STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RALEIGH AT CRABTREE VALLEY	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to seal, label and date food items in the refrigeration and freezer units, the dry storage room and 3 of 3 nourishment rooms. The facility failed to allow service ware to air dry and for staff with facial hair to wear facial hair restraints while working in the kitchen. Findings Include: Observation of the kitchen and nourishment rooms on 8/7/2016 at 5:30 pm revealed the following: 1. Walk-In Cooler: a. A package of sliced cheese open / exposed b. A container of parmesan cheese with no label or dated c. A package of hot dogs open / exposed d. A box of raw sausage patties open / exposed 2. Walk-In Freezer: a. A bag of crab cakes open / exposed with no label or date b. A large bag of freezer burned raw meat open / exposed with no label or date	F 371	This plan of correction constitutes Hillcrest Raleigh at Crabtree Valley□s (Hillcrest) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 371] It is the policy of Hillcrest to comply with the food safety and sanitation guidelines as outlined in the FDA Food Code and the North Carolina Health Department. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Dietary manager conducted a thorough survey of the kitchen	9/9/16

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

Electronically Signed | 09/06/2016

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F 371	Continued From page 1 c. A box of breaded flounder open / exposed 3. Reach-In Refrigerator: a. A partial case of sugar free mighty shakes with no thaw dates identified 4. Dry Storage Room: a. Open / exposed bags with no labels or dates on the following items: cornflakes, colored sprinkles, granulated sugar, pancake mix, egg noodles, elbow macaroni, potato chips and powdered sugar 5. Nourishment Room 100 Hall: a. Open carton of milk b. Open undated container of med pass supplement c. Bowl of chicken salad with no label or date 6. Nourishment Room 200 Hall a. 1 can of Nepro supplement with expiration date of 3/20/2016 7. Nourishment Room 300 Hall: a. One container of open yogurt 8. 47 clear glasses stacked together wet in storage rack 9. 1 male employee with a full beard and 1 male employee with a partial beard were working in the kitchen and not wearing beard guards. Observation of the kitchen on 8/10/2016 at 10:45 am with the Dietary Manager revealed: 1. 20 meal trays were wet and stacked together on a rack ready for lunch service. 2. 20 plate bases were wet and stacked together on the steam table ready for lunch service. 3. 20 plate domes were wet and stacked together on the steam table ready for lunch service.	F 371	immediately following the survey and there were no other concerns noted. The packages of sliced cheese open/exposed and container of parmesan cheese found in the walk-in cooler were discarded. It was verified by the dietary manager that the package of hot dogs open/ exposed and the raw sausage patties open/exposed had just been opened on 08/07/16, so these two items were immediately wrapped labeled and dated. All items noted under #2 -#7 were discarded. #8 The 47 clear glasses stacked together on 8/7/2016 were rewashed and properly air dried on 8/7/2016. Items #1-3, identified during 8/10/2016 inspection were rewashed and placed on drying racks immediately. #9 Male employees were instructed that beards are to be covered while preparing food. Dietary Manager observed male employees putting on beard guards. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice The Dietary manager conducted a thorough survey of the kitchen immediately following the survey and there were no other concerns noted. All dietary staff will be in-serviced on proper food storage, proper head and face guards, and proper drying techniques. Prior to completion of in-service for all dietary staff, there will be random inspections to ensure: (a) food in the	

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F 371	Continued From page 2 An interview on 8/11/2016 at 12:34 pm with the Dietary Manager and the District Dietary Manager revealed their expectations were that staff members should seal, label and date all food items prior to placing in storage. The District Dietary Manager stated all service ware and meal trays should be placed and staged on drying racks for complete air drying before being stored for meal service. He also stated that his expectation was that employees with facial hair should put on beard guards at the start of their shift and wear them at all times in the kitchen. An interview on 8/11/2016 at 12:54 pm with the Administrator of the facility revealed her expectations were that all food should be sealed, labeled and dated prior to being stored, service ware should be air dried and employees with facial hair should wear beard guards when working in the kitchen.	F 371	refrigeration units, freezer units, dry storage rooms, and nourishment rooms is properly sealed, labeled and dated; (b) service ware is being properly air dried; and (c) proper head and face guards are being worn by staff. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur The existing Hazard Surveillance form has been revised to specifically include references to: (a) proper storage of food, (b) drying of service ware; and, (c) use of proper head and face guards. Weekly, unannounced inspections by the Registered Dietitian or her designee of all locations where food is stored and prepared, and service ware is washed are taking place using the revised Hazard Surveillance form. The goal of this exercise is to continue a weekly inspection until three consecutive inspections indicate no issues of concern and then to maintain this process on a monthly unannounced basis. If concerns are identified, additional in-services will be performed consistent with the concerns identified and individuals involved. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility QA committee and administrator/designee will review monitoring results of Registered Dietician	

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F 371	Continued From page 3	F 371	or her designee during QA meetings. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting (October 28, 2016) and the dates to determine continuation of monitoring reports are subject to the vote of this interdisciplinary committee.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		9/9/16

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F 441	Continued From page 4 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to post contact precaution signage to inform staff and visitors of contact precautions for 2 of 2 residents, (Resident #160 and #14) and failed to keep the Personal Protection Equipment (PPE) caddy supplied with gowns. Findings included: A review of the infection control policy obtained 08/10/2016 at 9:44 AM revealed the policy for contact precautions stated, in part: A. Implement contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact. B. Examples include Methicillin Resistant Staphylococcus aureus (MRSA) infection and Clostridium difficile (c. difficile). C. The facility will implement a system to alert staff to the precautions required: Signage. During the initial tour of the facility on 8/7/16 at 5:30 pm, it was noted that two rooms had isolation caddies on the door, but no signs were posted to alert staff or visitors to the type of isolation being followed. 1. A review of the medical record for Resident	F 441	This plan of correction constitutes Hillcrest□s written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 441] It is the policy of Hillcrest to comply with the Infection Control regulations set forth in 42 C.F.R. 483.65 and in our infection control policy. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Additional signage/communication was placed on the doors of Resident 160□s and Resident 14□s rooms that informed of contact precautions. The supply of gowns for Resident 160□s room was replenished from readily available stock. Residents 160□s and Resident 14□s PPE caddies were inspected to confirm they	

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F 441	Continued From page 5 #160 showed the most recent Minimum Data Set (MDS) dated 7/11/16 assessed the resident was mildly cognitively impaired (some confusion and forgetfulness) and had diagnosis to include Stage 4 decubitus ulcer and c. difficile infection. He required extensive assistance with bed mobility, bathing, dressing, toileting and personal hygiene and was unable to ambulate and required one person total assistance with mobility. A review of the medical records lab results revealed a positive culture for MRSA in his sacral wound and c.difficile from stool. A review of the medication administration record and physician orders dated 7/26/2016 revealed the resident was prescribed oral metronidazole (Flagyl). A review of the physician orders dated 7/27/2016 revealed wound care orders to perform wound vacuum dressing change to sacral wound and was ordered to be performed Monday, Wednesday and Friday and a normal saline wet to dry dressing as needed if the wound vacuum came off. During an observation on 08/09/2016 at 2:27 PM, the isolation caddy was hanging on the door of Resident #160. The caddy was stocked with masks, gloves, BP cuff, and thermometer. There was a place for gowns, but there were no gowns in the box. On 08/09/2016 at 2:27 PM, an Environmental Services employee was observed collecting trash in Resident #160 room. He entered the room	F 441	contained all necessary supplies. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice The DON/designee inspected the facility to ensure no other residents were on isolation precautions and found no other residents were on isolation precautions and so no other residents were affected. In-services were conducted of all staff regarding the procedure for placement of additional signage/communication regarding contact precautions and actions to be taken when there is a PPE caddy in place. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur Weekly audits of the medical records will be completed by the DON/designee to identify if there are any residents who are on isolation precautions. On weeks when residents are identified that are on isolation precautions, checks will be performed to ensure all appropriate supplies are readily available and communication regarding the type of precaution is in place. Once three consecutive inspections have been completed for residents who are on isolation precautions identified with appropriate communication and supplies, than monthly reviews of medical records,	

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F 441	Continued From page 6 wearing gloves, but no gown, and no mask. The Environmental Services employee stated that he did not know what kind of precautions were in place, but he would assume the type of isolation by the PPE in the caddy on the door. The Environmental Services employee entered the room wearing gloves but without a gown or mask, obtained the trash, placed the trash in the covered cart in the hall and did not change gloves or perform hand hygiene after exiting the room with isolation precautions. During an interview with NA #1 on 08/09/2016 at 2:35 PM, she stated she would ask the nurse in charge what PPE she should apply when an isolation caddy was on the door and no sign was posted. An interview was conducted with Nurse #1 on 08/09/2016 2:32 PM. She was unable to state the type of isolation precautions for Resident #160. She stated she would apply the PPE available in the isolation caddy on the door, but no gowns were stocked in the caddy. Nurse #1 was identified as the treatment nurse for wound care in the facility. An interview was conducted with RN #6 on 08/09/2016 at 2:37 PM and she stated resident #160 was under c. difficile precautions. She stated gloves, mask and gown were required to enter the room and that he may have MRSA in his wound. She also stated that visitors to the room should check with the nurse before entering and that visitors should see the caddy on the door and ask a staff member. She did not know why the contact precaution sign was not on the door. An interview was conducted with NA #3 on	F 441	with identification of resident on isolation precautions, and corresponding checks of identified residents will take place. Additional in-services will be performed if it is determined appropriate communication regarding contact precautions is not in place. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting (October 28, 2016). The facility QA committee and administrator/designee will review the inspection results during QA meetings. The QA Committee will assess how long monthly monitoring will continue based on the results of the monthly inspections and other pertinent information available to the QA Committee.	

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08/09/2016 at 3:17 PM and she stated that she had been informed of contact precautions of Resident #160 and she would use the PPE on the door, but was not aware of the need to wear a gown because no gowns were stocked in the caddy.

2. Resident #14 was admitted on 9/18/15. During the medical record review, the most recent MDS dated 5/25/16 revealed that the resident was cognitively intact (alert and oriented). Review of Resident #14 chart revealed the diagnosis of recurring c.difficile infection. She required extensive assistance with personal hygiene and bed mobility, she was totally dependent on others for toileting, dressing and mobility and she required assistance of two other people for transfers, and was unable to ambulate.

Review of the physician orders revealed an order written on 7/31/2016 for oral vancomycin (antibiotic) to be administered for four weeks.

An observation of Resident #14 on 8/07/16 at 5:30 PM, showed the isolation caddy on the door to her room, but no sign was posted for contact precautions.

An interview was conducted with Nurse #6 on 08/08/2016 at 8:48 AM and she stated that resident #14 was on contact precautions and staff were to use gloves and gowns when entering the room and sometimes to wear masks. This nurse was identified as a direct care provider to Resident #14.

An interview was conducted with NA #2 on 08/09/2016 at 2:43 PM. She stated she would ask the charge nurse what she should do to care for

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the resident. She was unable to state the PPE to wear into Resident #14 room for resident care.

An observation of resident #14 on 08/09/2016 at 2:54 PM. The isolation kit caddy was on the door, gloves, mask and gowns available, as well as BP cuff, thermometer and stethoscope. There were no signs for contact precautions on the door or in the room.

An interview was conducted with Nurse #2 on 08/10/2016 at 10:40 AM. Nurse #2 was identified as the infection control nurse for the facility. She stated that the policy was followed for contact isolation for different contagious diseases and for drainage from a wound. She stated she would obtain an order from the physician, notify nursing staff, environmental services and would obtain a caddy for the door. Staff and family members were notified of isolation precautions. Staff and family members were notified of isolation precautions by phone or when they visited. She stated that visitors typically sign in with the concierge in the front lobby. The Concierge would direct visitors to speak to a nurse before entering the room. Nurse #2 was unable to state why the contact precaution signs were not on the doors of the two residents.

An interview was conducted with concierge on 08/10/2016 at 12:51 PM. She reported she did not know the status of residents and only directs visitors to the correct hall and room number.

An interview was conducted with the DON on 08/10/2016 at 3:19 PM. She stated the steps to determine if isolation and contact precautions were needed by first obtaining lab results from culture samples. If contact precautions were

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necessary, the environmental services were notified to place isolation kit caddy on the door, and the signage was put up. The DON was not aware that there were no signs on the door for resident #160 or resident #14. She stated the signage was part of informing visitors and staff to the contact isolation and her expectations were that the policy would be followed by all staff.

An interview was conducted with the Administrator on 08/11/2016 at 12:37 PM. She stated that it was her expectation that the policy would be followed by the staff. She stated that during renovations of the facility, the owner wanted a " certain look " , and that the owner did not want isolation signs placed on doors. The Administrator stated that expecting the concierge to inform visitors of contact precautions was incorrect.