STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345180	A. BUILDING _____ B. WING _____	08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY PINES RETIREMENT COMM	1000 WESLEY PINES ROAD LUMBERTON, NC 28358

(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 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to maintain a safe water temperature which did not exceed 116 degrees Fahrenheit (F) in 4 of 42 resident rooms and 1 of 2 spa shower rooms (Wisteria and Lantana hallways - rooms #133, #145, #159, #190, and wisteria spa shower room). Findings included: Record review of a facility policy entitled Water Temp Policy documented facility "is committed to the provision of safe bath and shower water temperatures for all residents in accordance with applicable codes, standards, and informed practices. Security monitors and documents waters temperatures Monday through Friday and documents to ensure resident bath water stays within the 100 - 116 F range. If a parameter is too high or too low, security immediately begins to adjust the valves to get the temperature in the appointed parameters." A temperature observation with the Assistant Maintenance Director (AMD) on 08/16/16 at 3:00 PM on the Wisteria and Lantana halls (rooms	F 323	Water temperatures above 116 degrees have the potential to harm all residents, therefore all residents were at risk. The facility received no complaints of water being too hot, nor were any residents or staff found to have been burned by hot water prior to the onset of the survey, nor during the survey. In order to ensure the facility's hot water in all patient areas remains between 100 and 116 degrees, the Plant Director called a professional licensed plumbing contractor to assess the facility's hot water system. The hot water mixing valve was found to be faulty and replaced with a new mixing valve. Henceforth, the facility's hot water mixing valve will be assessed annually. In addition to routinely testing the water temperatures leaving the boiler and returning to the boiler, and in patient whirlpool rooms, the maintenance director will ensure that water temperatures are also checked in patient rooms on a	9/15/16

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

Electronically Signed | 09/08/2016

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F 323	Continued From page 1 #133, #145, #159, #190, and 2 shower rooms), revealed the following water temperatures at residents' bathroom sinks and spa shower rooms using a calibrated thermometer: His immediate fix to lower the hot water temperatures, was to flush out the facility's main hot water line. Rm 133 - 121.3F Rm 145 - 122.6F Rm 159 - 119.4F Rm 190 - 120.4F Wisteria Spa Shower - 118.3F Lantana Spa Shower - 115F In an interview with the Director of Nursing (DON) on 08/18/16 at 3:45 PM, the DON stated no residents in the facility had received burns from hot water in the showers or from the residents' bathroom sinks. She stated she informed all nurses and aides to immediately stop giving baths or showers until the water temperatures were verified to be below 116F, as well as to prevent the facility's 5 cognitively impaired residents (in rooms 149A, 149B, 183A, 150A, and 189B) from using their sinks. An additional, temperature observation with the AMD was done on 08/16/16 at 4:30 PM. The thermometer was calibrated. He checked room 132, 145, 159, 190, and both Spa Showers. It revealed a temperature of 112.6F in room 133, 110.2F in room 145, 112.1F in room 159, 113.6F in room 190, Wisteria Spa Shower 105.6F, and Lantana Spa Shower 107.8F. The AMD stated the water was between 100F - 116 F. In an interview with the maintenance Director (MD) on 08/18/16 at 10:45 AM, the MD stated security documented weekly water temperatures	F 323	routine basis. Water temps will be checked in a randomly selected resident room on each of our 4 halls twice each week for 8 weeks. Each week these checks will occur once during mid morning and once in the evening. Any temperatures below 100 degrees or above 116 degrees will immediately be reported to the Director of Nursing, or in her absence the charge nurse so they can alert all care giving staff of the potential danger. The out of range temperatures will then be reported to the Plant Director so he or his delegate can take immediate action to bring the temperature back within the mandated range of 100 to 116 degrees. After 8 weeks, the random water temp checks in Residents rooms will occur once each week. The results of these audits will be reported to the QAPI committee at the next meeting on Wednesday, October 5, 2016. Thereafter, the Plant director will include in his quarterly QAPI report the results of the ongoing temperature audits. In the event that an out of range temperature occurs, the Plant Director will immediately report it to the Executive Director, along with what actions are being taken to bring the water temperature back within the acceptable range.	

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F 323	Continued From page 2	F 323		

in a log. The MD stated that morning (08/16/16) the water temperatures running out of the water heater was 111 F and returned at 108 F. The MD stated the facility was not checking the sink temperatures in the residents' bathrooms, and was relying solely on the temperatures leaving the water heater as safe water temperatures and had not been checking the water temperatures in the residents' rooms. He said he did not take into account, that in the summer, the water traveling through pipes in the hot attic would get hotter, ending up with residents' sink or bath/shower water becoming hotter than when it first left the water heater.

An additional, temperature observation with the MD was done on 08/18/16 at 11:00 AM. The thermometer was calibrated. He checked room 132, 145, 159, 190, and both Spa Showers. It revealed a temperature of 102F in room 132, 101F in room 145, 100F in room 159, 102F in room 190, Wisteria Spa Shower 101F, and Lantana Spa Shower 100F. The MD stated the water was between 100F - 116 F.

In an interview with the MD on 08/18/16 at 11:30 AM, he stated "security checks the water 5 times per week, and records it on my log sheets." He explained security documented the temperature of facility water as it left the water heater and as it returned through the mixing valve system. The MD provided a policy for water temperatures.

In an interview on 08/18/16 at 11:15 AM. with the Director of Nursing (DON), she stated water temperatures would be maxed at 116F and would be too hot at or above 116F. She reported if the water was too hot, the facility would adjust the water temperature down until it was within range

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F 323	Continued From page 3 (100 - 116 F), and until then the facility would stop the showers, and keep residents who were cognitively impaired away from their sinks until the temperatures were back within a safe range. In an interview with the Administrator on 08/18/16 at 11:15 AM, the Administrator stated it was his expectation that hot water in all patient areas be kept between 100F - 116F. And if the water was too hot, the facility would adjust the water temperature until it was within range. In an interview on 08/16/16 at 3:40 PM. with CNA #1, she stated she did not receive any complaints of hot water down the Wisteria hall or 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 08/16/16 at 3:50 PM. with CNA #2, she stated she had no resident complaints about hot water down the Lantana hall, and if there were any, she would immediately notify the maintenance Director as soon as possible. Observations from 08/15/16 through 08/18/16 revealed no staff or residents burned from hot water.	F 323		
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	F 371		9/8/16

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry tray pans prior to stacking them on top of one another in storage, failed to clean the faces/backs of fans blowing into the food preparation and tray line service areas of the skilled nursing kitchen, and failed to discard fry/saute pans with scratched coatings and cooking surfaces. Findings included: 1. At 9:42 AM on 08/17/16 during an inspection of kitchenware in the continuing care kitchen, used to help prepare food for the skilled nursing unit, 4 of 6 tray pans stacked on top of one another on a final storage unit were found with moisture trapped inside. At this time a dietary employee reported these tray pans were stacked in storage the night before. At 11:28 AM on 08/17/16 the director of food services stated there was a dedicated rack in the kitchen for air drying kitchenware before it was stacked in final storage. He reported stacking wet pieces of kitchenware on top of one another in storage could lead to bacterial formation that might cause foodborne illness, making residents sick. At 2:54 PM on 08/17/16 the cook in the skilled nursing kitchen stated the dietary staff had been in-serviced in the past to let kitchenware air dry before stacking pieces on top of one another in storage. She reported the staff was informed trapped moisture could breed germs that could	F 371	Pots, pans, and dishware stacked wet increases the possibility of bacteria growth. Dirty fans in food prep and serving areas increase the possibility of contaminating food with dust particles. Scratches to non stick coatings of fry/saut¿ pans increase the possibility that particles of the non stick coating will be mixed in with Resident food. Any and/or all of these issues have the potential to make a resident sick, therefore all residents were at risk by this deficient practice. The pots/pans in question were immediately rewashed and properly air dried. The fans were immediately cleaned. The fry/saut¿ pans with the scratched coatings were immediately discarded and replaced with new stock. The fans used in the Healthcare kitchen will be place on the weekly cleaning list. Dietary staff were in-serviced in the following: importance and significance of keeping fans used in a kitchen clean meaning of compromised cookware, how to identify compromised cookware, importance of removing compromised cookware from food prep, the dangers of stacking or storing wet kitchen wares, and proper air drying procedures. Food and Beverage Director James Sandrock,CDM/CFPP, will	

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F 371	Continued From page 5 make residents sick. 2. During the initial tour of the skilled nursing kitchen on 08/15/16, beginning at 6:40 PM, a fan sitting on a shelf above the steam table, which would have blown into food preparation and serving areas if it was turned on, was found to be dirty. There was a film and strands of dust/dirt on the front face and back sides on the fan. A second smaller fan sitting on a shelf near the hand sink, which would have blown into food preparation and serving areas if it was turned on, was found to be dirty. There was a film and strands of dust/dirt on the front face and back sides on this fan. During follow-up observations of the skilled nursing kitchen on 08/17/16 at 8:58 AM the smaller fan near the hand sink still had dust and dirt on the front face and back of the fan. At 11:28 AM on 08/17/16 the director of food services (DFS) stated employees in the dietary department cleaned the fans, but they were not on the cleaning schedule at present. He stated the two fans were put into use last summer because of the heat that built up in the small kitchen space. He commented the goal was to have the fans cleaned weekly. The DFS stated the fans needed to be clean to prevent the possibility of dust particles contaminating the food being prepared and served. At 2:54 PM on 08/17/16 the cook in the skilled nursing kitchen stated a dietary employee was responsible for cleaning the fans, but the fans had not been cleaned as frequently as usual because the dietary department had been short some key positions in the last two to three	F 371	conduct all in-service training. The Dietary Manager or his designee will monitor the cleanliness of the fans twice weekly for an 8 week period. Thereafter, the fans will be inspected weekly. The Dietary Manager or his designee will inspect all cooking wares for cleanliness and condition once a week for 8 weeks and then every other week thereafter. The Dietary Director or his designee will inspect all kitchen wares twice per week for 8 weeks to ensure proper air drying techniques are being used and thereafter will inspect kitchen wares for proper drying weekly. Any deficient practice identified during these audits will result in re-education of employees and then disciplinary action up to and including termination. The results of these audits will be presented at the next QAPI Committee meeting on Wednesday, October 5, 2016. Going forward, the Dietary Manager will include the results of these weekly audits in his quarterly report to the QAPI Committee.	

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months. The cook reported dirt and dust from the fans could blow on food being prepared or on the steam table and could blow on kitchenware exiting the dish machine which could make residents sick.

3. During the initial tour of the skilled nursing kitchen and the continuing care kitchens on 08/15/16, beginning at 6:40 PM, 1 of 3 fry/saute pans in the skilled nursing kitchen had non-stick coating and cooking surfaces which were scratched, and 7 of 8 fry/saute pans in the continuing care kitchen had non-stick coating and cooking surfaces which were scratched.

During a follow-up tour of the skilled nursing kitchen 1 of 3 fry/saute pans still had non-stick coating and cooking surfaces which were scratched.

During a followup tour of the continuing care kitchen 7 of 8 fry/saute pans still had non-stick coating and cooking surfaces which were scratched.

At 11:28 AM on 08/17/16 the director of food services (DFS) stated when kitchenware became compromised such as fry/saute pans with scratched and peeling coatings/cooking surfaces the dietary staff was supposed to reported it to the lead cook or himself so it could be replaced. The DFS reported he kept back-up sets of cookware on the premises. He commented the Teflon surface of the fry/saute pans could peel or flake off in resident foods which had the potential of making them sick.

At 2:54 PM on 08/17/16 the cook in the skilled nursing kitchen stated damaged kitchenware was to be removed immediately, reported to the DFS, and replaced. She reported damaged kitchenware posed a health and safety risk to residents.