STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345249	A. BUILDING _____ B. WING _____	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOREHEAD NURSING CENTER	205 EAST KINGS HIGHWAY EDEN, NC 27288

(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 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard 3 out of 3 blocks of expired three pound blocks of cream cheese, 1 out of 1 case of expired one ounce cream cheese containers, 1 out 3 containers of expired five pound container of cottage cheese. The facility also failed to dispose of 1 out 1 case of spoiled lemons. Findings Included: An observation during the initial kitchen tour on 10/5/15 at 9:35 am of the produce cooler and the dairy cooler revealed the following: 1. Three pound blocks of Cream Cheese (3 out 3 blocks) was expired on 7/9/15 2. One ounce individual containers of Cream Cheese (1 out of 1 case) was expired on 9/9/15 3. Five pound container of Cottage Cheese (1 out of 3 containers) was expired on 10/1/15 4. One case of spoiled/rotten lemons	F 371	1. All involved expired produce and dairy items were immediately discarded resulting in no residents being affected. 2. All involved expired produce and dairy items were immediately discarded so any potential residents were not affected. 3. The Dietary Chef, Director of Dietary Services and/or designee will conduct daily checks of expiration dates on dairy and produce items. Any items found to be out of date will be discarded immediately. 4. The Director of Dietary Services and/or designee will conduct quarterly audits of the daily audit information to ensure the daily auditing is being completed. The results of these audits will be reviewed at the facility Quality Assurance Meetings. 5. November 5, 2015	11/5/15

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

Electronically Signed | 10/30/2015

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F 371	Continued From page 1 During an observation on 10/5/15 at 9:35 am, the Chef discarded the expired items and spoiled lemons. An interview was conducted with the Chef on 10/8/15 at 12:15 pm. The Chef revealed a chart, which was in place for the dietary staff members responsible for checking their assigned coolers. The chart indicated that coolers are to be checked daily for expired products and soiled produce, and to be sure everything is dated and labeled. His expectations of his staff is to check their assigned coolers daily and to be sure to pull out any product that is expired or spoiled and to ensure everything is dated is labeled. The Chef was responsible for the dairy cooler and the produce cooler. He stated that the expired and spoiled products should have been discarded. The Chef further added the staff is to follow the " first in, first out " rule, which is the products with the most recent expiration date need to be pulled forward to be the first product out. The Chef stated the expired products were not used often and they were over looked. An interview was conducted with the Dietary Manager on 10/8/15 at 12:20 pm. The Dietary Manager revealed the expectation of the staff is to follow the " first in, first out " rule. Expects the staff to pull product forward with the most recent date and to monitor for expired product. The expired product should be pulled from the area immediately. An interview with the Administrator on 10/8/15 at 2:15 pm revealed the Administrator ' s expectation of his dietary staff is to monitor all food products for expiration dates and to discard it they are expired.	F 371		

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F 456 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to ensure side rails were functioning properly and secured for 1 of 1 residents with loose side rails (Resident #143). The findings included: Resident #143 was admitted to the facility on 3/10/14. The diagnoses included parkinson ' s disease, dementia with behaviors, dementia lewy bodies, hypotension and coronary artery disease. The quarterly Minimum Data Set (MDS) dated 8/18/15, indicated that Resident #143 had no memory or cognition or decision making problems. He was coded as needed limited assistance with activities of daily living and transfers. Review of the care plan updated 8/27/15, identified the problem as: multiple falls prior to admission and he continued to fall since admission. Resident was at risk for falls due to impaired thought process, weakness, impaired, mobility, hypotension, parkinson with lewy body dementia. He puts himself on the floor to work on things to get something off the floor, which he did at home. The goal included resident would transfer with 1 person assistance without having any fall related injuries, The approaches included	F 456	1. Resident #143's bed side rails were tightened by a Biomed staff member upon them being discovered by the survey team member. 2. All residents with a bed having side rails will be inspected by Biomed staff and/or designee to ensure the side rails are functioning properly. 3. Biomed staff and/or designee will conduct quarterly rounds for 12 months on the beds with side rails in the facility to ensure they are functioning properly. 4. The findings from the quarterly rounds conducted by Biomed staff and/or designee will be reviewed during the facility's Quality Assurance Meetings. 5. November 5, 2015	11/5/15

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document when you assist the resident to the floor and check on him frequently, monitor cognitive status and for agitation/attempts to leave or get up unassisted, place resident in fall prevention program-fall/injury prevention protocol, knee and elbow protectors for safety. Give verbal reminders not to attempt to transfer without assistance.

During an observation on 10/6/15 at 9:02AM, Resident #143 bed was close to the wall and the side rail closes to the door was extremely loose and flopped to the floor. The resident leaned against the side rail and pulled forward from the bed as he applied pressure to the side rail it fell to the floor.

During an observation on 10/6/15 at 9:48AM, Resident #143 reported that his side rail was very loose and had been in that condition for a long time. He indicated that staff use the side rails every day and never noticed how lose the side rails were. They just fall to the floor some times. Resident #143 stood from the wheelchair to lean again the side rail and they were extremely loose and wobbly. The resident applied body pressure on the rail and the rail began to shake and fell forward.

During an observation on 10/7/15 at 11:03AM, Resident #143 was lying in bed at low position sleep. Side rails in an upright position. They were rechecked when the resident awakened and they were still lose when pushed forward and backward. Resident stated staff put them up every day they should have noticed how loose they were

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F 456	Continued From page 4 During an observation on 10/7/15 at 11:08AM, the housekeeper supervisor (HKS) was asked to the room to check side rail position/safety. The HSK confirmed the side rails were loose when moved in front and backward directions, he indicated that maintenance was responsible for ensuring the side rails were secured and safe. During an interview on 10/7/15 at 11:22AM, the maintenance director indicated that he was unaware the resident's side rail was loose. He indicated the nursing staff or nursing assistance would be the personnel that would complete a work order or report the side rails for repair. He further stated that with the type of side rail this resident had they would become loose if the resident were to use body pressure on the rail, they were only used for positioning not support. When asked how often side rails was checked for securement, the response was when staff report or put in a work order, this would not be something checked on a routine bases unless reported as a problem. Resident reported to maintenance the rail had been loose for a while. The maintenance director checked the side rails and acknowledged and confirmed the side rails were very loose and not safe. During an interview on 10/7/15 at 11:30AM, Nurse #1 indicated that nursing/nursing assistance should be checking side rails for securement and safety, complete a work order and/or verbally report to maintenance. She indicated that she was unaware the side rails were loose. She checked the side rails and confirmed they were extremely loose.	F 456		

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F 456	Continued From page 5 During an interview on 10/7/15 at 2:59Pm, NA #4 indicated that she had worked with the resident and had not notice if the side rail were loose, because the resident had been in the wheelchair more lately. She indicated that if they were notice it was expected to be reported to nurse or maintenance for repair. During an interview on 10/7/15 at 4:00PM, the administrator indicated that there was no system in place for routine checks of side rails. The administrator further stated the expectation would be for staff to check them during care to ensure they were functioning properly or secured and reported reported to maintenance via verbal and/or work order.	F 456		