

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

7/10/13

PRINTED: 06/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/14/2013
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NAME OF PROVIDER OR SUPPLIER  WINSTON SALEM NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104
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F 160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to convey resident funds within 30 days of expiration. This was evident in 3 of 3 records in the sample reviewed for conveyance of funds. (Residents #14, #197 and #14)</p> <p>Findings included: Review of the facility 's policy and procedure page 7 (seven) titled " Accounting Upon Death or Discharge of Resident " undated revealed in part: " The facility must, within 30 days of a resident 's death or discharge, convey the resident 's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident 's estate. "</p> <p>1. Review of the facility record revealed Resident #197 expired on 2/20/13. The facility conducted a final accounting of Resident#197 's funds and sent a check to the _____ (name of the County Clerk of Court) for \$174 dated 6/11/13.</p> <p>2. Review of the facility record revealed Resident #14 expired on 4/10/13. The facility conducted a final accounting of Resident#14 's</p>	F 160	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Winston-Salem Nursing &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><b>F 160</b></p> <p>1. Corrective action for residents found affected-Resident #197, #14, #323- funds were conveyed by Accounts/Payable Person on 6/11/13.</p> <p>2. To assure corrective action for those residents having potential to be affected-On 6/11/13 the Business Office Manager and Accounts/Payable Manager completed an audit of resident accounts that had discharged/deceased for credit balances. The Accounts/Payable Manager assured resident accounts with credit balances were conveyed/dispersed by 6/14/13. On 6/14/13 the Administrator in-serviced Business Office Manager, Assistant Business Office Manager and Accounts Payable Manager on regulatory requirements for conveyance of resident funds upon death/discharge.</p>	6/14/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deon Wagon TITLE: Administrator (X6) DATE: 7/7/13

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.

M J  
PB  
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F 160	Continued From page 1 funds and sent a check to the _____ (name of the County Clerk of Court) for \$60 dated 6/11/13.  3. Review of the facility record revealed Resident #323 expired on 1/17/13. The facility conducted a final accounting of Resident #323 's funds and sent a check to the _____ (name of the County Clerk of Court) for \$12 dated 6/11/13.  Interview on 6/13/13 at 3 PM with the business office manager revealed the business office did not have enough staff in place to ensure all task could be done but we now have a system in place to do timely conveyance of funds.  Interview on 6/13/13 at 5 pm revealed her expectation was to have the final accounting and conveyance of funds completed within 30 days.	F 160	3. Systemic Changes to ensure practice will not reoccur- The Accounts/Payable person will check the census daily during regular work week. Any resident having been discharged/ deceased and meets resident funds criteria will have funds conveyed/dispersed within the 30 day requirement. 4. Monitoring process- The Business Office Manager will audit the Resident Fund accounts - weekly times eight weeks and then monthly times two months and report results of the audit to the Administrator & QA team at the Quality Assurance and Performance Improvement meeting times four months.	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	F356 1.No resident was named in this citation, or affected. 2.Corrective action for those with potential to be affected- On 6/10/13 the Staffing Coordinator moved the posted nursing staff information to the bulletin board in the main lobby . This board is readily accessible for residents and visitors viewing. On 6/10/13 the Director of Nursing & Administrator in-serviced the Staffing Coordinator on requirements for Posted Nurse Staffing Information.	6/10/13

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F 356	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview with staff the facility failed to post the nurse staffing information for 3 days and in a prominent place readily accessible to the residents and visitors. The findings included:</p> <p>Observation of the nurse staffing information on 6/9/13 at 4:35 PM revealed the form was date of 6/6/13 with a census of 193. The nurse staffing information was located in a locked glass case in the corner near the shower room. This was not in a prominent area for the public and residents to view.</p> <p>Interview on 6/9/13 at 4:49 PM with the staff development coordination (SDC) revealed the staffing coordinator has a key that broke off so " I gave her mine. " The SDC indicated the staffing coordinator post the staffing information on the week days and "I AM unsure who posts on the weekend."</p>	F 356	<p>3. Systemic Changes to ensure practice will not reoccur- The Staffing Coordinator will generate required information Monday through Friday and give to the receptionist to post in the main lobby bulletin board. The receptionist will post this information on weekends in the main lobby bulletin board and any adjustments to staffing will be done by the supervisor in charge for the weekends.</p> <p>4. Monitoring process- The Director of Nursing, Staff Development Coordinator and/or Nursing Supervisor will audit daily times two weeks, then three times per week times one week, then weekly times five weeks. The Director of Nursing will report results of the audits to the Administrator &amp; QA team at the Quality Assurance and Performance Improvement meeting times two months.</p>	6/14/13	

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F 356	Continued From page 3  Interview on 6/10/13 at 3:10 PM with the staffing supervisor revealed the staffing coordinator was responsible for the posting of the staffing each day. The staffing supervisor revealed the facility initially was going to choose the lobby area but chose the current location because it had a key lock. Continued interview with the staffing supervisor indicated "Don't think the public could particularly notice the staff positing" in this glass case.  The staffing coordinator was not available for interview.  Interview on 6/13/13 at 5 pm with the administrator indicated her expectation was nurse staffing information be daily for the current date.	F 356		
F 371 SS=F	483.35(l) 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 record review, observations, and staff interviews the facility failed to store food under sanitary conditions in the kitchen by not labeling, dating, and monitoring refrigerated items, not	F 371	<b>F371</b> 1.No resident was named in this citation. 2.Any resident may be affected by these practices. Therefore, on 6/11/13 the Dietary Manager discarded any potential food items affected by not dating, labeling, frozen consistencies, and any type of storage concerns identified by surveyor. On 6/9/13 the Maintenance Director repaired the leaky hose. On 6/10/13 The Maintenance Director assured the three compartment sink was working & draining properly. On 6/13/13 the Maintenance Director repaired &sealed the holes/gaps around pipes in dishwashing area. On 6/9/13 any potentially affected dishes were rewashed by dietary staff. On 6/9/13 dietary staff cleaned kitchen floors and removed any standing water. On 6/9/13 housekeeping staff removed debris and standing water identified around dumpster area. On 6/10/13 and 6/11/13 the Environmental Services Director and housekeeping completed further cleanup of any debris and standing water by dumpster area. On 6/11/13 the contracted Regional Managers and Dietary Manager in-serviced dietary staff on : Cleaning Schedules and compliance to the cleaning schedules, Labeling/dating, Food Storage (Dry, Refrigerator, Freezer), Scoops and handles storage, Food Safety, Dishware/Drying and overall Sanitation practice. On 6/14/13 the Maintenance Director in-serviced staff on work order procedure to ensure improved communication regarding any items needing repairs will be completed.	6/11/13

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F 371	<p>Continued From page 4</p> <p>keeping frozen foods solid in the outdoor freezer, and not protecting dishes, food trays, pots and pans from contamination.</p> <p>Findings included:</p> <p>The undated " Storage of Pots, Dishes, Flatware, Utensils " policy stated, "Pots, dishes, and flatware are stored in such a way to prevent contamination by splash, dust, pests, or other means. Air dry pots, dishes, flatware, and utensils before storage " .</p> <p>The Dietary Cleaning Schedule for May 2013 revealed the floors had not been cleaned weekly as scheduled, the tray line was not being cleaned daily as scheduled, and the bottom oven had not been cleaned weekly as scheduled.</p> <p>The 2/21/13 service call from the pest control company indicated structural concerns in the kitchen area included, "holes/gaps noted around pipes in dishwashing area. Seal to prevent pest entry or harborage."</p> <p>The 5/28/13 service call from the pest control company indicated structural concerns in the kitchen area included, "holes around pipes in dishwashing area need to be sealed".</p> <p>On 6/9/13 at 4:00 pm through 6:20 pm observations of the kitchen revealed the following:</p> <p>There was standing water on the floor of the kitchen in the dish washing area, and adjacent employee locker room and dish drying area, 3 compartment sink area and adjacent pot/pan</p>	F 371	<p>3. Systemic Changes--</p> <p>On 6/11/13 the Dietary Manager implemented a Daily opening/closing checklist to monitor labeling/dating of food. On 6/11/13 the Dietary Manager updated the Cleaning Matrix to include floors and oven. Cleanliness and dryness of floor to be monitored by staff and Dietary Manager after each meal. Staff assigned to the dish service area will assure cleanliness, sanitation and dryness of floor after each meal and dishwashing service. On 6/12/13 the Regional Manager and Dietary Manager updated the service line checklist to include monitoring for dry service ware at all three meals daily. On 6/12/13 the Regional Manager and Dietary Manager in-serviced the cooks on service line checklist tool. On 6/12/13 the Ecolab technician adjusted the drying agent in the dishwasher. On 6/24/13 the Dietary Manager ordered a freezer to place in kitchen so that magic cups can be kept frozen during service. On 6/26/13 the Maintenance Director placed a door closer on outside freezer to assure proper temperature maintained. By 7/1/13 the Environmental Services Director will have in-serviced housekeeping &amp; dietary staff on proper Refuse Disposal on grounds and around dumpster/compactor area.</p>		

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F 371	<p>Continued From page 5</p> <p>drying area. The floor was wet in the food preparation area. There was a water hose lying on the floor of the dish washing area. The hose had a leak and was spraying a continuous stream of water approximately 3 feet into the air and arching a distance of 8 feet toward the clean dish drying racks. The area of direct spray and splash from the water hose was 8 feet by 10 feet. There was a large dust pan with a handle, containing trash and dirt, sitting on the floor 3 feet in front of the drying racks. The leaking water spray was hitting the dustpan and splattering water onto the dishes on the drying racks. The affected dishes included 50 serving trays, a tray of 85 dessert cups, 40 drinking cups, 25 bowls, and 150 coffee cups. On 6/9/13 at 4:05 pm the dietary manager indicated he was unsure how long the hose had been leaking. There was a slippery, black film covering the yellow tiled floor under the clean dish side of the dish washing area.</p> <p>The clean side of the dish washing station revealed a rack of 80 4oz clear juice cups that were stacked 3 to 4 cups on top of each other and were still wet. The dietary manager stated, "They should not be stacked until they are dry" and indicated the cups were still wet. There was a 3 foot stream of food residue floating in standing in water at the front edge of the stainless counter. The dietary manager indicated he did not know why the food and standing water was there and it should be a clean counter. There was a twisted white cloth with a dark brown, greasy substance that was lying behind the rack of stacked cups on the clean side of the counter. The cloth appeared dry. The dietary manager indicated the dirty cloth should not be on the counter with the clean dishes.</p>	F 371	<p>4. Monitoring Process- On a daily basis the Dietary Manager and Assistant Manager will visually monitor/audit compliance regarding: Cleaning Schedules and compliance to the cleaning schedules, Labeling/dating, Food Storage inclusive of scoops/handles (Dry, Refrigerator, Freezer storage), Food Safety, Dishware/Drying and overall Sanitation practice, for twelve weeks and then weekly thereafter and document findings. The District Manager will perform audits weekly times 12 weeks and then monthly for three months. The Dietary Manager will report results of audits to the Administrator and QA team at the Quality Assurance and Performance Improvement meeting times six months.</p>	6/14/13

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F 371	<p>Continued From page 6</p> <p>The dietary manager indicated the bottom rack of the clean side of the dishwashing station was used for storage of various items to be used in food preparation and distribution. Observation revealed a wet surface that contained stacked, large, wet baking pans, a chaffing dish, 2 coffee dispensers, 2 storage containers, 2 glass bowls.</p> <p>In the walk-in refrigerator there were 12 turkey sandwiches that were undated. At 4:30 pm the night kitchen supervisor stated, "I made them yesterday" and indicated the sandwiches should have been dated when made. The following foods were also in the refrigerator, had been opened, partially used or prepared and were undated and/or unlabeled: 3 trays of 48 applesauce cups, 1 tray of 15 applesauce cups, a yellow sheet cake with icing, a yellow cake without icing that was uncovered, 8 salads on plates, 24 milk cartons and nutritional supplement shakes floating in a milky/white substances in a metal container, 7 heads of lettuce wilted and undated, chopped garlic container undated, unsealed carton of lettuce with no date, 3 cucumbers, 3 stalks of celery that were wilted and undated, ½ wrapped cucumber undated, turkey breast wrapped in plastic wrap and undated, an undated package of mozzarella cheese, and an undated, split opened package of 12 pancakes.</p> <p>In the outside walk-in freezer at 4:50 pm there was an opened package of hash browns that appeared freezer burnt, and 6 boxes of a nutritional supplement. Two opened boxes of the supplement revealed the contents were soft, not hard-frozen. The dietary manager indicated he had arrived at the facility about 3:30 pm to find</p>	F 371		

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F 371	<p>Continued From page 7</p> <p>the door of the freezer partially opened.</p> <p>On 6/9/13 at 4:55pm debris including paper products, straws, cups, and food containers was noted on the ground in piles of leaves around the dumpster and the oil disposal. The dietary manager indicated that housekeeping is responsible for cleaning the area and that 2 large, rolling containers belonged to housekeeping. The containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water.</p> <p>At 5:00 pm an observation of the food preparation area revealed 3 dry storage bins being used that were undated, covered with brown crumbs and pink drops of a dried liquid. The flour bin contained a scoop sitting in the flour. There were undated and uncovered red grapes on top of the food prep table. The dietary manager indicated there should not be a scoop left in the flour and the grapes should be covered and dated. He covered the grapes. The stacked double baking ovens had dark brown/black grease on the doors and bottom of the ovens. Two ovens and stove tops had thick grease covering the inside and top of stove. The top of the thickener bin was dirty and contained a scoop in it. The large can opener was dirty with grease on the opener and around the base. The dry cereal containers were greasy. There were hamburger buns undated on the shelving at the food preparation station. The shelving used for storing dried cereal was dirty with crumbs and a greasy film. There was opened and undated spices that included undated chicken and beef flavored base, orange extract, imitation vanilla, cumin, Italian seasoning and black pepper. On the shelving with the</p>	F 371		



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F 371	<p>Continued From page 8</p> <p>spices there was a small box that contained several alcohol wipe pads, ear phones, a key, and a packet of grape jelly.</p> <p>At 5:20 pm an observation of the 3 compartment sink area revealed standing water on the floor under clean pots, pans, and trays. There were three areas with bubbles that were under the drying, clean pots, pans, and trays and extended up to touch items on the lower rack. There were food particles floating in the water. The area of standing water that contained bubbles and food particles covered a 6x12 ft area. The dietary manager stated, "When they open up and drain both sinks the water overflows onto floor." He indicated the maintenance director had been informed of the drain overflow "last week" but he did not know when it would be fixed or how long the drain had been overflowing.</p> <p>At 6:13 pm on 6/9/13 an observation of the serving line revealed 200 clean serving trays that were stacked, still wet, and being used for the dinner meal. Wet lids were being used to cover food. Dietary aide #1 used a napkin to dry the wet trays and stated that he was told to dry trays for the dinner meal with a napkin. At 6:13 pm on 6/9/13 the District dietary manager stated she "was told last November by a surveyor in Charlotte that trays could be dried with a napkin or towel." At the beginning of the serving line, there was a package of about 200 napkins opened and sitting on the bottom shelf of a rolling utility cart. The bottom shelf was wet and the package of napkins was wet.</p> <p>On 6/10/13 at 8:30 am there was a ½ gallon container of orange juice on a shelf in the walk-in</p>	F 371		

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F 371	<p>Continued From page 9</p> <p>refrigerator that was labeled " use by 6/6 ". The orange juice was observed being poured into cups on the service line to be served to residents. The dietary manager indicated the orange juice should not be served on 6/10/13. Further observation of the walk-in refrigerator revealed: a ½ gallon unlabeled and undated container of apple juice, 2 undated peanut butter and jelly sandwiches, an unlabeled and undated disposable sectioned plate containing a fork and partially eaten strawberries and cream, an expired container of applesauce, unlabeled and undated chocolate sprinkles and uncovered chocolate syrup. There was a container of freezer burnt dumplings in the freezer. On a pallet at the back of the freezer, under the fan, there were 8 boxes of cookie dough that had a wet, slimy substance on the outside of the box. There were opened and undated gyros and dinner rolls. The water hose continued to spray and standing water remained in the clean dish area, unchanged from previous day.</p> <p>On 6/10/13 at 9:30 am debris including paper products, straws, cups, and food containers was noted on the ground in piles of leaves around the dumpster and the oil disposal. The containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water.</p> <p>On 6/10/13 at 2:00 pm the district dietary manager indicated the nutritional supplements are delivered frozen. The product information printed by the district dietary manager revealed the following: "Storage conditions: keep frozen. Storage after open: refrigerated up to 5 days @ 34-40 degrees." The dietary manager and</p>	F 371		

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F 371	<p>Continued From page 10</p> <p>district dietary manager indicated the product should be refrigerated and used within 5 days after thawing. There were a total of 6 cases of nutritional supplement present in the outdoor walk-in freezer. The most recent invoice dated 6/5/13 revealed 3 cases of frozen nutritional supplement. The dietary manager stated he did not know how long the nutritional supplement had been soft and unfrozen in the outdoor freezer.</p> <p>On 6/11/13 at 11:09 am the service technician who sprays for pests in the kitchen and at the facility was interviewed and indicated that standing water and other debris at the dumpster could harbor pests and should be removed.</p> <p>The 6/11/13 service call from the pest control company indicated sanitation issues that could cause pest problems included, "Spilled food material found on the floor. Please clean to reduce pest attraction and source for breeding. Spilled trash on ground around dumpster could attract pests".</p> <p>On 6/11/13 at 11:30 am debris including paper products, straws, cups, and food containers was noted on the ground in piles of leaves around the dumpster and the oil disposal. The containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water. The housekeeping director was interviewed and indicated that it was the responsibility of housekeeping to keep the area around the dumpsters clean and the 2 rolling carts with water and debris belonged to housekeeping and should not have standing water and trash left in them.</p>	F 371		

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F 371	Continued From page 11 On 6/12/13 at 1:30 pm the dietary manager was interviewed regarding the cleaning schedule for the kitchen. A copy of the Dietary Cleaning Schedule was reviewed and he indicated that cleaning had not been monitored as he would have expected. He confirmed there were many tasks for the month of May 2013 that had not been initiated as completed and there was no means of confirming they were done.  On 6/14/13 at 10:00 am the administrator indicated the dietary manager and maintenance director are able to communicated daily "in the standup meeting" about repairs needed in the kitchen and that she was aware the maintenance director had been working on the dishwashing drain lines lately. She stated, "I would expect that standing or leaking water in the food prep areas or clean dish storage areas to be taken care of in a timely manner." She also stated, "I expect food to be labeled when it is opened." She indicated the nutritional supplements "would not hard freeze due to being like a yogurt." An observation at 10:30 am of the freezer in the 4th floor nutrition room revealed hard frozen magic cups.	F 371			
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.	F 372			

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F 372	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to properly contain and dispose of garbage by not keeping the dumpster area free of debris.</p> <p>Findings included:</p> <p>On 6/9/13 at 4:55 pm an observation was made of debris including paper products, straws, cups, and food containers on the ground in piles of brown leaves around the dumpster and the oil disposal. Two large rolling containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water. The dietary manager was interviewed at 5:00 pm and indicated housekeeping was responsible for cleaning the area and the 2 large, rolling containers belonged to housekeeping.</p> <p>On 6/10/13 at 9:30 am an observation was made of debris including paper products, straws, cups, and food containers on the ground in piles of brown leaves around the dumpster and the oil disposal. Two large rolling containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water.</p> <p>On 6/11/13 at 11:09 am the service technician who sprays for pests in the kitchen and at the facility was interviewed and indicated that standing water and other debris at the dumpster could harbor pests and should be removed.</p> <p>The 6/11/13 service call from the pest control company indicated sanitation issues that could</p>	F 372	<p><u>F372</u></p> <p>1. No resident named in this citation. 2. Any resident may be affected by this practice therefore on 6/11/13 the Environmental Service Director assured entire dumpster area cleaned of debris and standing water. By 7/1/13 the Environmental Services Director will have in-serviced housekeeping &amp; dietary staff on proper Refuse Disposal on grounds and around dumpster/compactor area.</p> <p>3. Systemic changes- Every morning as part of Floor Technicians daily routine-they will check and clean these areas to ensure free of debris &amp; standing water. Rolling containers will be cleaned daily and flipped upside down when completed to avoid capturing rain water. The Floor Technicians will maintain a log via check off sheet.</p> <p>4. Monitoring process-the Environmental Services Director and Assistant Manager will audit dumpster areas for debris and standing water in any containers daily as well as check Floor Technicians log daily times four weeks and then weekly. The Environmental District Manager will audit dumpster area and Environmental Directors reports for compliance monthly times three months. The Environmental Director will report results of audits to the Administrator and QA team at the Quality Assurance and Performance Improvement meeting monthly.</p>	6/11/13	7/1/13

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F 372	Continued From page 13 cause pest problems included, " Spilled food material found on the floor. Please clean to reduce pest attraction and source for breeding. Spilled trash on ground around dumpster could attract pests. "  On 6/11/13 at 11:30 am an observation was made of debris including paper products, straws, cups, and food containers on the ground in piles of brown leaves around the dumpster and the oil disposal. Two large rolling containers were both filled with approximately 2 feet of dark water and a large amount of trash floating in the water.  On 6/11/13 at 11:50 pm the housekeeping director was interviewed and indicated that it was the responsibility of housekeeping to keep the area around the dumpsters clean and the 2 rolling carts with water and debris belonged to housekeeping and should not have standing water and trash left in them.	F 372		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

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F 441	<p>Continued From page 14 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to keep the catheter bag and tubing off the floor for 1 of 5 residents (Resident #188) who had an indwelling urinary catheter.</p> <p>The Findings included:</p> <p>Resident #188 was originally admitted to the facility on 2/25/11 and readmitted on 5/58/213.</p> <p>Observation on 6/10/13 at 10:40 am revealed Resident #188 ' s bed was low in position with the</p>	F 441	<p><u>F 441</u></p> <p>1. On 6/14/13 the Director of Nursing assessed resident #188 to assure no negative outcomes and appropriate placement of catheter bag and tubing. 2. Corrective action for those having potential to be affected- On 6/14/13 the Director of Nursing and Staff Development Coordinator completed a audit of residents with catheters to ensure catheters/tubing were securely anchored with appropriate placement. On 6/14/13 the Staff Development Coordinator in-serviced nursing staff on proper procedure for placement of catheter bags and tubing. 3. Systemic change- Upon admission/readmission residents with a hospital catheter bag will be changed to facility catheter bag . Unit Coordinator will assess any barriers to possible positioning of catheter and tubing and educate/communicate proper procedure to floor staff. 4. Monitoring process-The Director of Nursing, Unit Coordinators and/or Nursing Supervisor will audit residents with catheters every shift times seven days, then daily times fourteen days and then weekly for eight weeks. The Director of Nursing and/or Infection Control Coordinator will review the results of audit to the Administrator and QA team at the Quality Assurance and Performance Improvement meeting times three months.</p>	6/14/13

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F 441	<p>Continued From page 15</p> <p>urinary collection bag attached to the frame of the bed. The urinary collection bag was partially lying on the floor.</p> <p>Observation on 6/10/13 at 2:38 pm revealed Resident #188 ' s bed was low in position with the urinary collection bag attached to the frame of the bed. The resident ' s catheter tubing and urinary collection bag was also observed to on the floor.</p> <p>Observation on 6/10/13 at 2:45 pm revealed Resident #188 ' s bed was low in position with the urinary collection bag attached to the frame of the bed. The resident ' s catheter tubing and urinary collection bag was observed on the floor.</p> <p>Observation on 6/10/13 at 4:05 pm revealed Resident #188 had no urinary catheter tubing to be on the floor.</p> <p>Observation on 6/12/13 at 4:23 pm revealed Resident #188 urinary collection bag was not hung to the resident ' s bedside. The urinary collection bag was lying on the floor on the resident ' s bedside mat. The tubing to the urinary catheter bag was also lying on the floor.</p> <p>Interview with Nurse #1 on 6/14/13 at 3:10 pm revealed Resident #188 ' s catheter tubing should not have been on the floor on 6/12/13.</p> <p>Interview with the Director of Nursing (DON) on 6/14/13 at 1:42 pm revealed the catheter Resident #188 had on 6/10/13 was the original catheter the hospital had discharged the resident with on 5/28/13. The DON revealed the resident had the catheter was in place from 5/28/13 until 6/10/13. The DON indicated that Resident #188</p>	F 441		





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F 460	<p>Continued From page 17 between bed A and B.</p> <p>Observations on 6/11/13 at 4:45 PM revealed there were insufficient curtains with a 6 foot gap not allowing full privacy around 500B bed. Observation at 9:35 AM on 6/12/13 revealed no change in insufficient curtains. These measurements were from the wall of bed B to in between bed A and B.</p> <p>Observation on 6/13/13 at 8:55 AM of room 509 revealed an insufficient privacy curtain creating a 19 inch gap between bed A and bed B. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9 AM revealed the maintenance director joined the observations and measured the gaps of the privacy curtains. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:10 AM of room 511 revealed an insufficient privacy curtain creating a 16 inch gap between bed A and bed B. There was a blanket draped over the track of 511 B and did not afford privacy when the curtain was drawn. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:11 AM of room 500 revealed an insufficient privacy curtain creating a 5 1/2 foot gap between bed A and bed B. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:13 AM of room 502 revealed an insufficient privacy curtain creating a</p>	F 460		

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F 460	<p>Continued From page 18</p> <p>7 foot gap between A and B beds. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:18 AM of room 515 B revealed an insufficient privacy curtain creating a 6 foot gap between bed A and bed B. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:30 AM of room 522 B revealed an insufficient privacy curtain creating a 17 inch gap between bed A and bed B. There were no other methods to provide full visual privacy.</p> <p>Observation on 6/13/13 at 9:35 AM of room 529 B revealed an insufficient privacy curtain creating a 5 1/2 foot gap between bed A and bed B. There were no other methods to provide full visual privacy.</p> <p>Interview on 6/13/13 at 9:37 AM with the maintenance director revealed the housekeeping department was responsible for maintaining the hanging of the privacy curtains. The maintenance director indicated that some of these privacy curtains were way too short.</p> <p>Interview on 6/13/13 at 9:45 am with HK# 2 revealed we check for status of the privacy curtains but did not remember if she performed this task.</p> <p>Interview on 6/13/13 at 9:28 AM with an alert and oriented resident revealed sometimes "I can see the care and sometimes I can't" when the staff provide care to my roommate.</p> <p>Interview on 6/13/13 at 9:58 am with the director</p>	F 460		

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F 460	<p>Continued From page 19</p> <p>of housekeeping revealed he was not aware that the privacy curtains needed to go completely around the resident. The director of housekeeping indicated that every Thursday or deep cleaning day or when ever needed his staff would check the hooks, tracks and privacy curtains then change if necessary. Continued interview indicated that on 5/23/13 unit 500, on 5/30/13 unit 400, and on 6/6/13 on unit 300 were checked. The results of the housekeepers ' checks of the privacy curtains could not be was not provided.</p> <p>Observations on 6/13/13 after the interview with the director of housekeeping staff were removing privacy curtains out of resident rooms on the 5th floor.</p> <p>2. Observation on 6/11/13 at 4:10 PM in room 501 B revealed the hooks of the privacy curtain was stuck and would not move freely within the tracks. Observation on 6/12/13 at 9:45 AM revealed no changes.</p> <p>On 6/13/13 at 9 AM the maintenance director joined the observations. During the observations the maintenance director attempted to fix the privacy curtain hooks.</p> <p>Observation on 6/13/13 at 9:05 AM of room 501 A and B revealed the hooks for the privacy curtains were stuck and would not flow freely within the tracks.</p> <p>Observation on 6/13/13 at 9:13 AM of room 502 A and B revealed the hooks for the privacy curtains were stuck and would not flow freely within the</p>	F 460		

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F 460	<p>Continued From page 20 tracks.</p> <p>Observation on 6/13/13 at 9:15 AM of room 503 A revealed the hooks for the privacy curtains were stuck and would not flow freely within the tracks.</p> <p>Observation on 6/13/13 at 9:18 AM of room 515 B revealed the hooks were partially off the tracks.</p> <p>Observation on 6/13/13 at 9:20 AM of room 507 A revealed the hooks would not flow freely through the tracks and was stuck. For bed B the curtains were hanging partially off the track and the hooks would not flow freely through the track thus creating a 3 foot gap between bed A and B.</p> <p>Observation on 6/13/13 at 9:25 AM of room 526 A revealed the hooks would not flow freely through the tracks and were stuck. This created a 3 foot gap between A and B bed.</p> <p>Interview on 6/13/13 at 9:28 AM with an alert and oriented resident revealed sometimes "I can see the care and sometimes I can't" when the staff provide care to my roommate.</p> <p>Observations on 6/13/13 at 9:30 AM of room 522 B revealed the hooks for the privacy curtain were stuck and would not flow freely within the tracks.</p> <p>Interview on 6/13/13 at 9:37 AM with the maintenance director revealed that the maintenance department was responsible for the repair and upkeep of the privacy curtain tracks and hooks. The maintenance director indicated that his department functioned on work orders and that he could not recall receiving work orders for repairing the privacy tracks or hooks, but he</p>	F 460		

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F 460	<p>Continued From page 21</p> <p>would check. By 11:50 AM the maintenance director indicated that he could not locate any repair request or work orders for the repair of the privacy curtain tracks and/or hooks for the privacy curtains.</p> <p>Interview on 6/13/13 at 9:40 AM with (housekeeper) HK #1 revealed she had seen "damaged" privacy curtains [referring to the stuck hooks in the tracks] but did not tell anyone. HK#1 indicated that the supervisor has the privacy curtains on a special project and he has not told me to check them.</p> <p>Interview on 6/13/13 at 5 pm with the administrator indicated her expectation was to maintain privacy for the resident.</p>	F 460		

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

PRINTED: 07/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING-01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/16/2013
NAME OF PROVIDER OR SUPPLIER  WINSTON SALEM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, AND ZIP CODE 1900 W 1ST STREET WINSTON-SALEM, NC 27104	
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K 000	INITIAL COMMENTS  This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type II protected construction utilizing Delayed Egress locking arrangements, and is equipped with a complete automatic sprinkler system.  CFR#: 42 CFR 483.70 (a)	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston Salem Nursing and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
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: Based on the observations and staff interview during the tour on 7/16/2013 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry.  CFR#: 42 CFR 483.70 (a)	K 029	<u>K 029</u> 1. Corrective action for findings-On 7/16/13 the Maintenance Director removed any dust/lint build up from dryer combustion chamber identified. 2. To assure corrective action for other life safety issues related to this practice-On 7/16/13 the Maintenance Director checked facility dryer combustion chambers and removed any dust/lint build up. 3. Systemic Changes to ensure practice will not recur- On 7/16/13 the Maintenance Director changed the schedule for removal of dust/lint from dryer combustion chamber from monthly to bi-monthly. 4. Monitoring Process-The Maintenance Director will visually monitor the dryer combustion chamber weekly times eight weeks and then bi-monthly thereafter and report results of audit to the Administrator and  QA team at the Quality Assurance and Performance Improvement meeting times four months.	7/16/13
K 045	NFPA 101 LIFE SAFETY CODE STANDARD	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 8/2/13

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 045 SS=D	Continued From page 1  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 7/16/2013 the following Life Safety item was observed as noncompliant, specific findings include: The required exit from the first floor dining room side emergency door does not currently have exit discharge lighting on the emergency circuit.  CFR#: 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: Based on the observations and staff interviews on 7/16/2013 the following Life Safety item was observed as noncompliant, specific findings include:  1. The 5th floor long hallway has dissimilar sprinkler heads in one smoke zone. There are	K 045	<u>K 045</u> 1. Corrective action-On 7/16/13 the Maintenance Director ordered required lighting fixture for illumination of egress area. On 7/19/13 the Maintenance Director installed the required lighting fixture to stated egress area. 2. To assure Corrective action for other life safety issues related to this practice-on 7/16/13 the Maintenance Director checked other facility egress areas for required lighting for illumination. 3. Systemic changes to ensure practice will not recur- On 7/16/13 the Maintenance Director in-serviced Maintenance Department Assistants on proper inspections of egress areas for lighting fixtures and illumination and process of monitoring and reporting through the facilities TELs program which consists of preventive maintenance. 4. Monitoring process- the Maintenance Director will visually audit & inspect facility egress areas for lighting fixtures and illumination weekly times eight weeks and then monthly thereafter & report results of audit to the Administrator and QA team at the Quality Assurance and Performance Improvement meeting times four months.  <u>K 062</u> 1. Corrective action-on 7/16/13 the Maintenance Director notified Simplex Grinnell ( the facilities contracted company for fire safety) that we would need their services to assess dissimilar sprinkler heads on fifth floor, dietary department and boiler room for high temperature. The scheduled visit and correction of sprinkler heads to be completed by 8/30/13.
K 062 SS=E		K 062	7/19/13



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K 062	<p>Continued From page 2</p> <p>standard heads and red bulb quick response heads in this area.</p> <p>2. The Dietary department near the kitchen hood has dissimilar sprinkler heads in one smoke zone. There are standard heads and red bulb quick response heads around the kitchen hood.</p> <p>3. The boiler room near the laundry is a high temperature sprinkler head and the sprinkler head in the boiler room was not verified as having a higher temperature rating for that space.</p> <p>CFR#: 42 CFR 483.70 (a)</p>	K 062	<p>2.To assure corrective action for other life safety issues related to this practice-the Maintenance Director will work with the Technician from Simplex &amp; Grinnell and inspect facility sprinkler heads during their visit to ensure sprinkler heads in compliance.</p> <p>3.Systemic changes- To ensure continued compliance with sprinkler system, the facility is to continue with annual inspections with Simplex Grinnell. The Maintenance Department is to continue with monthly inspections of the sprinkler system via TELS Preventative Maintenance program.</p> <p>4.Monitoring System- The Maintenance Director will monitor monthly TELS reports, conduct monthly visual audits and report findings to the Administrator and QA team at the Quality Assurance and Performance Improvement meeting times four months.</p>	8/30/13