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

JUL 0 2 2013

PRINTED: 06/20/2013
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
	345423	A. BUILDING ____ B. WING ____	06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMED NURSING CARE CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

(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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 The facility will provide residents who are incontinent appropriate treatment and services to prevent UTI and to restore as much normal elimination function as possible. Based on the resident's comprehensive assessment the facility will ensure that each incontinent resident receives individualized care to promote comfort and maintain the highest level of functioning to optimize quality of life.	
	This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess 1 of 1 sampled residents (Resident #57) for participation in a toileting program following a change in continence status. Findings included: Resident #57 was admitted to the facility on 03/18/13. Cumulative diagnoses included hypertension, atrial fibrillation and diabetes mellitus. An Admission Minimum Data Set (MDS) assessment of 03/25/13 indicated Resident #57 needed extensive assistance with transfer, toilet use and hygiene. She was frequently incontinent of bladder and continent of bowel. The Care Area Assessment (CAA) detail indicated she triggered in several areas including urinary incontinence. According to another MDS assessment for her readmission, dated 04/15/13, she had improved with her bladder incontinence and was now		D.O.N. and QA Nurse interviewed Resident #57 and POA. Resident #57 had experienced a recent change in bowel incontinence due to a diet change; increased use of nutritional supplements and persistent loose stools for approximately 7 days. The consulting physician was aware and a Modified Barium Swallow study was being scheduled. The POA stated that the resident was being toileted more frequently than every 2 hours and the resident had frequency and urgency of urinary elimination prior to admission to the facility. The POA stated that the resident's current urinary incontinence was unchanged from her pre-admission status.	6/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty E. Lancaster
TITLE: Administrator
(X6) DATE: 6/28/2013

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 315	Continued From page 1 continent but she had declined with her bowel continence from being continent to being occasionally incontinent of bowel. Her care plan, dated 03/26/13, identified problems with bladder incontinence related to impaired mobility. An intervention was to assist Resident #57 with toileting. Resident #57 was observed in her room on 06/12/13 at 10:30AM. An interview was conducted with the social worker (SW) on 06/11/12 at 2:55 PM. She stated Resident #57 had been admitted for short term rehabilitation with a discharge plan to be returning home when therapy was completed. According to the SW, Resident #57 did not progress well enough to be able to return to her previous living situation so the decision was made to remain in the facility long term. During an interview with MDS Nurse #1, on 06/11/13 at 5:00 PM, she stated if residents had declines in their continence status, it would be picked up when their next MDS assessment was due. MDS Nurse #1 commented there was no formal toileting program in place. She stated she had not noticed any changes in her continence status and she would be due for another MDS assessment soon. MDS Nurse #1 reported that when she was completing assessments she reviewed the number of continent episodes a resident had versus the number of incontinent episodes. She also stated she reviewed to see how much staff assistance was needed for toileting. MDS Nurse #1 commented that she had printed a report from their computer tracking	F 315	F315 The QA Nurse received physician orders for Resident #57 for UA, stool culture, CBC, and Chemistry Panel to determine any contributing factors related to the resident's change in elimination status.	6/12/13
			The QA Nurse will assess Resident #57 to determine appropriate participation in an individualized toileting program.	7/10/13
			The MDS Nurses will assess all residents via Caretracker and provide a report to the D.O.N. of any identified residents who have had a change in continence.	6/24/13
			All new admissions that are classified as incontinent once the MDS 14 day assessment is completed will be referred to the QA Nurse for appropriate assessment for participation in an individualized toileting program.	7/10/13
			SCD/designee will in-service all nursing staff on the Elimination Management Program.	7/10/13
			QA Nurse will audit all residents on an individual toileting program weekly and report participation/ progress in weekly QIS meetings and provide a cumulative report at the Quarterly Quality Assurance meetings for 4 consecutive meetings.	7/10/13

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F 315	Continued From page 2 system for Resident #57 that indicated she was occasionally incontinent of bowel and bladder which was a change for her. She stated the report also indicated Resident #57 needed extensive assistance with toileting. She stated when MDS assessments were completed, she interviewed staff and reviewed the data from the computer tracking system. MDS Nurse #1 stated Resident #57 had periods of being continent as well as incontinent. An interview was conducted with the Assistant Director of Nurses (ADON) on 06/11/13 at 4:30 PM. She stated when Resident #57 was first admitted she required a lot of assistance from staff but had improved. She stated Resident #57 was more alert and had experienced an improvement in her continence status. The ADON stated the MDS nurses were usually the individuals who would notice a change in a resident's continence status since they were completing the MDS assessments. When questioned about the facility 's toileting program and what criteria a resident would need to meet to be placed on the program, she commented that she had been employed with the facility for 3 years and only one resident had been placed on a toileting program. The ADON commented she was not sure what the criteria was for a resident to be a candidate but she would research it and would interview Resident #57 to see if she would participate in a scheduled toileting program. The ADON commented that since Resident #57 had become more alert and staff were taking her to the toilet more often. The ADON stated on 06/11/13 at 5:35 PM that she felt Resident #57 would be a candidate for a	F 315		

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F 315	Continued From page 3 scheduled toileting program but she would need to speak with her about it. She also stated there was no one currently in the building who was on a scheduled toileting program. The ADON provided a "TOILETING MOTIVATION AND PREFERENCE ASSESSMENT" form and a "Prompted Voiding Trial" form and stated she would use these forms when she interviewed Resident #57. Upon review of the "Prompted Voiding Trial" form, it was noted that the form was used to record the results of wet checks and prompted voiding attempts. Nurse Aide #2 (NA #2) was interviewed on 06/1113 at 5:20 PM. She stated she was familiar with Resident #57 and was her aide today. She stated Resident #57 was very hard of hearing but alert. NA #2 stated Resident #57 usually used the call bell when she needed to use the bathroom. She reported at times she would be wet when she went to take her to the bathroom but most times she knew when she needed to use the toilet. NA #2 stated Resident #57 was capable of standing in the bathroom to hold onto the side rail to be toileted. NA #2 commented that she did not know what scheduled toileting was. NA #3 was interviewed on 06/12/13 at 10:45 AM. She stated when Resident #57 first came to her hall, she was continent but had declined. She stated Resident #57 knew when she needed to use the bathroom and usually called for assistance. She stated sometimes she called for assistance quite frequently. NA #3 reported her to be both continent and incontinent on her shift. She reported Resident #57 as having loose stools lately and was incontinent of her bowels. NA #3	F 315		

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F 315	Continued From page 4 commented that sometimes she would use the toilet when she took her to the bathroom and sometimes she wouldn't. Another interview was conducted with the ADON on 06/12/13 at 2:40 PM. She stated she had not interviewed Resident #57 about participation in the toileting program. She stated her family was visiting today so she interviewed the family. The ADON stated since Resident #57 was having frequent loose stools she would wait to make a determination as to whether she was appropriate for a voiding trial. The ADON added that she felt she would be appropriate once the frequency of stools decreased. She commented that staff should be communicating any changes in continence and the MDS nurses should also be noticing these changes when they were completing assessments.	F 315		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility failed to initiate, follow, and consistently monitor fluids for 1 of 2 residents (Resident #32) who had orders for fluid restrictions. The facility also failed to monitor the amount of fluids provided for 1 of 2 sampled residents (Resident #47) who had orders for fluid restrictions. Findings included:	F 327	F327 The facility will provide each resident with sufficient fluid intake to maintain proper hydration and health based on individual needs of each resident. D.O.N. received an order clarification from the attending physician regarding fluid restriction for Resident #32. Staff Nurse re-instituted intake recording for Resident #32. D.O.N. placed a sign in Resident #32 room regarding fluid restriction in terms of allotment of ml/day. D.O.N. updated Resident #32 care plan.	6/12/13 6/12/13 6/12/13 6/12/13

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F 327	Continued From page 5	F 327	F327	
	Resident #32 was admitted to the facility on 1/26/10 with cumulative diagnoses of anemia, hypertension, and end stage renal disease (ESRD). Resident #32 was receiving hemodialysis three times each week.		D.O.N. provided surveyor with the following documents on Resident #32 --Pre/Post dialysis weights --Recent lab work from the dialysis unit --Documentation from the consulting physician noting no signs or symptoms of fluid volume overload upon physical examination --Copy of venous Doppler study to right leg with negative results.	6/12/13
	Resident #32's quarterly Minimum Data Set (MDS) dated 4/8/13 indicated that Resident #32 was cognitively aware and was independent with eating.			
	Review of Resident #32's Intake and Output Record showed a partially completed record for March 2013 with 2 missing entries for the 7-3 shift, 9 missing entries for the 3-11 shift, and 5 missing entries for the 11-7 shift. There were no Intake and Output records for April, May or June 2013.		RN Supervisor conferred with Dietary Manager regarding any other residents with orders for fluid restriction. No other residents were identified.	6/12/13
			D.O.N. reviewed p.o. intake of Resident #32.	6/24/13
	Review of Resident #32's Fluid Intake Report from the caretracker dated March 6-June 11, 2013 showed a partially completed record. There were 20 missing fluid entries for breakfast, 21 missing fluid entries for lunch, and 43 missing fluid entries for dinner.		D.O.N. interviewed a direct care staff member regarding p.o. intake documentation and provided one-on-one education.	6/24/13
			SDC/designee will in-service nursing staff on Fluid Restriction Policy/ Procedure and p.o. intake documentation.	7/10/13
	Review of Resident #32's Physician Telephone Orders showed an order for a one liter (1000 milliliters) fluid restriction dated 3/6/13.		Dietitian will computerize all dietary recommendations and send to D.O.N., QA Nurse, Dietary Manager, and RN Supervisor at the completion of each visit.	7/10/13
	Review of the Nurses' Notes dated 3/6/13 showed that Resident #32 continued to have swelling in the legs. The note also showed that Resident #32 was to be put on a one liter (1000 milliliter) fluid restriction.		Dietitian will review all residents with orders for fluid restrictions monthly.	7/10/13
	Review of the Physician Progress Note dated 3/14/13 showed that Resident #32 had 4+ (on a			

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F 327	Continued From page 6 scale of 1+-4+) swelling to her legs. Review of the Physician Order sheets for April, May and June 2013 all listed a one liter fluid restriction. Review of the Medication Administration Record (MAR) for April, May and June 2013 did not show a fluid restriction listed. Review of the Care Plan updated 4/9/13 showed that Resident #32 required hemodialysis. Interventions included a renal diet and a fluid restriction as ordered. Review of Resident #32's laboratory values for May 11, 2013 showed a creatinine (a measurement for the waste products of the normal breakdown of muscle tissue that is filtered through the kidneys) level of 6.3 milligrams per deciliter (mg/dL). Normal range for a creatinine level should be 0.5-1.0 mg/dL. The creatinine value for 6/8/13 was 6.1 mg/dL. Resident #32's Blood Urea Nitrogen (BUN an indictor of kidney health) laboratory values for May 11, 2013 pre-dialysis was 66 mg/dL. A normal range is considered to be 6-20 mg/dL. Post dialysis the level was 22 mg/dL. On 6/8/13 the BUN level pre-dialysis was 79 mg/dL and post dialysis was 26 mg/dL. Review of the Dietary Progress Notes dated 5/21/13 showed that Resident #32 continued to have swelling in her right lower leg and was on a one liter fluid restriction. In an observation on 6/11/13 at 12:45 PM Resident #32's was sitting in a wheelchair in her	F 327	F327 QA Nurse will review all residents on fluid restriction weekly for compliance to policy/procedure and report to QIS meetings weekly. A cumulative report will be presented at each Quarterly Quality Assurance meeting for 4 consecutive meetings.	7/10/13

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F 327	Continued From page 7 room and her legs were swollen. The meal card provided on the lunch tray noted a 1500cc (cubic centimeter) fluid restriction. A 240cc glass of tea was noted on the tray. In an interview on 6/11/13 at 4:00 PM Nurse #1 (Resident #32's nurse) indicated she did not have any residents on her assignment who were on a fluid restriction. She stated that if a resident was on a fluid restriction it would be listed on the MAR and there would also be an Intake and Output sheet to fill out with the amount of fluids the nurse gave the resident each shift. In an observation on 6/11/13 at 5:35 PM Resident #32 was eating dinner sitting in a wheelchair. Resident #32's legs were noted to be swollen. Resident #32's meal card showed a fluid restriction of 1500cc. In an interview on 6/12/13 at 8:45 AM the Dietary Manager (DM) stated that when she reviewed Resident #32's chart the previous evening she had discovered the wrong fluid restriction was being provided. She indicated that she had changed Resident #32's meal card and the corrected amount of fluids would be provided. In an interview on 6/12/13 at 9:00 AM Nurse #2 stated that for a resident on a fluid restriction, dietary allows for what nursing provides during medication administration. She indicated that nursing did not track the fluids they provided to a resident on a fluid restriction. Nurse #2 stated she provided 120ml of fluid each time she gave Resident #32 any medications. (Resident #32 was scheduled to receive medications three different times on Nurse #2's shift).	F 327		

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F 327	Continued From page 8 In an interview on 6/12/13 at 9:30 AM the DM stated she had not received a copy of the Physician's Order for the fluid restriction for Resident #32 that should have been started on 3/6/13. She indicated she had received a telephone call from the Dietician sometime in May (approximately 5/21) informing her that Resident #32 should be on a fluid restriction. She began a fluid restriction of 1500ml for Resident #32 at that time. In an interview on 6/12/13 at 11:11 AM the Dietician indicated that she did an initial assessment of each resident when they were admitted and annually after that. She stated she would only review the medical record more often if an issue arose such as weight loss, wounds or if a resident were on dialysis. She stated that she had reviewed Resident #32's medical record after receiving a telephone call from the dialysis center dietician with questions about Resident #32's weight. It was at that time (5/21/13) that she discovered the 1000ml fluid restriction of 3/6/13 was not being provided and placed a telephone call to the DM. The dietician indicated that she did not follow-up with the DM to make sure the correct fluid restriction had been initiated. The dietician stated that she had not notified Resident #32's physician that the fluid restriction he had ordered was started 2 ½ months late or that when it was started it was incorrect. In an interview on 6/12/13 at 12:15 PM the Assistant Director of Nursing (ADON) stated the dietician reviewed the medical record for residents on a fluid restriction each time she	F 327		

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F 327	Continued From page 9 came into the facility. She indicated the dietician and the DM should be monitoring the totals of the resident's fluid intake. In an interview on 6/12/13 at 2:30 PM the ADON stated when an order for a fluid restriction was written, the nurse who noted the order was to transcribe the order onto the MAR. She stated it was also the responsibility of the nurse performing the 24 hour chart check to make sure that all the orders were transcribed on to the MAR as appropriate and to place an Intake and Output sheet into the MAR book for the nurses to record the amounts of fluid given to the residents who were on a fluid restriction. She indicated it was her expectation that the nurses record any fluids they provided on the Intake and Output sheets for residents on a fluid restriction. She also expected the Nursing Assistants (NA) to record the fluids the residents drank in the caretracker. In an interview on 6/12/13 at 3:20 PM the DM stated she did not monitor what nursing provided to any of the residents on fluid restrictions. She indicated that when she was working on the paperwork for the MDS she looked in the caretracker for the amount of fluids the residents were receiving during the seven day look-back period. She indicated she did not look at the Intake and Output record that the nurses were keeping.	F 327		

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F 327	Continued From page 10	F 327	F327	
	2. Resident #47 was admitted to the facility on 09/17/12. Cumulative diagnoses included end stage renal disease (ESRD) with hemodialysis, seizure disorder, depression, diabetes mellitus and hypertension.		RN Supervisor received an order from the attending physician to d/c fluid restriction on Resident #47 due to resident non-compliance.	6/12/13
	The March, April and May 2013 Medication Administration Record (MAR) for Resident #47 included an order for a fluid restriction of 1200 ml per day. In the "HOUR" column, 7-3, 3-11 and 11-7 was listed. There were initials noted in each of the daily blocks on the MAR but no totals for fluid intake.		RN Supervisor conferred with Dietary Manager regarding any other residents with orders for fluid restriction. No other residents were identified.	6/12/13
			D.O.N. reviewed p.o. intake of Resident #47.	6/24/13
	The June 2013 MAR included the 1200 ml fluid restriction with a discontinued written in for 06/12/13. There were no total fluid amounts noted on the MAR to indicate how much fluid Resident #47 had been provided nor did it indicate how much fluid she had actually taken in.		SDC/designee will in-service nursing staff on Fluid Restriction Policy/ Procedure and p.o. intake documentation.	7/10/13
			Dietitian will computerize all dietary recommendations and send to D.O.N., QA Nurse, Dietary Manager, and RN Supervisor at the completion of each visit.	7/10/13
	The most recent Quarterly Minimum Data Set (MDS) assessment of 05/20/13 for Resident #47 indicated she was cognitively intact. She needed minimal assistance with bed mobility, toilet use and hygiene. She was continent of both bowel and bladder.		Dietitian will review all residents with orders for fluid restrictions monthly.	7/10/13
	Resident #47's care plan, last reviewed on 05/23/13, identified problems with hemodialysis due to ESRD. Included in the intervention section was fluid restriction as ordered. There was no mention of non-compliance by Resident #47.		QA Nurse will review all residents on fluid restriction weekly for compliance to policy/procedure and report to QIS meetings weekly. A cumulative report will be presented at each Quarterly Quality Assurance meeting for 4 consecutive meetings.	7/10/13
	An annual nutritional assessment written by the Registered Dietician (RD) of 05/22/13 indicated Resident #47 was on 1200ml fluid restriction with			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMED NURSING CARE CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

(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 327	Continued From page 11 50% to 75% intake. There was no indication that the RD had reviewed Resident #47's actual intake for adherence to the 1200 ml fluid restriction order. A dietary note written by the Dietary Manager (DM) of 05/23/13 at 2:05 PM indicated Resident #47 was eating an average of 25% to 50% of her renal 1200 ml fluid restriction diet. The note indicated to monitor weights, labs and intake. There was no indication that the DM had reviewed her actual fluid intake versus the amount provided by the facility. According to the June 2013 physician's orders, Resident #47 was to be limited in her fluids to 1200 milliliters (ml) of fluids daily. She was also to receive 2 ounces of Nepro four times daily for a total of 8 ounces daily. Resident #47 was observed sitting in her wheelchair watching television on 06/10/13 at . There was a water pitcher sitting on the overbed table which was approximately ¼ full. On 06/11/13 at 5:00 PM, the water pitcher was observed in Resident #47's room on the night stand. During an observation of Resident #47 on 06/12/13 at 9:00 AM, she was noted to have an unopened 8 ounce can of diet Shasta cola, an unopened 12 ounce apple juice and an opened 16 ounce Mountain Dew soft drink. The water pitcher was on the night stand and was approximately ½ full. Nurse #3 was interviewed on 06/12/13 at 9:30 AM	F 327		

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F 327	Continued From page 12 about fluid restrictions. She stated Resident #47 was non-compliant with her diet as well as with the fluid restrictions. She stated she had been educated as to the importance of following the physician's orders but she chose not to. Nurse #3 stated the nurse aides document the total amounts of fluid for Resident #47 into the computer tracking system. She commented the nurses also documented in the computer the amount of fluids given during medication administration. Nurse #3 stated if staff observed her drinking extra fluids those fluids were recorded in the computer as well. She stated Resident #47 did not have an intake and output sheet on her chart. The RD was interviewed on 06/13/13 at 11:11 AM. She stated she only reviewed fluid intake if there was a problem. She stated she had spoken with Resident #47 about her non-compliance with the fluid restriction order. The RD stated she would agree with her but still chose to drink and eat outside of her renal diet restriction. The RD commented her family would bring in foods and fluids that she liked. The RD stated she would expect the facility to provide the fluid she needed and it was important for it to be monitored. She added that she did not track the amount of fluids Resident #47 was taking in. The Assistant Director of Nurses (ADON) was interviewed on 06/12/13 at 12:15PM. She stated when a resident had an order for fluid restriction the dietary department was given a copy of the order. She stated staff were informed of the fluid amount that the resident was to have. The ADON stated the water pitcher was usually removed from the room. She stated the dietary	F 327		

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F 327	Continued From page 13 department was responsible for determining how much fluid was provided on the resident's meal trays and the remaining amount was to be divided between the 3 shifts for nursing. The ADON stated the amount given with each meal was noted on the resident's meal tray slip. She stated the RD and DM calculated the amount of fluid provided on the meal trays and the RD reviewed it when she visited. The ADON commented the RD and the DM should be monitoring totals for Resident #47 but she didn ' t know how often they reviewed the fluid restriction residents. The ADON added that when nurses administered medications the amount of fluid given was recorded on intake and output sheets. She stated the fluid amounts were documented and tracked in the computer care tracker system. She reported Resident #47 to be non-compliant with the fluid restriction order but had been educated. The DM was interviewed on 06/13/13 at 3:20 PM. She stated the RD reviews her notes when she reviews the resident's chart. She stated when a resident was placed on a fluid restriction by the physician she calculated the amount of fluid to be provided on the meal trays as well as adding the restriction on the tray slip. The DM stated she makes the nursing staff aware of the amount they were allowed to provide. She commented the amount was usually 360 ml for the nursing department depending upon the amount of the restriction. The DM stated Resident #47 was non-compliant with both her diet and the fluid restriction. She stated her family would bring in food and beverages for her and she leaves the facility with family as well. The DM stated she did not monitor daily fluid totals for Resident #47.	F 327		

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F 327	Continued From page 14 She stated she runs the quarterly intake and output from the care tracker system and looks at the 7 day look back period when she completes her quarterly review. The DM added that she monitors the amounts that were provided on the meal trays and would not review intake until time for a quarterly review. A physician's telephone order of 06/12/13 indicated to discontinue the fluid restriction for Resident #47.	F 327		
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 and staff interview the facility failed to maintain the temperature of chicken salad sandwiches at 41 degrees Fahrenheit or below during operation of the tray line, failed to cover baked rolls during trayline operation in a kitchen in which gnats were observed previously, and failed to dispose of plastic soup/cereal bowls which had been compromised when the inside lining was abraded. Findings included:	F 371	F 371 The facility will store, prepare, distribute and serve food under sanitary conditions.	

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F 371	Continued From page 16 out of the reach-in refrigerator on 06/11/13 to get another food item, and forgot to put them back into refrigerated storage. She stated usually sandwiches containing a chilled filling made with meat and other protein were stored in the walk-in refrigerator until the trayline began operation, and then were transferred to the reach-in refrigerator once resident trays began to be prepared. The aide commented all cold foods should remain at 40 degrees Fahrenheit or colder during the entire operation of the trayline.	F 371		
	2. At 10:23 AM on 06/12/13 there were gnats observed at the hand sink in the kitchen. At 12:37 PM on 06/12/13 baked rolls were observed uncovered, sitting on a large tray which was housed on a shelf above the steam table. At this time the cook stated the lunch trayline began operation around 12:00 noon.		F 371 2. Baked rolls had been covered until start of tray line. Dietary Manager (DM) immediately bagged rolls when notified rolls were uncovered on shelf above steam table.	6/12/13
	At 2:58 PM on 06/12/13 the dietary manager (DM) stated usually the dietary staff placed bread, rolls, and cookies into sleeves/baggies so that it would be protected from contamination during storage and trayline operation. She reported in discussion with the dietary staff they told her that at the lunch meal on 06/12/13 they ran out of time so they did not put the rolls in baggies because they were afraid the process would cause the trayline to be late beginning operation.		Dietary staff will place all baked goods and ready to eat foods in plastic bags or kept covered when prepared and during tray line process.	6/12/13
			DM will re-in-service staff on keeping all baked goods and ready-to-eat foods from contamination by bagging or keeping covered.	6/25/13
	At 3:12 PM on 06/12/13 a dietary aide stated the staff was supposed to put any type of bread, including loaf bread, rolls, and cornbread, in baggies to keep it from being exposed to excessive moisture in the kitchen and being exposed to possible gnats and flies.		DM will audit bagging or covering of baked goods weekly for four weeks, monthly for three months, then randomly thereafter. DM will report results in Quarterly QA meeting for four consecutive meetings.	6/17/13

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F 371	Continued From page 17	F 371	F371	
	3. At 10:27 AM on 06/12/13 7 of 17 (41%) plastic cereal/soup bowls, among the inventory of kitchenware to be used at the upcoming lunch meal, were compromised. The interior surface had begun to peel and was rough to the touch. A dietary employee commented she thought this was caused by the staff heating soup in the microwave.		3. Dietary Manager (DM) disposed of all bowls observed to be compromised.	6/12/13
	At 12:35 PM on 06/12/13 the cook was observed placing a bowl of soup in the microwave to heat it up before placing it on a resident's tray.		DM will in-service dietary staff on the following: - utilizing the stove top to heat soup - bringing all compromised cereal/ soup bowls to DM for removal and replacement - avoiding use of plastic bowls to heat soup in microwave resulting in compromised kitchenware	6/25/13
	At 2:58 PM on 06/12/13 the dietary manager (DM) stated during in-servicing of the dietary staff she had never instructed the employees to dispose of plastic bowls when the interior became abraded and rough to the touch. She reported the staff was taught to bring kitchenware which was chipped or cracked to her so she could count it, dispose of it, and make sure replacements were ordered. She commented she was not aware that her staff was heating soup bowls in the microwave. According to the DM, soup should be kept hot on the steamtable or a burner of the stove.		Dietary staff will avoid using plastic bowls to heat soups in microwave causing bowl compromise and will use stove top to heat soups.	6/12/13
			DM will audit bowls weekly for four weeks, monthly for two months, then randomly thereafter. DM will report results in Quarterly QA meeting for four consecutive meetings.	6/17/13
	At 3:12 PM on 06/12/13 a dietary aide stated she tried to separate out bowls which had be abraded on the inside, but they sometimes got mixed back in with regular stock. She commented these bowls were damaged, and posed a risk because of the plastic which was breaking down and the rough surface which could harbor germs.			

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Lancaster — TITLE: Administrator — (X6) DATE: 8-1-2013

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.

GW

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include; 1. Med Prep. door by nurse station on 100 and 200 hall , would not close and latch. 2. door to nurse station on Rehab, hall being held open with cloth strip tied to desk. 3. door to doctors office at nurse station(100 and 200 hall) being held open with wooden wedge.	K 018	(KO18) 1 - Med Prep door by Nurse Station on 100 and 200 hall was adjusted to close properly. All smoke/fire doors will be inspected quarterly (BMP) and doors found non-compliant will be repaired immediately by maintenance staff. 2 -- Cloth strip removed. 3 -- Wooden wedge removed.	8-30-13 7-18-13 7-18-13
K 025 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: smoke barrier(at cross corridor doors) above ceiling on 200 hall has opening that is not properly seal to maintain the 1/2 hour	K 025	Nurse Supervisor/designee will in-service staff on safety practices on: - Proper storage of O_2 - Avoiding the propping of doors Nursing Home Admin or designee will monitor for door wedges and other hold open devices 5 times per week for 2 weeks then randomly. Results will be reported at department staff meeting monthly for two months. (K025) Opening sealed. All fire/smoke barrier walls will be inspected semi-annually. All penetrations/openings will be repaired immediately by maintenance staff or designee.	8-16-13 7-22-13 8-1-13 8-30-13

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K 025	Continued From page 2 construction rating of building.	K 025		
K 027 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: cross corridor doors on 100 hall and Rehab. area beside R10 did not close and latch. Also, doors on 300 corridor not latching.	K 027	(K027) Cross corridor doors on 100 hall and Rehab area beside R10 and doors on 300 corridor adjusted to latch properly. Doors requiring new parts ordered and installed. All smoke/fire doors will be inspected quarterly (BMP) and doors found non-compliant will be repaired immediately by maintenance staff.	7-23-13 8-30-13 8-30-13
K 029 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029		

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K 029	Continued From page 3 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: oxygen storage room door would not close and latch(waiting area 200 hall). 42 CFR 483.70(a)	K 029	(K029) Oxygen storage room door in waiting area 200 hall was adjusted to close and latch properly. All smoke/fire doors will be inspected quarterly (BMP) and doors found non-compliant will be repaired immediately by maintenance staff.	8-30.-13 8-30-13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: Conference room door requires two motion of hand to open door. 42 CFR 483.70(a)	K 038	(K038) New door ordered with one motion of hand to open lock. New door installed. All smoke/fire doors will be inspected quarterly (BMP) for one motion of hand to open door. Doors found non-compliant will be repaired immediately by maintenance staff.	7-31-13 8-30-13 8-30-13
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056	Continued From page 4 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: newly remodeled bathroom on 200 hall, does not have adequate sprinkler coverage for back section (shower walls). 42 CFR 483.70(a)	K 056	(K056) One sprinkler head added in back section of shower to provide adequate sprinkle protection in the area.	8-30-13
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	(K062) 1. Sprinkler contractor assessed all sprinkler heads. New sprinkler heads installed in all outside areas. Continue quarterly and annually sprinkler head inspections and replace heads as needed.	7-29-13 8-30-13 8-30-13

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STREET ADDRESS, CITY, STATE, ZIP CODE: 1705 SOUTH TARBORO STREET, WILSON, NC 27893

(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 062	Continued From page 5 Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include: 1. sprinkler heads under canopy at front entrance are not maintained in reliable condition(heads have a green corrosion on heads). 2. walk in cooler in kitchen has boxes stored within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 062	(K062) 2. Boxes in cooler removed. Dietary and Nursing Supervisor/Designee in serviced staff on clearance requirement around sprinkler heads. Dietary Supervisor will monitor walk in cooler weekly for one month then quarterly.	7-19-13 8-16-13 8-16-13
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 pm onward, the following items were noncompliance, specific findings include; deep fat fryer in kitchen is not 18 inches from adjacent equipment. Therefore, a splash guard be installed at a minimum of 8 inches on fryer. 42 CFR 483.70(a)	K 069	(K069) Equipment was adjusted/relocated to allow more than 16" of clear space from adjacent equipment. Dietary Supervisor in-serviced dietary staff on required clearance between equipment. Dietary supervisor will monitor location of deep fat fryer weekly for one month then quarterly.	7-26-13 7-30-13 8-16-13