STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING ______ B. WING ______	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE 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 000	INITIAL COMMENTS IDR process: the survey team reviewed the facility submitted information to dispute F 353 and made a decision to delete the tag.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to identify a lap tray attached to a geriatric reclining chair that prevented rising as a physical restraint and failed to provide medical justification for the use of a physical restraint for 3 of 3 sampled residents (Resident #114, Resident #141 and Resident #143). Findings included: Review of Resident #114's medical record revealed the resident was admitted to the facility on 12/18/2012. The resident ' s current diagnoses included Alzheimer's Dementia and Anxiety. The Minimum Data Set (MDS) dated 05/25/2016 indicated Resident #114 had severe cognitive impairment. The MDS also indicated the resident required extensive to total assistance for all activities of daily living and physical restraints were not being utilized. The MDS further indicated the resident had no psychoses or negative behaviors. Review of physician orders from 01/2016 through	F 221	1. It is not the intent of the facility to restrain any of our residents. All lap trays have been removed from the facility. 2. A Residents had the potential to be effected. No other Residents were effected by this deficiency. We have removed all lap trays from the facility. 3. The facility is in the process of educating all staff on restraint use. This education will be done upon hire and semi-annually and on an as needed basis. 4. This has been added to the facility quality assurance program to be monitored weekly times 4 weeks then monthly by April Oxendine RN, PI nurse/educator and reported to the team in monthly quality assurance meetings. 5. Completion date for this deficiency is 09/16/2016.	9/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/07/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 08/17/2016 indicated no orders for any type of restraint. The resident's care plan dated 05/25/2016 did not indicate the resident used any type of restraints. Nursing progress notes reviewed from 08/15/2016 through 08/18/2016 indicated no documentation of any physical restraints used. The following observations were made during the survey. On 8/16/16 at 9:15 AM, Resident #114 was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and moving around in the chair mumbling to herself. The resident was not engaged in an activity or eating during the observation. Due to the resident's severe cognitive status, an interview was not attempted. On 8/16/16 at 11:30 AM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and moving around from side to side in the chair. The resident was not engaged in an activity or eating during the observation. On 8/16/16 at 3:40 PM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident ' s body in the common/living area in front of nurse ' s station. Nothing was observed on top of the tray which was attached to the resident ' s chair. The resident was awake and quietly moving around from side to side in the chair. The resident was not engaged in an activity or eating during the observation.	F 221		

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F 221	Continued From page 2 On 8/17/16 at 7:17 PM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and quietly moving around from side to side in the chair mumbling. The resident was not engaged in an activity or eating during the observation. During an interview on 08/18/16 at 1:45 PM with Nurse #5, who worked on the resident's unit, the nurse stated Resident #114 was not able to remove the tray from the chair. The nurse stated she was not sure why the tray was on the resident's chair, and she stated it kept the resident from falling from the chair. During an interview with Nurse #1 on 08/18/2016 at 2:30 PM, the nurse stated it was the staff ' s understanding if the resident used the tray for an activity, it was not considered a restraint. The nurse also stated there were times the tray was observed on the chair, and the resident was not involved in an activity. The nurse further stated the resident had a history of falling, and the tray prevented her from falling forward out of the chair. The nurse stated the resident could not remove the tray from the chair. The facility Director of Nursing (DON) was interviewed on 08/19/2016 and stated a tray should not have been attached to Resident #114 's chair unless a resident was involved in an activity. The DON also stated the facility did not consider the attached tray a restraint, as it was only supposed to be used during an activity. The DON further stated if the tray was used for any other reasons, it would be a restraint. 2. Record review indicated Resident #143 was admitted to the facility on 01/08/2015. The	F 221		

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F 221	Continued From page 3 resident's cumulative diagnoses included Alzheimer's Disease and Anxiety Disorder. The most recent quarterly Minimum Data Set (MDS) dated 07/03/2016 indicated Resident #143 used no physical restraints and had no negative behaviors. Review of the resident's current Plan of Care initiated on 01/21/2015 did not indicate the resident used any type of restraints. The care plan for risk of falls indicated an intervention dated 07/11/2015 " Resident placed in geriatric chair with table top during meals and activities." Review of Resident #143's physician orders indicated no orders for any type of physical restraint. On 8/17/16 at 7:25 PM, Resident #143 was observed seated in a reclining geriatric chair with a tray attached across the front of the resident ' s body in the unit dayroom. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and quiet. The resident was not engaged in an activity, nor was the resident eating. The resident was not interviewed due to severe cognitive impairment. On 08/18/2016 at 8:30 PM Nurse #3 was interviewed and stated she was the nurse assigned to Resident #143 on second shift 08/17/2016. Nurse #3 stated she put the tray on the resident's chair, because the resident fought with her and bent the nurse's finger back when the nurse was trying to keep the resident in her chair. The nurse also stated the resident had a history of falls, and the nurse said she did not want her to fall, and the tray kept her in the chair. The nurse stated she used it for safety purposes when she was worried about the resident ' s safety. The nurse further stated it was her understanding if a resident was in the geriatric	F 221		

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chair, the tray could be used too. The nurse also stated the resident was unable to remove the tray when it was attached to the chair.
An interview was conducted with the Minimum Data Set (MDS) RN Coordinator on 8/19/2016 at 1:30 PM. The MDS Coordinator indicated she had never observed Resident #143 with the tray attached to her chair. The MDS nurse also stated the tray was not considered a restraint, as it was supposed to be used only during an activity.
The facility Director of Nursing (DON) was interviewed on 08/19/2016 and stated the trays should not have been on the resident's chair unless the resident was involved in an activity. The DON confirmed if the tray was used for any other reason, it would be considered a restraint.

3. Record review indicated Resident #141 was admitted to the facility on 12/2/2014. The resident ' s cumulative diagnoses included Alzheimer ' s disease, Dementia, Hypertension and Falls.

The most recent Minimum Data Set (MDS) dated 5/23/2016 indicated the resident was rarely/never understood and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident #141 was totally dependent on staff for personal hygiene, eating, transfers and all activities of daily living (ADL ' s). The Minimum Data Set (MDS) indicated the resident did not use restraints in or out of bed.

Review of the resident's Care Plan dated 5/23/2016 through 8/21/2016 revealed Resident #141 had a problem with impaired cognitive function, was provided a busy apron and other items to keep him busy and was placed in a

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geriatric reclining chair with a table top for safety. The goal was the resident would remain oriented to person through the review date. No intervention listed mentioned the chair with table top. The Care Plan dated 5/23/2016 did not indicate a physical restraint was in place for the resident.

There was no physician order for a physical restraint in Resident #141's medical record.

The following observations were made of Resident # 141 on 8/16/2016:

At 9:15 AM-Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. Nothing was observed on top of the tray which was attached to the resident ' s chair. The resident attempted to stand numerous times and was unable to.

At 11:30 AM- Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 Skilled Nursing hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. Nothing was observed on top of the tray which was attached to the resident ' s chair. The resident attempted to stand numerous times and was unable to.
At 1:30 PM- Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. Nothing was observed on top of the tray which was

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F 221	Continued From page 6 attached to the resident ' s chair. The resident attempted to stand numerous times and was unable to. At 3:40 PM- Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. Nothing was observed on top of the tray which was attached to the resident ' s chair. The resident attempted to stand numerous times and was unable to. On 8/17/2016 at 7:17 PM, Resident # 141 was observed was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. Nothing was observed on top of the tray which was attached to the resident ' s chair. An interview was conducted with NA #3 on 8/17/2016 at 2:00 PM. NA # 3 indicated she cared for the resident often during the day shift. NA #3 reported when the resident ' s morning care was completed he was placed in the geriatric chair with the lap tray so Resident # 141 would not fall. NA # 3 stated Resident # 141 had a history of falls and the lap tray prohibited the resident from standing and falling. An interview was conducted with Nurse # 5 on 8/18/2016 at 1:45 PM. Nurse #5 indicated she worked on the resident's hall most of the time during the day shift. Nurse #5 stated Resident #141 was in the geriatric chair with the lap tray almost every day. Nurse #5 reported the tray kept	F 221		

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the resident from standing and getting out of the chair. The nurse stated the resident was unable to remove the tray.

An interview was conducted with Nurse # 1 on 8/18/2016 at 2:25 PM. Nurse # 1 indicated Resident # 141 was unable to remove the table top from the geriatric chair and the tray prohibits the resident from getting out of the chair.

An interview was conducted with the Minimum Data Set (MDS) RN Coordinator on 8/19/2016 at 1:30 PM. The MDS Coordinator indicated the information for the resident assessment was collected from the charts, interviews with family members and staff, observations and interviews with the resident. The MDS Coordinator reported observing Resident # 141 in the chair with the lap tray on several occasions. The MDS Coordinator stated she was told by the Director of Nursing (DON) as long as there was an activity on the lap tray it was not considered a restraint. The MDS Coordinator stated there were times she observed Resident # 141 in the chair with the lap tray attached and no activity on the tray. The MDS Coordinator stated the lap tray prohibited Resident #141 from standing and would be a physical restraint.

An interview was conducted with the Director of Nursing (DON) on 8/19/2016 at 11:30 AM. The DON stated she was aware the use of the lap tray on the geriatric chair for Resident # 141. The DON indicated the lap tray was to be utilized for activities and stated she was unaware the tray was used at other times. The DON indicated the lap tray was a physical restraint if there was not an activity on the lap tray. The DON stated the expectation was for the tray to be removed from

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F 221	Continued From page 8 the geriatric chair when Resident # 141 was not engaged in an activity.	F 221		
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, record review and staff and family interviews, the facility failed to treat a resident in a dignified manner by allowing 1 of 1 residents (Resident #154)with severe cognitive impairment to eat in a main dining room in a nightgown, facility staff failed to remove 1 of 1 residents (Resident #141)sleeping in bed in the commons/day area in full visual view of other residents, facility staff and visitors, facility staff failed to be seated while feeding 4 of 4 residents(Resident # 134, Resident #141, Resident #139, and Resident # 79)and facility staff administered medications to 1 of 1 residents(Resident # 202)while eating in a dining area. Findings included: 1. Review of the clinical record of Resident #154 indicated the resident was admitted to the facility on 08/18/2015 with cumulative diagnoses which included Alzheimer's and Dementia without behaviors. Review of the most recent comprehensive Minimum Data Set (MDS) dated 05/17/2016 indicated the resident had severe cognitive impairment. The MDS also indicated the resident	F 241	1. It is the facility's goal to ensure all Residents are treated with the utmost dignity and respect. No further occurrences have been identified with these deficient practices, education on these began immediately. 2. No other Residents were effected, but all other Residents had the potential to be effected by the deficiency. Education began immediately and no other instances have been observed. 3. All employees are in the process of being educated on dignity and respect, and how to ensure this is always maintained with each Resident. Education on dignity and respect will be given bi-annually, to all new employees when hired, and as needed. 4. This has been added to the facility quality assurance program to be monitored weekly times four weeks then monthly. 5. Completion date for this deficiency is 09/16/2016.	9/9/16

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required extensive assistance of one person with dressing.
During an observation of a breakfast meal on 08/16/2016 at 8:10 AM, Resident #154 was observed seated at a table in the main dining room on the Alzheimer's Unit in a short sleeved just below the knee green night gown eating breakfast. There were 10 other residents, 8 females and 2 males, also seated and eating their breakfast meal.

The resident's family member/responsible party was interviewed on 08/17/2016 and stated the resident was a very distinguished lady in her younger years and worked for 40 years in a distinguished position in her career. The family member stated the resident was always very meticulous about her looks and clothing during her life.

Staff Nurse #2 was interviewed on 08/19/2016 at 9:00 AM. The nurse stated Resident #154 was mild mannered and never resisted care. When questioned about the resident wearing a short light material gown to the main dining room on 08/16/2016, the nurse stated she saw the resident that morning in the gown, and she knew it was not appropriate dress for the resident out in public common areas. The nurse gave no reason the resident was allowed to be in a public common area dressed in a nightgown.

Nursing Assistant(NA)#2 was interviewed on 08/19/2016 about the events on the morning of 08/16/2016. The NA stated she noticed the resident wearing the gown in the dining room, but she said the resident walked to breakfast on her own that morning. The NA also stated the gown was inappropriate for the main dining room but

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gave no reason why this was allowed.

The facility Director of Nursing (DON)was interviewed about the events and her expectations. The DON stated the expectation was if staff saw the resident out of her room in inappropriate dress, they should assist her back to her room and dress her properly.

2. Record review indicated Resident # 141 was admitted to the facility on 12/2/2104. The resident's cumulative diagnoses included Alzheimer ' s disease, Dementia, Hypertension and Falls.

Review of the annual Minimum Data Set (MDS)dated 11/27/2015 revealed the resident was rarely/never understood and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident #141 was totally dependent on staff for personal hygiene, eating, transfers and all activities of daily living (ADL's).

Review of the Care Plan dated 5/23/2016 through 8/21/2016 indicated Resident #141 was at high risk for falls related to an unawareness of safety needs, confusion and gait/balance problems. The interventions included the resident ' s bed placed at the nurse ' s station at night for closer observation.

On 8/18/2016 the following observations were made:
-8:00 AM, Resident #141 was sleeping in bed, with the bed located in the commons/day area in front of the nurse 's station. Resident #141 was in full visual view from the entrance door of the unit

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and all the commons areas. He was dressed in a hospital gown and covered with a sheet to his waist. There was a female resident sitting in a wheelchair on the opposite side of the commons/day area.
-8:30 AM, Resident #141 was sleeping in bed, with the bed located in the commons/day area in front of the nurse's station. There was a female resident sitting in a wheelchair on the opposite side of the commons/day area and 2 family members stopped at the nurse's station and spoke with Nurse #1 for approximately 5 minutes. Resident #141 was in full view of the family members.
-9:00 AM, Resident #141 continued sleeping in the commons/day area in front of the nurse's station.
-9:30 AM, Resident #141 continued sleeping in the commons/day area in front of the nurse's station.
-10:15 AM, Resident #141 was observed in bed in the same location. A facility employee brought 2 residents in wheelchairs to the commons/day area and turned the television on. The 2 residents were watching television. The television was located in a wooden cabinet located approximately 3 feet from the resident's bed.
-10:45 AM, Nurse #1 pushed Resident #141 in his bed from the commons/day area to his room. The resident was awake at that time.
There were numerous facility staff and visitors interacting at the nurse's station and the commons/day area during the times of 8:00 AM to 10:45 AM on 8/18/2016.

An interview with Nurse #1 on 8/18/2016 at 1:45 PM revealed Resident #141 was placed in the commons/day area in front of the nurse's station each night so the staff could watch him closely

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due to poor safety awareness and a history of falls. Nurse #1 stated there was no specific time Resident #141 was returned to his room in the mornings. Nurse #1 stated if the resident was sleeping and quiet, his NA would try to get some of the other resident's morning care completed during that time.

On 8/19/2016 the following observations were made:
-8:15 AM, Resident #141 was sleeping in bed in the same location he was observed on 8/18/2016 in the commons/day area.
-9:00 AM, Resident #141 was sleeping in bed in the same location he was observed on 8/18/2016 in the commons/day area.
-9:30 AM, Resident #141 was sleeping in bed in the same location he was observed on 8/18/2016 in the commons/day area.
-10:10 AM, Nurse #1 pushed Resident #141 in his bed from the commons/day area to his room. The resident was awake at that time.

There were numerous facility staff and visitors interacting at the nurse's station and the commons/living area during each observation.

An interview was conducted with the Director of Nursing (DON) on 8/19/2016 at 11:00 AM. The DON reported she was aware Resident #141's bed was moved to the commons/day area each night to ensure the staff could provide observation for the resident ' s safety. The DON stated she expected the resident to be returned to his room early in the morning and not left in bed in the commons/day area for staff convenience.

3.. Resident # 141 was admitted to the facility on

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F 241	Continued From page 13 12/2/2104. The resident's cumulative diagnoses included Alzheimer's disease, Dementia, Hypertension and Falls. Review of the annual Minimum Data Set (MDS) dated 11/27/2015 revealed the resident was rarely/never understood and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident # 141 required total assistance for feeding. During dining observation on 8/16/2016 at 8:30 AM, Nurse #1 was observed standing beside Resident #141 ' s bed and feeding the resident. The resident's bed was in the low position. There was an empty chair in the room next to the wall beside the resident. Resident #141 was observed in the commons/day area in a geriatric chair with a lap tray attached on 8/16/2016 at 1:50 PM. Nurse #1 was standing on the left side of the resident feeding him chocolate pudding. There was an empty chair on the right side of the resident's wheelchair. During an interview on 8/17/2016 at 10:50 AM, Nurse #1 stated Resident #141 required total assist with feeding. Nurse #1 indicated she would feed the resident standing up because he was difficult to feed and would swing his arms at times. Nurse #1 stated the resident did not swing his arms and did not display any other behaviors when she fed him earlier in the day. Nurse #1 stated staff should be seated when feeding residents. An interview was conducted with the Director of Nursing (DON) on 8/19/2016 at 11:30 AM. The	F 241		

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DON stated the expectation was for staff to be seated when feeding residents

4. Resident # 139 was admitted to the facility on 5/27/2016. The resident's cumulative diagnoses included Alzheimer ' s disease, Hypertension and Congestive Heart Failure.

Review of the admission Minimum Data Set (MDS) dated 6/3/2016 revealed the resident was rarely/never understood and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident # 139 required extensive assistance of 1 staff for feeding.

During dining observation on 8/16/2016 at 9:20 AM, NA #3 was observed standing beside Resident #139 ' s bed and feeding the resident. The resident ' s bed was in the low position. There was an empty chair in the room next to the wall.

An observation on 8/19/2016 at 8:10 AM, NA #3 was observed standing beside Resident 139 ' s bed and feeding the resident. The resident ' s bed was in the low position. There was an empty chair in the room next to the wall.

During an interview on 8/19/2016 at 11:00 AM, NA #3 stated Resident # 139 required total assist with feeding. NA #3 indicated she fed the resident standing beside the bed because of foot pain when she went from a seated to a standing position. NA #3 stated she learned in school if you were at eye level with the resident it was acceptable to stand and feed. NA #3 stated when the beds were raised it was acceptable to stand and feed. NA #3 indicated if she was observed

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F 241	Continued From page 15 standing and feeding she must have forgotten to adjust the bed position. An interview was conducted with the Director of Nursing (DON) on 8/19/2016 at 11:30 AM. The DON stated the expectation was for staff to be seated when feeding residents. The DON also stated she would expect to be informed if a staff member had a physical condition which prohibited feeding residents in a seated position. 5. Resident # 79 was admitted to the facility on 8/8/2012. The resident's cumulative diagnoses included Alzheimer ' s disease and Diabetes. Review of the last comprehensive Minimum Data Set (MDS) dated 10/19/2015 revealed the resident was rarely/never understood and was moderately impaired with cognitive skills for daily decision making. The MDS indicated Resident # 79 required assistance of 1 staff for feeding. During dining observation on 8/16/2016 at 8:15 AM, NA #3 was observed standing beside Resident #79 ' s bed and feeding the resident. The resident ' s bed was in the low position. There was an empty chair in the room next to the wall. An observation on 8/19/2016 at 8:00 AM, NA #3 was observed standing beside Resident 79 ' s bed and feeding the resident. The resident ' s bed was in the low position. There was an empty chair in the room next to the wall. During an interview on 8/19/2016 at 11:00 AM, NA #3 stated Resident # 79 required total assist with feeding. NA #3 indicated she fed the resident	F 241		

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F 241	Continued From page 16 standing beside the bed because of foot pain when she went from a seated to a standing position. NA #3 stated she learned in school if you were at eye level with the resident it was acceptable to stand and feed. NA #3 stated when the beds were raised it was acceptable to stand and feed. NA #3 indicated if she was observed standing and feeding she must have forgotten to adjust the bed position. An interview was conducted with the Director of Nursing (DON) on 8/19/2016 at 11:30 AM. The DON stated the expectation was for staff to be seated when feeding residents. The DON also stated she would expect to be informed if a staff member had a physical condition which prohibited feeding residents in a seated position.	F 241		

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6. Resident # 134 was admitted to the facility on 7/15/16 with diagnoses that included dementia, stroke, and left side weakness. The Minimum Data Set (MDS) assessment of 7/22/16 revealed Resident # 134 required total assistance with feeding.

During dining observations on the Intermediate Care Facility (ICF) hall dining area on 8/16/16 at 8:05 AM, Rehabilitation Technician (RT # 1) was observed feeding Resident # 134 while standing next to him. Two empty chairs were noted against the wall behind Resident # 134.
During an interview on 8/19/16 at 10:40 AM, RT

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F 241	Continued From page 20 # 1 stated she transported residents from their rooms or halls to the rehabilitation unit for therapy and then back when therapy was finished. She stated she was on the ICF unit to take Resident # 134 to therapy when he finished eating breakfast. She stated she noticed Resident # 134 had stopped eating and no one had come to assist him with feeding. She stated she began to feed Resident # 134 to help him finish so he could go on to therapy. She stated she remained standing while feeding him. She stated no one had explained to her she should not stand over a resident while feeding, but should be seated. During an interview on 8/19/16 at 12:48 pm, the Administrator stated it was her expectation staff would be seated while feeding a resident. 7. Resident # 202 was admitted to the facility on 8/11/16 with diagnoses which included dementia. The admission Minimum Data Set (MDS) was in progress. A review of Resident # 202's Progress Notes revealed the resident was oriented to self. During dining observations on the Intermediate Care Facility (ICF) hall dining area on 8/16/16 at 8:20 AM, Resident # 202 was observed seated at a table with three other residents eating breakfast. At 8:26 AM, Nurse # 4 was observed giving medications to Resident # 202 while she was feeding herself breakfast. During an interview on 8/19/16 at 12:41 PM, Nurse # 4 stated, "I do not recall specifically giving (Resident # 202) her medications in the day room. We had a lot of people up that day beause of therapy. We have a lot of new rehab residents and they were gotten up early and brought to the Day Room for breakfast. I was	F 241		

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F 241	Continued From page 21 trying to get their medications done because they were going to therapy. Usually, I give them their medications in their rooms." During an interview on 8/19/16 at 12:48 PM, the Administrator stated her expectation was that staff would give the residents' medications in a private area. ,	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to honor choices for 2 of 40 sampled residents by making the 2 residents stay in a dining room after a meal (Resident #52 and Resident #154). Findings included: 1. Review of the clinical record of Resident #52 indicated she was admitted to the facility on 02/12/2012 with diagnoses which included Alzheimer's. Review of the resident's most current	F 242	1. It is the goal of the facility to allow Residents to make decisions and choices of their own. The Residents have always been allowed to wander safely on the unit as they wish. Education on this deficiency began immediately. 2. Everyone had the potential to be affected by this deficiency, but no other Residents were effected. 3. All staff are being educated on self-determination and the Resident's right to make choices. The Nursing assistant was conferenced with a final written warning. Education will occur upon hire,	9/9/16

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F 242	Continued From page 22 comprehensive Minimum Data Set (MDS) indicated the resident had severe cognitive impairment. A continuous dining observation was conducted in the Alzheimer main dining room on 8/16/2016 from 8:10 AM through 9:16 AM with the following observations: At 8:10 AM Resident #52 was seated at a table in a wheelchair and stated "I ' m freezing." Two nursing assistants (NA) NA #1 and NA#2 were assisting residents in the room. Neither of the NAs responded to the resident. The resident wore a short sleeve shirt and a pair of cropped pants. At 8:18 AM, the resident stated " I am freezing. I ' m ready to go." NA #1 did not respond to the resident but went about the room assisting other residents. At 8:20 AM, the resident yelled "it's cold, I'm freezing. " NA #1 responded "I'll get you a jacket." At 8:24 AM, NA #1 put a long sleeved jacket on the resident. The resident stated she was through with her breakfast and ready to go. The NA removed the tray from the table. At 8:30 AM, the resident stated "I ' m ready to go. I'm freezing to death." NA #1 stated "You have a jacket on, you'll warm up." At 8:32 AM, the resident yelled "I need to go now. I'm freezing." NA #1 replied "You can't go, you have to wait until your medicine comes."	F 242	bi-annually,and as needed. 4. This has been added to the facility quality assurance program to be monitored weekly times 4 weeks then monthly. 5. 09/16/2016	

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At 8:40 AM, the resident yelled out "I'm ready to go." NA #1 stated "You can't go. You have to sit there and wait for your medicine."

Staff nurse #2 was observed at the door of the dining room talking to another staff member.

At 8:57 AM, Resident #52 was observed still seated at her table and now appeared sleeping in her chair.

On 8/16/2016 at 9:09 AM, resident # 52 was observed still seated at the table. Several residents were observed throughout the observation leaving the room on their own or assisted by NA #2 out of the room.

At 8/16/2016 at 9:13 AM, resident #52 was still seated at her table awake and talking now. The resident was trying to get up from her chair and stated she needed to go and pee. The NA told her to sit back down. She told her she needed to sit down and wait for her medicines. She also told her she was trying to get the nurse down here, and she would have to wait a minute.

8/16/2016 at 9:16 AM, NA #1 rolled the resident out of the dining room.

2. Review of the clinical record of Resident #154 indicated the resident was admitted to the facility on 08/18/2015 with cumulative diagnoses which included Alzheimer ' s and Dementia without behaviors.

Review of the most recent comprehensive Minimum Data Set (MDS) dated 05/17/2016 indicated the resident had severe cognitive impairment.

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An observation of the breakfast meal was conducted on 08/16/2016 8:10 AM. Resident #154 was observed seated at a table in the main dining room. There were 10 other residents, 8 females and 2 males, also seated and eating their breakfast meal.

On 8/16/2016 at 8:30, Resident #154 stood up from table after her tray was removed and attempted to leave. NA #1 assisted her back to her chair and told her she had to sit down and wait for her medicine.

On 8/16/2016 at 8:35 AM, Resident #154 stood up from table and attempted to leave the table. NA #1 assisted the resident back to her chair and told her she had to sit down and wait for her medicine.

On 8/16/2016 at 8:45 AM, Resident #154 stood up from her table and attempted to walk away from the table. NA #2 walked over and assisted the resident back in her chair and told the resident she had to sit and wait for her medicine.

On 8/16/2016 at 9:00 AM, Resident #154 was still seated in her chair at her table. Several residents were observed throughout the observation leaving the room on their own or assisted by staff out of the room.

On 8/16/2016 at 9:17 AM, NA #2 entered the dining room and wheeled one resident from the room and told Resident #154 to "come on", at which time the resident walked out of the room behind the NA.

During this continuous observation, no medications were offered to the resident.

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F 242	Continued From page 25 Staff Nurse #2 was interviewed on 08/19/2016 at 9:00 AM about the observations on 08/16/2016. The nurse stated Resident #154 was mild mannered and never resisted care. When questioned about the observations of 08/16/2016, the nurse stated she did not know why the residents were made to wait that morning to leave the dining area. She further stated if they asked to exit the room, staff should have assisted them out. NA #1 was not available for an interview. NA #2 was interviewed on 08/19/2016 about the events on the morning of 08/16/2016. The NA stated she heard residents saying that morning they were ready to leave the dining room, but the unit had rules about how many staff are needed in certain places, and there were not enough staff to grant the wishes of the residents plus monitor them by the rules of the unit. The facility Director of Nursing (DON) was interviewed about the events and her expectations. The DON stated residents should be escorted from the dining room if they want to exit. She further stated if staff on the unit thought there wasn't enough staff to assist in the care of the residents, they should have asked for help.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		9/9/16

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F 253	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean environment for their residents by allowing two residents to use wheelchairs that were heavily soiled, a resident to use a geri-chair that was soiled and allowing resident common areas to accumulate dust and dirt in two of four resident units. (ICF unit and SNF unit) The findings include: In observations that began on 8/15/2016 at 5:05pm, Resident # 109 and Resident #106 were observed in the ICF Day Room Common Area in dirty wheel chairs. These two residents were observed again sitting in soiled wheelchairs on 8/16/2016 at 10:35am and 8/17/2016 at 4:31pm. . Resident #134 and Resident #202 were observed to be seated in soiled geri-chairs on 8/15/2016 at 5:05pm, 8/16/2016 at 10:39am, and 8/17/2016 at 4:35pm. Resident # 134 was observed at each of these times in the ICF Day Room Common Area to be seated in a reclining geri-chair that had dried spills on both sides and back of the chair. Resident # 202 was observed at each time to be seated in the ICF Day Room in a geri-chair that had dried spills on the back of the chair. In an observation made on 8/15/2016 beginning at 6:20pm, the following residents were found to have over the bed tables that had soiled bases. The bases of the tables were dusty and dirty and were being used at meal times for feeding surfaces. The soiled over the bed tables belonged to Resident #70, Resident #146, Resident #130, Resident #90, Resident #138, and Resident #9. The soiled over the bed tables	F 253	1. It is the goal of the facility to always maintain a comfortable and sanitary environment for the Residents. Cleaning of the defected areas began immediately by the nursing and housekeeping staff. Dirty, cloth chairs were removed immediately. A work order was replaced for the painting. 2. All Residents had the potential to be affected by this deficiency, but no Residents were affected. Correction of the deficient areas began immediately. The over bed tables, recliners, and wheelchairs have all been pressure washed. Education for the clinical staff and housekeeping staff is being done. Blinds have been ordered, and the painter has come to give asses painting needs so the painting will be completed. 3. A weekly inspection by the maintenance and housekeeping department will occur and deficient areas will be corrected immediately. Staff have been educated that it is all our duties to make sure the environment is clean and safe for our Residents. 4. This has been added to the facility quality assurance program to be monitored weekly times 4 then monthly by the quality assurance nurse, April Oxendine. 5. Completion date for this deficiency is 09/16/2016.	

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were observed again on 8/16/2016 beginning at 2:45pm and on 8/17/2016 with observations beginning at 4:33pm.

Another observation of the ICF Day Room Common Area on 8/16/2016 at 8:30am noted a TV armoire with a large dried brown stain on the lower right side. The stain remained on the armoire on 8/19/2016 at 10:40am. The ICF Day Room Common Area has door to outside that opens with a large push bar. The push bar is heavily covered with dust. The dust on the bar was noted on 8/17//2016 at 4:59pm, 8/18/2016 at 9:14am, and 8/19/2016 at 10:25am. There was also a wooden chair with a green cushion in the ICF Day Room Common Area. The wooden support bars beneath the seat of the chair was observed to have a heavy accumulation of dust. This was observed on 8/17/2016 at 5:05pm and 8/19/2016 at 10:30am.

Observations made in the SNF Day Room Common Area were made beginning on 8/16/2016 at 8:10am. Two doors that led to the outdoors both were found to have bent mini blinds. The glass in one door was observed to be heavily clouded with dirt on 8/16/2016 at 8:13am. It was observed again on 8/17/2016 6:10pm, and 8/18/2016 9:24am. One door leading to the outside in the SNF Day Room Common Area has a push bar device to open the door that is heavily covered with dust. This was observed again on 8/16/2016 8:15am, 8/17/2016 at 6:15pm and 8/19/2016 10:40am.

Other observations in the SNF Day Room Common Area noted large areas under 2 side by side bulletin boards that has patched sheet rock that has not been repainted. These observations

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were made on 8/16/2016 at 8:19am and 8/19/2016 10:38am. The SNF Day Room Common Area has a nursing station that is framed with a waist high wall. Five of the wall areas have areas that measure at least 4 inches in length. These places appear to have the finish missing and a different color shows through. These areas were noted 8/16/2016 at 8:25am and 8/18/2016 at 9:35am. At the end of the SNF Hallway with rooms 1201-1212, there is a door at the end of the hallway that had mini blinds that were bent and broken in several places. This was noted on 8/16/2016 at 8:20am and 8/19/2016 at 9:05am.

Other concerns that were also noted in the SNF Day Room Common Area near the nurses ' station were a mauve-colored upholstered chair that was positioned by the television. The seat cushion on the chair had four dried white spills. There was also a metal hair with red cushion that was heavily soiled in the area. These chairs were observed on 8/16/2016 at 9:55am, 8/17/2016 at 4:00pm, and 8/19/2016 at 10:20am.

A staff interview with the facility Administrator on 8/19/2016 at 10:35am revealed that there is a person who is responsible for the Housekeeping Staff in the facility. She stated that the person in charge of housekeeping staff has the responsibility to follow behind the housekeeping staff to see that they were doing an adequate job of their assignment. The facility administrator stated that they routinely
power wash wheel chairs, over the bed tables, geri chairs once a year. She reported that half of the unit had been cleaned recently, but they were waiting for the remainder to be cleaned. She also stated that she had put in a request some time

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F 253	Continued From page 29 ago for the wheelchairs, over the bed tables, and geri chairs to be cleaned/ power washed. She stated that part of these items had been power washed, but there were some that still needed to be cleaned. Staff interview with the Unit Manager on 8/19/2016 at 10:50am revealed that she thought night shift nursing assistants are also supposed to be wiping wheel chairs, over the bed tables, and geri chairs off routinely. The Unit Manager also reported that the painting that needs to be done at the nurses station had been requested of the maintenance department 6/17/2016. Additional staff interview with the Interim Housekeeping Manager on 8/19/2016 at 11:05am revealed that they needed to power wash the wheel chairs, over the bed tables and geri chairs. He reported that those are done annually and part of the building was completed not long ago. He reported they would be coming back to clean the remainder of these immediately. An additional staff interview was conducted with the Housekeeping Supervisor on 8/19/2016 at 11:15am who reported that she is the person who is responsible for looking behind the housekeeping staff to be sure their areas are being cleaned appropriately. She stated that she looks behind her staff daily and at times, even works with them on the halls. She stated the soiled and dirty items that were pointed out had not been noticed by the housekeeping staff in the facility.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 272		9/9/16

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F 272	Continued From page 30 reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review	F 272	1. All laptops have been removed from	

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F 272	Continued From page 31 and staff interviews, the facility failed to assess a lap tray which prevented a resident from rising as a restraint for 2 of 3 residents (Residents #114, #141). Findings included: Review of Resident #114's medical record revealed the resident was admitted to the facility on 12/18/2012. The resident's current diagnoses included Alzheimer 's Dementia and Anxiety. The Minimum Data Set (MDS) dated 05/25/2016 indicated Resident #114 had severe cognitive impairment. The MDS also indicated the resident required extensive to total assistance for all activities of daily living and physical restraints were not being utilized. The MDS further indicated the resident had no psychoses or negative behaviors. Review of physician orders from 01/2016 through 08/17/2016 indicated no orders for any type of restraint. The resident's care plan dated 05/25/2016 did not indicate the resident used any type of restraints. Nursing progress notes reviewed from 08/15/2016 through 08/18/2016 indicated no documentation of any physical restraints used. The following observations were made during the survey. On 8/16/16 at 9:15 AM, Resident #114 was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and moving around in the chair mumbling to herself. The resident was not engaged in an activity or eating during the observation. Due to the resident 's severe cognitive status, an interview was not attempted.	F 272	the facility. The facility is dedicated to providing comprehensive assessments for the Residents as directed by the state. The laptops were not care planned as restraints because they were not being used as a means for restraining the Residents. The intent was to provide a means for the Resident to have activities to enhance quality of life. 2. There were no other Residents affected by this deficiency, although all residents had the ability to be affected. 3. The laptops were removed from the facility immediately. Education for the staff began immediately. Care plans have been reviewed for accuracy, and no other deficient areas have been identified. A percentage of the care plans will be audited monthly for accuracy. The MDS nurse will continue to attend MDS and care plan workshops as they become available. 4.This has been added to the facility quality assurance program to be monitored weekly times 4 weeks then monthly to ensure the accuracy of the assessments. 5. Completion date for this deficiency is 09/16/2016.	

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F 272	Continued From page 32 On 8/16/16 at 11:30 AM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and moving around from side to side in the chair. The resident was not engaged in an activity or eating during the observation. On 8/16/16 at 3:40 PM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and quietly moving around from side to side in the chair. The resident was not engaged in an activity or eating during the observation. On 8/17/16 at 7:17 PM, the resident was observed in a reclining geriatric chair with a tray attached across the front of the resident's body in the common/living area in front of nurse's station. Nothing was observed on top of the tray which was attached to the resident's chair. The resident was awake and quietly moving around from side to side in the chair mumbling. The resident was not engaged in an activity or eating during the observation. An interview was conducted with the Minimum Data Set (MDS) RN Coordinator on 8/19/2016 at 1:30 PM. The MDS Coordinator indicated the information for the resident assessment is collected from the charts, interviews with family members and staff, and from assessments, observations and interviews with the resident. The MDS Coordinator reported observing Resident # 114 in the chair with the lap tray on several occasions. The MDS Coordinator stated	F 272		

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she was told as long as there was an activity on the lap tray it was not considered a restraint. The MDS Coordinator stated there had been times she observed Resident # 114 in the chair with the lap tray attached and no activity on the tray.
During an interview on 08/18/16 at 1:45 PM with Nurse #5, who worked on the resident ' s unit, the nurse stated Resident #114 was not able to remove the tray from the chair. The nurse stated she was not sure why the tray was on the resident's chair, and she stated it kept the resident from falling from the chair.
During an interview with Nurse #1 on 08/18/2016 at 2:30 PM, the nurse stated it was the staff's understanding if the resident used the tray for an activity, it was not considered a restraint. The nurse also stated there were times the tray was observed on the chair, and the resident was not involved in an activity. The nurse further stated the resident had a history of falling, and the tray prevented her from falling forward out of the chair. The nurse stated the resident could not remove the tray from the chair.
The facility Director of Nursing (DON) was interviewed on 08/19/2016 and stated a tray should not have been attached to Resident #114's chair unless a resident was involved in an activity. The DON also stated the expectation was the comprehensive assessment should be accurate.

2. A review of the clinical record revealed Resident # 141 was admitted to the facility on 12/2/2104. The resident's cumulative diagnoses included Alzheimer 's disease, Dementia, Hypertension and Falls.

The annual Minimum Data Set (MDS) dated 11/27/2015 indicated the resident was

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rarely/never understood and was severely impaired with cognitive skills for daily decision making. The MDS indicated Resident #141 was totally dependent on staff for personal hygiene, eating, transfers and all activities of daily living (ADL's). The Minimum Data Set (MDS) indicated the resident did not use restraints in or out of bed.

Review of the resident's Care Plan dated 5/23/2016 through 8/21/2016 revealed Resident #141 had a problem with impaired cognitive function, was provided a busy apron and other items to keep him busy and was placed in a geriatric reclining chair with a table top for safety. The goal was the resident would remain oriented to person through the review date. No intervention listed mentioned the chair with table top.

The following observations were made of Resident # 141 on 8/16/2016:

9:15 AM-Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. The resident attempted to stand numerous times and was unable to.

11:30 AM- Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. The resident attempted to stand numerous times and was unable to.

1:30 PM- Resident # 141 was sitting in a geriatric

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reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. The resident attempted to stand numerous times and was unable to.

3:40 PM- Resident # 141 was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body. The resident attempted to stand numerous times and was unable to.

On 8/17/2016 at 7:17 PM, Resident # 141 was observed was sitting in a geriatric reclining chair in the day room area in front of the 1200 hall nursing station. The chair was in the sitting position with a lap tray attached across the front of the resident's body.

An interview was conducted with Nurse #2 on 8/18/2016 at 1:45 PM. Nurse #2 indicated she worked on the resident's hall most of the time during the day shift. Nurse #2 stated Resident #141 is in the geriatric chair with the lap tray almost every day. Nurse #2 reported the tray kept the resident from standing and getting out of the chair. The nurse stated the resident was unable to remove the tray.

An interview was conducted with Nurse #1 on 8/18/2016 at 2:25 PM. Nurse #1 indicated Resident # 141 was unable to remove the table top from the geriatric chair and the tray prohibits the resident from getting out of the chair.

An interview was conducted with the Minimum

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F 272	Continued From page 36 Data Set (MDS) RN Coordinator on 8/19/2016 at 1:30 PM. The MDS Coordinator indicated the information for the resident assessment is collected from the charts, interviews with family members and staff, and from assessments, observations and interviews with the resident. The MDS Coordinator reported observing Resident # 141 in the chair with the lap tray on several occasions. The MDS Coordinator stated she was told as long as there was an activity on the lap tray it was not considered a restraint. The MDS Coordinator stated there had been times she observed Resident # 141 in the chair with the lap tray attached and no activity on the tray. An interview was conducted with the Administrator on 8/19/2016 at 11:30 AM. The Administrator stated she was aware of the lap tray on the geriatric chair for Resident #141. The Administrator indicated the lap tray was to be utilized for activities and stated she was unaware the tray was used at other times. The Administrator stated the expectation was for clinical information and MDS comprehensive assessments to be accurate when completed to ensure the appropriate and individual care of each resident.	F 272		
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	F 371		9/9/16

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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to label and date refrigerated opened food items, failed to store thawed meat properly and failed to discard expired products. Findings included: 1. During initial tour of the kitchen on 8/15/2016 at 6:35 PM, refrigerator #1 contained 2 cardboard boxes with partially thawed pork chops in plastic unsealed bags and a tray of thawed pork chops covered in clear plastic wrap on top of the 2 boxes. The boxes were stored on a stainless sheet pan approximately 1 inch deep. The stainless pan contained a red liquid which covered the bottom of the pan and saturated the cardboard box approximately 2 inches up the sides. The pork chops were not labeled or dated. The dietary worker reported the pork chops were to be cooked the next day. On the top left shelf was an opened box of thawed prune juice. There was no date on the box indicating when the prune juice was removed from the freezer. The product instructions on the top of the box specified to thaw overnight in 38 degrees or cooler, after thawing keep refrigerated and use within 14 days of thawing initiation. The box contained 88 4oz plastic cups with foil lids. 3 of the foil lids were compromised and there was a brown, sticky substance on 15 of the containers of juice. The dietary worker stated the box had been on the shelf for a "while" and she was unsure when the box had been removed from the freezer.	F 371	1. The deficiencies were corrected immediately. There were no Residents affected by the deficiency. 2. All Residents had the potential to be affected by the deficiency. Corrections were made immediately and education began. 3. It is the expectation for the refrigerators to be checked twice daily (once on day shift and evening shift)for expired and unlabeled products, and for no items to be opened from the original packaging without dates. All staff will be educated on this deficiency. 4. This has been added to the Quality assurance program to be monitored by the quality assurance nurse, April Oxendine. She will monitor it weekly times 4 weeks, then monthly. 5. Completion date for this deficiency is 09/16/2016	

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WOODHAVEN NURS & ALZHEIMER'S C	1150 PINE RUN DRIVE LUMBERTON, NC 28358

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F 371	Continued From page 38 2. During initial tour of the kitchen on 8/15/2016 beginning at 6:35 PM, refrigerator #2 contained a stainless steel container covered with clear plastic wrap which contained 18 eggs. The dietary worker indicated the eggs were boiled. The eggs were not labeled or dated. The Dietary worker reported the eggs should have been labeled and dated. Refrigerator #2 also contained two 32-ounce cartons of unopened Egg Substitute with expiration date of Aug 12, 2016 and two gallons of unopened milk with expiration dates of July 31, 2016 and August 14, 2016. The Dietary worker reported the refrigerators were supposed to be checked for expired foods/beverages daily and all food is supposed to be labeled and dated. The Dietary worker was unsure why the expired items had not been removed. 3. On 8/18/2016 at 2:10 PM the refrigerator of the Rehab Unit nourishment room contained an unopened carton of fat free milk with the expiration date of 7/25/2016. The Dietary Manager was present and explained the dietary staff stocked the nourishment room refrigerators and the Unit staff was responsible for dating, labeling and monitoring of the expiration/use by dates. The Dietary Manager removed and discarded the milk. An interview was conducted with the Administrator on 8/19/2016 at 11:30 AM. The Dietary Manager was present during the interview. The Administrator stated the expectation was for all food/liquid items to be stored properly, opened items to be labeled and dated and all food/nourishment items past the expired/use by dates to be discarded.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345054	A. BUILDING ______ B. WING ______	08/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 39	F 520		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility Quality Assurance Committee failed to maintain and monitor interventions that were put into place 10/9/15. These interventions were in areas originally cited in the recertification survey of 9/17/15 and recited in the recertificaton survey of 8/19/16. The deficiency was in the area of F371..	F 520	1. There were no Residents affected by this deficiency. 2. All Residents have the potential to be affected when the quality assurance program isn't working. The facility has had great successes from the program. We have been able to make a huge impact on decreasing psychotropic medications,	9/8/16

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F 520	Continued From page 40 Findings included: This citation is cross referenced to: 1. F371 - Food Procure, Store / prepare / serve - Sanitary: Based on observation and staff interviews, the facility failed to label and date refrigerated opened food items, failed to store thawed meat properly and failed to discard expired products. The facility was cited during the 9/17/15 recertification survey for F371 for failing to label and date opened food items in the refrigerator and freezer of the main kitchen and one of four refrigerators in the nourishment rooms. During an interview on 8/19/16 3:30 pm, the Administrator stated, "The adminstrative staff from the facility meets monthly with the hospital Quality Assurance (QA) committee. The facility has target goals for the areas we have identified but if the facility does not meet the goal, we have to meet with the hospital QA committe to resolve the problem."	F 520	readmissions, and falls to name a few. We will continue our quality meetings, but will include more frontline staff. We have found that our greatest need for audits is on off-shifts since this has been identified as our biggest challenge. 3. All staff is being educated on the quality assurance program and the team will meet monthly to discuss quality findings and implement action plans as needed. 4. Performance improvement audits have traditionally been done on day shift. We have implemented these audits being done on off-shifts as well. If anything is found to be below 100% from the data collection, an action plan will be put in place to ensure 100% compliance. The quality assurance audits will be conducted by non-dietary staff since they have traditionally been done by dietary. 5. Completion date for this deficiency is 09/16/2016.	