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
	345483	A. BUILDING _____ B. WING _____	05/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DR LENOIR, NC 28645

(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 5/23/12 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 #76. The administrator was notified of the immediate jeopardy on 5/24/12. Immediate jeopardy was removed on 5/25/12 when the facility provided and implemented an acceptable credible allegation of compliance.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	This Plan of Correction is submitted to address deficiencies cited under Tag #F278. This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies On May 25, 2012, a care plan meeting was held with resident #16. Resident verbalized desire to once again begin to wear left hand palm guard. Occupational Therapy has assessed proper fit via contracture assessment completed on May 31, 2012 with no wear time limitations. Resident #16 has also verbalized a desire to re-enter restorative nursing program for passive range of motion to her left hand and active assistance range of motion to left leg. Left palm guard will be placed on her left hand each morning and removed at bedtime. Range of motion to upper and lower extremities will be performed six times per week.	6/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/14/12

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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BY:

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F 278	Continued From page 1 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interview the facility failed to accurately assess two (2) of three (3) residents reviewed for ROM (Range of Motion). Resident #16 and #9). The findings are: 1. Resident #16 was admitted to the facility 11/04/02 with diagnoses which included late effect CVA (Cerebral Vascular Accident). Review of a significant change assessment MDS (Minimum Data Set) dated 02/25/12 assessed Resident #16 as having no cognitive or memory problems, independent in bed mobility and transfers. Resident #16 was assessed as needing limited assistance with dressing, independent in eating, toilet use and personal hygiene and needed one person assistance to help with transfers when bathing. Resident #16 was coded as being impaired on one side of the lower extremities. Upper extremity impairment was documented as "none". Review of a significant change assessment MDS dated 11/28/11 and a quarterly MDS dated 08/18/11 also coded no impairment on either side of the upper extremities. The CAAS (Care Area Assessment Summary) dated 02/29/12 documented the resident had a	F 278	On May 30, 2012, a contracture assessment was completed on resident #9. Resident #9 was noted to have decreased in extension of the left hand. Resident #9 has past medical history of refusal to wear split on her left hand do to pain. Resident #9 and responsible party do wish for resident #9 to wear a palm guard to prevent skin breakdown. They do not wish for resident #9 to be fitted with splits or participate in restorative nursing program due to pain and belief this would not add to her quality of life. An inservice was conducted for MDS coordinator and all administrative nurses that have the responsibility of completing Minimum Data Set (MDS) assessments by the director of nurses on June 12, 2012. Topics discussed were a review of the facility policy for MDS assessments being completed accurately to reflect the resident's status; assessments must be conducted or coordinated by a registered nurse with the appropriate participation of health professionals; each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment; and a registered nurse must sign and certify that the assessment is completed. Contracture assessments or therapy evaluations were completed by nursing or occupational therapy on all residents and reviewed by MDS coordinator. Section G0400 of the MDS was reviewed for	

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F 278	Continued From page 2 recent surgical repair of the left foot tendon and used a foot splint to assist with contractures. There was no summary regarding the Resident's left hand contracture. A Care Plan (CP) for ROM was updated 02/29/12 with appropriate goals and interventions for upper and lower extremities. The CP included a note which documented Resident #16 had difficulty attending to the left side and refused to wear splint for left hand and that further contractures were expected. On 05/24/12 at 9:00 AM, Resident #16 was observed in the hallway self propelling in a wheel chair. The Resident's left hand was contracted and no hand splint was noted. At this time Resident #16 reported the use of a palm guard "most days" but had not put it on today. The Resident demonstrated how she could not open her fingers of the left hand. During an interview on 05/25/12 at 09:30 AM, MDS Nurse #1 stated Resident #16's MDSs were incorrectly coded for the upper extremity impairment. The MDS coordinator further stated she felt this had been inaccurately assessed because the resident was so independent. 2. Resident #9 was admitted to the facility with diagnoses including late effect hemiplegia and senile dementia. An annual Minimum Data Set (MDS) dated 03/07/12 indicated Resident #9 was severely cognitively impaired and required limited to extensive assistance for most activities of daily living. Further review of the MDS indicated the	F 278	proper coding accuracy of all residents with contractures and/or range of motion limitations by the MDS coordinator on June 14, 2012. Accuracy of proper coding of MDS will continue to be monitored by the director of nurses on a weekly basis for a period of 90 days. The director of nurses will report to the QA committee on a monthly basis as to compliance for a period of 90 days.	

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F 278	Continued From page 3 resident had no impairment of the upper extremities (which included the wrist and fingers) in regards to functional range of motion (ROM). Further review of the medical record revealed Resident #9 had been assessed to have no impairment of the upper extremities in regards to functional range of motion on three (3) quarterly Minimum Data Sets dated 12/12/11, 09/14/11 and 06/17/11. An observation on 05/23/12 at 4:29 PM revealed Resident #9 in her room, sitting in a reclining chair, wearing a palm protector on her left hand. An observation on 05/24/12 at 8:50 AM revealed Resident #9 in her room, sitting in a reclining chair, wearing a palm protector on her left hand. An observation on 05/25/12 at 8:20 AM revealed Resident #9 sitting in a wheelchair, in the assistive dining room, wearing a palm protector on her left hand. An interview with Licensed Nurse (LN) #1 on 05/22/12 at 1:52 PM revealed Resident #9 had a left hand contracture and wore a palm protector; she refused to wear a hard splint. An interview on 05/25/12 at 8:28 AM with Nursing Assistant (NA) #2 revealed NAs applied a palm protector to Resident #9's left hand in the morning and removed the palm protector at bedtime. NA #2 also stated that the restorative aide monitored positioning devices to make sure they were applied correctly. An interview on 05/25/12 at 11:21 AM with the Restorative Aide (RA) revealed that Resident #9's	F 278		

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F 278	Continued From page 4 palm protector was applied to her left hand daily by nursing staff when the resident gets up in the morning and stays in place until the resident goes to bed at night. Resident #9 wore the palm protector to keep her nails from digging into her skin and reduce the progression of her contracture. The RA further stated the resident had worn the palm protector for the last two (2) years. An interview on 05/25/12 at 3:49 PM with MDS Nurse #1 revealed that a review of the annual MDS dated 03/07/12 for Resident #9 noted the resident was not assessed as having a contracture or ROM limitations. MDS Nurse #1 stated that Resident #9 should have been assessed to indicate an impairment of upper extremity functional ROM; the incorrectly coded MDS was a clerical oversight.	F 278		
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 and resident interviews, record review and manufacturer's instructions the facility failed to use pasteurized	F 371	This Plan of Correction is submitted to address deficiencies cited under Tag #F371. This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies Patient #63, #69, #78, #76, #33, and #66 that were served an over easy egg for breakfast the morning of May 24, 2012, had vital signs monitored and were assessed for any gastrointestinal disturbance including but not limited to abdominal pain, nausea, vomiting, and/or diarrhea every four hours for a period of three days. All residents were noted to	6/13/12

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F 371	Continued From page 5 eggs to prepare cook-to-order eggs and conduct temperature monitoring of unpasteurized shell eggs for 6 of 8 sampled residents who routinely requested and were served eggs cook-to-order (Resident #63, #69, #78, #76, #33 and #66). Immediate jeopardy began on 05/23/12 when the facility failed to cook an unpasteurized shell egg until the yolk was congealed, conduct temperature monitoring of the egg and served the egg promptly after preparation to Resident #76. Immediate jeopardy was removed on 05/25/12 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 acquisition system (ordering and receipt of only pasteurized eggs). The findings are: During an observation of the breakfast meal on 05/23/12 at 8:00 AM, Resident #33 was noted dipping her biscuit into liquid runny egg yolk. At 8:05 AM Resident #69 was noted with two eggs on his plate, his eggs had been cut into and liquid yolk flowed onto his biscuit. On 05/23/12 at 11:00 AM an observation of the kitchen was made. A cardboard box of shell eggs was noted in the walk-in refrigerator with a USDA inspection stamped seal on the box which included the following instructions "Cook eggs thoroughly, raw eggs must be heated to 140	F 371	have no signs or symptoms of any gastrointestinal disturbance. A mandatory staff inservice was conducted for all dietary employees by Shaire Nursing Center's Registered Dietician on June 12, 2012. Topics discussed were a review of the facility policy to only use pasteurized eggs for any and all cooking recipes and when preparing eggs to order for residents. Facility policy for ordering and delivery of pasteurized eggs was discussed with dietary manager along with charge cooks. Dietary manager and charge cook are the only employees that hold the responsibility of ordering and receiving groceries. Order invoices and facility pasteurized egg check-in log will be used by the dietary manager or charge cooks to identify the order and delivery of only pasteurized eggs. On June 8, 11 and 13, 2012, the preparation of the breakfast meal was monitored by the charge cook. Findings resulted in four made to order over easy eggs served each date. All eggs served were found to be pasteurized as evidence by a red 'P' stamped on each eggshell. Egg preparation will continue to be monitored by the dietary manager or charge cook on a weekly basis for a period of 90 days. The dietary manager will report to the QA committee on a monthly basis as to compliance for a period of 90 days.	

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F 371	Continued From page 6 degrees for at least 3 ½ minutes and hold hot eggs above 140 degrees." An interview with Dietary staff #1 on 05/23/12 at 11:15 AM revealed that the carton of USDA eggs were used in the morning to prepare breakfast. She further explained that eggs are prepared cook-to-order and residents could order fried eggs, over-light or shell eggs scrambled. Dietary staff #1 went on to explain that over-light eggs were the same as an over-easy egg which meant that the center was "not cooked". Dietary staff #1 confirmed that four of six residents (Resident #69, #33, #63 and #76) received cook to order over-light eggs the morning of 05/23/12. An observation was made of the kitchen on 05/24/12 at 7:15 AM. A cork board was noted on the wall in the kitchen central to food preparation and tray line serving areas with a sign that read: "Temperature requirements for the cooking of potentially hazardous foods in North Carolina: 145 degrees Fahrenheit- eggs cracked and cooked for immediate service." An observation of the breakfast tray line occurred on 05/24/12 at 7:45 AM. On 05/24/12 at 7:50 AM, Dietary staff #2 was observed to crack the shell of two eggs and place each in the same frying pan to cook. Dietary staff #2 was observed at 7:52 AM to remove the cook-to-order shell eggs from the frying pan and plate the eggs. The plate was observed to be placed on the meal ticket for Resident #76. Upon request, temperature monitoring was conducted on 05/24/12 at 7:54 AM by Dietary staff #2 using the facility's calibrated	F 371		

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F 371	Continued From page 7 thermometer. The temperature of the cook-to-order shell egg for Resident #76 was 125.7 degrees Fahrenheit. As the thermometer was removed the yolk dripped from the tip of the thermometer. During an interview with the Dietary Manager (DM) on 05/24/12 at 8:05 AM, she affirmed that the eggs were pasteurized and stated that she couldn't serve anything but pasteurized eggs. The DM further explained that her grocery supplier could not send anything but pasteurized eggs. The DM then stated that she would provide verification of the eggs being pasteurized. Observation of the breakfast tray line on 05/24/12 at 8:07 AM revealed that Resident #76's cook-to-order over-light eggs were plated and sent out to the dining room for service. During an observation of the breakfast meal in the main dining room on 05/24/12 at 8:30 AM, Resident #33's egg yolk flowed onto her plate as she cut into her egg. Resident #69 had two eggs which were cut into and the yolk poured out onto the whites of the eggs. Resident #63 had one egg in his divided plate whose yolk was liquid when sliced into. Resident #78 was observed to cut into her egg and the yolk flowed over the biscuit in her bowl. During an observation of the breakfast meal in the assisted dining room on 05/24/12 at 8:45 AM Resident #76 and #66 were noted to have eggs with the yolk not congealed. On 05/24/12 at 9:33 AM the DM was interviewed and stated that she did not think the shell eggs	F 371		

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F 371	Continued From page 8 were pasteurized but would verify with the grocery supplier. At 9:40 AM the DM stated she had not received a response from the grocery supplier but felt that the grocery supplier would confirm that the shell eggs would be inspected and not pasteurized. During a telephone interview with the District Sales Manager for the facility's grocery supplier on 05/24/12 at 10:15 AM, the District Manager stated that the facility only purchased two types of egg products: a raw shell egg that is not pasteurized and a liquid whole egg product that is pasteurized. He also explained that if pasteurized raw shell eggs were brought to a high enough temperature then that would kill the egg's bacteria, making the egg safe for raw consumption. An interview with Dietary staff #1 on 05/24/12 at 11:30 AM revealed that temperature monitoring of over-light eggs was not always practiced because it would cause the yolk of the egg to break. She also explained that residents can receive eggs cook-to-order daily. Dietary staff #1 further explained that she did not know what the difference was between pasteurized and unpasteurized eggs. An interview with Dietary staff #2 on 05/24/12 at 11:35 AM revealed that temperature monitoring of over-light eggs was not routinely done because it would break the yolk. She also stated that when temperatures of over-light eggs were checked they usually registered at approxiamately120 degrees Fahrenheit. Dietary staff #2 stated that eggs were served like this 4-5 times a week. She also explained that she did not know the	F 371		

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F 371	Continued From page 9 difference between pasteurized and unpasteurized eggs, and thought that all USDA eggs were the same. On 05/24/12 at 11:50 AM 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 there was a difference between pasteurized and unpasteurized raw shell eggs. She explained that she had not trained her staff regarding temperature monitoring of unpasteurized eggs for cook-to-order use and that she was sure that her staff did not monitor the temperature of every cook-to-order egg that had been prepared. During a telephone interview with the Registered Dietician (RD) on 05/24/12 at 3:08 PM, the RD revealed that she was unaware that the facility was using unpasteurized eggs for cook-to-order preparation and that most of the facilities she consulted used pasteurized eggs. She also stated that she made a monthly visit to the facility and on her last visit she must have missed that residents were receiving unpasteurized cook-to-order eggs. On 05/24/12 at 12:50 PM the Administrator was notified of the immediate jeopardy. The facility provided a credible allegation of compliance on 05/24/12 at 5:05 PM which included: Resident #63, #69, #78, #76, #33, and #66 that were served an over easy egg for breakfast the morning of May 24, 2012, will have vital signs monitored along with assessment of any	F 371		

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F 371	Continued From page 10 gastrointestinal disturbance including but not limited to abdominal pain, nausea, vomiting, and/or diarrhea every four hours for a period of three days per recommendations of the facility Medical Director. The facility grocery supplier Institution Food House was contacted at 12:30 PM on May 24, 2012 with the need to deliver pasteurized eggs immediately. The pasteurized eggs were delivered to the facility at 2:30 PM, May 24, 2012. These pasteurized eggs will be used for all residents who request over easy style eggs as their menu choice. In addition, the facility shall only use pasteurized eggs for any and all of its cooking recipes. The facility disposed of all USDA approved un-pasteurized eggs currently in inventory at 1:30 PM, May 24, 2012. The dietary manager was inserviced on May 24, 2012 at 12:30 PM by the facility Administrator as to facility protocol using only pasteurized eggs. In addition, the dietary manager has inserviced all dietary employees in person, by phone and has posted a written memo as to the need to use pasteurized eggs for any and all cooking recipes and when preparing eggs to order for residents. Inservice was completed May 24, 2012 at 3:00 PM. All new dietary employees will be oriented to this facility protocol using only pasteurized eggs. The dietary manager along with charge cook shall hold the responsibility to assure all purchased eggs are pasteurized upon delivery by checking the invoice as well as the product package. The dietary manager will report to the QA committee on a monthly basis as to compliance for a period	F 371		

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F 371	Continued From page 11 of 90 days. The immediate jeopardy was removed 05/25/12 at 4:00 PM following interviews with dietary staff on both shifts related to education on egg preparation and temperature monitoring. The walk in refrigerator was observed on 05/25/12 at 7:50 AM with only pasteurized shell eggs available for use. Documentation was reviewed regarding staff in-services related to the identification of pasteurized shell eggs.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	This Plan of Correction is submitted to address deficiencies cited under Tag #F441. This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies A mandatory staff inservice was conducted for all dietary and nursing employees by Shaire Nursing Center's Registered Dietician on June 12, 2012. Topics discussed were a review of the facility infection control policy to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Inservice focused on hand hygiene during meal set up and feeding of residents. Staff was educated on proper	6/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345483	A. BUILDING _____ B. WING _____	05/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DR LENOIR, NC 28645

(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 441	Continued From page 12 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility staff failed to perform hand hygiene after touching their hair and before handling residents' food during two (2) of four (4) meal observations (Residents #145 and #63). The findings are: A continuous observation of the breakfast meal occurred on 05/23/12 from 8:15 AM to 8:35 AM. At 8:17 AM NA #3 was observed to scratch her hair with her left hand. She then obtained a coffee cup from the kitchen and held the rim of the coffee cup with the fingers of her left hand as she traveled to the coffee cart. NA #3 poured coffee into the cup and set the cup down in front of Resident #145. She then placed the palm of her left hand over the top of Resident #63's coffee cup as she offered him another cup of coffee. NA #3 did not sanitize her hands. A continuous observation of the lunch meal occurred on 05/23/12 from 12:02 PM to 12:21	F 441	handling of resident's cups, glasses and utensils. The facility will continue to provide hand sanitizer for mounted hand sanitizer dispenser along with anti-bacterial soap at each sink located in all dining areas. On June 12, and 14, 2012, meal service was monitored by the director of nurses to assure facility infection control policy was followed. Monitoring included proper handling of cups, glasses and utensils; appropriate hand hygiene during meal set-ups and feeding; and staff refraining from re-adjustment of self during meals. Meal service and proper hand hygiene will continue to be monitored by the dietary manager, director of nurses, or staff development coordinator on a weekly basis for a period of 90 days. The staff development coordinator will report to the QA committee on a monthly basis as to compliance for a period of 90 days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 13 PM. At 12:05 PM NA #3 entered the dining room and did not sanitize her hands. NA #3 began to hand out clothing protectors. At 12:10 PM NA #3 combed her right hand through her hair and then with her right hand she proceeded to remove the plastic top from Resident #145's coffee cup. On 05/24/12 at 8:37 AM an interview was conducted with NA #3. NA #3 explained that hand sanitizer was available in the dining rooms. NA #3 stated that she should have washed her hands between residents and should not have touched resident's food after touching her hair. An interview with the director of nursing (DON) was conducted on 05/24/12 at 8:50 AM. The DON explained that she expected nursing staff to utilize standard precautions throughout the facility, including the dining room. She stated that nursing staff were trained to wash hands prior to assisting residents with meals and that she would have expected the NAs to utilize hand sanitizer between residents when they touch their hair while assisting residents with setting up their food.	F 441		