STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews and physician interview the facility failed to administer tube feeding as ordered by the physician for 1 of 1 residents (Resident #67). Findings included: Resident #67 was admitted to the facility on 4/2/2015. Diagnosis included: Cerebral Vascular Accident (CVA), Dysphagia, Diabetes, Heart Failure and Pain Disorder with related psychological factors. Review of the quarterly Minimum Data Set (MDS) dated 8/3/2016 revealed Resident #67 ' s cognition was severely impaired. She required extensive assistance with all activities of daily living (ADL ' s), received tube feeding that provided 51% or greater of her total caloric intake and 501 cc ' s or greater of her average daily fluid intake over the 7 day look back period. Review of Resident #67 ' s care plan dated 4/25/2016 revealed that she required a PEG tube for adequate nutrition and hydration. The care plan goals included Resident #67 would: maintain current weight, would not experience adverse effects from the PEG tube and would remain free of signs / symptoms of dehydration. The care plan approaches included: Dietitian to evaluate current nutritional status, weigh resident monthly and monitor for signs / symptoms of dehydration	F 281	1) The tube feeding for Resident #67 was set up and connected by Nurse #1 on 9/20/16 at 12:45pm. The MD was made aware of the event on 9/22/16 at 3:19PM. 2) All residents receiving tube feedings have the potential to be affected. A 100% audit of all residents receiving a tube feeding was completed by the Regional Clinical Manager on 10/13/16 at 3:42PM to assure all tube feedings were delivering the ordered formulas. No concerns were noted. An in-service was initiated by the ADON for licensed staff on 9/22/16 to assure tube feeding formulas are replaced when a bag is completed. An additional nursing in-service was initiated by the ADON on 10/14/16 for nurses to notify the physician for any unexpected lapse in tube feeding delivery of greater than 30 minutes and to document in the nurse notes. A 100% in-service was initiated by the ADON on 9/22/16 for all nursing assistants to notify the nurse when feeding pumps are beeping and to never turn a feeding pump off. All newly hired nursing staff will receive the in-service during orientation. 3) Utilizing a Tube Feeding Audit QI tool, the Unit Managers x 2 will monitor the	10/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2016

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F 281	Continued From page 1 and notify MD immediately. Review of the current physician ' s orders for Resident #67 included: nothing by mouth (NPO), Diabetasource AC via gastrostomy tube at 75 cc per hour continuously and flush gastrostomy tube with 120 cc of normal saline every hour continuously. Review of the medication administration record (MAR) for September 1st through September 21st 2016 revealed that Diabetasource AC at 75cc per hour continuously was signed of as being given at 6:00 am and 6:00 pm. The volume of tube feeding that was administered was not documented. Observations of Resident #67 revealed: 1. 9/20/2016 at 9:05 am Resident #67 was observed lying in bed. A 1500 cc ready to hang (RTH) bag of Diabetasource AC which was dated as being hung on 9/19/16 at 6:30 am was infusing at 75cc per hour. The bag contained approximately 75cc ' s of formula. 2. 9/20/2016 at 9:30 am Resident #67 ' s tube feeding pump was beeping. A continuous observation was made of her room. At 9:40 am a nursing assistant entered Resident #67 ' s room and the feeding pump stopped beeping. 3. 9/20/2016 at 10:53 am Resident #67 was lying in bed. A 1500 cc RTH bag of Diabetasource AC which was dated as being hung on 9/19/16 at 6:30 am was empty. The tube feeding pump was turned off. 4. 9/20/16 at 1:27 pm Resident #67 was observed lying in bed. A 1500 cc RTH bag of Diabetasource AC which was dated as being	F 281	residents with continuous feedings to include Resident #67 twice daily Monday through Friday x 2 weeks to assure all feedings are being delivered as ordered. The Manager on Duty will monitor the residents with continuous feedings twice on Saturday and Sunday x 2 weekends to assure feedings are being delivered as ordered. Then monitoring by the Unit Managers will occur 3 times weekly x 2 weeks, then weekly x 1 month, then monthly x 1 month to assure feedings are being delivered as ordered. The ADON will review and initial the audit tools weekly for trends and/or concerns. 4) The ADON will present the findings to the Executive Quality Assurance Meeting x 3 months for trends and the need for continued monitoring.	

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F 281	Continued From page 2	F 281		

hung on 9/20/16 at 12:45 am was infusing at 75 cc per hour.

An interview on 9/21/2016 at 3:48 pm with nursing assistant #1 revealed that she has worked with Resident #67. She stated that if she heard a tube feeding pump alarm going off she would put it on pause and let the nurse know.

An interview on 9/21/2016 at 4:45 pm with nurse #1 revealed that she has been the nurse for Resident #67. She stated that she has told the nursing assistants that if the tube feeding pump is beeping they can turn it off and they should notify her. She stated that typically continuous tube feedings are hung by the third shift nurse and should last until 6:00 pm and that she usually doesn ' t have to hang another bag of tube feeding formula on her shift. She stated she works 12 hour shifts. She stated that continuous tube feeding should not be empty. She stated that she doesn ' t record the specific volume of the tube feeding that is infused on her shift; only her signature is recorded on the MAR.

An interview on 9/22/2016 at 8:39 am with the Assistant Director of Nursing (ADON) revealed that it was not acceptable that Resident #67 ' s tube feeding was off from 9:30 am until 12:45 pm. She stated that her expectation was that the nursing assistant should have notified the nurse immediately that Resident #67 ' s tube feeding pump was beeping so that a new bag of formula was re-hung and the pump restarted. She stated that the nurses should be clearing the tube feeding pumps and documenting the volume of tube feeding that was infused on their shifts on the MAR.

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F 281	Continued From page 3 An interview with the facility Administrator on 9/22/16 at 10:57 am revealed that it was his expectation that tube feeding is administered per the physician ' s orders. An interview on 9/22/16 at 3:19 pm with Resident #67 ' s physician revealed that it was his expectation that her tube feeding be administered continuously per his order unless she was experiencing a physical complication or residuals. He would expect to be notified if there was a physical complication with tube feeding administration and he had not been notified of any concerns recently.	F 281		
F 371 SS=F	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, policy review and staff interviews the facility failed to seal, label and date food items in the refrigeration and freezer units, reach in coolers, the dry storage room, and the food preparation area of the kitchen. The facility failed to thoroughly clean service ware and failure for staff to properly wear hair restraints for facial	F 371	1. The Dietary Manager applied a hair net to completely cover all of her hair on 9/21/16 at 11:45AM and the male Dietary Employee #1 covered his chin hairs with respiratory mask on 9/21/16 at 11:45AM. Dietary employee #2 covered all of her hair with a hair net on 9/21/16 at 11:50AM.	10/25/16

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F 371	Continued From page 4 hair and head hair while working in the kitchen. Three of the five dietary staff members were observed to have unrestrained hair. Findings Included: A. Observation of the kitchen and nourishment rooms on 9/19/2016 at 10:15 AM revealed the following: 1. Walk-In Cooler: a. Undated opened gallon jug Balsamic vinaigrette b. Mold was present on one of the strawberries that were in the undated opened container of fresh strawberries c. Undated opened bottle of drinking water d. Nine unlabeled and undated covered plastic cups that contained pre-poured tea colored liquid that were on a plastic service cart e. Nine unlabeled and undated covered plastic cups that contained pre-poured thickened liquid that were on a plastic service cart f. Nine dark colored bananas that were in a box on the shelf next to box of yellow bananas 2. Walk-In Freezer: Undated opened bag of hot dogs 3. Reach-In Refrigerator: a. There was an opened clear glass jar with a metal top that had a label for Mandarin oranges. The jar was undated and unlabeled. The product that was in the jar and the product was visibly not Mandarin oranges. b. Undated orange juice 4. Prep Cooler: Undated opened clear plastic jug that had a label on the jug for cranberry juice that contained a clear liquid. 5. Dry Storage Room: a. Undated and unlabeled Styrofoam cup covered with clear cellophane wrap that	F 371	An in-service was initiated by the Regional Clinical Manager on 10/13/16 to all facility staff to assure no staff enters the kitchen or satellite kitchen area without a hair net and/or beard covering as appropriate. Beard guards were ordered by the Dietary Manager and were received 9/29/16 and are available for use in the kitchen and Dining Room satellite kitchen. Respiratory masks were utilized until the guards were delivered. Hairnets, beard guards, thermometers, gloves, and the temperature log will remain in the satellite dining room in a drawer. A. Opened food containers that were undated; undated plastic covered drink glass liquids were discarded; and molded/discolored fruits were discarded by the Dietary Manager on 9/19/16 after the 10:15AM walk-through. The Administrator and Dietary Manager completed a 100% audit of the Walk-In Cooler on 9/21/20 at 5PM to assure all stored foods were dated when opened and fruits were mold-free and of acceptable color. No other foods were noted without an open date, and no molded or discolored fruits were noted. B. The opened bag of hot dogs was discarded by the Dietary Manager after the initial walk-through of the kitchen at 10:15am on 9/19/16 along with the jar with the Mandarin orange lid. The Administrator and Dietary Manager completed a 100% audit of the Walk-In-Freezer on 9/21/16 at 6PM to assure all foods were properly dated when opened. No other foods were noted without an opened date.	

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F 371	Continued From page 5 contained multiple colored sprinkles. b. Undated opened syrup in a plastic jug. c. Carnival sprinkles in a carton that was not completely sealed after it had been opened. 6. General Kitchen: a. The can opener had visible debris/food build up on the blade b. Uncovered rainbow colored cake that was in a baking pan adjacent to wet cooking containers on a food prep shelf. There were no dietary employees observed working with the containers or cake. c. Opened cranberry cocktail container on prep shelf that was warm to the touch. The product packaging stated to refrigerate after opening. d. The Dietary Manager was observed to have a baseball hat with no hair net and had braided hair extending from the back of the hat that was not contained in a hair restraint. An interview on 9/19/2016 at 10:30 am with the Dietary Manager revealed her expectations were that staff members should seal, label and date all food items prior to placing in storage. The dietary manager identified the unlabeled product in the Mandarin oranges jar as the fruit, dates. B. Observation of the kitchen and tray preparation on 9/21/2016 at 11:35 am revealed the following: 1. Tray Preparation Line: a. Seven of eight clear lightweight spill proof cups had visible debris on the inside of the cup that were ready to be served b. Eleven of the twenty plate covers on the rack that were identified as being ready to use had debris on the inside of the lid. c. Two of the twenty plate covers had a non-smooth and cleanable surface on the inside of the cover.	F 371	C. The unlabeled orange juice was discarded by the Dietary Manager on 9/19/16 after the 10:15AM walk-through. The Administrator and Dietary Manager completed a 100% audit of the Reach-In Refrigerator on 9/21/16 at 6:30PM to assure all foods were properly labeled. No other concerns were noted. D. The jug of clear liquid stored in the Cranberry juice container was discarded by the Dietary Manager on 9/29/16 after the 10:15AM walk-through. The Administrator and Dietary Manager completed a 100% audit of the Prep Cooler on 9/21/16 at 7PM to assure foods/liquids were properly labeled. No other concerns were noted. E. The Styrofoam cup of sprinkles, bagged syrup and the Carnival sprinkles were discarded by the Dietary Manager on 9/19/16 after the 10:15AM walk-through. The Administrator and Dietary Manager completed a 100% audit of the Dry Storage Room on 9/21/16 at 7:30PM to assure all foods were properly labeled. No other concerns were noted. F. The can opener was cleaned by a dietary employee on 9/19/16 at 11AM. The cranberry cocktail on the prep shelf were discarded by the Dietary Manager on 9/19/16 after the 10:15AM walk-through. G. The 8 clear spill proof cups were removed from the tray line by the Dietary Manager on 9/19/16 at the time of the observation. The 11 plates with food debris and 2 plate covers were removed from service to be washed by the Dietary Manager on 9/19/16 at the time of the observation. The cart used to dry and	

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F 371	Continued From page 6 d. The cart that was used to dry and store the lids and bases for resident plates was observed to have dirt build up. e. Facial hair not covered on dietary employee #1. Dietary manager observed to have a baseball hat with no hair net and had braided hair extending from the back of the hat that was not contained in a hair restraint. Dietary employee #2 observed to have a bandana on her head with hair net restraining hair on the back of her head and unrestrained hair on the front of her head. f. Staff were observed serving gelatin deserts in small plastic cups from one baking pan that had visible buildup of black debris around the edges. 2. General Kitchen: An open bucket of chemical sanitizer was observed adjacent to an unlabeled, undated, and uncovered pitcher of a white granular substance that was identified by the dietary manager as being sugar. 3. Dry Storage Room: a. Undated and unlabeled Styrofoam cup covered with clear cellophane wrap that contained multiple colored sprinkles. b. Carnival sprinkles in a carton that was not completely sealed after it had been opened. c. Three of four containers of old fashioned rolled oats were observed to have sustained damage which resulted in the packaging becoming unsealed and the product being exposed. An interview on 9/21/16 12:00 pm with the Dietary Manager revealed the following: 1. Her expectation was that staff check for cleanliness of food service ware and food preparation equipment prior to prep for service or use. 2. Her expectation was that all of exposed hair on a staff member ' s head should be covered.	F 371	store lids, bases, and plates was removed from use by the Dietary employee on 9/21/16 at 11:30AM and was cleaned by the employee. H. The baking pan used for storing the gelatin deserts was removed and discarded from service by the Dietary Manager on 9/21/16 at 12PM. The opened bucket of sanitizer was removed from the food area and the Styrofoam cup of sugar was discarded by the Dietary Manager on 9/21/16 at 12:15PM. I. Food temperatures have been taken and recorded for the satellite kitchen steam table since 9/21/16 by the Dietary Employee serving the meal J. Desserts for the Dining Room will be delivered on a baking sheet with the baking sheet identified with the name of the item, the date the food item was made, and the meal to be served. 2. In-service was provided to the Dietary Manager and male dietary staff on 9/21/16 by the Regional Clinical Manager to maintain a hair net and beard guard/covering for covering all of their hair at all times when in the kitchen and serving areas to assure no hair comes in contact with food. The in-service was initiated on 9/21/16 for all Dietary staff to maintain a hair net at all times covering all of their hair while in the kitchen and serving areas, and to all facility staff to wear a hair/beard covering before entering the kitchen was initiated 9/21/16 by the Regional Clinical Manager. An in-service was initiated by the Regional Clinical Manager on 9/20/16 to the Dietary Manager and Dietary staff to assure all	

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F 371	Continued From page 7 3. Her expectation was that damaged product should either be refused at the time of delivery or if found at a later time be pulled from the stock room and in both instances the dietary manager should be informed. 4. Her expectation was that the baking trays be clean and if not clean then the pans needed to be soaked. 5. Her expectation was that chemicals should not be stored near food and that the sanitizer buckets be kept on the shelves under the food prep table. C. Observation of the satellite kitchen in the main dining room on 9/21/2016 at 12:15 PM revealed 1. Dietary employee #2 was observed to have placed pans of food from the kitchen into the steam table. Dietary employee #2 then started to plate the food from the steam table. The plates were delivered to the residents in the dining room by nursing assistants. Dietary employee #2 was not observed to have taken the temperature of the food that was delivered from the kitchen prior to plating the food. 2. NA #2 observed entering the satellite kitchen area without a hair net. 3. Unlabeled and undated deserts being served being served by the nursing assistants to the residents in the dining room. An interview with dietary employee #2 on 9/21/16 at 12:20 PM revealed that she had not taken temperatures on the food that she was serving that had been transported from the kitchen. Dietary employee #2 stated that they do not check the temperature of the food when it is delivered to the satellite kitchen of the main dining room.	F 371	food containers are covered, labeled, and (dated “use by date”) when opened. The Regional Clinical Manager on 9/21/16 2016 initiated an in-service to the Dietary Manager and Dietary staff that the temperature of foods held in steam tables will be monitored and recorded for each meal by Dietary staff to include the satellite Dining Room. All newly hired staff will receive the in-service during orientation. An in-service was initiated on 10/25/16 by the Regional Clinical Manager to 100% of Dietary staff to maintain sanitizing solution on a lower level away from foods; the dish machine solution will be changed 2 to 3 times during each meal and as needed for noted food debris on clean dishware; dishware to be checked for cleanliness prior to use and dirty dishware to be returned for re-washing; the can open will be disassembled and cleaned daily and as needed for visible residue; foods and liquids to be stored in original or new containers; and to discard baking pans with built up residue and replace as needed. 3. Using a Dietary QI Audit tool, the Administrator or ADON will monitor Dietary Staff to include the Dietary Manager and male Dietary staff daily Monday through Friday x 2 weeks and on weekends x 2 weekends to assure Dietary staff hair and chin hair is covered with the appropriate net/guard. The Administrator or ADON will The Administrator will monitor food storage daily x 2 weeks	

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F 371	Continued From page 8 An interview on 9/22/2016 at 5:00 pm with the Administrator revealed his expectations were that all food should be sealed, labeled and dated prior to being stored, that temperatures needed to be taken at the satellite kitchen in the main dining room, that food contact services be clean of food and debris, that open chemicals not be stored next to open food, and that all employees working in a food service and preparation have their hair covered and not exposed.	F 371	Monday through Friday on weekends x 2 weekends to assure opened containers are dated with a “used by” date. The Administrator will monitor the steam table in the main dining room daily x 2 weeks to assure food temperatures are monitored before serving meals. Then monitoring for all areas will occur three times weekly x 2 weeks, then weekly x 4, then monthly x 1. An additional Dietary QI Audit Tool was developed on 10/25/16 by the Regional Clinical Manager to monitor storage of sanitizing liquids, dishware cleanliness and baking pan debris, the can opener for cleanliness, foods and liquids stored in original or new containers, and facility staff entering the kitchen without hair nets or beard guards. Monitoring will be completed daily by the Administrator or ADON x 2 weeks, then 3 times weekly x 2 weeks, then weekly x 4 weeks, then monthly x 1. 4. The Administrator will present the results of the monitoring to the Executive Quality Assurance Committee monthly x 3 for trends, concerns, and the need for continued monitoring.	