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
	345102	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTON CHRISTIAN CONVALESCENT CTR	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 000	INITIAL COMMENTS Immediate jeopardy began on 2/29/12 when staff failed to cook an unpasteurized shell egg until the egg yolk was congealed, conduct temperature monitoring of the egg and serve the egg promptly after preparation for Resident #4. The administrator was notified of the immediate jeopardy on 3/1/12 . Immediate jeopardy was removed on 3/2/12 when the facility provided and implemented an acceptable credible allegation of compliance.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required under federal and state law.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Silvers	Administrator	3-15-12

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 164	Continued From page 1 release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to cover one (1) of three (3) sampled resident's breasts when incontinence care was provided. (Resident #57) The findings are: Resident #57 had diagnoses which included vascular dementia with depressed mood. Review of the annual Minimum Data Set dated 09/20/11 assessed the resident as being severely impaired in making daily decisions, as needing extensive assistance with ADL (Activities of Daily Living) and always incontinent of bowel and bladder. Review of the Resident #57's care plan updated 12/22/11 included interventions to assist the resident as needed due to decline in self care ability. Observations on 03/01/12 from 07:55 AM through 8:05 AM revealed Resident #57 being assisted with morning care. NA #1 assisted the resident wash her face and hands. After the resident's face and hands were washed, NA#2 removed the resident's gown leaving the resident's upper body and breasts exposed. NA #2 proceeded to remove a soiled incontinent brief and provide incontinent care. The resident's upper body was left completely exposed during the entire procedure. At 8:05 AM the resident was dressed	F 164	The door to the resident room was closed with no other resident in the room and the privacy curtain pulled and the resident was draped and dressed appropriate, a sweater was placed on the resident and she was placed in the chair. Resident # 57 is being draped to provide modesty during incontinence care. Any resident acquiring incontinence care can be affected by this practice. Therefore, Licensed Staff and C.N.A.'s were in serviced on 3/7/12, 3/8/12, and 3/9/12 by the RN Supervisor and the SDC, regarding maintaining dignity and privacy during incontinence care. The facility has initiated a QA Audit tool that has been implemented regarding privacy during care. The administrative nursing staff, (QA Nurse, RN Supervisor, SDC and MDS Coordinator) will observe and record privacy during care. The tool will be completed 5 times a week x 1 month and then 3 x a week for 1 month. Any staff not in compliance with providing privacy and dignity during incontinence care will be educated and/or counseled and continued non-compliance can lead to termination. The administrative nurse will be responsible for addressing any privacy issues and staff education will begin immediately. The audits will be forwarded to the Director of Nursing Services for her review each day and the Director of Nursing Services and the Director of Nursing will provide the results of the QA Audit Results to the Quality Assurance Team x 3 months.	3-28-12

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F 164	Continued From page 2 and transferred to a chair. During the transfer process the resident stated, " I am cold." During an interview on 03/01/12 at 08:07 AM, NA #2 stated she should have kept Resident #57 covered during the incontinence care and did not know why she had left the resident's upper body uncovered. During an interview on 03/01/12 at 10:15 AM, NA #1 stated she had been trained to keep residents covered during care and should have covered the resident or at least left her gown on while providing incontinence care. NA #1 stated she did not know why she had not covered Resident #57 earlier. During an interview on 03/01/12 at 3:00 PM, the Director of Nursing stated she expected staff to keep a resident's body covered during care except for the part of the body being washed.	F 164		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to position two (2) of six (6) sampled residents with supportive devices.	F 309		

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F 309	Continued From page 3 (Residents #32 & #57). The findings are: 1. Resident #32 was admitted with abnormal gait, osteoporosis, esophageal reflux, macular degeneration and congestive heart failure. On 10/13/11 a physician order included Resident #32 was to be out of bed in recliner with positioning devices as tolerated. Resident #32's annual Minimum Data Set (MDS) dated 11/22/11 coded her with long and short term memory impairment and severely impaired decision making skills. She was coded as requiring extensive assistance for bed mobility and transfers, was nonambulatory and had functional impairment for range of motion on both upper extremities. Regarding balance during transitions, Resident #32 was not steady and only able to stabilize during transfer to a wheelchair with human assistance. The Care Area Assessment summary (CAAs) dated 12/6/11 assessed Resident #32 as having behaviors and being resistive to care daily with very fragile skin. The Activities of Daily Living Skills current care plan updated 1/10/12 revealed Resident #32 was changed from a rock and go wheelchair to a recliner. Her care plan which addressed fragile skin and need to be assisted with positioning, updated 2/21/12, included the interventions to reposition frequently as needed to promote comfort and maintain skin integrity and to use positioning devices in bed and recliner.	F 309		

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F 309	Continued From page 4 Resident #32 was observed on 2/29/12 at 8:00 AM, up in the assisted feeding room in the recliner leaning to the right with no bolsters or positioning device in place. At 8:44 AM a pillow was placed under her right arm. She remained leaning to the right. On 2/29/12 at 9:16 AM she was in her room in the recliner, pillow under her right arm and she was leaning to the right. A bolster positioning device was observed on the resident's bed. On 2/29/12 at 11:47 AM Resident #32 was transferred to the recliner by Nurse Aide #5 and another nurse aide. No bolster or pillow was placed in the wheelchair with the resident. The bolster was observed on the resident's bed. At 12:04 PM, Resident #32 was taken to the dining room for the noon meal. No positioning device was in place and she was leaning to the right. At 12:23 PM, Resident #32 was being fed and she was observed leaning to the right. Interview with NA #5 on 3/1/12 at 9:57 AM revealed bolsters are put into place when Resident #32 leans to the right. NA #5 stated she often does not need them. On 3/1/12 at 10:00 AM Licensed Nurse (LN) #1 stated nurse aides knew what each resident's individual needs are by the information posted inside the closet door. On 3/1/12 at 10:40 AM, the staff development coordinator stated nurse aides knew what to do via the information on the ADL status sheets inside the resident's closet door. Interview with the Assistant Director of Nursing on 3/1/12 at 11:35 AM revealed Resident #32 used	F 309		

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F 309	Continued From page 5 to scoot and slide in the recliner and the bolsters helped position her. ADON stated she does not always need the bolsters. Review of the information inside Resident #32's door revealed it had no information regarding the use of bolsters or positioning devices. 2. Resident #57 had diagnoses which included vascular dementia with depressed mood, muscle weakness and unsteady gait. Review of the annual Minimum Data Set dated 09/20/11 assessed the resident as being severely impaired in making daily decisions and as needing extensive assistance with ADL (Activities of Daily Living). Review of the Resident #57's care plan updated 02/10/12 focused on potential for decline in bed mobility and self care ability. Interventions included assisting Resident #57 with ADLs as needed, assist up in recliner or Rock-N-Go chair daily and back to bed for rest periods as indicated. The care plan was revised on 02/20/12 and indicated the resident could be left up in the Rock-N-go chair for meals for her comfort. Observations on 02/27/12 at 5:19 PM revealed Resident #57 sitting in her in room in the Rock-N-Go chair. The resident's feet were dangling from the chair with no foot rest or support noted. Observations on 02/27/12 at 5:35 PM revealed the resident in the dining room in the Rock-N-Go chair with feet still dangling, no support or foot rest noted.	F 309		

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F 309	Continued From page 6 Observations on 02/28/12 at 8 AM revealed Resident #57 in the TV room sitting in the Rock-N-Go chair with her feet dangling, no support or foot rest noted. Observations on 02/28/12 at 4:15 PM revealed the resident sitting in the hallway in the Rock-N-Go chair with her feet dangling, no support or foot rest noted. The resident was saying "push me, push me." Observations on 02/29/12 at 07:50 AM revealed Resident #57 sitting in the TV room in Rock-N-Go chair with her feet dangling, no support or foot rest noted. Staff was observed staff taking resident into dining room at 8 AM and placed her at the table. Her feet continued to dangle with no foot rest or support noted. Observations on 02/29/12 at 11:50 AM revealed Resident #57 in the dining room seated in the Rock-N-Go chair with her feet dangling, no support or foot rest noted. During an interview on 02/29/12 at 4:30 PM, Restorative NA #3 stated Resident # 57 should have foot rests on her Rock-N-Go chair for comfort and support. NA #3 proceeded to look in the resident's room for foot rests but none were found. During an interview on 02/29/12 at 4:35 PM Physical Therapist (PT) #1 stated if staff had problems with any resident's positioning that a referral would be made for a therapy screening. PT #1 stated she did not recall whether Resident #57 had foot rests on her chair but stated any time a special chair was used to make a resident	F 309	Residents #32 and #57 are being positioned and provided supportive devices per physicians order and plan of care. Resident #32 Care Plan has been updated to reflect Resident's choice of attire during episodes of being hot., family has been notified to bring a choice of clothing. An order for the Rock-n-Go foot rest has been placed by Central Supply on 3/9/12for Resident #57. In the interim , therapy will be consulted for recommendations for a temporary foot support until the foot rest arrives. The Resident Status Sheet (RSS) for resident's #32 and resident #57 was reviewed and updated by the RN Supervisor on 2/29/12 to reflect the current needs of the residents. Any resident requiring positioning and supportive devices can be affected by this practice. Therefore, the RN Supervisor audited and reviewed the resident status sheets and updated them to reflect the resident's current positioning needs on 3/5/12. The resident status sheet will reflect the current Care Plan regarding positioning and assistive devices, was completed by the RN Supervisor on 3/5/12. Resident's Status Sheets (RSS) have been audited by the RN Supervisor to ensure they reflect the current needs of each resident. The licensed staff and C.N.A's were in-serviced on 3/7/12, 3/8/12 and 3/9/12 by the RN Supervisor and the SDC regarding using the resident status work sheet as a reference for identifying the residents need for positioning and assistive devices.	

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F 309	Continued From page 7 more comfortable or safe, foot rest should be used for comfort and support. Observations on 02/29/12 at 4:45 PM revealed NA #4 took the resident while seated in the Rock-N-Go chair into the dining room with her feet dangling, no support or foot rest noted. At this time NA #4 stated she did not know if the resident had foot rests for the Rock-N-Go chair. NA #4 stated she thought the resident may have some foot rests somewhere but did not know if they were ever used. Observations on 03/01/12 at 8:05 AM revealed Resident #57 being transferred from bed to the Rock-N-Go chair. NA #1 stated the resident had never had foot rests to her knowledge. NA #1 proceeded to take the resident into the dining room with no foot rests on the chair and the resident's feet dangling. During an interview on 03/01/12 at 10 AM, the ADON (Assistance Director of Nursing) stated all residents who sat up in a chair should have foot rests if their feet did not touch the floor. The ADON stated she did not know why Resident #57 did not have foot rests in place.	F 309	The RN Supervisor will update the resident status sheet weekly on Friday as well as make any changes to the list of positioning/assistive devices that are in front of the Residents MAR. The facility has initiated a QA Audit tool that has been implemented regarding positioning/assistive devices. The administrative nursing staff, (QA Nurse, RN Supervisor, SDC and MDS Coordinator) will observe and record positioning/assistive devices. The tool will be completed 5 times a week x 1 month and then 3 x week for 1 month. Any staff not in compliance with providing positioning devices will be educated and/or counseled and continued non-compliance can lead to termination.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	The administrative nurse will be responsible for addressing any positioning/assistive device issues and staff education will begin immediately. The audits will be forwarded to the Director of Nursing Services for her review each day and the Director of Nursing Services and the Director of Nursing will provide the results of the QA Audit Results to the Quality Assurance Team x 3 months.	3-28-12

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F 312	Continued From page 8 by: Based on observation, record review and staff interview the facility staff failed to rinse soap from one (1) resident's skin for one (1) of one (1) sampled resident observed during bathing. (Resident #38). The findings are: Resident #38 was admitted on 11/22/11 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, vascular dementia, chronic kidney disease and transient cerebral ischemia. The most recent Minimum Data Set (MDS), a quarterly assessment dated 12/20/11, indicated the resident required extensive assistance of two or more staff with bed mobility, transfers and toileting, required extensive assistance of one staff with dressing, eating and hygiene and was totally dependent on one staff for bathing. An observation was made on 3/1/12 from 9:45 AM - 10:45 AM of Nursing Assistant (NA) #8 and NA #9 providing a bed bath for Resident #38. NA #8 washed the resident's right shoulder and arm using bar soap which was rubbed on a wet washcloth. NA #8 then patted Resident # 38's skin dry with a towel. NA #8 did not rinse the soap off the resident's skin before patting it dry. NA #8 and NA #9 then moved Resident #38 onto her right side. NA #9 washed the resident's left arm, back and buttocks using bar soap which was rubbed on a wet washcloth. NA #9 then patted Resident #38's skin dry with a towel. NA #9 did not rinse the soap off the resident's skin before patting it dry. Resident requested lotion be put on her back and NA #9 applied lotion to her back.	F 312	Resident # 38 is being bathed with dial soap as per her request and rinsed. Nursing Assistants #8 and #9 were counseled on 3/7/12 by The Director of Nursing Services regarding the importance of rinsing after bathing residents with bar soap or other soap that requires rinsing. Any resident requesting no-rinse soap can be affected by this practice . Therefore, an in service was done on 3/7/12, 3/8/12, and 3/9/12 by the RN Supervisor and SDC regarding the importance of rinsing residents that use bar soap or soap brought from outside the facility requiring rinsing. The facility utilizes non-rinse soap for all residents that do not request bar soap and non-rinse soap is utilized for community baths and showers. The facility has initiated a QA Audit tool that has been implemented regarding baths followed by rinsing during care as applicable. The administrative nursing staff, (QA Nurse, RN Supervisor, SDC and MDS Coordinator) will observe and record bathing technique to include rinsing during care. The tool will be completed 5 times a week x 1 month and then 3 x week for 1 month. Any staff not in compliance with providing proper rinsing techniques during care will be educated and/or counseled and continued non-compliance can lead to termination.	

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F 312	Continued From page 9 In an interview on 3/1/12 at 10:28 AM, NA #8 acknowledged that she did not rinse the resident after washing her. She stated she usually uses rinse-free soap and forgot to rinse Resident #38 after using the bar soap. In an interview on 3/1/12 at 10:30 AM, NA #9 acknowledged that she did not rinse the resident after washing her. She stated she got nervous and forgot to rinse her. In an interview on 3/1/12 at 5:08 PM with the Director of Nursing (DON), the DON stated she expected residents who are not washed with rinse-free soap to be rinsed after bathing.	F 312	The administrative nurse will be responsible for addressing any rinsing issues and staff education will begin immediately. The audits will be forwarded to the Director of Nursing Services for her review each day and the Director of Nursing Services and the Director of Nursing will provide the results of the QA Audit Results to the Quality Assurance Team x 3 months.	3-28-12
F 323 SS=D	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 observations, record review and staff interviews, the facility failed to protect the skin integrity by providing long sleeves, pants and skin sleeves for one (1) of three (3) sampled residents and use safe transfer techniques by locking the gerichair for one (1) of four (4) sampled residents. Resident #32.	F 323		

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F 323	Continued From page 10 The findings are: 1. Resident #32 was admitted with abnormal gait, osteoporosis, esophageal reflux, macular degeneration and congestive heart failure. Review of the Treatment Administration Records (TARs) starting in July 2011 through February 2012 revealed Resident #32 was to wear skin sleeves to bilateral forearms when out of bed. Review of these TARs revealed Resident #32 received treatments as follows: *7/12/11 through 7/18/11 to skin tear on right hand; *8/23/11 through 9/31/11 to two small abrasions on left shin; *10/12/11 through 11/1/11 to skin tear on right elbow and abrasion right lower extremity; Review of the incident report dated 10/12/11 noted a 3 cm x 1.5 cm skin tear. It was unknown if skin sleeves were in place. The note continued that it was assumed skin sleeves were in place and staff should be aware resident can be combative during care. She may also unknowingly self inflict skin injury. Resident #32's annual Minimum Data Set (MDS) dated 11/22/11 coded her with long and short term memory impairment and severely impaired decision making skills. She was coded as requiring extensive assistance for bed mobility, hygiene, dressing and transfers, was nonambulatory, and had functional impairment for range of motion on both upper extremities. Regarding balance during transitions, Resident #32 was not steady and only able to stabilize during transfer to a wheelchair with human	F 323		

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F 323	Continued From page 11 assistance. The Care Area Assessment summary (CAAs) dated 12/6/11 assessed Resident #32 as having behaviors and being resistive to care daily with very fragile skin. Resident #32's care plan, last updated 2/21/12 which addressed her very fragile skin, combative behaviors and ability to self inflict injury included the interventions to dress in pants and long sleeve shirts when possible when out of bed and to apply skin sleeves when up. Ongoing review of the TARs, physician orders and nursing notes revealed Resident #32 received treatments: *12/10/11 through 1/22/12 to skin tear on right lower extremity; *2/3/12 treatment to skin tear to 2nd finger; *2/10/12 skin tear to right lower extremity; *2/10/12 skin tear to right hand after hitting and scratching staff during care. *2/16/12 skin tear to a 3 cm x 1.5 cm upper outer arm received during a transfer. Nursing notes dated 2/16/12 revealed skin sleeves were in place but below the skin tear. On 2/28/12 at 8:39 AM, Resident #32 was observed with skin sleeves in place and long sleeved shirt. She was observed to have a bandage on her right shin a bandage on her upper right arm. On 2/29/12 at 8:00 AM, Resident #32 was in the dining room, in her recliner wearing a short sleeved shirt and crop pants. She was observed with a bandage on her right shin and a	F 323		

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F 323	Continued From page 12	F 323		

transparent dressing on her right upper arm. No skin sleeves were in place. She remained dressed without skin sleeves on 2/29/12 at 8:44 AM, 9:16 AM, while in her room, at 11:47 AM after being transferred from bed to the recliner, and at 12:23 PM while being fed in the dining room.

On 2/29/12 at 2:57 PM interview with Nurse Aide #5 revealed she dressed Resident #32 this morning. She stated she knew what residents' individual needs are because she worked this resident's hall regularly. She also stated she obtained information from other nurse aides and the nurses.

Resident #32 remained with short sleeves, crop pants and no skin sleeves on 2/29/12 at 4:18 PM while in the resident lounge and on 2/29/12 at 5:04 PM while in the dining room. On 3/1/12 at 7:22 AM while in her room, Resident #32 again had a short sleeved shirt on and no skin sleeves in place. She was observed scratching her right upper arm. She was also observed with a short sleeved shirt and no skin sleeves on 3/1/12 at 8:09 AM while in the dining room, and on 3/1/12 at 9:18 AM while in her room.

Review of the TARs revealed as of 2/29/12 at 3:40 PM the skin sleeves were not signed off as being in place. On 3/1/12 at 8:10 AM the skin sleeves were signed off as being applied on 2/29/12 during the 7a-7p and 7p-7a shift.

On 3/1/12 at 9:57 AM, Nurse Aide (NA) #5 could not be specific when Resident #32 should wear skin sleeves. She stated "it depends" and "if she needs them." When asked to clarify, NA #5

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F 323	Continued From page 13 stated when Resident #2 grabs at staff On 3/1/12 at 10 AM, Licensed Nurse #1 stated Resident #32 should have skin sleeves on whenever she is out of bed. LN #1 further stated nurse aides knew what each individual resident needed by the information posted inside the closet door. She offered no comment regarding the skin sleeves being signed off on the TAR for 2/29/12. Observation of the care card in Resident #32's closet revealed, skin sleeves should be worn when out of bed. On 3/1/12 at 10:40 AM, the staff development coordinator stated Resident #32 should have had on skin sleeves. On 3/1/12 at 11:19 AM, the Assistant Director of Nursing (ADON) stated Resident #32 should have skin sleeves on when ever out of bed which was on the ADL care information in the resident's closet. On 3/1/12 at 3:15 PM, the Director of Nursing and Administrator stated NA #5 was new and still learning. 2. Resident #32 was admitted with abnormal gait, osteoporosis, esophageal reflux, macular degeneration and congestive heart failure. Resident #32's annual Minimum Data Set (MDS) dated 11/22/11 coded her with long and short term memory impairment and severely impaired decision making skills. She was coded as requiring extensive assistance for bed mobility,	F 323	Residents #32 and #57 are being positioned and provided supportive devices per physicians order and plan of care. Resident #57 Care Plan has been updated to reflect Resident's choice of attire during episodes of being hot., family has been notified to bring a choice of clothing. An order for the Rock-n-Go foot rest has been placed by Central Supply on 3/9/12. The Resident Status Sheet (RSS) for resident's #32 and resident #57 was reviewed and updated by the RN Supervisor on 2/29/12 to reflect the current needs of the residents. Any resident requiring positioning and supportive devices can be affected by this practice. Therefore, the RN Supervisor audited and reviewed the resident status sheets and updated them to reflect the resident's current positioning needs on 3/5/12. The resident status sheet will reflect the current Care Plan regarding positioning and assistive devices, was completed by the RN Supervisor on 3/5/12. Resident's Status Sheets (RSS) have been audited by the RN Supervisor to ensure they reflect the current needs of each resident. The licensed staff and C.N.A's were in-serviced on 3/7/12, 3/8/12 and 3/9/12 by the RN Supervisor and the SDC regarding using the resident status work sheet as a reference for identifying the residents need for positioning and assistive devices. The RN Supervisor will update the resident status sheet weekly on Friday as well as make any changes to the list of positioning/assistive	

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F 323	Continued From page 14 hygiene, dressing and transfers, was nonambulatory, and had functional impairment for range of motion on both upper extremities. Regarding balance during transitions, Resident #32 was not steady and only able to stabilize during transfer to a wheelchair with human assistance. The care plan updated 2/21/12 which addressed Resident #32's risk of fall due to need for assist with all transfers included the intervention of "two staff assist with all transfers. May use Hoyer lift." On 2/29/12 at 11:52 AM, Nurse Aides (NA) #5 and #6 were observed transferring Resident #32 from bed to the gerichair/recliner. A gait belt was applied to Resident #32 and NA #5 told NA #6 to make sure the gerichair was locked. NA #6 adjusted the gerichair mechanism. Resident #32 was very drowsy and during the transfer she did not bear weight. With the NAs on each side of her, Resident #32 was lifted and pivoted. When the resident was sat down in the chair, the gerichair slid backward and NA #6 had to catch the chair from sliding out from under the resident. After the transfer, NA #6 was asked about the gerichair locking and he replied things just happen. No further explanation was provided. On 2/29/12 at 2:57 PM, NA #5 stated she had no trouble locking her side of the gerichair and could not say what happened with the other side of the gerichair that caused it to move during the transfer. On 3/1/12 at 11:19 AM, the Assistant Director of Nursing revealed the nurse aides should have made sure the gerichair was locked prior to	F 323	The administrative nursing staff, (QA Nurse, RN Supervisor, SDC and MDS Coordinator) will observe and record Geri-Sleeves. The tool will be completed 5 times a week x 1 month and then 3 x week for 1 month. Any staff not in compliance with providing positioning devices will be educated and/or counseled non-compliance can lead to termination. The administrative nurse will be responsible for addressing any Geri-Sleeves issues and staff re-education will begin immediately. The audits will be forwarded to the Director of Nursing Services for her review each day and the Director of Nursing Services will provide the results of the QA Audit to the Quality Assurance Team x 3 months.	3-28-12

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F 323	Continued From page 15 transferring Resident #32.	F 323		
F 371 SS=K	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, staff interviews, facility record review and manufacturer's instructions, the facility failed to use pasteurized eggs to prepare eggs cook-to-order and conduct temperature monitoring of unpasteurized shell eggs, for 12 of 12 sampled residents who routinely requested and were served eggs cook-to-order (Residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, and 89). Additionally, the facility failed to serve milk that was within the manufacturer's date of expiration, wear hair restraints to contain exposed hair during food preparation, and store sausage patties under refrigeration in an enclosed container. Immediate jeopardy began on 2/29/12 when the facility failed to cook an unpasteurized shell egg until the egg yolk was congealed, conduct temperature monitoring of the egg and serve the egg promptly after preparation for Resident #4. Immediate jeopardy was removed on 3/2/12	F 371		

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F 371	Continued From page 16 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring of the revised food preparation systems put in place. The findings are: 1. An observation of the breakfast tray line occurred on 2/29/12 at 7:56 AM. On 2/29/12 at 8:03 AM, Dietary staff #2 was observed to crack the shell of five eggs and placed each egg in the same frying pan to cook the eggs to order for residents. Dietary staff #2 was observed at 8:05 AM to remove the cook-to-order shell eggs from the pan and placed each egg into an individual insulted bowl with a lid. The five bowls with shell eggs were stored on top of existing pans of food on the tray line. Temperature monitoring of the cook-to-order shell eggs was not observed before the eggs were placed on the steam table. At 8:09 AM one of the cook-to-order shell eggs was observed placed on the meal tray for Resident #4. The tray was placed on a cart for delivery. Upon request, temperature monitoring was conducted on 2/29/12 at 8:10 AM by Dietary staff #1 using the facility's calibrated thermometer. The temperature of the cook-to-order shell egg for Resident #4 was 115 degrees Fahrenheit and the yolk was not congealed. Dietary staff #1 stated during temperature monitoring that it was hard to keep the cook-to-order shell eggs hot. Dietary staff #2 stated on 2/29/12 at 8:11 AM that	F 371	Pasteurized eggs were purchased on 3/1/12 for Residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89, who request shell eggs cooked to order. Pasteurized eggs will be used for any resident requesting cooked to order shell eggs. The Monthly Infection Control log has been reviewed by The Director of Nursing Services on 3/1/12 at 8:15 pm for the past six months and no infections were documented relating to cook to order eggs for residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89. The attending physician examined residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89 who received soft eggs and found there are no signs and symptoms of food borne pathogens. The Dietary Manager was in serviced on 3/1/12 at 7:00 pm by the Administrator concerning the use of pasteurized eggs used for cooked to order shell eggs and checking the temperature of cooked egg. Any resident has the potential to be affected by improperly cooked eggs. Any resident who request cooked to order eggs, pasteurized eggs will be used and provided to the resident as requested.	

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F 371	Continued From page 17 she was trained to pan-fry shell eggs to order until the white of the egg was done, and the yolk was not "runny". She further stated that she had not been trained to check the egg temperature before the eggs were served and confirmed that she did not check the temperature of the five cook-to-order shell eggs when she prepared them. Dietary staff #2 was observed to discard the five cook-to-order shell eggs that were placed on the steam table. On 2/29/12 at 9:10 AM, a cardboard box of shell eggs was observed in the walk-in refrigerator with a USDA inspection seal stamped on the box which included the following manufacturer instructions: "Safe handling instructions to prevent illness from bacteria: keep eggs refrigerated, cook eggs until yolks are firm and cook foods containing eggs thoroughly. Hold hot egg dishes above 140 degrees Fahrenheit." On 2/29/12 at 9:12 AM the Dietary Manager (DM) was interviewed and stated that she thought that the shell eggs were not pasteurized, but that she would verify that to be sure. She further stated on 2/29/12 at 9:20 AM that to her knowledge the practice of using unpasteurized shell eggs to prepare eggs cook-to order had been ongoing since April 2011. The DM stated that she expected staff to conduct temperature monitoring of cook-to-order shell eggs before the eggs were served, to cook the eggs to 165 degrees Fahrenheit and hold the eggs at least 140 degrees. The DM also stated that she had not provided the dietary staff an in-service on how to prepare shell eggs to order for residents. The DM also stated that she was not sure if dietary staff #2 had received instruction on how to prepare	F 371	Allll newly hired dietary employees will be in-serviced by the Dietary Manager during orientation on the proper cooking of eggs and identification and storage of pasteurized and non-pasteurized eggs. Audits tools have been put in place on 3/2/12 and will be performed by the Dietary Manager/ Head Cook and the Quality Assurance Nurse seven times a week x 4 weeks, five times a week for 4 weeks and two times a week bi-weekly x 3 months to ensure that the cited practice does not reoccur auditing the staffs knowledge of storage of eggs, preparation of eggs, identification and labeling of eggs and proper temperatures of eggs. This tool will monitor for the use of pasteurized eggs for cooked to order shell and monitoring of temperatures of the non-pasteurized eggs. A policy was developed on 3/1/12 by the Administrator and implemented on 3/2/12 by the Administrator stating the correct temperatures for cooking non-pasteurized eggs, proper storage and identification of eggs and temperature monitoring. The Dietary Manager will be responsible for ensuring compliance and reporting findings to the QA committee monthly beginning 3/2/12 Any staff person found out of compliance with the policy will be given written counseling by the Dietary Manager. The QA Committee will review the finding of completed audits monthly to identify any non-compliance and implement immediate corrective action as needed.	3-2-12

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F 371	Continued From page 18 cook-to-order shell eggs safely. On 2/29/12 at 2:09 PM the Consulting Registered Dietitian (RD) was interviewed via phone. The RD stated her primary role for the facility was to provide clinical support, but that she also observed the food served to residents, tasted the food and walked through the kitchen during her visits. She confirmed that each shell egg cooked to order should be monitored for temperature prior to service and served immediately. On 3/1/12 at 3:37 PM a follow-up interview was conducted with the DM. The DM confirmed that the shell eggs used to prepare cook-to-order eggs were not pasteurized. The DM stated that she did not know it was a problem to serve residents cook-to-order eggs using unpasteurized shell eggs if the yolk was not congealed. The DM stated there were additional Residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, and 89 who also requested cook-to-order shell eggs, as often as daily to twice weekly. The DM stated that cook-to-order shell eggs were not served to residents the morning of 3/1/12 and would not be served until the facility could purchase pasteurized eggs. The DM stated that she had not discussed with the RD that unpasteurized shell eggs were used for cook-to-order eggs for residents who requested them. On 3/1/12 at 6:30 PM the administrator was notified of the immediate jeopardy. The facility provided a credible allegation of compliance which included: Corrected Action to be accomplished for each resident found to have been affected by the	F 371		

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F 371	Continued From page 19 deficient practice. Pasteurized eggs were purchased on 3/1/12 for Residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89, who request shell eggs cooked to order. Pasteurized eggs will be used for any resident requesting cooked to order shell eggs. The Monthly Infection Control log has been reviewed by The Director of Nursing Services on 3/1/12 at 8:15 PM for the past six months and no infections were documented relating to cook to order eggs for residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89. The attending physician examined residents #1, 4, 11, 17, 27, 35, 43, 48, 50, 53, 77, 89 who received soft eggs and found there are no signs and symptoms of food borne pathogens. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. The Dietary Manager was in serviced on 3/1/12 at 7:00 PM by the Administrator concerning the use of pasteurized eggs used for cooked to order shell eggs and checking the temperature of cooked egg. Any resident has the potential to be affected by improperly cooked eggs. Any resident who request cooked to order eggs, pasteurized eggs will be used and provided to the resident as requested. Monitoring of compliance All newly hired dietary employees will be in-serviced by the Dietary Manager during orientation on the proper cooking of eggs and identification and storage of pasteurized and non-pasteurized eggs. Audits tools have been put in place on 3/2/12 and will be performed by the Dietary Manager/ Head Cook and the Quality Assurance Nurse seven	F 371	No resident was named in this citation. The dietary employees adjusted their hairnets immediately on 2/29/12 to prevent hair around neck, ears and front from escaping from the hairnet. The milk was removed from the delivery cart and the milk cooler on 2/29/12 by the Dietary Manager and Admissions Coordinator prior to any resident receiving it. The sausage was removed from the freezer and the packaging was closed tighter to prevent exposure to air by the Dietary Manager on2/27/12. Any resident has the potential to be affected by this practice, therefore, the Dietary employees were in-serviced on 3/5/12 by the Dietary Manager concerning the proper use of hairnets to prevent hair from being exposed. The facility purchased different styles of hairnets as well as clips to prevent hairnets from slipping and exposing hair. All dietary employees were in-serviced on 3/5/12 by the Dietary Manager concerning the proper storage of foods and ensuring the packaging is properly closed to prevent the product from being exposed to air. All dietary employees were in-serviced on 3/5/12 by the Dietary Manager concerning the monitoring of the milk cooler to prevent outdated milk from being placed in the cooler or being left in the milk cooler.	3-28-12

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F 371	Continued From page 20 times a week x 4 weeks, five times a week for 4 weeks and two times a week bi-weekly x 3 months to ensure that the cited practice does not reoccur auditing the staffs knowledge of storage of eggs, preparation of eggs, identification and labeling of eggs and proper temperatures of eggs. This tool will monitor for the use of pasteurized eggs for cooked to order shell and monitoring of temperatures of the non-pasteurized eggs. A policy was developed on 3/1/12 by the Administrator and implemented on 3/2/12 by the Administrator stating the correct temperatures for cooking non-pasteurized eggs, proper storage and identification of eggs and temperature monitoring. Quality Assurance The Dietary Manager will be responsible for ensuring compliance and reporting findings to the QA committee monthly beginning 3/2/12 Any staff person found out of compliance with the policy will be given written counseling by the Dietary Manager. The QA Committee will review the finding of completed audits monthly to identify any non-compliance and implement immediate corrective action as needed. The immediate jeopardy was removed on 3/2/12 at 5:41 PM following interviews with dietary staff on both shifts related to education on egg preparation, storage and temperature monitoring. The walk-in refrigerator was observed on 3/2/12 at 3:40 PM with pasteurized and unpasteurized shell eggs available for use. The eggs were stored separately, on the bottom shelf and labeled with a sign for identification. Documentation was reviewed regarding staff in-services related to the preparation, storage and	F 371	All dietary employees will wear their hairnet in a manner that will cover all of their hair. The facility has purchased different styles of hairnets and clips to prevent hair from slipping out. The Cooks are responsible for checking the milk delivery on Monday, Wednesday and Friday to ensure that no outdated milk is placed in the cooler upon delivery, correcting any non-compliance immediately and document findings on an audit tool. If the milk is found to be outdated, the milk will be removed and returned to the delivery man and the Administrator immediately. The Cooks are responsible for monitoring the cooler daily and ensuring that the food is covered appropriately. Any non-compliance will be documented and the results of the audits will be given to the Administrator. The Dietary Manager and/or Administrator will review the audit sheets daily to ensure continued compliance. These audits will be continued for 3 months. Any staff person found to be out of compliance with the proper techniques of wearing an appropriate hairnet will be educated and/or counseled and continued non-compliance can lead to termination. The Administrator and/or Dietary Manager will bring the dietary audits to the QA Committee will review the findings of completed audits monthly to identify any non-compliance and implement immediate corrective action as needed.	3-28-12

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F 371	Continued From page 21 temperature monitoring of pasteurized and unpasteurized shell eggs and facility monitoring. The facility provided a copy of a revised policy, Safe Serving of Food, dated 3/2/12 which was reviewed. 2. A kitchen observation occurred on 2/27/12 and a follow-up observation occurred on 2/29/12. The following concerns were identified regarding food storage, hair nets and expired foods. A. On 2/27/12 at 2:35 PM the walk-in refrigerator was observed with a case of breakfast sausage stored on a utility cart in a cardboard box. The box was closed with approximately a 2 inch gap. The sausage was stored inside a plastic bag that was open to air. On 2/27/12 at 2:39 PM, the dietary manager (DM) stated that the sausage was used for breakfast that morning and should be stored in a closed container. She was observed to remove the sausage from refrigeration and instructed staff to secure the sausage in a closed container. B. On 2/29/12 at 7:56 AM, dietary staff #1 was observed plating food for the breakfast tray line and at 9:36 AM dietary staff #1 was observed preparing vegetables for lunch. During each observation dietary staff #1 wore a hair net that left her bangs, sides and back of her hair exposed. On 2/29/12 at 9:36 AM dietary staff #1 stated she was instructed that ninety percent of hair should be covered and that it was okay to have the front of her hair uncovered as long as hair was not hanging down in her face. She further stated that she did not realize that hair net was not covering the front part of her hair. C. On 2/29/12 at 7:59 AM, the DM was observed pouring coffee and wearing a hair net that left the hair hanging on her forehead exposed. On	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING _____ B. WING _____	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTON CHRISTIAN CONVALESCENT CTR	75 FISHER LOOP MAGGIE VALLEY, NC 28751

(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 22 2/29/12 at 9:45 AM the DM stated that she monitored staff for the use of hair nets and reminded them on Monday (2/27/12) to make sure their hair was completely covered. She further stated that sometimes the hair nets slide back, but hair and bangs of staff should be covered if they are preparing food. D. On 2/29/12 at 8:03 AM, dietary staff #2 was also observed preparing eggs and at 9:40 AM dietary staff #2 was observed placing frozen bread dough on a sheet pan for lunch. During each observation, dietary staff #2 wore a hair net that left the front portion of her hair exposed. On 2/29/12 at 9:40 AM, dietary staff #2 stated that she was trained to keep all her hair covered including her bangs, but that she did not realize her bangs were uncovered. E. On 2/29/12 at 8:56 AM, the milk cooler was observed with 7 cartons of skim milk, each carton bore a manufacturer's expiration date stamp of 2/27/12. Additionally, on 2/29/12 at 9:07 AM, a breakfast cart on the 400 hall was observed with 2 cartons of skim milk that also bore a manufacturer's expiration date stamp of 2/27/12. Staff was observed distributing the breakfast trays. The DM stated during the observation that milk was delivered every Monday and staff were responsible for checking the milk daily and upon receipt from the vendor to make sure all items were served and received within date.	F 371	We respectively submit for our public record the following clarification/disclaimer. The level "K" as presented for F-371 shows up on our permanent Plan of Correction because an IJ survey shows up in the NC State System as "K"; however the Facility abated the immediate IJ and the Scope and Severity was decreased to an "E", which is isolated and represents a pattern of potential for minimal harm. Please refer to page 17 of the Plan of Correction for clarification written by the State of NC. However, in a good faith effort the Facility will respond to the alleged deficiency in totem. Brenda Silvers Administrator	3-28-12