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
	345119	A. BUILDING _____ B. WING _____ MAR 21 2011	03/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITTHAVEN OF NORTHCHASE	3015 ENTERPRISE DR WILMINGTON, NC 28405

(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 ensure: plastic containers are stored in a manner to air dry; the meat slice is cleaned and sanitized thoroughly before covering as clean and walk-in cooler floor is free of spills. The findings include: 1. An observation was made during the initial tour on 02/28/11 at 6:50 PM of 6 plastic containers stacked wet on a vented rack. A second observation was made on 03/01/11 at 8:35 AM of 4 plastic containers stacked wet on a vented rack. Interview with the Kitchen Manager on 03/02/11 at 11:30 AM revealed that it is her expectation that the all containers and dishware are air-dried individually before stacking. 2. An observation was made during the initial tour on 02/28/11 at 6:55 PM of the meat slicer	F 371	The plastic storage containers were cleaned and air dried. 100% The dietary staff have been Inserviced on safe cleaning practices in the kitchen.	3/2/11 3/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen M Stidwell — TITLE: Administrator — (X6) DATE: 3/18/11

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 with a moderate amount of brown flaky substance on the blade. The meat slicer was stored with a plastic cover over the entire machine. A second observation was made on 03/01/11 at 8:37 AM of the meat slicer with a moderate amount of brown flaky substance on the blade. The meat slicer was stored with a plastic cover over the entire machine. A third observation was made on 03/02/11 at 11:25 AM of the meat slicer with a moderate amount of brown flaky substance on the blade. The meat slicer was stored with a plastic cover over the entire machine. Interview with the Kitchen Manager on 03/02/11 at 11:30 AM revealed that it is her expectation that the meat slicer is taken apart and cleaned and sanitized thoroughly before the machine is covered. Interview with the Cook on 03/02/11 at 11:11:37 AM revealed that the meat slicer should be taken apart and cleaned and sanitized thoroughly before the machine is covered. 3. An observation was made during the initial tour on 02/28/11 at 7:00 PM of a white milky wet substance in the far right corner of the walk-in cooler floor near the milk. A dry white substance was observed on the floor under the shelve where crates of milk were stored. A second observation was made on 03/01/11 at 8:35 AM of a white milky wet substance in the far right corner of the walk-in cooler floor near the milk. A dry white substance was observed on the floor under the shelve where crates of milk were	F 371	Dietary Staff have been provided with cleaning schedules that occur daily And weekly. A weekly audit has been completed by the Kitchen Manager and reported to the Dietary Manager and Administrator for review. The results of the rounds and the Audit will be shared in the QI meeting Once a month for 3 months. The QI Committee will decide if modifications of the audits need to be made based on trends. The meat slicer was cleaned on 3/2/11 And covered. The slicer Is cleaned when used and when needed. 100 % of Dietary Staff have been in-serviced regarding the proper cleaning routine for the slicer. Dietary Staff have been provided with cleaning schedules that occur daily And weekly. A weekly audit has been completed by the Kitchen Manager and reported to the Dietary Manager and Administrator for review. The results of regular kitchen rounds and The weekly audit will be shared in the QI meeting once a month for 3 months. The QI monthly committee will decide if modifications of the audits need to be made based on trends.	3/2/11 monthly 3/2/11 3/4/11 3/2/11 Monthly

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F 371	Continued From page 2 stored. A third observation was made during on 03/02/11 at 11:20 AM of a white milky wet substance in the far right corner of the walk-in cooler floor near the milk. A dry white substance was observed on the floor under the shelve where crates of milk were stored. Interview with the Kitchen Manager on 03/02/11 at 11:30 AM revealed that it is her expectation that the walk-in cooler floor is mopped daily. Interview with the Food Service staff on 03/02/11 at 11:35 AM revealed that the evening shift is responsible for mopping the walk-in cooler at night.	F 371	The floor in the walk-in was cleaned On 3/2/11. Dietary staff will mop and Clean this area daily. 100% of dietary staff have been Inservice on maintaining a clean kitchen environment. Dietary Staff have been provided with Cleaning schedules that occur daily And weekly. A weekly audit has been completed by the Kitchen Manager and reported to the Dietary Manager and Administrator for review. The results of the rounds and the Audit will be shared in the QI meeting Once a month for 3 months. The QI Committee will decide if modifications of the audits need to be made based on trends.	3/2/11 3/4/11 3/2/11 Monthly

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	345119	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/23/2011

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K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 11:30 am onward, the following smoke barrier was observed as noncompliant: specific findings include the smoke wall, across from the kitchen/back entrance had two penetration that was not sealed. In order to maintain the required fire resistance rating of the smoke barrier penetrations must be sealed with approved fire rated caulk. 42 CFR 483.70(a)	K 025	NorthChase Nursing and Rehab Center acknowledges receipt of the Statement of deficiencies and proposes this plan of correction To the extent that the summary of findings is factally correct and in order to maintain compliance with applicapble rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. NorthChase Nursing and Rehab Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, NorthChase Nursing and Rehab Center reserves the right to refute any of the deficiencies on this statement of deficiencies through informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Sherwalt | TITLE: Administrator | (X6) DATE: 4-6-11

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K 056	Continued From page 1 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 11:30 am onward, the following closets was observed as noncompliant: specific findings include: Activity Dept. and Occupational Therapy closet had storage within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 056	K25 The smoke barriers in the attic have been sealed with approved fire rated caulk by facility Maintenance Director. Outside contractors will be supervised by the maintenance director. Regular rounds in the attic will be done by the maintenance department and any issues/findings will be corrected and reported to the quarterly Quality Improvement (QI) meeting.	3/23/11
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 11:30 am onward, the following was observed as noncompliant: specific findings include, resident bedroom and bathroom door had a paper wrap of flammable decoration(311). 42 CFR 483.70(a)	K 073	K 56 The activity and occupational therapy closet were cleaned immediately. No closets will have storage above 18 inches from the sprinkler head. Maintenance and department head rounds will occur daily to ensure that all closets remain in compliance. The issue will be brought to the quarterly Quality Improvement Meeting.	3/23/11
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 11:30 am onward, the following was observed as noncompliant: specific findings include, generator failed to start/crank and transfer power on activation of test. 42 CFR 483.70(a)	K 144	K73 One resident in 311 had decorated her door with a paper wrap. Education has been done with staff, residents and families about appropriate decorations. All decorations will be flame retardant or will be treated with an approved flame retardant solution by maintenance. Rounds will ensure the compliance. The quarterly Quality Improvement Committee will discuss the concern and interventions. K144 Covington Generators came in and corrected the generator to be able to test on a load. Montly load testing will be conducted of the generator by the maintenance man. Any issues will be reported to the Administrator and corrected. The results of the monitoring will be shared with quarterly QI.	3/24/11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 11:30 am onward, the following was observed as noncompliant: specific findings include, resident bedrooms 315 and 321 has objects on overhead light over bed. 42 CFR 483.70(a)	K 147	K 147 Items were found on a light on 100 hall and they were removed immediately. Daily rounds of the halls will monitor the personal belongings of the residents to be sure that they are safely stored. The results of the monitoring will be shared with the quarterly QI committee.	3/24-25, 3/23/11