STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN TRAIL HEALTHCARE & REHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

(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	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry 8-ounce and 4-ounce cups before stacking them on top of one another in storage, failed to remove dried food debris from a utensil drawer, and failed to label and date opened food times. Findings included: 1. During initial tour of the kitchen, beginning on 11/19/17 at 11:15 AM, 8 of 15 8-ounce cups and 8 of 15 4-ounce cups stacked on top of one another	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility'□s allegation of compliance such that all alleged	12/15/17

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

Electronically Signed | 12/13/2017

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F 371	Continued From page 1 in storage had moisture trapped inside them. At 9:28 AM on 11/21/17, during a follow-up tour of the kitchen, 8 of 15 8-ounce cups and 5 of 15 4-ounce cups stacked on top of one another in storage had moisture trapped inside of them. At 10:35 AM on 11/22/17 the dietary manager (DM) stated his expectation was that dietary staff ensure pieces of kitchenware were clean and air-dried before stacking them on top of one another in storage. He explained kitchenware should be completely dry before stacking it in storage because trapped moisture could grow bacteria which had the potential of making residents sick. At 10:42 AM on 11/22/17 the AM cook stated she was taught that kitchenware needed to be clean and dry before stacking it in storage. She reported if moisture was trapped in between pieces of kitchenware mold could grow which might make residents sick. 2. During initial tour of the kitchen, beginning on 11/19/17 at 11:15 AM, the utensil drawer had dried food debris in it. This drawer contained utensils such as spoons, spatulas, and scoops. At 8:52 AM on 11/21/17, during a follow-up tour of the kitchen, there was dried food debris in the utensil drawer which contained an assortment of different utensils. At 10:35 AM on 11/22/17 the dietary manager (DM) stated the utensil drawer was on the kitchen's cleaning list, and was supposed to be cleaned weekly. He reported it was important to keep the drawer clean to reduce the chance of	F 371	deficiencies cited have been or will be corrected by the dates indicated. F371 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to air dry 8-ounce and 4-ounce cups before stacking them on top of one another in storage, failed to remove dried food debris from a utensil drawer, and failed to label and date opened food items. a. The glasses were re-washed immediately on 11/21/2017. b. The Freezer was checked and all opened items were properly labeled & dated on 11/21/2017. c. The Refrigerated Storage areas were checked and all opened items were properly labeled and dated on 11/21/2017. d. The Dry Storage area was checked and all opened items were properly labeled and dated on 11/21/2017. e. The utensil drawer was cleaned and sanitized immediately on 11/21/2017. A revised daily cleaning schedule was initiated on 11/25/2017 to ensure that service ware storage areas are routinely cleaned and sanitized. Staff are to check off schedule once items are cleaned according to policy. The Dietary Manager will audit completion of the cleaning schedule. 2. Procedure for implementing the acceptable plan of correction. All Dietary staff were reeducated by the Liberty Healthcare and Rehabilitation Services, Sr. Nutrition Services	

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F 371	Continued From page 2 pest infestation in the kitchen and to prevent cross-contamination between compromised utensils and foods being prepared for resident meals. At 10:42 AM on 11/22/17 the AM cook stated the utensil drawer should be wiped out after every shift because it was easy to spill liquids and crumbs into the drawer which could contaminate the utensils which were then used for preparing resident foods. 3. During initial tour of the kitchen, beginning on 11/19/17 at 11:15 AM, a bag of Graham cracker crumbs, two 42-ounce containers of quick rolled oats, and a 5-pound bag of instant nonfat dry milk crystals found in the dry storage room were opened but without labels and dates. In addition, a 5-pound package of American cheese slices and a gallon container of Coleslaw dressing found in the walk-in refrigerator were opened but without labels and dates. A package of sausage dogs, a bag of pizza crusts, a bag of diced green pepper, and a bag of seafood found in the walk-in freezer were opened but without labels and dates. A cart in the kitchen contained an opened package of country style mashed potato buds and an opened 42-ounce container of quick rolled oats which were without labels and dates. Opened bags of plain and frosted corn flake cereals were found on top of the microwave but were without labels and dates. During a follow-up tour of the kitchen, beginning at 8:48 AM on 11/21/17, a 4-pound bag of cheese cake mix, two 42-ounce containers of quick rolled oats, a 5-pound bag of instant nonfat dry milk crystals, and a 24-ounce package of red raspberry gelatin found in the dry storage room	F 371	Coordinator (Dietitian) on 12/11/17. Information presented included Food Service Sanitation Practices including proper cleaning, sanitizing & storage of Service ware; completion of scheduled cleaning assignments and monitoring of completed assignments; as well as Proper Food Storage practices including proper resealing, labeling and dating of Food Items in storage and monitoring of storage areas. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. . Cleaning schedules were revised to include all areas identified during survey process on 11/25/2017. Cleaning schedules were posted and staff was assigned to clean identified areas. Completed cleaning schedules will be kept on file in the Dietary Department for a period no less than one (1) year and will be stored at the facility for a period of five (5) years. Any in-house staff member who did not receive in-service training by 12/11/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 371	Continued From page 3 were opened but without labels and dates. In addition, a bag of raisin bran cereal being stored on top of the microwave was opened but without a label and date. At 10:35 AM on 11/22/17 the dietary manager (DM) stated the last in-service provided to dietary employees about labeling and dating opened food items was provided in October 2017. He reported during the in-servicing staff were instructed to label and date opened food items, foods removed from their original packaging, and leftovers. He commented he checked the storage areas for dating and labeling twice weekly. At 10:42 AM on 11/22/17 the AM cook stated it was the responsibility of all dietary staff to label and date the food items which they opened and were unable to completely use at the time. She reported it was important to label and date food items so that the older products could be used up first and the food served by the facility stayed as fresh as possible.	F 371	and/or in compliance with regulatory requirements. The Dietary Manager will monitor cleaning of the Kitchen and Equipment using the "Dietary QA Audit" tool which evaluates proper Food Storage Practices and Department Cleaning & Sanitizing Practices beginning 12/11/17. This audit will be completed 5 days/week for 4 weeks and then weekly times 2 months or until resolved by QOL/QA committee. The Dietary Manager will present reports to the weekly QA committee to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 431		12/15/17

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F 431	Continued From page 4	F 431		

supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

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F 431	Continued From page 5 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: 1) dispose of an expired bottle of insulin for 1 of 3 bottles (Resident #29) and failed to date an opened insulin pen for 1 of 4 insulin pens (Resident #25) on the 400 hall medication cart; 2) failed to date an opened insulin pen for 1 of 4 insulin pens observed (Resident #16) on the 600 hall medication cart; 3), failed to secure two of six mobile medication carts observed on the 400 and 500 hall, and: 4) failed to dispose of 4 of 4 bags of expired intravenous solution observed in one of three medication storage rooms. Findings included: 1) On 11/19/17 an observation at 1:00 pm in the mobile medication cart on the 400 Hall revealed an insulin bottle which was opened on 10/9/17 for Resident #29. The instructions on the insulin bottle read to be discontinued 28 days from date opened. An additional observation included an insulin pen for Resident #25 which was opened but not dated. The instructions for the insulin pen indicated to discard 42 days from date opened. An interview with Nurse #3 on 11/19/17 at 1:00 pm confirmed that the bottle of insulin exceeded the date and it should have been discarded. Nurse #3 reported the insulin should have been removed from the medication cart 28 days from the day it was opened. Nurse #3 stated she did	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility'□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 431 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to dispose of an expired bottle of insulin, failed to date two opened insulin pens, failed to secure two medication carts, and failed to dispose of 4 bags of intravenous fluids. On 11/21/2017 the hall nurse disposed of the expired bottle of insulin and 4 bags of expired intravenous fluids. On 11/21/2017 the hall nurse replaced the two undated insulin pens with new dated insulin pens.	

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F 431	Continued From page 6 not know when the insulin pen for Resident #25 was opened. Nurse #3 stated the nurses should be dating insulin bottles and insulin pens whenever they were opened so the nurses would know which day to discard them. 2) On 11/19/17 an observation at 1:15 pm in the mobile medication cart on the 600 hall revealed one out four insulin pens was opened but not dated for Resident #16. The instructions on the insulin pen read to discard 42 days from date opened. An interview with Nurse #3 on 11/19/17 at 1:15 pm was conducted. Nurse #3 reported she did not know when the insulin pen for Resident #16 was opened. Nurse #3 stated all the nurses were responsible for checking their medication storage carts to make sure the insulin was dated when opened, there were no expired products and the carts were clean and orderly. 3) On 11/19/17 at 4:15 pm the mobile medication cart was observed to be unlocked and unsupervised on the 500/600 hall. An interview was conducted with Nurse #3 on 11/19/17 at 4:16 pm. Nurse #3 stated she was supposed to secure the cart whenever she walked away from the cart or the unit. Nurse #3 stated she forgot to lock it after she last used it. On 11/21/17 an observation at 10:30 am of the mobile medication cart on the 400 hall was noted to be unlocked and unsupervised. Nurse #4 was noted to be away from the nurse ' s station and walking down the hall. Nurse #4 was observed returning back to the 400 hall at 10:37 am.	F 431	On 11/21/2017 the Consultant RN observed 5 out of 5 med carts noted to be locked and secured when not in use and in sight of the nurse. On 12/13/2017 the Assistant Director of Nursing audited 100% of the following " all medication carts for securement when not in use or in sight of the nurse " All medication rooms for expired medications " All medication carts for undated or expired multi use insulin vials and insulin pens The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 12/13/2017 the Assistant Director of nursing began in servicing all FT, PT, and PRN RN□s, LPN□s, Med Tech□s, and Supply Clerk on the following procedures: " When opening multi-use medications such as insulin vials and insulin pens, the date opened must immediately be written on the medication label by the nurse or Med Tech opening the vial or the nurse or Med Tech placing the insulin pen on the medication cart. Each nurse and Med Tech is responsible for looking at the date opened on the insulin pen to determine when to discard the pen. This is to be completed prior to using the insulin pen. Insulin vials are discarded according to the Recommended Maximum Storage for	

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F 431	Continued From page 7 An interview was conducted with Nurse #4on 11/21/17 at 10:37 am. Nurse #4 reported the nurses are supposed to lock the medication carts whenever they were left unattended. Nurse #4 stated she usually locked the cart, but she forgot at this time. 4) An observation of the medication storage room on the 400 hall was conducted on 11/21/17 at 10:40 am. The medication room on the 400 hall revealed there were four out of four 150 milliliters bags of intravenous (IV) fluid which had expired on 9/17/17. An interview with Nurse #4 on 11/21/17 at 10:45 am was conducted. Nurse #4 confirmed the IV fluid was expired and should have been discarded. Nurse #4 stated all the nurses were responsible for the medication carts and the medication rooms to monitor for expired medications, ensuring opened bottles were dated when opened, discarding any medications when they were expired, and keeping the medication carts and the medication rooms clean. An interview was conducted with the acting Director of Nursing (DON) on 11/21/17 at 3:43 pm. The DON revealed her expectation was all insulin bottles and pens should be dated with the date opened as soon as it was opened by the nurse, and if there were any medications that needed to be discarded per the instructions on the bottle, they should be discarded. The DON stated all the nurses on all the shifts were responsible for cleaning and checking the medication rooms and carts to ensure there were no expired medications. Additionally, the DON reported her expectations was for the nurses to secure the medication carts whenever the	F 431	Insulin and Other Selected Injectable. Prior to using the insulin vial, the nurse or Med Tech must check the date opened to determine if the insulin is expired. Discard immediately if expiration is noted. The recommended maximum storage guidelines are posted in each medication room and in front of each narcotic book on each medication cart. " When obtaining supplies from the medication room, the nurse or Med Tech obtaining the supplies are to check for the expiration date of the product you are getting. If the product is expired notify the Supply Clerk and dispose of the expired product. " The supply clerk will audit each medication room on a weekly basis to identify any products expired or nearing expiration dates. " It is each nurses responsibility to ensure your medication cart is locked when not in use and in sight of the nurse. Any in-house staff member who did not receive in-service training by 12/15/2017 will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 431	Continued From page 8 medication cart was left unattended or unsupervised.	F 431	requirements: The Assistant Director of Nursing will audit medication carts and medication rooms weekly for two weeks then monthly for three months for securement of the medication cart when not in use and not in sight, for expired medications and to ensure open multi-use medications are dated with the date opened. This monitoring will continue until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	
F 520 SS=F	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 520		12/15/17

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F 520	Continued From page 9 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. 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 staff interview and record review the facility's quality assurance (QA) committee failed to prevent the reoccurrence of deficient practice related to kitchen sanitation which resulted in a repeat deficiency at F371. The re-citing of F371	F 520	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal	

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F 520	Continued From page 10 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F371: Kitchen Sanitation: Based on observation and staff interview the facility failed to air dry 8-ounce and 4-ounce cups before stacking them on top of one another in storage, failed to remove dried food debris from a utensil drawer, and failed to label and date opened food times. Review of the facility's survey history revealed F371 was cited during the facility's 10/27/16 annual recertification and complaint investigation survey, and was re-cited during the current 11/22/17 annual recertification and complaint investigation survey. In an interview on 11/22/17 at 11:42 AM the Administrator stated the facility probably received a repeat deficiency at F371 because there had not been consistent leadership in the kitchen. He explained a new dietary manager assumed management responsibilities in the kitchen in July 2017, and it took time to get staff trained and used to using the best sanitation practices. The Administrator also reported in 2016 the facility was cited for the inadequate strength of sanitizing solutions and the lack of cleanliness of the deep fryer and microwave where as in 2017 the facility was cited for not air-drying kitchenware before stacking it in storage, not keeping the utensil drawer clean, and not labeling and dating food items. He commented even though the problem areas in 2016 and 2017 were completely different, they still fell into the overall area of	F 520	and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F520 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility'□s Quality Assurance Committee (QA) failed to prevent the reoccurrence of deficient practice related to kitchen sanitation which resulted in a repeat deficiency at F371. The re-citing of F371 during the last year of federal survey history showed a pattern of the facility'□s inability to sustain an effective QA program. a. The glasses were re-washed immediately on 11/21/2017. b. The Freezer was checked and all opened items were properly labeled & dated on 11/21/2017. c. The Refrigerated Storage areas were checked and all opened items were properly labeled and dated on 11/21/2017. d. The Dry Storage area was checked and all opened items were properly labeled and dated on 11/21/2017. e. The utensil drawer was cleaned and sanitized immediately on 11/21/2017. A revised daily cleaning schedule was initiated on 11/25/2017 to ensure that service ware storage areas are routinely cleaned and sanitized. Staff are to check off schedule once items are cleaned	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 11/22/2017

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F 520	Continued From page 11 dietary services/kitchen sanitation.	F 520	according to policy. The Dietary Manager will audit completion of the cleaning schedule. 2. Procedure for implementing the acceptable plan of correction. Inservice education was provided to the Administrator on 12/13/2017 by the Corporate Nursing Consultant. Topics included the importance of maintaining implemented procedures and monitoring interventions identified in the facilities plan of correction for survey that began on 11/19/2017 and ended on 11/22/2017. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Administrators and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Consultant Dietitian will monitor food storage areas and the cleaning and storage of service ware during monthly site visits and complete the Dietary QA audit and will give the completed QA audit to the Administrator. This monitoring will continue for 6 months or until resolved by QOL/QA committee. Reports will be presented to the weekly QA committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 520	Continued From page 12	F 520	weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. 4. The title of the person responsible for implementing the plan of correction. The Administrator is responsible for implementation and completion of the acceptable plan of correction.	