp in the water heater that morning on 04/19/16.

In an interview on 04/19/16 at 2:47 PM. with Nurse #1, she stated she did not notice water being too hot that morning, and would have let the Maintenance Director know as soon as possible if she noticed the water was too hot.

In an interview on 04/19/16 at 2:51 PM. with CNA #1, she stated she had no resident complaints about hot water down the 200 short hall, and if there were any, she would immediately notify the MD as soon as possible. She said there was only 1 of the 10 residents (Resident #82) residing down the 200 short hall who had dementia, and she never used her bathroom or sink.

In an interview on 04/19/16 at 3:21 PM. with Resident #82, she stated she never use the sink in my bathroom.

In an interview on 04/19/16 at 2:53 PM. with the Director of Nursing (DON), she stated water temperatures would be maxed at 115 F and would be too hot at or above 120 F. She reported if the water was too high, the facility would adjust the water temperature down until it was within range, and then the facility would stop the showers until the temperatures were back within

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| F 323 | Continued From page 11<br>a safe range.<br><br>In an interview on 04/19/16 at 3:18 PM. with Nurse #2, she stated all the aides and nurses used Bath-C and not Bath-B, to bathe their residents down the 200 short hall; because, it had a better set-up. She and the MD verified, that aides only used Bath-C for bathing and showering the residents down the 200 short hall, and that Bath-C was on a completely different water line and water heater than Bath-B. The MD also stated that Bath-B, was the only bath on the 200 short hall's water heater and water line, and that it was not being utilized at all for any residents' baths or showers.<br><br>Observations from 04/17/16 through 04/20/16 revealed no staff or residents used the Bath-B. | F 323 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and record review, the facility failed to provide podiatry | F 328 | 1. Resident #45 was sent out to the podiatrist on 4-29-16. | 5/18/16 |

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| F 328 | Continued From page 12<br>care for one of four residents, Resident # 45, who were reviewed for activities of daily living care. Findings included:<br><br>Review of a nurse's note of 01/15/2016 upon Resident #45's admission to the facility documented the following: " ...admitted per services of [MD name] ...Toenails need cut ... "<br><br>A review of the admission assessment dated 01/22/16 revealed Resident #45 was moderately cognitively impaired and required limited assistance with toilet use, and supervision for bathing and personal hygiene. The note was signed by Nurse #1.<br><br>Resident #45's nursing care plan initiated on 01/27/16 included goals and interventions related to her need for assistance with her activities of daily living.<br><br>During an observation of a shower provided by nursing assistant (NA) # 2 on 04/19/16 at 10:10 AM, the toenails on Resident #45's great toe, second, third, and fourth toes appeared long, thick, and mycotic. Resident #45's right fourth toe was completely black. All of Resident #45's toenails on her left foot were long, dark, and thick.<br><br>In an interview with NA #2 on 04/19/16 at 11:00 AM, she stated that she provided fingernail and toenail cleaning for her residents during daily baths and showers, and nail trimming about once per week for residents. NA #2 stated if a resident was diabetic or had very thick toenails, then someone else would provide toenail trimming. NA #2 stated she would talk with the nurse, who would then figure out who would cut residents' toenails. | F 328 | 2. An audit was performed on all other residents in the facility to see if podiatry care was needed. Any residents that were found to be in need of being seen by a podiatrist will have appointments made to be seen.<br><br>3. An audit will be completed by either the DON or designated nursing staff member on a minimum of 20 residents weekly x 4 weeks then monthly x 3 months to ensure that those residents in need of podiatry care are seen by a podiatrist.<br><br>4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee meeting (QA&A) to ensure that all residents that are in need of podiatry care are seen by a podiatrist. | |

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| F 328 | Continued From page 13<br><br>A review of the Activities of Daily Living (ADL) flow sheets for February 2016 revealed there was no indication that any filing or clipping of Resident #45's toenails had been provided on any of the three shifts per day. (A key on the ADL flow sheet was as follows: "Nail Care (Filed or Clipped: F=Feet, H = Hands, Both, N = No." A grid was provided on the ADL flow sheet for each of the three shifts, 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM.) Each of the spaces on the ADL flow sheet for each shift for February 2016 were marked with "N," except for 02/01/16, 02/02/16, 02/15/16, 02/25/16, and 02/29/16, which were left blank on the flow sheet.<br><br>A review of the ADL flowsheet for March 2016 revealed there was no indication any filing or clipping of Resident #45's toenails had been provided on any of the three shifts per day of the month. Each of the spaces on the ADL flow sheet were marked with "N," except for the 3:00 PM to 11:00 PM shift on 03/31/16, which was left blank.<br><br>An observation was made of Resident #45's toenails on 04/19/16 at 2:15 PM with the Director of Nursing (DON.)<br><br>In an interview with the DON on 04/19/16 at 2:17 PM, she stated the resident's toenails were long, thick, and appeared to be mycotic, and that they needed to be trimmed. The DON stated she would check to see if an appointment had been made with for the podiatrist for Resident #45.<br><br>A review of the physician's orders revealed there was no podiatry consult ordered for Resident #45. | F 328 | | |

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| F 328 | Continued From page 14 | F 328 | | |

On 04/19/16 at 2:25 PM, Nurse #2 stated in an interview at the nurse's station that a podiatry consult required a physician's order. Nurse #2 stated there was no order for a podiatry consult for Resident #45. During the interview, Nurse #2 reviewed the resident appointment book and stated there were no podiatry appointments scheduled for Resident #45.

On 04/18/16 at 2:30 PM, Nurse #1 was observed making a call to the physician's office to secure an order for a podiatry consult for Resident #45.

In an interview with the DON on 04/19/16 at 2:40 PM, she reviewed the ADL flow sheets and stated that nail care was not documented according to the key code provided on the sheet. The DON stated that there was a "Y" documented on the January 2016 on 01/24/2016 on the 7:00 PM to 3:00 PM shift, but that a "Y" was not an appropriate code. The DON also stated the ADL flowsheets for nail care for February 2016 and March 2016 did not reflect that any toenail care was provided. The DON stated Resident #45's toenails should have been trimmed by a podiatrist.

Nurse #1 stated in an interview on 04/19/16 at 3:13 PM that she wrote the admission note on 01/15/16 for Resident #45 which documented the resident's toenails needed to be cut. Nurse #1 stated when a nurse's note documented that toenails needed to be trimmed, the matter would be referred to the nurse who was assigned to the resident's hall. Nurse #1 stated the nurse on the hall would then ask the nursing assistant to trim the toenails, or if the toenails looked thick or "bad enough" the nurse would decide whether a podiatrist would need to trim them. Nurse #1

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| F 328 | Continued From page 15<br>stated she did not know why toenail care had not been provided or why a podiatry consult did not take place for Resident #45. | F 328 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to maintain a cold salad made with mayonnaise at or below 41 degrees Fahrenheit during the operation of the tray line. Findings included:<br><br>During an observation at 6:00 PM on 04/19/16 the supper tray line was in operation in the facility's kitchen. Two trays with bowls of slaw on them were placed in an open cart in front of the steam table. The dietary staff was removing the bowls of slaw from the cart and placing them on resident meal trays.<br><br>At 6:08 PM on 04/19/16, using a calibrated thermometer, the dietary manager (DM) checked the temperature of two different bowls of slaw. The thermometer in the first bowl registered 52.1 degrees Fahrenheit, and the thermometer in the | F 371 | 1. The coleslaw that was out of temperature range was immediately thrown away and a substitute was provided.<br><br>2. All dietary staff members were inserviced regarding the proper temperatures to serve cold food and what to do if the temperature is not within the required range.<br><br>3. An audit on cold food temperatures will be performed weekly x 4 weeks then monthly x 3 months by the Dietary Manager or designated dietary employee to ensure that all food that is to be served cold is within the required temperature range. | 5/18/16 |

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| F 371 | Continued From page 16<br>second bowl registered 47.9 degrees Fahrenheit. There were 19 bowls of slaw still left to be distributed to resident meal trays, and at this time the cook reported she had 20 resident supper trays left to prepare. The cook stated the slaw preparation was completed at approximately 1:00 PM on 04/19/16, and the slaw was stored in refrigeration until the supper tray line started up at approximately 5:40 PM on 04/19/16. She also commented she used chilled cabbage, mayonnaise, mustard, and relish in the preparation of the slaw.<br><br>At 6:16 PM on 04/19/16 the DM removed a large plastic container of back-up slaw from the facility's reach- in refrigerator, and using a calibrated thermometer, the DM checked the temperature of the slaw. The thermometer registered 48.8 degrees Fahrenheit. The DM stirred the slaw in the container, which was approximately 10 inches deep, and at 6:18 PM on 04/19/16 she re-inserted the calibrated thermometer into the stored slaw. The thermometer registered 47.5 degrees Fahrenheit. At this time the DM stated the slaw could not be served because it should remain at 41 degrees Fahrenheit or below during the entire operation of the tray line.<br><br>At 1:56 PM on 04/20/16 during an interview with the DM she stated she asked the cook to store the slaw prepared on 04/19/16 in the freezer for a short period of time before it was brought to the tray line for the supper meal. The DM reported this was not done, and instead the slaw was stored in refrigeration only for the entire time before tray line initiation.<br><br>At 2:07 PM on 04/20/16 during an interview with a | F 371 | 4. The results of these audits will be taken to the facility's Quality Assurance & Assessment Committee meeting (QA&A) to ensure that all cold food is served within the required temperature range. | |

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| F 371 | Continued From page 17<br>dietary employee, who frequently assumed cooking responsibilities, she stated she was trained that cold salads made with mayonnaise should be kept at or below 41 degrees Fahrenheit during the entire operation of the tray line. She reported she ensured this was done by keeping the salads refrigerated after preparation and placing them on ice during the operation of the tray line. | F 371 | | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. | F 520 | | 5/18/16 |

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| F 520 | Continued From page 18<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to accidents which resulted in a repeat citation at F 323. The re-citing of F 323 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included:<br><br>This tag is cross-referenced to:<br><br>F323: Accidents and Hazards: Failure to ensure the facility provides an environment that is from accident hazards over which the facility has control: Based on observation, record review and staff interviews the facility failed to identify and correct hazardous water temperatures in 7 of 10 resident's lavatories where the temperature exceeded 116 degrees Farenheit.<br><br>Review of the facility's survey history revealed F 323 was cited during the facility's 03/19/15 annual recertification survey, and was re-cited during the current 04/20/16 annual recertification survey.<br><br>During an interview on 04/20/15 at 6:00 PM, the Administrator stated that the entire QA Committee met on a quarterly basis with their meetings focusing on solutions for problems identified by the facility's department managers, the interdisciplinary team, family members, and/or doctors. The Administrator stated the specific identified issues, such as accidents or other concerns, were addressed to discuss the causes and to provide plans to correct and improve the facility. The Administrator stated if problems were identified during the survey process, they would | F 520 | East Carolina Rehab and Wellness has a functioning QA committee that has various components that function daily, weekly, monthly, and quarterly.<br><br>The QA committee is made up of numerous individuals that include the administrator, DON, MDS coordinators, environmental services director, wound care nurse, therapy director, activity director, certified dietary manager, medical director, pharmacy consultant, social worker, rest home manager, medical records and dietician.<br><br>Our policy indicates that we will meet quarterly although our practice is to meet monthly to ensure if for some unforeseen reason (weather, survey, etc.) our meeting is missed that we are still in compliance with the federal regulation an dour policy for quarterly QA meetings and attendance by key personnel. All of the positions above normally attend the QA meeting except for the registered dietician who usually attends quarterly.<br><br>Standard items for review are safety meeting, falls, pressure ulcers, weight loss/gain, psychotropic drug use, infectious control to include any necessary infectious disease information, complaints and assisted device use. In addition, we have areas for improvement that are discovered in the normal course of operating and normal monitoring of systems. This process has been | |

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| F 520 | Continued From page 19<br>be addressed at the QA meetings in order to implement a strategy to prevent reoccurrence of cited issues. | F 520 | validated through having specific complaint allegations that have been unsubstantiated.<br><br>In addition to our big monthly meetings, we have weekly IDT meetings that include the facility IDT made up of the social worker, therapy director, administrator, DON, MDS coordinators, wound care nurse, certified dietary manager, activities director and QA nurse. In these meetings, all falls from the week are reviewed to determine that the IDT agrees with any interventions that have been put in place and review the overall adequacy of any interventions and review the plan of care to ensure any changes have been included. The IDT designates someone, usually the QA nurse, to document an IDT note in the chart of specific residents that are discussed. Wounds and weights are also reviewed weekly to ensure that any significant changes or issues are caught and resolved.<br><br>In addition to the monthly and weekly meetings, every morning a meeting is conducted like a mini QA. Any incident reports and complaints are discussed by the IDT team. The 24 hour acute logs are reviewed to ensure that anything that happened in the last 24 hours that needs to be followed up on will be and appropriate staff resources can be allocated to issues as they arise to ensure that they are resolved. | |