

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345495	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2017
NAME OF PROVIDER OR SUPPLIER THE STEWART HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6920 MARCHING DUCK DRIVE CHARLOTTE, NC 28210	
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F 584 SS=E	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p>	F 584	<p>1.) Corrective action to be accomplished for each resident affected by the deficient practice: Painting/wall repair contractors were on site and actively repairing and painting affected areas prior to survey entrance on 11/28/2017. This team completed work throughout the health center on 12/5/2017. All affected areas were repaired within regulatory compliance 12/5/2017. To correct this practice moving forward, wall integrity needs inclusion in weekly maintenance rounds in addition to staff education on proper procedure for submitting work orders.</p> <p>2.) Corrective action to be accomplished for those residents having the potential to be affected by deficient practice: Director of Plant and Environmental Services or designee completing weekly audits x 6 months beginning 12/1/2017 to wall areas in Resident rooms, Common Areas, and hallways to ensure wall integrity is maintained. These audits will be reviewed in each monthly QAPI meeting to ensure maintained compliance.</p>	12/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cory Cain

TITLE Administrator

(X6) DATE 12/28/17

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 584	<p>Continued From page 1</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, the facility failed to maintain the walls in the residents' rooms in good repair for 4 of 14 sampled resident rooms: 109, 207, 205, and 209 and the facility failed to fix a hole in the wall located in the main living room utilized as a common area for residents on hall 100.</p> <p>The findings included:</p> <p>1. An observation on 11/28/17 at 11:23 AM of room 109 revealed a large hole in the wall behind the door in the area of contact with the door knob (measuring 2" (inches) X 4").</p> <p>An interview with a family member was conducted on 11/28/17 at 11:23 AM. The family member indicated staff had told the family the hole was from a disgruntled family member of a prior resident no longer allowed in the facility. The current resident had lived in the room since June 2016 and the hole had always been noticeable.</p> <p>An observation on 11/29/17 at 3:56 PM of room 109 revealed the hole behind the door had been partially patched with an open area still visible.</p> <p>An observation on 12/01/17 at 9:24 AM of room 109 revealed the hole behind the door that had been partially patched on 11/30/17, had a large hole through the patch.</p> <p>An interview on 12/01/17 at 9:24 AM with the Maintenance Supervisor, indicated the wall was</p>	F 584	<p>3.) Measures put in place or systemic changes made to ensure that the deficient practice will not occur: In-Service training conducted by Administrator 11/30/17 for all SHC staff regarding appropriate manner for submitting a work order for completion. In-service to be added to new hire training to be completed by Administrator or designee Weekly audits to identify affected areas in addition to staff knowledge on work order submission will ensure no deficient practice will occur.</p> <p>4.) Monitoring Process: Results of above audits to be presented by Maintenance designee at monthly QAPI meeting until compliance is maintained.</p>		

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F 584	<p>Continued From page 2</p> <p>weak in room 109 and he would place wood over the spot to prevent further damage. He stated he was not aware the area was damaged since 6/2016. He stated he was aware the area had been a concern.</p> <p>2. An observation on 11/28/17 at 10:50 AM of room 207 revealed an area behind the bed exposing sheet rock (measuring 3" X 2").</p> <p>An interview with Nurse #1 conducted on 11/30/17 at 2:58 PM revealed she was unaware of any concerns on Hall 200 pertaining to areas on the wall needing maintenance.</p> <p>An interview with maintenance personnel on 12/01/17 at 10:45 AM, revealed his responsibility to inspect each hall weekly and log had not included wall integrity.</p> <p>3. An observation on 11/28/17 at 10:58 AM of room 209 revealed 2 areas exposing sheet rock behind the bed (measuring 6" X 0.75" and 0.5" X 1") and 1 area exposing sheet rock behind the head board (measuring 1.5" X 1").</p> <p>An interview with Nurse #1 conducted on 11/30/17 at 2:58 PM revealed she was unaware of any concerns on Hall 200 pertaining to areas on the wall needing maintenance.</p> <p>An interview with maintenance personnel on 12/01/17 at 10:45 AM, revealed his responsibility to inspect each hall weekly and log had not included wall integrity.</p> <p>4. An observation on 11/28/17 at 3:43 PM of room 205 revealed 3 areas on the wall to the right-side of the bed marred with intermittent scratching</p>	F 584			

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F 584	<p>Continued From page 3</p> <p>(measuring 10" X 6", 6" X 4", and 5" X 15") and 1 area behind the rocking chair marred with exposed drywall (measured 2" X 1.5").</p> <p>An interview was conducted with Nurse #1 for Hall 200 on 11/30/17 at 2:58 PM. Nurse #1 stated the process for maintenance requests was to complete a slip kept at the nurses station and then to take the completed slip to the main nursing station downstairs to be processed. She had no maintenance requests or concerns at the time of the interview.</p> <p>An interview with the Maintenance Supervisor on 11/30/17 at 3:15 PM, revealed the new process for maintenance requests started about 2 years ago and anyone including staff, residents, or family called the dispatcher or emailed directly work orders. The Maintenance Supervisor stated the usage of maintenance slips had been part of the old process. He continued to indicate the holes behind the beds and chairs, and in common areas for residents were very hard to keep up with because it happened so frequently. He stated he had ideas for improvement related to usage of a better product and would share with his Administrator to better manage concerns for wall integrity.</p> <p>5. An observation on 11/30/17 at 3:15 PM, revealed an area with a large hole in the wall behind the desk in the main living room.</p> <p>In an interview with the Administrator on 12/01/17 at 9:48 AM, he stated the hole behind the desk in the main living room (measuring 1.25cm X 3.75cm) was from a refreshment station that had been removed a while ago. He could not specify how long a while ago meant. He stated the</p>	F 584			

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F 584	Continued From page 4 facility was told to remove the refreshment station and a cover had not been placed to the date. In an interview and facility round with the Administrator and Maintenance Supervisor on 12/01/17 at 9:48 AM, both stated the wall integrity had been an ongoing concern and difficult to keep up with. The Administrator explained ongoing meant, "a long time." During the facility round, areas with damaged wall integrity were measured by the Maintenance Supervisor. An additional interview with maintenance personnel on 12/01/17 at 10:45 AM revealed he had the responsibility for inspection of each hall weekly for maintenance concerns and reported to the dispatcher. He stated he had a log of his findings however wall integrity had not been monitored on the log. He indicated future inspections with the log would include wall integrity and had been added to the QAPI (Quality Assurance Performance Improvement) agenda. He further stated he had been assigned the responsibility. An interview with the Administrator on 12/01/17 at 12:08 PM revealed his expectation was for staff to report maintenance requests related to wall integrity using the new process and for maintenance to ensure requests were processed timely.	F 584			
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	1.) . Corrective action to be accomplished for each resident affected by the deficient practice: All improperly labeled or stored food immediately discarded by Food and Beverage director, Executive Chef, or designee.	12/29/17	

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F 812	<p>Continued From page 5</p> <p>approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interviews the facility failed to have expired food dated in 2 of 2 walk-in refrigerators and 1 of 1 dry storage area, were discarded and not available for consumption by residents and use in residents ' meals and failed to ensure male staff wore facial hair covering while preparing food items.</p> <p>The findings included:</p> <p>1. Review of undated, "Label and Dating Policy", provided by facility, revealed the following guidelines for refrigeration and dry storage:</p> <ul style="list-style-type: none"> - All items must be dated when opened. - All items made in house must be dated with a 4 day shelf life. - All other items must be dated with a 7 day shelf life. - All exceptions in by chef and sous-chef approval only for guidance with food safety standards. <p>During the initial tour of the main kitchen on 1/28/17 from 11:32am to 11:54am the following</p>	F 812	<p>Process review to include full review of food storage and facial hair protection to be completed by Administrator and executive chef. Staff training on policies and appropriate food storage audits to be implemented.</p> <p>2.) Corrective action to be accomplished for those residents having the potential to be affected by deficient practice: Executive Chef and Administrator to review all food storage policies to ensure regulatory compliance. In-Service training on proper procedures to store, label, date, and dispose of food in all food storage areas to be completed for all Kitchen and Dietary staff by Executive Chef 12/29/2017. Completion of training to be documented and presented to QAPI committee.</p> <p>Additional in-service to all staff regarding appropriate utilization of hair nets and beard guards to be completed 12/29/17 by Executive Chef for all Kitchen and Dietary Staff.</p> <p>All above training to be included in new hire training for all Kitchen and Dietary Staff and to be repeated annually.</p> <p>3.) Measures put in place or systemic changes made to ensure that the deficient practice will not occur:</p>		

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F 812	<p>Continued From page 6</p> <p>items were observed in refrigeration and available for use.</p> <p>a. Walk-in refrigerator #1:</p> <ul style="list-style-type: none"> - One quart size carton of liquid egg whites open with no date. The manufacturer 's expiration date was 1/19/18. - One quart size carton of orange juice open with no date. The manufacturer ' s expiration date was 12/17/17. - One quart size carton of orange juice with spout open and no date. The manufacturer ' s expiration date was 12/19/17. - One large, closed container of ham bones with a written label that revealed an open date of 11/22/17 and discard date of 11/26/17. <p>b. Walk-in refrigerator #2:</p> <ul style="list-style-type: none"> - One large, closed container of shrimp with a written label that revealed an open date of 11/24/17 and discard date of 11/26/17. <p>c. Dry storage area:</p> <ul style="list-style-type: none"> - One large bag of dried onions on a shelf in the dry storage room with a written label that revealed an open date of 11/23/17 and a discard date of 11/25/17. - One large, closed container of icing on a shelf in the dry storage room with a written label that revealed an open date of 11/22/17 and a discard date of 11/25/17. <p>Observation of the main kitchen on 12/1/17 at 10:35am the following items were observed in the dry storage area and available for use:</p> <ul style="list-style-type: none"> - A partially full bag of tortilla chips on a shelf in the dry storage area that had been opened and reclosed with tape that was peeling off. There 	F 812	<p>Inspection of all food storage areas daily by Sous-Chef completed daily x 1 month, weekly by 2 months, and bi-weekly x 3 months to be documented and presented to QAPI committee. Additionally, executive chef to complete weekly audits x 6 months and F&B director to complete audits weekly x 6 months. Results of all audits to be presented to QAPI committee for assurance of continued compliance.</p> <p>4.) Monitoring Process: Results of all above audits to be presented by F&B Director or designee at each month's QAPI meeting. Training requirements to be added to Annual and new-hire training. Daily monitoring of beard cover utilization to be performed by Executive Chef or the Kitchen Manager on duty. If violation of policy is noted the date, time, and name individual in violation will be reported to Food and Beverage Director and Administrator. Results of these findings be brought to QAPI committee for process review.</p>		

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F 812	<p>Continued From page 7</p> <p>was no open date on package.</p> <p>- One 5 pound bag of flour sitting on a shelf in the dry storage area with top of bag opened and partially covered with plastic wrap. There was no open date found on package.</p> <p>During an interview with the Executive Chef on 11/28/17 11:32am - 11:54am, he stated that many food items were good for much longer than the 3 or 4 day discard dates and some of them up until manufacturer ' s expiration date. He stated that his expectation was for kitchen staff to stop putting written labels with discard dates on food items as this is a waste of food and not required. He stated that he will re-educate his staff. He stated he does not know what the facility policy is for food storage.</p> <p>Interview with the Executive Chef on 12/1/17 revealed that the dry storage room items were checked weekly for expiration dates but there was not a schedule or designated person to perform this task. He stated that a person had been hired that would be performing that task routinely and that person was to start working tomorrow.</p> <p>2. Review of undated policy labelled, "Employee - Personal Cleanliness", provided by facility, revealed the following guidelines that included, hair nets or caps should always be worn in food preparation areas and during food preparation. Facial hair covers to be worn when appropriate.</p> <p>During an initial tour of the kitchen on 11/28/17 at 11:32am - 11:54am revealed 6 male kitchen employees with facial hair uncovered. The 6 male kitchen staff were observed to be directly handling and prepping food items for the lunch</p>	F 812			

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F 812	Continued From page 8 meal. Observation of the main kitchen on 12/1/17 at 10:35am revealed three male employees with facial hair uncovered. They were actively prepping food items for residents. Interview on 11/28/17 11:32am - 11:54am with the Executive Chef revealed that his expectation was that all staff working in the kitchen would wear hair and beard covers if facial hair present. He stated that hair nets and beard covers were available for staff use.	F 812		