STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING ______ B. WING ______	C 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH CITY HEALTH AND REHABILITATION	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to send the bed hold policy upon a resident's discharge to the hospital for 1 of 2 residents (Resident #27) reviewed for hospitalization. The findings included:	F 625	Elizabeth City Health and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of	7/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 07/13/2018

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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Continued From page 1

Resident #27 was originally admitted to the facility on 2/9/11 and was readmitted on 4/9/18 with diagnoses including Diabetes Mellitus Type 2, Atrial Fibrillation, Congestive Heart Failure, Hyperlipidemia, Hypertension and Hypothyroidism.

Resident #27 was discharged to the hospital on 4/2/18 and readmitted to the facility on 4/9/18.

During an interview on 6/27/18 at 2:50 PM, Staff Nurse #1 revealed when a resident was discharged to the hospital, she usually sent doctor's orders, history and physical and transfer summary. She stated she did not know anything about the bed hold policy.

During an interview on 6/27/18 at 4:39 PM, Staff Nurse #2 revealed when a resident was discharged to the hospital, she sent the face sheet, doctor's orders, recent labs and transfer sheet. She stated she did not know about the bed hold policy.

During an interview on 6/28/18 at 10:08 AM, the Director of Nursing (DON) explained the bed hold policy was reviewed during admission and the bed hold policy was in the admission packet. She revealed staff in the business office talked to family members the next day to determine whether or not they want to pay to hold the bed. She stated her expectation would be that when someone was sent to the hospital, the bed hold policy would be sent. She emphasized everything would be placed in an envelope to make it easier for staff.

F 625

residents. The Plan of Correction is submitted as a written allegation of compliance.
Elizabeth City Health and Rehabilitation response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Elizabeth City Health and Rehabilitation reserves the right to refuse refute any of the deficiencies on this statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F625 NOTICE OF BED HOLD POLICY BEFORE/UPON TRANSFER
Elizabeth City Health and Rehabilitation informs residents or their representative the facility bed hold policy at the time of transfer to a hospital or therapeutic leave.

The corrective action accomplished for Resident #27 is the resident representative was notified of the facility bed hold policy April 3, 2018. Corrective action would be to provide education and a copy of the policy and bed hold to the Representative. The resident chose not to hold the bed.

Through Root Cause Analysis the Quality Assurance Performance Improvement Committee (QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEEC) identified the following processes needed improvement the

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F 625	Continued From page 2	F 625	communication of the Licensed nurses were unaware they were to give the resident at the time of transfer a copy of the facility policy on bed hold. The measures put in place or systemic changes made are: A copy of the bed hold policy is given to the resident and/or representative at the time of admission. Also bed hold policy along with the discharge policy is placed in an envelope for Nursing Staff to give to the resident at the time the resident is being transferred to the Hospital or is going on Therapeutic leave. The Licensed Nurse is to document in the medical record they have given a copy of policy. The business office contacts the resident or their financial representative the next business day after discharge to see if they wish to hold the bed. The Director of Nursing (DON) and Unit Mangers will in-serviced all licensed nurses on giving a resident at the time they are transferred to the hospital a copy of the bed hold and discharge policies and document in the medical record. This was conducted June 27 through July 6, 2018. During Morning Meeting the medical record will be reviewed and checked to ensure it is documented the bed hold policy was given to the resident and/or representative. The Director of Nursing (DON) and/or Unit Managers, ensures the process is completed. All newly hired licensed staff will receive the education during onboarding. Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure	

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F 625	Continued From page 3	F 625	the practice was corrective and will not reoccur is utilizing a Quality Improvement (QI) Audit Tool, to review discharges to the hospital and the documentation for notation of bed hold policy is being sent to the hospital. The monitoring will occur at least five times a week for 4 weeks, then two times a week for 4 weeks, then monthly x 1 month to monitor for trends or concerns by the Director of Nursing and/or Administrator The Director of Nursing will be responsible for implementing the plan of correction. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance and Performance Improvement Committee meeting for 3 months for trends and recommendations for any modification of the process. The correction date for substantial compliance is July 26, 2018.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		7/26/18

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F 688	Continued From page 4 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide services for contracture management for 1 of 3 residents reviewed for range of motion (Resident #19). The findings included: Resident #19 was originally admitted to the facility on 2/2/11 and had a diagnosis of stroke with left hemiplegia (paralysis of one side of the body). The resident ' s Care Plan revealed an entry dated 3/7/16 That read as follows: "SPLINT/BRACE (Name of resident) presents with left hemiparesis contributing to risk for contracture development and/or worsening. Passive stretch to effective (sic) limb." The approach was for the resident to be assisted in performing 10 repetitions of passive range of motion exercises 3 times to the left extremity as tolerated." The Care Plan noted the goal was achieved on 12/11/17. The Care Plan also listed a problem with impaired mobility secondary to a stroke. Among the approaches were for physical therapy and occupational therapy as indicated or ordered. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 4/5/18 revealed the resident was cognitively intact and had a functional limitation in range of motion of the	F 688	F 688 INCREASE/PREVENT DECREASE IN ROM/MOBILITY Elizabeth City Health and Rehabilitation ensures that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavailable. The corrective action accomplished for Resident #19 is Occupational Therapist evaluated Resident #19 on June 28, 2018. A 100% audits of residents with contracture management were reviewed for range of motion. Through Root Cause Analysis the Quality Assurance Performance Improvement Committee (QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEEC) identified the following processes needed improvement when Resident #19 had a Significant Change in Condition Therapy did not screen the resident for possible changes in range of motion or mobility. The measures put in place or systemic changes made are: the Minimum Data Set Nurse will give written notification to	

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F 688 Continued From page 5

upper and lower extremity on one side.

The resident ' s Care Plan updated on 4/5/18 did not include information regarding the resident ' s contractures with range of motion or splinting of the left upper extremity.

On 6/26/18 at 10:16 AM Resident #19 was observed sitting in her room in a wheelchair with a contracture of the left hand. NA #1 was in the room and stated the resident used to have a splint but they were currently not doing any splinting or range of motion of the left upper extremity.

On 6/27/18 at 10:04 AM the Rehab Director stated in an interview that the resident was discharged from occupational therapy on 2/14/17 to the restorative nursing program for left upper extremity range of motion and splinting. The Rehab Director stated the resident went out to the hospital on 12/3/17 and returned to the facility on 12/11/17 with hospice services and had not been seen by therapy since that time. The Rehab Director further stated when residents were re-admitted to the facility, therapy would re-screen the resident to see what services were needed but if a resident was on hospice, therapy did not re-screen unless hospice initiated the therapy or they received an order for therapy services.

On 6/27/18 at 10:31 AM an interview was conducted with Restorative Nursing Assistant (RNA) #1. The RNA stated at one time the resident was getting passive range of motion to the left side and splinting of the left hand and elbow but the resident went out to the hospital and upon re-admission therapy would re-evaluate

F 688

Therapy there has been a Significant Change in Condition and to evaluate/screen the resident for possible change in their mobility. Minimum Data Set Nurse will also discuss during the Morning Meeting. The Director of Nursing in-serviced the Minimum Data Set nurses to discuss during morning meeting when a resident is to have a Significant Change in Condition and notify Therapy in writing. This was conducted July 10, 2018. During Morning Meeting the medical record will be reviewed to see if any changes to a resident's mobility during a Significant Change in Condition. The Director of Nursing and/or Administrator ensures the process is completed. All newly hired licensed staff will receive the education during onboarding.

Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrective and will not reoccur is utilizing a Quality Improvement (QI) Audit Tool, to review Significant Change in Condition and note if the Therapy Department had been notified and to note if there had been a change in mobility for the resident. The monitoring will occur at least five time a week for one month during morning meeting, then two time a week for one month, then one time a month for trends or concerns by the Director of Nursing and/or Administrator.

The Director of Nursing will be responsible for implementing the plan of correction. The Director of Nursing will report the results of the monitoring at

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F 688	Continued From page 6 and the RNA would get orders from therapy on what to do next. The RNA stated Resident #19 was not currently on the restorative nursing program for range of motion or splinting. On 6/27/18 at 2:25 PM Unit Manager #1 stated in an interview Resident #19 was discharged from hospice services on 2/12/18 and when time for the next quarterly MDS the resident should have been referred to therapy if any changes. The Unit Manager further stated the Rehab Director and the RNAs meet regularly and talk about residents in the facility and could not explain why the resident was not put back on the restorative nursing program. On 6/27/18 at 2:53 PM an interview was conducted with MDS Nurse #1 who also headed up the Restorative Nursing Program in the facility. The MDS Nurse stated when therapy screened a resident and referred to restorative, therapy would let the RNAs know and have them sign a form and would give her the form and she would put the order in the system. The MDS Nurse stated she never received a form to put the resident back on the Restorative Nursing Program. On 6/28/18 at 1:25 PM an interview was conducted with Occupational Therapist (OT) #1. The OT stated she did another evaluation of the resident today and there was no worsening of the resident ' s hand and elbow contractures. The OT stated the resident told her she had been wearing the splints intermittently but had not worn them in about a month. On 6/28/18 at 10:30 AM the Director of Nursing stated in an interview at the point the resident came off hospice the MDS Nurse should have	F 688	monthly Quality Assurance and Performance Improvement Commitee meeting for 3 months for trends and recommendations for any modification of the process.	

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F 688	Continued From page 7 screened the resident as an admission and picked up on the contracture and therapy should have screened the resident to see if she required any services.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		7/26/18

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F 690	Continued From page 8 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to identify and document medical justification for an indwelling urinary catheter for 1 of 2 residents reviewed for urinary catheters (Resident #31). The findings included: Resident #31 was admitted to the facility on 11/21/17 and had a diagnosis of cerebrovascular accident (stroke) with left hemiplegia (paralysis of one side). There was a physician ' s order dated 1/15/18 for an indwelling urinary catheter. The diagnosis was listed as urinary retention. The resident was discharged to the hospital on 5/28/18 with the urinary catheter and re-admitted to the facility on 6/15/18 with the urinary catheter. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 6/22/18 revealed the resident had short and long term memory loss with severe cognitive impairment and required total assist with all activities of daily living. The MDS noted the resident had an indwelling urinary catheter. Section I of the MDS (diagnoses) did not provide a diagnosis to support the need for a urinary catheter. On 6/26/18 at 8:55 AM Resident #31 was observed lying in bed and a urinary drainage bag containing urine was hanging on the frame of the	F 690	F 690 BOWEL/BLADDER INCONTINENCE, CATHETER, UTI Elizabeth City Health and Rehabilitation ensures that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Residents who enter the facility with an indwelling catheter are assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. The corrective action accomplished for Resident #31 is the indwelling catheter was removed on June 28, 2018. A 100% audit was completed for medical justification for residents with an indwelling urinary catheter June 28, 2018 by Unit Mangers. It was noted all resident had justification for an indwelling urinary catheter. Through Root Cause Analysis the Quality Assurance Performance Improvement Committee identified the following processes needed improvement on admission the documentation for medical justification for an indwelling urinary catheter was not obtained.	

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F 690	Continued From page 9 bed. On 6/28/18 at 8:17 AM an interview was conducted with Unit Manager #2. The Unit Manager stated she was unable to find a diagnosis in the medical record to justify the indwelling urinary catheter and could not explain why the resident had urinary retention. On 6/28/18 at 10:26 AM the Director of Nursing (DON) stated in an interview upon re-admission she expected the admitting nurse or the nurse the next day to call the physician to justify the catheter.	F 690	The measures put in place or systemic changes made are: the checklist for new admission/readmission was updated to include entering orders for indwelling catheter with appropriate diagnosis. The Director of Nursing and Unit Manager will in-serviced all licensed nurses to follow the revised admission/readmission checklist when admitting a resident. This was conducted July 13, 2018. During Morning Meeting the medical record will be reviewed and checked to the checklist is complete. The Director of Nursing/Administrator/Unit Managers ensures the process is completed. All newly hired licensed staff will receive the education during onboarding. Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrective and will not reoccur is utilizing a Quality Improvement (QI) Audit Tool, to review the admission/readmission of a resident for indwelling catheter and there is the documentation for medical justification. The monitoring will occur at least five time a week for one month during morning meeting, then two time a week for one month, then monthly for one month for trends or concerns by the Director of Nursing. The Director of Nursing/Administrator will be responsible for implementing the plan of correction. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance and	

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F 690	Continued From page 10	F 690	Performance Improvement Committee meeting for 3 months for trends and recommendations for any modification of the process. The correction date for substantial compliance is July 26, 2018.	
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure timely physician ' s visits for 2 of 32 resident ' s reviewed (Residents #86 and #115). The findings included:	F 712	F 712 PHYSICIAN VISITS-FREQUENCY/TIMELINESS/ALT NPP Elizabeth City Health and Rehabilitation ensures residents are seen by a physician	7/26/18

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F 712	Continued From page 11 1. Resident #86 was originally admitted to the facility on 5/31/13 and had a diagnosis of multiple sclerosis, dysphagia (difficulty swallowing), hypertension and anemia. The resident was discharged to the hospital on 12/25/17 and re-admitted to the facility on 12/29/17. Review of the medical record revealed one physician ' s progress note and was dated 5/1/18. An interview was conducted with Unit Manager #1 on 6/27/18 at 2:20 PM. The Unit Manager stated the resident ' s physician had 2 residents in the facility and was supposed to see the residents every 60 days. The Unit Manager stated that medical records manager was responsible for tracking physician ' s visits to ensure residents were seen timely. On 6/27/18 at 2:44 PM the Medical Records Manager stated in an interview she did not track this physician ' s visits. On 6/28/18 at 9:30 AM the Director of Nursing (DON) provided physician progress notes dated 4/2/17 and 11/10/17. The DON stated these were the only physician notes she could find. On 6/28/18 at 10:03 AM the Director of Nursing (DON) stated in an interview that apparently the physician ' s visits were not being monitored and it was her expectation that medical records would track physician ' s visits. The DON further stated she was not aware there was a problem with this physician seeing his residents in a timely manner. 2. Resident #115 was admitted to the facility on	F 712	at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. The corrective action accomplished for Resident #86 and #115 is current physician are up to date. An 100% audit was completed on June 28, 2018 by the Medical Records Manager and attending physicians were notified of their visits were within every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Through Root Cause Analysis the Quality Assurance Performance Improvement Committee (QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT COMMITTEEC) identified the following processes needed improvement the attending physician for these two residents only sees these two residents and had not make a visit in March, 2018. The measures put in place or systemic changes made are: the facility faxed to each physician on June 28, 2018 a list of their residents and if there was a need to see their resident. The Administrator sent a letter on July 13, 2018 to each resident's attending physician as to the requirements for physician visits. Medical Records is tracking physician visits and keeping the attending physician up-to-date as to when their next visit is due. The Medical Records Manager is to document when the physician is notified. Medical Records Manager will notify the Administrator and DON when compliance date is within 15 days of compliance. The Director of	

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	345036	A. BUILDING ______ B. WING ______	C 06/28/2018

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F 712

Continued From page 12

9/25/15 and had a diagnosis of dementia, depression, seizure disorder, hypertension, diabetes mellitus, hyperlipidemia, peripheral vascular disease and a psychotic disorder.

Review of the medical record revealed a physician ' s note dated 1/29/18 and 5/2/18.

On 6/27/18 at 2:20 PM an interview was conducted with Unit Manager #1. The Unit Manager stated she was unable to find any other physician ' s notes since their last survey. The Unit Manager further stated the resident ' s physician had 2 residents in the facility and was supposed to see the residents every 60 days. The Unit Manager stated the medical records manager was responsible for tracking physician ' s visits to ensure residents were seen timely.

On 6/27/18at 2:44 PM the Medical Records Manager stated she did not track this physician ' s visits.

On 6/28/18 at 10:03 AM the Director of Nursing (DON) stated in an interview that apparently the physician ' s visits were not being monitored and it was her expectation that medical records would track physician ' s visits. The DON further stated she was not aware there was a problem with this physician seeing his residents in a timely manner.

F 800 SS=E

Provided Diet Meets Needs of Each Resident
CFR(s): 483.60

§483.60 Food and nutrition services.
The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the

F 712 (Plan of Correction)

Nursing (DON) ensures the process is completed. Medical Records Manager was educated by the Administrator as the requirement for physician visits.
Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrective and will not reoccur is utilizing a Quality Improvement (QI) Audit Tool. Medical Records Manager will provide an audit of physician visits to the Director of Nursing. Medical Records Manager will monitor and report issues or concerns to the Director of Nursing or the Administrator for follow up. The Director of Nursing and/or Unit Managers will review physician visits each month and monitor for trends or concerns.

The Director of Nursing will be responsible for implementing the plan of correction. The Director of Nursing will report the results of the monitoring at monthly Quality Assurance and Performance Improvement Committee meeting for 3 months for trends and recommendations for any modification of the process.

The correction date for substantial compliance is July 26, 2018.

F 800 — 7/26/18

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F 800	Continued From page 13 preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to maintain steam table temperatures during meal service for one of two meals observed. The Findings included: A review of the undated Blue Print Menu Management System manual, under Sanitation page 4, read: "Holding and displaying standards need to be established for all food items in order to keep food safe and appealing. The following practices will ensure food safety and maximize customer appeal: Bullet # 4 Establish holding standards to preserve quality. #5 Maintain hot food temperatures at 135 F. or higher. #10. Never use hot-holding equipment or steam tables to heat food. They are not designed for rapid reheating of foods. The food must be above minimum temperatures when it is put in the holding equipment." During the meal observation on 6/27/18 at 8:08 AM the breakfast meal service was observed with the CDM (certified dietary manager) present. A temperature reading of the scrambled eggs revealed the eggs were at 112 degrees Fahrenheit. In interview with CDM on 6/27/18 at 8:10 AM he stated that the steam table element was bad. In an interview with the Administrator on 6/27/18 at 8:40 AM he stated that he expected dietary would report that the steam table well was not working. In interview with CDM on 6/27/18 at 11:38 AM he	F 800	F 800 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT Elizabeth City Health and Rehabilitation provides each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutrition and special dietary needs, taking in consideration the preferences of each resident. The corrective action accomplished the steam table was repaired on June 28, 2018 and temperatures are correct. An 100% audit of food items was taken at Breakfast, Lunch and Dinner on July 27th, 28th and 29th. Temperatures were within the correct range for all food items on the steam line. Through Root Cause Analysis the Quality Assurance Performance Improvement Committee identified the following processes needed improvement the dietary staff were taking temperatures at the beginning of the meal service and not checking during the meal service. The measures put in place or systemic changes made are: A new temperature log was developed to include taking temperatures at the beginning and during meal service to ensure food safety and appealing. The Cook is to document on the temperature log the temperatures of all food items on the steam line and to remove any items that go below the	

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F 800	Continued From page 14 stated he expected staff to take the food temperatures when placed on the steam table and periodically take the temperatures during meal.	F 800	recommended food safe temperature. The Dietary Manager and/or Assistant Director Manager in-serviced all cooks and dietary aides on the new temperature log and to remove any items that go below the recommended food safe temperature This was conducted July 2, 2018. The Dietary Manager or Assistant Dietary Manager ensures the process is completed. All newly hired Dietary staff will receive the education during onboarding. Elizabeth City Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrective and will not reoccur is utilizing a Quality Improvement (QI) Audit Tool, to review temperature logs and monitor the steam line for correct temperatures. The monitoring will occur at least five time a week including weekends for one month, then two time a week for one month, and then one time a week for one month to monitor for trends or concerns by the Dietary Manager or Assistant Dietary Manager. The Dietary Manager or Assistant Dietary Manager will be responsible for implementing the plan of correction. The Dietary Manager or Assistant Dietary Manager will report the results of the monitoring at monthly Quality Assurance and Performance Improvement Committee meeting for 3 months for trends and recommendations for any modification of the process. The correction date for substantial	

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F 800	Continued From page 15	F 800	compliance is July 26, 2018.	