DEPARTMENT OF HEALTH AND HUMAN SERVICES
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
	345111	A. BUILDING ______ B. WING ______	06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	**500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		7/8/15
	This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to discard expired food in the kitchen cooler and freezer, maintain sanitary conditions of the hood vents in the kitchen, failed to label and date foods in one of two nourishment refrigerators (station 1) and failed to monitor freezer temperatures in two of two nourishment refrigerators that contained food items for residents. The findings included; 1. On 6/15/15 at 10:25AM, a tour of the kitchen was conducted with Administrative staff #1. There was a package of provolone cheese in the kitchen cooler labeled with an expiration date of 6/10/15. The following items were noted in the kitchen freezer: 16 vanilla ice cream opened with some of the containers of ice cream melted, 18 chocolate ice cream opened with some of the containers melted. Ice was noted around all of the containers. There was also a package of thirty-six (36) Danish with an expiration date of 6/1/15. On 6/15/15 at 10:30AM, Administrative staff #1		It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under satisfactory conditions. Criteria One: No residents were found to have been affected by the alleged deficient practice. Criteria Two: All residents had the ability to have been affected by the alleged deficient practice. Criteria Three: The following systemic changes will be put into place to ensure the alleged deficient practice does not recur. Effective immediately, three times a day,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/02/2015

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 371	Continued From page 1 stated all of the items should have been thrown away. He stated there had been problems with the freezer leaking when it was in the defrost mode. 2. On 6/15/15 at 10:30AM, the hood vents above the cook area (sixteen in number) were noted to have a coating of dust. Two or three of the hood vents had dust and a black material noted covering the vent. On 6/17/15 at 9:50AM, a tour of the kitchen was conducted with Administrative staff #1. An observation of the hood vents revealed the following: a total of 16 vents (8 on each side of the cooking area) was observed to be dusty with a greasy-type appearance. Also there were two--three hood vents black in appearance. Administrative staff #1 stated the hood vents were on the cleaning schedule and were done monthly. He said they were last cleaned in May 2015. He stated the hood vents were dusty and dirty and should have been cleaned. 3. On 6/17/15 at 10:00AM, a tour of the nourishment refrigerator on station two was conducted. There was not a thermometer in the freezer section of the refrigerator to monitor the temperature of the freezer. On 6/17/15 at 10:10AM a tour of the nourishment refrigerator on station two was conducted with Administrative staff #2. She stated she expected nursing staff to have a thermometer in the freezer and to check the temperature daily. She stated, if there was not a thermometer in the freezer, she should be notified so one could be obtained. The facility policy titled "Refrigerator temperature monitoring" dated July 2, 2013 was reviewed	F 371	The North Building refrigerators and freezer will be audited for accurate labeling and dating of food products by the Director of Dining Services or the Chef Manager. Any expired or unlabeled products will be discarded. A tracking log will be kept outside the coolers and freezer for auditing purposes. Chef Manager or Dietician will bring audits to be reviewed during the monthly QAPI meeting. Monitoring for the labeling and dating of food products will be a permanent part of the monthly QAPI process. Hood vents were cleaned by dining services staff on 6/19/15. The schedule for cleaning of the hood vents has been reviewed by the Director of Dining Services and the Chef Manager. The cleaning schedule for the hood vents will be changed to weekly effective July 8. The Chef Manager or assigned Cook for the day will be responsible for the cleaning of the hood vents. Director of Dining Services or Chef Manager will be responsible for auditing cleanliness of vents and bringing signed cleaning schedule to QAPI committee for review during monthly QA. Monitoring of cleanliness of hood vents will be a permanent part of the monthly QAPI process. Training on labeling and dating of food products with instructions to discard any non dated or expired food products has been completed by the Registered	

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F 371 Continued From page 2

with Administrative staff #2 who stated she was unaware they did not have a policy about the freezer temperatures and only checked and documented the refrigerator temperatures.

4. A facility policy titled "Labeling food in nourishment refrigerators" dated March 2015 stated it was the policy of (name) nursing staff that all personal food that belonged to a resident was labeled prior to placing in refrigerators in nourishment rooms and must be labeled with resident name, date and room number.

On 6/17/15 at 10:00AM, a tour of station one nourishment refrigerator was conducted. There was not a thermometer in the freezer section of the refrigerator to monitor the temperature of the freezer. Also, there were two (2) plates of salad (chicken or tuna salad) on a bed of lettuce with fresh fruit unlabeled and undated.

On 6/17/15 at 10:10AM a tour of the nourishment refrigerator on station one was conducted with Administrative staff #2. She stated she expected nursing staff to have a thermometer in the freezer and to check the temperature daily. She stated, if there was not a thermometer in the freezer, she should be notified so one could be obtained. Administrative staff #2 stated she expected staff to label and date all resident food items that were in the refrigerator. The facility policy titled "Refrigerator temperature monitoring" dated July 2, 2013 was reviewed with Administrative staff #2 who stated she was unaware they did not have a policy about the freezer temperatures and only checked and documented the refrigerator temperatures.

F 371

Dietician for all dining services staff, to include full time, part time and as needed (PRN) staff on 6/15/15 and 6/26/15. These in-services will be repeated weekly for three months then monthly thereafter for 9 months to ensure problem does not recur. All documentation of the training will be kept with the Healthcare Administrator and reviewed during monthly QAPI meeting.

Thermometers have been placed in the freezers in the nourishment room on Station 1 and Station 2. The Policy and Procedure for monitoring refrigerator temperatures has been modified as of 6/19/15 to include monitoring of freezer temperatures.
In-service training has been done on 6/19/15, by the Director of Nursing (DON)for licensed staff responsible for documenting on freezer temperatures as well as labeling and dating of resident food items prior to placing in the refrigerator or freezer.

The DON or Admissions Coordinator will monitor refrigerator and freezer temperatures for Station 1 and Station 2 nourishment rooms daily for 2 weeks, then once a week for four weeks, then weekly to ensure compliance with accurate temperature monitoring by staff and labeling and dating of food products in refrigerator and freezer.

Criteria Four:

The corrective action will be monitored as

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F 371	Continued From page 3	F 371	follows: For the first three months, for the North Building kitchen refrigerators and freezer, the Healthcare Administrator will do five random checks per week for accurate dating and labeling of food products. The Chief Executive Officer (CEO), or Chief Operating Officer(CCO), the Healthcare Administrator or Director of Nursing (DON), and the Director of Dining Services or Chef Manager will inspect three times weekly for accurate dating and labeling of food products. If deemed appropriate after 3 months, the Healthcare Administrator will do three random checks per week and the CEO or COO will inspect once a week for the next 9 months the accurate dating and labeling of food products. All results and follow up action items will be documented and shared with the Quality Assurance Performance Improvement Committee (QAPI) monthly. Penick Village's Healthcare Committee Board will review at its meetings held quarterly, the documented reports and action items that are created by CEO and/or Healthcare Administrator. The DON will report on monitoring of the refrigerator and freezer temperature logs during the monthly QAPI meeting. The Plan of Correction (POC) will be reviewed monthly during the QAPI meeting and minutes will be signed off by the Chief Operating Officer or the Chief	

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F 371	Continued From page 4	F 371	Executive Officer. Monitoring will continue through next standard survey to ensure continued compliance. 6/19/15	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		6/22/15

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F 431	Continued From page 5 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to maintain medication storage refrigerator temperatures according to manufacturer recommendations for safe drug storage for 1 of 2 nursing station refrigerators (Refrigerator #1). Findings included: Medication storage review was conducted on 6/16/15 at 11:30 AM. The log of the June 2015 refrigerator temperatures at Nursing Station 2 showed 10 consecutive days of temperatures below the manufacturer recommended storage temperature of 36-46 degrees Fahrenheit (June 6 - 35 degrees, June 7 - 33 degrees, June 8 - 34 degrees, June 9 - 32 degrees, June 10 - 34 degrees, June 11 - 34 degrees, June 12 - 32 degrees, June 13 - 34 degrees, June 14 - 33 degrees, June 15 - 32 degrees). It was noted that a handwritten note at the top of the log stated "Temp Range is 36 degrees - 46 degrees F". Medications observed in the refrigerator included Lorazepam injections, Humalog and Novolog insulins, Promethiazine suppositories, Bisacodyl suppositories, Gabapentin oral suspension, and lactobacillus oral tablets, all of which are to be stored at a temperature range of 36-46 degrees Fahrenheit per manufacturer recommendations. Logs for April and May were requested and noted to be outside of the manufacturer recommended range for 15 days in April and for 3 days in May 2015. Nurse #1 was interviewed on 6/16/15 at 11:45 AM. He indicated that temperatures are checked	F 431	Criteria One: For the resident found to have been affected by the alleged deficient practice: No resident was found to have been affected by the alleged deficient practice. Criteria Two: For other residents who may have been affected by the deficient practice: All residents with medication stored in the refrigerator had the potential to have been affected by the alleged deficient practice. All medications in the refrigerator; Lorazepam injections, Humalog and Novolog insulins, Promethiazine suppositories, Gabapentin oral suspension, Bisacodyl suppositories, and lactobacillus oral tablets were discarded and reordered. Criteria Three: The following systemic changes will be put into place to ensure the deficient practice does not recur: Medication refrigerators for Station One and Station 2 have been replaced as of 6/22/15.	

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F 431	Continued From page 6 on third shift and that no third shift nurse had indicated to him of any problems with refrigerator temperatures. He further indicated that sometimes when he arrives to work he has noticed the freezer portion of the refrigerator is often covered in a "thick layer of ice" for which he takes the medications out and defrosts the ice with hot water just because "that much ice just cannot be a good thing" . He indicated that it never occurred to him that the thick layer of ice would affect the refrigerator temperatures to be out of range and so he never reported it as an issue to maintenance or administration. The Director of Nursing was interviewed on 6/16/15 at 4:40 PM. She indicated that she was not informed of any medication refrigerator issues by the nursing or maintenance staff. After reviewing the logs for April - June 2015, she indicated that nursing staff were monitoring the temperatures as required on a daily basis but apparently not understanding the need for monitoring and not recognizing the issue of out of range temperatures. She stated that her expectations are that "nursing staff readjust the refrigerator temperature, recheck in an hour to ensure appropriate temperature, alert maintenance and administration if the problem continues, and contact pharmacy to have the affected medications replenished." She indicated that, based on the logs for the past few months and her lack of knowledge in this matter, none of this was happening.	F 431	Nursing staff to include full time, part time and as needed (PRN) staff, received in-service training by the Director of Nursing (DON) on 6/18/15 -6/19/15 on the range for refrigerator temperatures and action to be taken when a temperature is below or above the recommended temperature of 36 to 46 degrees Fahrenheit. Licensed staff will monitor and record medication refrigerator temperatures nightly on 7p-7a shift and needed adjustments reported to (DON). Criteria Four: The corrective action will be monitored as followed: The DON or Admissions Coordinator will complete an audit weekly x 4 weeks, monthly x 4 months and quarterly to ensure proper documentation of medication refrigerator temperatures. All audit results will be presented by the DON at the monthly QAPI committee for continued monitoring. 6/22/15	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		6/26/15

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F 456	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the kitchen freezer in good working order as evidenced by a large build-up of ice and an observation of cartons of previously melted ice cream with large amounts of ice in the boxes of ice cream noted in the kitchen freezer. The findings included: On 6/15/15 at 10:25AM, a tour of the kitchen was conducted with Administrative staff #1. The following items were noted in the kitchen freezer: 16 vanilla ice cream opened with some of the containers of ice cream melted, 18 chocolate ice cream opened with some of the containers melted. Ice was noted around all of the containers. Ice build-up was noted near the top of the ceiling of the freezer and ice was noted in the boxes of ice cream. On 6/15/15 at 10:30AM, Administrative staff #1 stated there had been problems with the freezer leaking when it was in the defrost mode. He stated there had been several maintenance requisitions filled out for freezer repair. Administrative staff #1 stated if there was something that needed repair in the kitchen, he would fill out a maintenance slip, keep a copy and give a copy to the maintenance personnel. A review of the maintenance repair requisitions revealed the following repair requisitions were sent to maintenance for repair: 3/12/15--Freezer drains out on floor; 4/20/15--leak in freezer, drips on during defrost; 5/17/15--freezer leak, pile of ice on floor.	F 456	Criteria One: For the resident found to have been affected by the alleged deficient practice. No one resident was found to have been affected by the alleged deficient practice. Criteria Two: For other residents who may have been affected by the alleged deficient practice. All residents had the potential to have been affected by the alleged deficient practice. Criteria Three: The following systemic changes will be put into place to ensure the deficient practice does not recur: The freezer was defrosted on 6/19/15 by our on-site heating and cooling technician. The pipe in question was wrapped in insulation and will be monitored daily for leaks by the Director of Dining Services or Chef Manager with any leaks being reported immediately to the Healthcare Administrator who will advise maintenance of problem. Synder Refrigeration, INC. serviced the freezer on 6/26/15. Old caulking was removed along with insulation, ice melted per torch,leak was located, pipe replaced where leak occurred along with new	

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F 456	Continued From page 8 On 6/17/15 at 10:45AM, a tour of the freezer was conducted with Administrative staff #1 who stated someone had come on 6/16/15 and repaired the freezer. There was no ice buildup noted in the freezer. On 06/18/2015 9:55:16 AM, Administrative staff #4 stated if something needed repair, there was a work order form that would be completed. It would be given to one of the maintenance personnel or put under the maintenance office door for repair for the next day. If it was an emergency, the kitchen staff might directly call the service contractor for repair. The kitchen freezers and coolers were part of a monitoring system so maintenance received an automated phone call at any time if one of the freezers or coolers malfunctioned. Administrative staff #4 stated the facility had an on-site heating and cooling technician as well as an outside service contract. Maintenance personnel were in the building from 8:00AM-4:30PM and on call seven days a week. On 6/18/15 at 11:30AM, Administrative staff #4 stated he could not find any responses to the March requisition or the requisition cone on 5/17/15. He stated maintenance checked the freezer on 4/20/15, 4/21/15 and the contract company repaired the freezer on 4/22/15. On 6/18/15 at 12NOON, Administrative staff #3 stated she was not aware of any problem with the freezer and had not been informed of any problems with the freezer by dietary or maintenance staff. She stated she expected dietary or maintenance staff to let her know of any kitchen freezer problems whenever	F 456	caulking and insulation was secured with a roll of pipe insulator tape. According to Synder Refrigeration, Inc., "dripping has stopped". Scheduled maintenance for the freezer will be done by our on-site heating and cooling technician every month for three months, then every 6 months thereafter. Monitoring for leaks in the freezer will be added to the five random checks to be done by Healthcare Administrator per week. The CEO or COO, and Dining Services Director or Chef Manager will inspect three times weekly for one month, then monthly for three months, then every 6 months through next survey. Criteria Four: The corrective action will be monitored as followed: The Dining Services Director or Chef Manager will report findings to the QAPI committee monthly through next survey. 6/26/15	

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F 456	Continued From page 9 problems/ repairs were needed for the kitchen freezer. On 06/18/2015 at 12:37PM, Administrative staff #5 stated the repair on the kitchen freezer was done by facility staff in March and the problem was fixed. He stated he did not have a record of the May 17, 2015 requisition and did not have any record of servicing the unit in May, 2015.	F 456		
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 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.	F 520		6/19/15

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F 520	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility ' s Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the 5/1/14, 2/7/13, 12/15/11 and 11/5/10 recertification surveys in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on proper labeling, dating and the disposal of expired food items (F371) on the 5/1/14, 2/7/13, 12/15/11 and 11/5/10 recertification surveys. The findings included: This tag is cross referenced to F 371. Based on observation and staff interviews, the facility failed to discard expired foods in the kitchen cooler and freezer, maintain sanitary condition of the hood vents in the kitchen, failed to label and date foods in one of two nourishment refrigerators (station one) and failed to monitor freezer temperatures in two of two nourishment refrigerators that contained food items for residents. An interview was conducted with the Administrative Staff #3 and Administrative Staff #1 on 6/18/15 at 12:07 PM. She stated a new dietary manager was hired in March 2015 and the kitchen staff had been educated on proper labeling, dating and disposal of food items. Administrative Staff #3 did not indicate that the Quality Assessment and Assurance Committee had been monitoring the labeling, dating and disposal of expired foods. Administrative Staff #3 stated revision of their operational system would be needed to correct the problem.	F 520	Criteria One: For the resident found to have been affected by the alleged deficient practice: No resident was found to have been affected by the alleged deficient practice. Criteria Two: For other residents who may have been affected by the alleged deficient practice: All residents had the potential to have been affected by the deficient practice. Criteria Three: The following systemic changes will be put into place to ensure the alleged deficient practice does not recur. Penick Village has a monthly QAPI Meeting, held the last Thursday of each month. In addition to the monthly QAPI meeting, the Healthcare Administrator will meet weekly with the CEO to review and track progress for all action items in the POC and QAPI Committee recommendations for six months. At this time, if the CEO and Healthcare Administrator determine monitoring systems are effective, monitoring will continue by-weekly for the next three months and monthly thereafter. Documentation of actions required will be maintained by Healthcare Administrator. In the absence of the CEO and/or Healthcare Administrator, the COO and DON will be responsible for monitoring of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING ______ B. WING ______	06/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	**500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387**

(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 520	Continued From page 11	F 520	action items. 6/19/15 Criteria Four: The corrective action will be monitored as follows: Penick Village's Healthcare Committee Board will review at its meetings held quarterly the documented reports and action items that are created by the POC and QAPI committee. The POC will be reviewed monthly during the QAPI meeting and minutes will be signed off by the Chief Operating Officer or the Chief Executive Officer. Monitoring will continue through next standard survey to ensure continued compliance. 6/19/15	