DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to transfer 1 (Resident #19) of 3 sampled residents using two person assist, resulting in a fall with injury. The findings include: Resident #19 was admitted to the facility on 02/06/03 and was re-admitted on 07/28/05 with multiple diagnoses including Paralysis Agitans, Alzheimer's disease and Panic Disorder. The Minimum Data Set (MDS) assessment dated 07/06/11 indicated that the resident had memory and decision making problems and was dependent on the staff with two person assist for transfer. The care plan for falls dated 08/13/11 was reviewed. The care plan problem was " resident in need of safety monitoring and the provision of a safe environment related to history of falls, use of antidepressant and anti anxiety and hypnotic medications, confusion, poor judgment, history of cerebrovascular accident (CVA) with hemiplegia and behavioral issues ". The goal was " no injury related to falls or accident times three months ". The approaches did not include two	F 323	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiency exists and/or was correctly cited or required correction.** **323** **1. The following was accomplished for resident #19 who was affected by the practice:** Resident # 19 had no significant injury from the fall. The scratch required no treatment and has healed. Resident # 19 is being transferred with the assist of two. **2. The following was accomplished for other residents who may be affected by the practice.** Residents who have been assessed as needing the assist of two for transfers are being transferred by two persons.	10-1-11 10-1-11

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

Christine Parsons Administrator Revised 10-10-11

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 323	Continued From page 1 person assist for transfer. On 09/08/11, new approaches were added to the care plan to include ensure bed and wheelchair wheels locked prior to transfer, ensure proper transfer technique utilized and investigate need for +2 assist for transfer as indicated. Review of the resident care guide revealed under special instruction " two persons assist for transfer " (added on 04/02/11). The rehabilitation referral notes were reviewed. On 04/20/11, physical therapist indicated that Resident #19 needed +2 assist for all transfers due to her behaviors. On 08/24/11, the physical therapist had screened Resident #19 and indicated that she required maximum assist of 2 for some time now for transfers. The nurse's notes and the incident reports were reviewed. The nurse's notes dated 09/04/11 at 8 PM indicated " called to resident room, resident lying on floor by bed, blood on floor, laceration 1.0 x 0.1 cm noted on back of head, right side and swelling noted, no other injury noted ". The notes further indicated ' resident was being transferred from bed to chair and the certified nursing assistant (CNA) fell to the floor ". The incident report dated 09/04/11 indicated " CNA was transferring resident from bed to wheelchair as she turned and started to set resident down in wheelchair, the wheelchair moved, resident and the CNA fell to floor, blood noted in floor, resident noted to have laceration right side back of head with swelling ". On 09/08/11 at 10:24 PM, the administrative staff was interviewed. The administrative staff stated	F 323	These residents care cards and care plans reflect this transfer requirement. The CNAs are provided with assignment sheets at the start of their shift. The assignment sheet has a line item that the CNA must initial to indicate they reviewed the care card for transfer status. **3. The following measures were initiated to ensure that the practice does not reoccur:** The CNA (CNA #1) involved in the situation was disciplined and again in-serviced on the use of Care Cards and the requirement to review care cards of residents on their assignment daily prior to the provision of care. All CNAs were again in-serviced on 9-8-11 on the use of the Care Cards by the DON and the requirement to review care cards of residents on their assignment daily prior to the provision of care.	10-1-11

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UNIVERSAL HEALTH CARE/RAMSEUR	7155 JORDON ROAD RAMSEUR, NC 27316

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F 323	Continued From page 2 that he had investigated the incident by talking to the CNA. The CNA indicated that she locked the wheelchair before the transfer. The administrative staff indicated that he and the maintenance staff member had checked the wheelchair locks and they were in good working condition. He indicated that he did not give any in-service after the fall because the CNA stated that she locked the wheelchair before the transfer. The administrative staff member revealed that he did not know if the resident needed 2 persons assist on transfer. When the care guide was checked, he stated that it was written on the care guide to use 2 persons assist on all transfer. On 09/08/11 at 11:08 AM, NA #1 (nursing assistant) was interviewed. She stated that she was the one who transferred Resident #19 from the bed to the wheelchair when both the resident and she fell to the floor. She stated that she locked the wheelchair before the transfers. She also acknowledged that she transferred the resident by herself. She stated that she was not aware that the resident needed 2 persons assist on all transfer. NA #1 also stated that she did not check the care guide because she was not assigned to the resident that day and that she was just helping other CNAs.	F 323	The CNAs were in-serviced on 9-27-11 by the DON to investigate the transfer status of any resident not on their assignment that they may be required to help prior to transferring the resident. To ensure that CNAs are consistently reminded of the requirement to review care cards of residents on their assignment daily, the assignment sheet now has a line item for CNAs to initial that acknowledges that they have read and will follow the care card instructions. All CNAs were provided with "Outline of a Day" by the DON on 9-21-11 which lists the daily mandatory tasks. This information sheet includes care card review requirements and will also be provided during orientation to new CNAs. The DON or designee will review all daily assignment sheets to ensure that CNAs are complying.	10-1-11
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		

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F 334	Continued From page 3 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	**4. The following monitoring initiatives have been put in place to ensure that the corrective action is achieved and sustained and that the plan is evaluated for its effectiveness:** The DON or nursing designee will randomly observe 3 transfers weekly for four weeks to ensure that the proper method is utilized as stated on the care card. The DON or designee will quiz 3 CNAs, at random, weekly for four weeks regarding transfer techniques required on the care card of specific residents on their assignments. The DON or designee will observe the CNAs at the beginning of their shift at least 3 times weekly for four weeks to ensure that CNAs review their care cards. Observations, quizzes and the observation of CNAs reviewing the care cards will occur on all shifts. The weekend and weekday CNA staff are the same so the audits do not have to be done on weekends.	10-1-11

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F 334	Continued From page 4 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility policy on immunizations and staff interview, the facility failed to provide education regarding risks and benefits of influenza immunization prior to vaccination on 5 (Residents # 1, #49, # 18, #19 & #7) of 5 sampled residents. The findings include: The facility's policy on Immunizations: Influenza (Flu) Vaccination of Residents, Staff and Volunteers (undated) was reviewed. The policy reads in part " Informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination " . 1. Resident # 1 was admitted to the facility on 11/28/06. Review of the immunization record	F 334	Individual in-services/discipline will occur on the spot as needed. Results of these audits will be brought to the QAA meeting monthly by the DON or designee and evaluated by the QAA Committee to determine the effectiveness of the corrective action and the need for continued monitoring. 334 **1. The following was accomplished for the residents affected by the practice:** The Responsible Parties and/or resident s #1, #49, #18, #19 and #7 were provided with education on the potential side effects and benefits of the Influenza immunization and the pneumococcal immunization and that they have the opportunity and right to refuse the immunizations. The information includes both a line item for a consent or a declination for the immunizations and a signature line. This was provided by a mailing on 9-8-11.	10-1-11

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F 334	Continued From page 5 revealed that Resident #1 had received influenza vaccine on 10/13/10. There was no documentation in the record that the responsible party (RP) or the resident was provided education regarding the risks and benefits of influenza immunization prior to vaccination of 10/13/10. On 09/07/11 at 3:45 PM, the staff development coordinator (SDC) and the Minimum Data Set (MDS) nurse were interviewed. They both stated that consent and the education regarding the risks and benefits of the immunizations was only provided to the RP or the resident on admission and not yearly. 2. Resident # 49 was admitted to the facility on 09/11/06. Review of the immunization record revealed that Resident #49 had received influenza vaccine on 10/13/10. There was no documentation in the record that education regarding risks and benefits of influenza immunization was provided to the RP or resident prior to vaccination of 10/13/10. On 09/07/11 at 3:45 PM, the staff development coordinator (SDC) and the Minimum Data Set (MDS) nurse were interviewed. They both stated that consent and the education regarding the risks and benefits of the immunizations was only provided to the RP or the resident on admission and not yearly. 3. Resident #18 was admitted to the facility on 01/05/04. Review of the immunization record	F 334	Discussions with residents who are able regarding the risk/benefits will occur just prior to vaccination and documented. **2. The following was accomplished for residents having the potential to be affected by the practice:** All Responsible Parties and the residents (if appropriate) were provided with education on the potential side effects and benefits of the influenza immunization and that they have the opportunity and right to refuse the immunization. The information includes both a line item for a consent or a declination for the immunizations and a signature line. This was provided by a mailing on 9-8-11. Risk/benefit discussions with residents who are able will occur just prior to vaccinations and documented. **3. The following measures will be put in place to ensure that the practice will not occur:**	10-11-11

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F 334	Continued From page 6 revealed that Resident #18 had received influenza vaccine on 10/13/10. There was no documentation in the record that the RP or the resident was provided education regarding the risks and benefits of the influenza immunization prior to vaccination of 10/13/10. On 09/07/11 at 3:45 PM, the staff development coordinator (SDC) and the Minimum Data Set (MDS) nurse were interviewed. They both stated that consent and the education regarding the risks and benefits of the immunizations was only provided to the RP or the resident on admission and not yearly. 4. Resident #19 was admitted to the facility on 05/30/06. Review of the immunization record revealed that Resident #19 had received influenza vaccine on 10/13/10. There was no documentation in the record that the RP or the resident was provided education regarding risks and benefits of the influenza immunization prior to vaccination of 10/13/10. On 09/07/11 at 3:45 PM, the staff development coordinator (SDC) and the Minimum Data Set (MDS) nurse were interviewed. They both stated that consent and the education regarding the risks and benefits of the immunizations was only provided to the RP or the resident on admission and not yearly. 5. Resident #7 was admitted to the facility on	F 334	The policy on Influenza Vaccination of Residents, Staff and Volunteers has been amended, in part, to read "Informed consent and education regarding the risks and benefits of the vaccination will occur on admission and yearly, thereafter, prior to the vaccination"; a "Vaccination refusal and reasons why will be documented by the facility in the resident's medical record"; and "The risk/benefit education on the signed consent form will serve as evidence that the benefit and risk information and the opportunity to refuse was offered. The most recent signed consent form will be included in the medical record of all residents." The Staff Development Coordinator or designee, who administers the vaccinations, will review , initial and date the Informed Consent Form prior to vaccine administration to ensure that it is in the medical record and is current.	

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F 334	Continued From page 7 03/30/09. Review of the immunization record revealed that Resident #7 had received influenza vaccine on 10/15/10. There was no documentation in the record that the RP or the resident was provided education regarding risks and benefits of the influenza immunization prior to vaccination of 10/15/10. On 09/07/11 at 3:45 PM, the staff development coordinator (SDC) and the Minimum Data Set (MDS) nurse were interviewed. They both stated that consent and the education regarding the risks and benefits of the immunizations was only provided to the RP or the resident on admission and not yearly.	F 334	The Staff Development Coordinator who is solely responsible for the implementation of this policy including providing education, procuring signed consents, administering and documenting per policy was in-serviced by the ADON/Infection Control Nurse on September 9, 2011. **4. The following QA initiatives have been put in place to insure that the corrective action is put in place and sustained:**	10-1-11 10-1-11
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 observation, staff interview and facility policy review the facility failed to 1) thaw poultry in a sanitary manner 2) date opened food containers and discard refrigerated food by its use by date, and 3) clean a nourishment refrigerator.	F 371	The DON or designee will audit the medical record of all residents during the flu vaccination period to ensure that (1) a current informed consent is in place; (2) a resident verbal discussion and informed consent (as appropriate)is in place and documented; (3) vaccine is documented as given per policy in a nursing note; (4) documentation for reason for refusal is documented in the medical record.	

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F 371	Continued From page 8 1 On 9/7/11 at 10:25 AM 7 chicken breasts were observed in a container of still water on the food preparation table. Review of the facility procedure for " Thawing " (undated), provided by the Regional Dietary Consultant revealed: " Thawing: Acceptable methods include: " 1. " Thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross contamination. " 2. " Completely submerging the item under cold water (at a temperature of 70 degrees F or below) that is running fast enough to agitate and float off loose particles. " 3. " Thawing the item in a microwave oven, then cooking and serving it immediately afterward. " 4. " Thawing as part of a continuous cooking process. " On 9/7/11 at 10:26 AM Dietary Aide #1 stated that she had taken the frozen chicken out of the freezer about 10 minutes ago and put it in the water to thaw. She indicated she was thawing the chicken in a container of water because she just needed a small amount for the alternate for lunch that day and it hadn ' t been put in the refrigerator to thaw the day before. On 9/7/11 at 10:27 AM interview with the Assistant Dietary Manager revealed that meats, including poultry products, were typically thawed in the refrigerator but that the other acceptable option was to thaw it under cold running water, in the meat preparation sink. She further stated that Dietary Aide #1 had been trained in the proper procedure for thawing meat and that it was her	F 371	The requirement for a current informed consent for Flu vaccination and a consent for Pneumococcal vaccination to be in the medical record will be added to the QA monthly chart check for all residents to ensure compliance with the plan of correction. This audit will be ongoing. The results of the audits will be brought to the QA Committee for evaluation of the effectiveness of the plan. At that time changes will be made as necessary to ensure that the corrective action is achieved and sustained. 371 **1. The following was accomplished for residents affected by this practice:** The chicken being thawed improperly was discarded. The Cook responsible was in-serviced on acceptable thawing procedures and received disciplinary action.	10-1-11 10-1-11

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F 371	Continued From page 9 expectation that the proper procedure for thawing meat was followed even if only a few pieces of meat need to be thawed. On 9/7/11 at 10:30 AM the Regional Dietary Consultant was interviewed and stated that the chicken should have been thawed in the refrigerator or under cold running water in the meat preparation sink. She also added that it could have been cooked in the oven from a frozen state. She then instructed Dietary Aide #1 to discard the chicken. 2a. On initial tour at 10:30 AM on 9/6/11 the walk in refrigerator was observed to have 3 containers of extra heavy duty mayonnaise that had been previously opened but were not labeled with the date they were opened. One container was almost empty, one had approximately 1/4th of its contents left with a cracked lid, and one container had approximately half of its contents left in the container. There was also a previously opened container of applesauce that was half full that was labeled with an opened date of 6/2/11. Also observed was a bag containing heads of lettuce that had been opened but was undated and a quarter head of lettuce wrapped in plastic wrap and undated. Review of the facility policy for " Date Marking Ready-to-Eat Potentially Hazardous Foods " (undated) provided by the Regional Dietary Consultant revealed, in part: " Label ready-to-eat, potentially hazardous foods; label should include product name, the date and time product is prepared or opened. "	F 371	Outdated and undated food items were immediately removed from the nourishment refrigerator and the kitchen cooler and the nourishment refrigerator was cleaned. Other refrigerator located in the memory unit was checked but no additional problems were noted. **2. The following will be accomplished for other residents who may be affected by the practice.** The dietary staff was in-serviced 9-8-11 and 9-29-11 by Sherry Parson Interim FSD on infection control, proper food handling/thawing procedures, labeling/dating/discard procedures. The nursing staff was in-serviced on 9-21-11 by the DON on the need to date all food items in the nourishment refrigerators/ freezers located in the LTC unit and the Memory Unit and to remind/assist residents and families to do so.	10-1-11

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7186 JORDON ROAD RAMSEUR, NC 27316

(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	Continued From page 10 " Serve or discard all ready-to-eat, potentially hazardous foods within 7 days. " On 9/6/11 at 10:32 AM interview with the Assistant Dietary Manager revealed that the mayonnaise containers and the lettuce should have been labeled with the date they were opened and the ¼ head of lettuce should have been labeled with the date it was used. In addition, she stated that food items were to be discarded 7 days after their opened date or by their expiration date if they have not been opened, although she thought the mayonaise could be kept for 14 days after opening. She further indicated that the apple sauce was overdue to be discarded and there was no way to know when the mayonaise should be discarded since it had not been dated when it was opened. On 9/7/11 interview with the Regional Dietary Consultant revealed that she would expect food items to be labeled with the date they are opened and then discarded 7 days after that date. 2b. On 9/6/11 at 10:45 AM the nourishment refrigerator at the 100/200 hall area was observed. The deli drawer was opened and contained an opened zip top package of dried cranbarries with an opened date of 5/24/11 and a resident name written on it; there was also red liquid inside the package which was not completely closed. Red liquid had seeped out of the bag into the bottom of the deli drawer. There was also a Tupperware type container of spaghetti in this drawer that was not labeled with a resident ' s name or the date it was prepared. The nourishment refrigerator contained an unlabeled bag from McDonalds containing French	F 371	*Staff on 3rd shift was additionally* in-serviced on 9-27-11 by the DON and reminded again that discarding undated food immediately and outdated food within 72 hours or by the "do not use after date and cleaning the refrigerators as needed with soap and water is their responsibility each night. **3. The following measures/systems were put in place to ensure that practice does not occur:** A nursing refrigerator "Daily Cleaning Log" has been developed on which the staff member who cleans the nourishment refrigerators/freezers signs when task completed. The charge nurse checks the refrigerator at the end of the shift and co-signs that the refrigerator is clean and free of outdated and undated food items. This system is ongoing A system requiring each cook to verify the thawing techniques used at each meal has been instituted to ensure that proper thawing methods are used.	10-1-11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7156 JORDON ROAD RAMSEUR, NC 27316

(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	Continued From page 11 fries and chicken nuggets. Also observed was a whipped topping container with a date of 8/29/11 written on it. Inside the container was an unknown food item with a fuzzy white substance on approximately 1/8th of the top of it. Review of the facility policy for " Date Marking Ready-to-Eat Potentially Hazardous Foods " (undated) provided by the Regional Dietary Consultant revealed, in part: " Label ready-to-eat, potentially hazardous foods; label should include product name, the date and time product is prepared or opened. " " Serve or discard all ready-to-eat, potentially hazardous foods within 7 days. " On 9/8/11 at 10 AM the Housekeeping Manager stated that 3rd shift Nursing was responsible for cleaning out the nourishment refrigerators. On 9/8/11 at 10:29 the nourishment refrigerator at the 100/200 hall area was observed. The package of dried cranberries that contained a red liquid and was dated 5/24/11 were still in the deli drawer. The McDonald ' s bag, spaghetti and whipped toping container dated 8/29/11 were no longer in the refrigerator. On 9/8/11 at 11 AM the Director of Nursing (DON) was interviewed and stated that there is a schedule for the 3rd shift Nursing Assistants and one of them is assigned every night to remove expired food items. He stated that he instructs his staff to discard prepared and opened food items 1 day after being opened or prepared but that they must be discarded after 3 days.	F 371	The cook must document on the menu the method used to thaw meat . This system is ongoing. The FSD will monitor for proper technique and verify accuracy of documentation of method used 5 times weekly on an ongoing basis. This audit will become part of Dietary Department's routine QA program. The FSD will monitor for proper dating and storage of food weekly on an ongoing basis. **4. The following monitoring initiatives have been put in place to ensure that the corrective action is achieved and maintained:** The DON or designee and the Administrator will each check the nourishment refrigerator/freezers located in the LTC nourishment room and the Memory Unit Nourishment room 3 times weekly for two weeks and then 2 times weekly for two weeks to ensure that all food is dated, outdated food has been removed and that the surfaces are clean.	10-1-11 10-1-11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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	Continued From page 12 3. On 9/6/11 at 10:45 AM the nourishment refrigerator at the 100/200 hall area was observed to have a thick tan color residue dripped on the bottom areas of the refrigerator near the crispers, there was also red liquid in the bottom of the deli drawer, covering approximately ¼ of the bottom of the drawer. The glass shelves of the refrigerator appeared to be coated with smudges and had a white color film in many areas. On 9/8/11 at 10 AM the Housekeeping Manager stated that 3rd shift Nursing was responsible for cleaning out the nourishment refrigerators. On 9/8/11 at 10:29 the nourishment refrigerator at the 100/200 hall area was observed. The red liquid in the deli drawer had been cleaned up but the package it was dripping from was still present and continued to leak. The thick tan color residue at the bottom of the refrigerator was still present and the glass shelves still appeared unclean. On 9/8/11 at 11 AM the DON was interviewed and stated that there is a schedule for the 3rd shift Nursing Assistants and one of them is assigned every night to remove expired food items. He stated that his staff had not been instructed to clean the nourishment refrigerator as cleaning the refrigerator is the responsibility of Housekeeping.	F 371	A log will be maintained for this audit and results will be reported the QA Committee monthly for evaluation and action as necessary to sustain the corrective action. The FSD/or designee will actively observe and direct, as needed, the use of proper thawing methods for 12 meals weekly for 4 weeks and then 10 meals per week for 2 weeks and document findings on a "Thawing Log". The results of the audit will be reported to the QA Committee monthly for evaluation and action as necessary to achieve and sustain the corrective action. The FSD or designee will monitor/audit for the proper dating of food and discarding of outdated food in coolers 5 times weekly for 4 weeks. The result of this audit will be reported to the QA Committee each month for evaluation and action needed to ensure that the corrective action is achieved and sustained.	10-1-11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING 01 - MAIN BUILDING B. WING _____	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(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
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 10/11/2011 the facility had unsecured oxygen cylinders in the clean linen /utility room across from the nurses station in the special care wing of the building. CFR#: 42 CFR 483.70 (a)	K 076	**Submission of this response to the statement of deficiencies does not constitute an admission that the deficiency exists and/or was correctly cited or required correction.** **1. The following corrective action was accomplished to correct the practice:** The empty oxygen cylinders were immediately removed from the utility room and secured in a rack in a room with a one hour separation. **2. The following was accomplished to identify other life safety issues having the potential to affect residents by the same practice:** All other storage areas for both empty and full oxygen tanks were immediately checked. No other problems were noted. **3. The following measures were put into place to ensure that the practice will not reoccur:** The staff was in-serviced on the correct storage of oxygen tanks, Additional storage racks were purchased and placed in the utility rooms to ensure safe storage of oxygen containers. **4. The following monitors were put in place to ensure that the practice will not recur:** The supply clerk will check the utility rooms five times weekly to insure that adequate racks are available for storage and that oxygen tanks are stored properly. A log will be maintained. The results will be brought to the QA Meeting monthly for evaluation and further action as necessary.	11-4-11 11-4-11 11-4-11 11-4-11

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

Christine Plaumeau | Administrator | 10-28-11

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.