1/8/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164		

Summary Statement of Deficiencies (F 164):

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interview of resident and staff the facility failed to provide privacy while administering insulin and eye drops for 2 of 10 residents (Residents # 8 and Resident #97) receiving medications during

Provider's Plan of Correction (F 164):

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

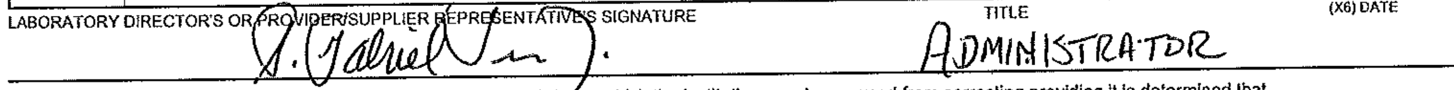
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F 164 — Completion date: 1/10/13

Corrective Action for Resident Affected
For resident's # 8 and 97, the involved staff member was provided with an in-service education on providing privacy to residents when administering eye drops and injections. This was completed by the Staff Development Coordinator on 12-19-12.

Corrective Action for Resident Potentially Affected
All residents who receive eye drops and injectable medications are at risk for the alleged deficient practice. On 12-19-12, all FT, PT and PRN Nurses were in-serviced by the Staff Development Coordinator on the importance of providing privacy when administering eye drops and injections to a resident. These medications should be administered in the residents room with the blinds closed and the privacy curtain pulled

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



ADMINISTRATOR

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 164	Continued From page 1 medication pass. 1. Resident #8 was admitted to the facility on 6/7/07 with diagnoses of blindness, diabetes mellitus and severe stage glaucoma. A review of the resident's record revealed the resident had an order for Novolin 70/30 15 units every morning. Insulin is indicated for use in the treatment of diabetes. She had an order for Coscopt eye drops to be administered twice a day. Coscopt is indicated for use in the treatment of glaucoma. She also had an order for Alphagan eye drops in both eyes to be administered three times a day. Alphagan is indicated for use in the treatment of glaucoma. Review of the resident's quarterly Minimum Data Set (MDS) dated 12/7/12 revealed she had no short or long term memory problems and for cognitive skills for daily decision making she had modified independence with some difficulty in new situations only. 1a. During med pass on 12/12/12 at 8:08 am, Resident #8 was observed lying in her bed with her privacy curtain opened in view of the hall. Resident # 8 roommate was observed sitting up in a chair facing the resident. Nurse #1 was observed walking into Resident #8 ' s room without knocking on the door. Nurse #1 did not close the door, did not close the blinds to outside and did not close the privacy curtain between the two residents. Nurse #1 was observed administering Novolin 70/30 15 units subcutaneous into Resident #8 ' s left upper arm. Nurse #1 was observed walking out of the resident ' s room.	F 164	unless the room is a private room in which the door should be shut. In addition to this, the Staff Development Coordinator presented the following video to all FT and PT Nurses: Passing Medication: ASCP's Medication Administration Video Series. **See Attachment #5.** **Systemic Changes** On 12-19-12, all FT, PT and PRN Nurses were in-serviced by the Staff Development Coordinator on the importance of providing privacy when administering eye drops and injections to a resident. These medications should be administered in the residents room with the blinds closed and the privacy curtain pulled unless the room is a private room in which the door should be shut. In addition to this, the Staff Development Coordinator presented the following video to all FT and PT Nurses: Passing Medication: ASCP's Medication Administration Video Series. ***Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training 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.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 164	Continued From page 2 1b. On 12/12/12 at 8:14am, Resident #8 was observed lying in her bed with her privacy curtain opened in view of the hall. Resident # 8 roommate was observed sitting up in a chair facing the resident. Nurse #1 walked into Resident #8 ' s room with the door remaining opened, the privacy curtain open and the window blind remaining opened in view of the outside. The resident ' s roommate was observed sitting across the room facing the resident. Nurse #1 was observed administering Resident #8 ' s Coscopt eye drops. Nurse #1 was observed walking out of the resident ' s room 1c. On 12/12/12 at 8:28 am, Resident #8 was observed lying in her bed with her privacy curtain opened in view of the hall. Nurse #1 was observed walking into Resident #8 ' s room and placing Alphagan eye drops 1 drop in both eyes with her roommate and two facility staff in full view of the treatment. The door was observed opened, the privacy curtain and window blind remained opened and a family member was observed walking by the door with the resident in full view. During an interview on 12/12/12 at 9:05 am Nurse #1 stated she did not provide privacy because she over looked it. During an interview on 12/12/12 at 2:06 pm Resident #8 stated she was blind and was not aware that staff had not provided privacy while giving care. She stated she wished staff would close the privacy curtain when they were giving her treatments. During an interview on 12/12/12 at 3:24 pm the	F 164	**Quality Assurance** The Staff Development Coordinator will monitor this issue using the "Survey Quality Assurance Tool for Monitoring Privacy on the Medication Pass". **See Attachment #5.** The monitoring will include verifying that privacy is provided to residents when receiving ophthalmic or injectable medications. See attached monitoring tool. This will be completed on 5 resident's a week for four weeks and then monthly two months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 164	Continued From page 3 Director of Nursing (DON) stated it was a regulation that you have to give treatments in privacy. She further stated her expectations would be for a nurse to provide privacy in a resident's own room without being in view of the roommate or anyone when administering insulin and eye drops. 2. Resident #97 was admitted to the facility on 2/1/10 and readmitted on 10/28/10 with diagnoses including diabetes mellitus and glaucoma. A review of the resident's physician ' s orders revealed the resident had an order for Novolin 70/30 18 units every morning. Insulin is indicated for use in the treatment of diabetes. He had an order for Coscopt eye drops to the right eye to be administered twice a day. Coscopt is indicated for use in the treatment of glaucoma. He also had an order for Alphagan eye drops in both eyes to be administered three times a day. Alphagan is indicated for use in the treatment of glaucoma. Review of the resident's annual Minimum Data Set (MDS) dated 10/22/12 revealed Resident #97 scored a 7 (resident was cognitively impaired) on the brief interview for mental status with a score of 15 as the highest. 2a. During med pass on 12/12/12 at 8:21 am, Resident #97 was observed sitting on the side of his bed with his privacy curtain opened in view of the hall. Nurse #1 was observed walking into Resident #97 ' s room announcing she was entering the room. Nurse #1 walked across the room and opened the closed blind to the window viewing the outside. Nurse #1 was observed administering Resident #97 ' s Coscopt eye drop	F 164		

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F 164	Continued From page 4 into his right eye. The nurse then administered the Novolin 70/30 18 units subcutaneous into Resident #97 ' s left upper arm. Resident #97 ' s door in view of the hall and the window blind viewing the outside remained opened. Nurse #1 was observed walking out of the resident's room. 2b. During an observation on 12/12/12 at 8:32 am, Nurse #1 walked into Resident #97 ' s room with the window blind viewing to outside and the door remaining opened. Nurse #1 was observed placing Alphagan eye drops in both of the resident ' s eyes. Resident #97 ' s door in view of the hall and the window blind viewing the outside remained opened. Nurse #1 was observed walking out of the resident's room. During an interview on 12/12/12 at 9:05 am Nurse #1 stated she did not provide privacy because she over looked it. During an interview on 12/12/12 at 3:24 pm the Director of Nursing (DON) stated it is a regulation that you have to give treatments in privacy. She further stated her expectations would be for a nurse to provide privacy in a resident's own room without being in view of the roommate or anyone when administering insulin and eye drops.	F 164		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334	**F 334** **Corrective Action for Resident Affected** Beginning 12-12-12, Resident's # 48, 13, 36, 97, 22, 99, 40, 125, 71, 23, 95, 86, 194, 154 had their responsible party contacted by the Nurse Management Team and	1/10/13

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F 334 Continued From page 5

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal

F 334

informed consent was requested and received via telephone to administer the flu vaccine if they had not already received it. This was completed by 12-21-12. For Residents #114, 12, 62, 68, 31, 52, 198, 196, 148, 26, 29, 20, 197 there were no corresponding names for the numbers provided. However, an audit was conducted on 12-21-12 by the Staff Development Coordinator to verify that all current residents had received the flu vaccine with the exception of sixteen residents that refused. **See Attachment #1.**

Corrective Action for Resident Potentially Affected

All residents who have not received the flu vaccine have the potential to be affected by the alleged deficient practice. On 12-12-12, an audit was initiated by the Staff Development Coordinator of all current residents' charts to identify the Residents who have not received their flu vaccine for 2012-2013 flu season. The responsible parties for the identified residents were contacted for consent or declination of the flu vaccine. This was completed by the Nurse Management Team. All current residents' flu vaccines were administered and up to date unless declined effective 12-21-12. **See attachment #1.**

Systemic Changes

On 12-12-12, an in-service was conducted by the Director of Nursing on obtaining residents flu vaccine consent forms and administering the flu vaccine as outlined in

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 334	Continued From page 6 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy and staff interviews the facility failed to vaccinate all residents against influenza and failed to obtain signed influenza consent/declination forms for every resident for the annual resident vaccinations for 27 of 40 sampled residents. (Residents #48, #13, #114, #12, #36, #62, #97, #31, #198, #22, #68, #52, #196, #99, #40, #125, #148, #71, #23 #,26,#197, #154, #95, #20, #86, #194,and #29). The findings include: The facility's policy for Annual Resident Flu vaccinations dated April 2007, read in part " It is the policy of this facility to vaccinate all residents against influenza unless the vaccine is medically contraindicated or the individual refuses after	F 334	the policy ICP 116. **See attachment #2.** Those who attended were the Staff Development Coordinator, Assist DON and Unit Support Nurse. In addition to policy ICP 116, the Staff Development Coordinator, Assist DON and Unit Support Nurse were in-serviced on the new tracking form, Flu Consent Tracking Log, initiated to track the receipt of flu consents in order to ensure all consents/declinations are received back to the facility and the vaccine is administered for all current residents no later than November 30 of each year. **See attachment #3.** This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Nurse Management employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "Quality Assurance Tool for Flu vaccine consent and administration". The monitoring will include randomly assessing 5 residents for flu consent or declination on file and validating if each resident has been given the flu vaccine. The monitor will be completed weekly x 4 weeks then monthly x 2 months or until resolved by Quality Of Life/Quality Assurance Committee. **See attachment #4.** Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator,	

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F 334	Continued From page 7 being fully informed. Obtain a signed influenza consent / declination form for every resident. This should be completed between October 1 when the vaccine becomes available and November 30 of every year". The facility Infection Control Nurse provided a list of residents who had received or declined the influenza vaccine from 10/1/12 - 12/12/12. A review of facility records revealed 27 of 40 sampled residents had not been vaccinated or had no documentation of refusal for the influenza immunization for the 2012 flu season. During an interview on 12/12/12 at 9:00 AM, the Infection Control Nurse stated a mass mailing of influenza immunization consent/declination forms were sent out to responsible parties and alert and oriented residents around the end of September or the first of October 2012. The Nurse stated she obtained an MD order for a vaccination for each resident when a signed consent was returned. The Nurse could not state how many forms had been returned or how many no responses she had. During an interview on 12/12/12 at 9:52 am with the Administrator (ADM), the Director of Nursing (DON), and the Infection Control Nurse revealed the Infection Control Nurse restated she sent out consent letters and obtained medical orders for flu immunizations when the forms were returned. The Nurse revealed she did not do any follow up for the consent forms that were not returned. The Infection Control Nurse stated she had been pulled to do other duties and she had not had time to follow up consent forms that had not been returned. The Nurse revealed she had not	F 334	Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 334	Continued From page 8 completed any documentation in medical charts to record refusals. She indicated she did not have any monitoring tool in place to indicate which residents had not returned their forms. During the interview the DON stated the Infection Control Nurse had been working on other tasks during the fall and her time had been limited. The DON stated the no responses should have been followed up by telephone or by talking with responsible parties when they were in the facility to obtain consent. The DON indicated a monitoring tool was needed to assure all forms were received back so residents would be vaccinated.	F 334		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to hold hot food on the steam table at or above 135 degree to prevent food borne illness. The findings include: The facility Policy Titled: Safe Food Handling Issuing Date: February 1, 2004, Revision Dates: 11-05, 5-08, 5-09, 5-10, 9-11, 9-12 Reads as follows: " Safe Food Handling	F 364	**F 364** **Corrective Action for Resident Affected** During the survey corrective action was taken by the cook when the temperature of the ground sausage was found to be below 135 degrees F. All hot TCS (Temperature Controlled for Safety) PHF (Potentially Hazardous Food) must be held at or above 135 degrees F. Tray line monitoring forms are completed prior to the start of each meal by the lead cook and/or supervisor. Corrective action is to be taken immediately when TCS (PHF) items are found to be outside of the acceptable parameters. **Corrective Action for Resident Potentially Affected**	1/10/13

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F 364	Continued From page 9 Policy: It shall be the policy of this facility to comply with the current " North Carolina Rules Governing the Sanitation of the Food Services Establishments " document which is based on the 2009 FDA model food code and current food science. All health care center staff involved in the preparation and service of food will adhere to safe food handling techniques. In Incidences where variations in interpretation occur between state and federal guidelines, the strictest regulations will be followed. All Dietary Services employees will practice the following rules of safe food handling: Monitor Time and Temperature (complete logs). Prevent Cross Contamination. Store foods promptly and correctly, resealing, labeling and dating as appropriate. Cook PHF/TCS food to the required endpoint cooking temperature or higher (complete logs). Hold PHF/TCS food at 135 degrees F or higher and Cold PHS/TCS food at 41 degrees F or lower. " A review of the Tray Line Temperature Log dated Tuesday 12/11/12 recorded the ground sausage temperature as 168 degree F (Fahrenheit). During the initial kitchen tour on 12/11/12 at 7:38 AM dietary staff was observed preparing breakfast trays and placing into food carts for delivering to resident halls. Meal temperatures taken at 8:09 AM revealed the grits 180, oatmeal 170, eggs 150, ground sausage 110, pureed eggs 135 and pureed oatmeal 180 degrees. The cook continued to serve one regular tray adding bacon to the plate. At 8:11AM the cook was	F 364	All residents have the potential to be affected by the alleged deficient practice. On 12/14/12, the Dietary Services Manager held an in-service with all FT, PT and PRN dietary staff. The topics included: How to prepare and serve hot foods. **See attachment #6.** Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. **Systemic Changes** On 12/14/12, the Dietary Services Manager held an in-service with all FT, PT and PRN dietary staff. The topics included: How to prepare and serve hot foods. **See attachment #6.** Any in-house staff member who did not receive in-service training 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 dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Dietary Services Manager will monitor this issue using the "Dietary QA Audit: The monitoring will include verifying that food temperatures are checked at the beginning of each meal and that temperatures fall within the acceptable range. **See attachment #6.** This will be completed 5 x's a week for 4 weeks then weekly x 2 months or until resolved by Quality Of	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	121 RACINE DRIVE WILMINGTON, NC 28403

(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 364	Continued From page 10 observed to remove the ground sausage off the line, placing into another pan and putting into the microwave to reheat. At 8:13 AM the cook was observed removing the ground sausage from the microwave and tested the temperature revealing a temperature of 165 degree. The cook then returned the ground sausage to the tray line and resumed plating up breakfast trays. During an interview on 12/10/12 at 8:20 AM the cook indicated the ground sausage was the correct temperature when he put it on the serving line. During an interview with the Certified Dietary Manager on 12/12/12 at 11:00 AM, he stated, " Yes, he took food temperatures yesterday, the ground sausage was to temperature. I do not know what happened. "	F 364	Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	
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 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and policy review the facility failed to clean one of one confection oven and one of one ice machine to	F 371	**F 371** **Corrective Action for Resident Affected** On 12/14/12, the convection oven and affected ice machine were deep cleaned by Simone Newkirk. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by the alleged deficient practice. On 12/14/12, the convection oven and affected ice machine were deep cleaned by the Dietary Services Supervisor. **Systemic Changes**	1/10/13

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F 371	Continued From page 11 prevent the harboring of pests and insects. The findings include: The facility Policy Title: Ice Machine, Cleaning & Sanitizing, Issuing Date: March 2007 and Revision Dates: 5-08, 5-09, 5-10, 9-11 reads as follows: " Ice Machine, Cleaning & Sanitizing. Policy: Dietary Services cleans, sanitizes and maintains the ice machine(s) in the Kitchen, Maintenance cleans, sanitizes and maintains ice machines on the nursing units. The following procedure is to be followed monthly (Procedures for specific pieces of equipment may be available and used). 1. Once each month, or more often if required, empty the ice machine and defrost (turn off). 2. Open up top area to be sure all tubes are clean. 3. Using a solution of Ecolab Oasis system-multipurpose cleaner, brush wash all parts of the machine, inside and out, using a clean long-handled mop. Wipe all areas including gasket, under the door rim and inside the ice machine bin ' s roof. " The undated facility cleaning schedule daily checklist reads as follows: " Dietary Services Cleaning Schedule Tuesday: Clean and sanitize ice machine (monthly-check schedule). " 1. During the initial kitchen inspection on 12/11/12 at 7:45 AM the ice machine was observed. The inner edge under the door rim of the ice machine was observed to have a layer of accumulated dirt. A second observation on 12/12/12 at 10:00 AM revealed the ice machine was in the same	F 371	Cleaning schedules are maintained for all areas in the Dietary Department (Storage, Production, Service and Warewashing). Daily cleaning tasks are assigned by the Manager based on scheduled tasks and areas requiring immediate attention. Periodic inspections by the Dietary Services Supervisor are to be done to ensure that all tasks are completed properly. All equipment, food prep areas (including floors, walls) must be clean. All equipment, service ware, utensils that come in contact with food must be cleaned and sanitized. The Dietary Services Director reviewed all cleaning schedules and assignments with staff and reviewed the ice machine cleaning procedure. This was completed on 12/17/12. **Quality Assurance** The Dietary Services Director (or designee) will utilize the QA audit form to monitor cleaning duties (scheduled & completed) as well as specific areas requiring attention (convection oven and ice machine). See attached monitoring tool. This will be completed 5 x's a week for 4 weeks then weekly x 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary	

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F 371	Continued From page 12 condition. The undated facility cleaning schedule reads as follows: " Cleaning - Cooks Daily-clean work area, make sure Ovens/Steamer, spices, spice rack and plate warmer are wiped down daily, utensil bins needs to stay clean also sweep and mop, keep dish area walls and floor clean. Each week of the month there will be different cooks Deep Cleaning the fryer, stoves, ovens and steamer. " 2. During the initial kitchen inspection on 12/11/12 at 8:15 AM the convection oven was observed. The convection oven was observed to have a build up of black burnt food debris in the left lower corner of the oven. A second observation of the convection oven on 12/12/12 at 10:05 AM revealed the oven was in the same condition. During an interview with the CDM on 12/12/12 at 10:05 AM, he stated, " The cook and I cleaned the convection oven about two to three weeks ago. No, I do not have a scheduled date of when we last cleaned the oven. "	F 371	Manager and Social Worker.	
F 520 SS=E	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	F 520	**F 520** **Corrective Action for Resident Affected** Beginning 12-12-12, Resident's # 48, 13, 36, 97, 22, 99, 40, 125, 71, 23, 95, 86, 194, 154 had their responsible party contacted by the Nurse Management Team and informed consent was requested and received via telephone to administer the flu vaccine if they had not already received it.	1/10/13

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F 520	Continued From page 13 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's Quality Assessment and Assurance (QAA) committee failed to develop and implement appropriate plans of action to address the identified need to offer the pnemococcal immunization vaccine to 28 of 40 sampled residents (Residents #48, #13, #114, #12, #36, #62, #97, #31, #198, #22, #68, #52, #196, #99, #40, #125, #148, #71, #23 #,26,#197, #154, #95, #20, #86, #194,and #29). . Findings include: Review of the Quality Assurance Program revised April 2011, read in part, " Quality Assurance is a comprehensive, ongoing, organization-wide system of mechanisms for monitoring and evaluating the quality and appropriateness of the care provided, so that important problems and	F 520	This was completed by 12-21-12. For Residents #114, 12, 62, 68, 31, 52, 198, 196, 148, 26, 29, 20, 197 there were no corresponding names for the numbers provided. However, an audit was conducted on 12-21-12 by the Staff Development Coordinator to verify that all current residents had received the flu vaccine with the exception of sixteen residents that refused. **See Attachment #1.** **Corrective Action for Resident Potentially Affected** All residents who have not received the flu vaccine have the potential to be affected by the alleged deficient practice. On 12-12-12, an audit was initiated by the Staff Development Coordinator of all current residents' charts to identify the Residents who have not received their flu vaccine for 2012-2013 flu season. The responsible parties for the identified residents were contacted for consent or declination of the flu vaccine. This was completed by the Nurse Management Team. All current residents' flu vaccines were administered and up to date unless declined effective 12-21-12. **See attachment #1.** **Systemic Changes** On 12-13-12, the Monthly Quality Assurance form was updated to include monitoring for the progress of flu consents and vaccination status of all current residents and new admissions from October 1 to March 31st of each year. **See attachment #4.**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	Continued From page 14 trends in the delivery of care are identified and that steps are taken to correct problems and to take advantage of opportunities to improve care. Objectives to implement maintain and support a Quality Assurance Program which includes effective mechanisms for monitoring and evaluating resident care and responding appropriately to the findings. Committee Members Responsibilities: Each committee member should be prepared to discuss their assigned area and ensure that needed charts and documents are available. " The facility ' s policy for Annual Resident Flu vaccinations dated April 2007 read in part " It is the policy of this facility to vaccinate all residents against influenza unless the vaccine is medically contraindicated or the individual refuses after being fully informed. Obtain a signed influenza consent / declination form for every resident. This should be completed between October 1 when the vaccine becomes available and November 30 of every year. " During an interview on 12/13/12 at 9:25 am the Director of Nursing (DON) stated the QAA committee met on 12/6/12. The DON stated the Infection Control Coordinator did not attend but gave the infection control information to the DON to present to the committee. The DON further stated there was no information concerning the November 30, 2012 deadline for residents to receive all flu shots according to the facility policy. It was the Infection Control Coordinator ' s responsibility to tell the committee she did not have the consent forms from the families and the facility had past their deadline to have all residents receive their flu shots. The committee	F 520	An in-service was conducted on 12-13-12 by the Administrator. Those in attendance were the Director of Nursing. The in-service topics included the addition of the Flu consent and vaccination status of all current residents and new admissions to be monitored monthly every year October 1st thru March 31st in the Monthly QOL Meeting. **See attachment #4.** This information has been integrated into the standard orientation training for all Director of Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the ""Quality Assurance Tool for Flu vaccine consent and administration". The monitoring will include verifying that the monthly QOL tool is utilized to follow up the progress of obtaining flu consents and vaccinations monthly from October 1st thru March 30th. **See attachment #4.** This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by Quality Of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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F 520	Continued From page 15 did not identify there was a problem because the Infection Control Coordinator was not aware of the deadline. She further stated her expectation was for the Infection Control Coordinator to know the policy and to have included the information in her report so that the facility could have taken corrective action. During an interview on 12/13/12 at 9:36 am the Infection Control Coordinator stated she did not inform the committee concerning the deadline. She stated she was not aware that by November 30, 2012 all residents had to be vaccinated. She stated she had become the Infection Control Coordinator in September 2012 and was also the Staff Development Coordinator (SDC) and had not had time to look at the policy. She stated she had not set up a monitoring system and the consent forms and flu vaccines had not been completed.	F 520		

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V-prot. construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: dry storage room door in kitchen is not self closing. 42 CFR 483.70(a)	K 029	**K 029** **Correction of Deficient Practice:** Installed closer on dry storage door in kitchen. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** Inspected doors in facility that require closers. All required doors had working closers. **Systemic Changes to Prevent Recurrence:** Task to inspect monthly presence and proper function of closers where required added to TELS, the facility's preventive maintenance scheduling program. **Monitoring through Quality Assurance Program:** All TELS tasks will be reported monthly at monthly QA Committee Meeting.	**2/18/13**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE ADMINISTRATOR (X6) DATE 2/2/13

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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K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: facility is using North Carolina State Special Locking. On activation of fire alarm system test doors on 300 and 400 hall(also small rehab. gym) did not release. Also, doors did release with emergency release switch at nurse station. 42 CFR 483.70(a)	K 038	**K 038** **Correction of Deficient Practice:** Release system on exit doors on 300 and 400 halls and small rehab gym repaired so that doors release on activation of fire alarm system test and on activation of emergency release switch at nurse station. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** Inspected all exit doors to assure their release on activation of fire alarm system test and emergency release switch at nurse station. Repaired system so that all exit doors release upon such. **Systemic Changes to Prevent Recurrence:** Task to inspect daily the release of all exit doors on activation of fire alarm system test and on activation of emergency release switch at nurse station added to TELS. **Monitoring through Quality Assurance Program:** All TELS tasks will be reported monthly at monthly QA Committee Meeting.	1/18/13
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	**K 056** **Correction of Deficient Practice:** 1. First tamper switch on sprinkler system repaired. 2. Sprinkler installed in closet on dirty linen side. **Correction of Other Issues with Potential**	3/1/13

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K 056	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: 1. first tamper switch on sprinkler system did not send signal to fire alarm control panel(riser room located in maint shop). 2. closet on dirty linen side is not sprinkled.	K 056	**to Affect Residents by Same Deficient Practice:** 1. The two other tamper switches were tested to assure they sent signal to fire alarm control panel, which they did. 2. Building checked for other spaces requiring sprinkler. None were found. **Systemic Changes to Prevent Recurrence:** 1. Task to inspect daily that tamper switches send signal to fire alarm panel added to TELS. 2. Will use existing TELS task to test fire sprinkler system.	
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: 1. facility could not provide proper documentation that a 3 year full flow test has been preformed on sprinkler system. 2. facility could not provide proper documentation that a 5 year obstruction investigation has been performed on sprinkler system.	K 062	**Monitoring through Quality Assurance Program:** 1. & 2. All TELS tasks will be reported monthly at monthly QA Committee Meeting. **K 062** **Correction of Deficient Practice:** 1. Documentation obtained that a 3 year full flow test has been performed on sprinkler system. 2. 5 year obstruction investigation performed on sprinkler system. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** No other issues found. **Systemic Changes to Prevent Recurrence:** 1. Task to have 3 year full flow test performed on the sprinkler system added	2/22/13

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K 062	Continued From page 3 42 CFR 483.70(a)	K 062	PERFORMED ON SPRINKLER SYSTEM ADDED to TELS. 2. Task to have 5 year obstruction investigation on the sprinkler system added to TELS. **Monitoring through Quality Assurance Program:** 1. & 2. All TELS tasks will be reported monthly at monthly QA Committee Meeting.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: items listed below where found not to be working on HVAC system serving dining room(Location of unit is in attic in maint. shop) 1. motorized damper did not close on activation of fire alarm system test. 2. no access door on return/supply line to view dampers. Also, return fire/smoke damper located at service entrance to kitchen has excess ceiling spray on fuse able link. 42 CFR 483.70(a)	K 067	K 067 **Correction of Deficient Practice:** 1. Repaired motorized damper to close on activation of fire alarm system test. 2. Installed access door on return/supply line to view damper. Removed ceiling spray from fuse able link. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** 1. Inspected other motorized dampers throughout facility to assure closing on activation of fire alarm system test and they all did. 2. Inspected return/supply lines throughout facility to assure presence of access doors to view dampers. There was one location that did not have an access door; installed access door. Removed ceiling spray from fuse able links throughout facility.	2/15/13
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	**Systemic Changes to Prevent Recurrence:** 1. Will use existing TELS task to test closing of motorized dampers on activation of fire alarm system. 2. Will use existing TELS task	

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K 072	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: chair lifts were stored on 100 and 200 halls. Lifts were not moved during survey. 42 CFR 483.70(a)	K 072	ALARM SYSTEM. 2. WILL USE TELS TASK TO ASSURE THAT ~~to~~ access doors are present to view dampers and that dampers are functioning properly. **Monitoring through Quality Assurance Program:** All TELS tasks will be reported monthly at monthly QA Committee Meeting. **K 072** **Correction of Deficient Practice:** Chair lifts were removed from 100 and 200 hallways and stored in their designated storage room. **Correction of Other Issues with Potential to Affect Residents by Same Deficient Practice:** Facility was checked for other items stored in hallways. None were found. All staff received in-service training re: storage of equipment and keeping hallways open. **Systemic Changes to Prevent Recurrence:** Task added to TELS to assure daily that hallways are kept open. **Monitoring through Quality Assurance Program:** All TELS tasks will be reported monthly at monthly QA Committee Meeting.	2/15/13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: generator failed to crank and transfer within 10 seconds when tested(main generator). 42 CFR 483.70(a)	K 144	**K 144** **Correction of Deficient Practice:** ~~Main generator repaired and tested to~~	1/31/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING 01 - BUILDING 0101 B. WING ______	01/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliant, specific findings include: generator failed to crank and transfer within 10 seconds when tested(main generator). 42 CFR 483.70(a)	K 144	Will use existing TELS task to assure cranking and transferring within 10 seconds. **Monitoring through Quality Assurance Program:** All TELS tasks will be reported monthly at monthly QA Committee Meeting.	