STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. BUILDING _____ B. WING _____	01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep sandwiches with a meat/egg and mayonnaise filling at or below 41 degrees during the operation of the trayline. The facility also failed to remove food particles and stains from sectional plates and powdery residue from coffee mugs before placing the kitchenware into storage. Findings included: 1. At 5:32 PM on 01/28/14 chicken and egg salad sandwiches were observed sitting on a tray as resident plates were being prepared at the steam table. The sandwiches were not placed over ice, and the tray containing them was sitting on a food preparation counter opposite the steam table. A calibrated thermometer registered 46 to 47 degrees Fahrenheit when the chicken salad filling was checked, and registered 46 degrees Fahrenheit when the egg salad filling was checked. At this time the cook stated the dietary staff still had three carts of meal trays to prepare. According to the dietary manager (DM), the egg and chicken salads were prepared in the facility the day before being served. She reported the	F 371	**DISCLAIMER** RESPONSE PREFACE: *GlenFlora* acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. *GlenFlora's* response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, *GlenFlora* reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures. **F-371 Plan of Correction** Upon being notified of unacceptable temperatures (of chicken/egg salad alternate) the DM re-checked the sandwiches and disposed of all sandwiches. The DM then checked temperature of chicken salad stored in refrigerator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	2/25/2014

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F 371	Continued From page 1 sandwiches were pre-assembled and stored in the walk-in refrigerator until right before the trayline began operation (which was approximately 5:15 PM). She commented the supper trayline usually remained in operation until about 6:00 PM. At 3:38 PM on 01/29/14 the DM stated the facility made its own chicken and egg salads. She reported the chicken salad contained chicken, mayonnaise, eggs, and pickles, and the egg salad contained eggs, mayonnaise, and pickles. The DM commented once removed from storage in the walk-in refrigerator, these sandwiches should have been placed over ice as the trayline began operation so that the filling would remain between 39 and 40 degrees Fahrenheit during the entire operation of the trayline. At 3:48 PM on 01/29/14 the PM cook stated she was instructed to keep cold salads and sandwich filling at or below 40 degrees Fahrenheit during operation of the trayline by pulling small batches of pre-assembled sandwiches/salads from the walk-in refrigerator at a time. She explained after five minutes of being out of refrigerated storage, she swapped out the remaining sandwiches/salads with new batches which were chilling in the walk-in refrigerator. 2. During an inspection of kitchenware, beginning at 11:18 AM on 01/29/14, 8 of 17 sectional plates in storage had dried food particles on them, and 10 of 17 had stains in at least one plate compartment (82% of the sectional plates were compromised in some way). 8 of 21 coffee mugs in storage had a powdery residue inside them (38% of the coffee mugs were compromised).	F 371	Temperature of new chicken salad was in acceptable range, placed on ice at serving line and was prepared as needed with periodic temperature checks. All subsequent temperature checks were in an acceptable range. The dietary staff will be in-serviced on accurate food temperatures on 2/12/2014. The DM and Assistant DM will implement a Food Temperature Audit Tool (Attachment I). The audit will be performed, unannounced, five times a week to insure accurate food temperatures at the serving line. The results of the food temperature audit tool will be reported quarterly to GlenFlora's Quality Assurance Committee. Negative trends will be reported immediately to the facility administrator. Upon discovery of plates with dried food particles the DM removed plates from service immediately. Dietary staff was in-serviced on 2/25/2014 regarding inspecting plates for dried food particles & general cleanliness post-dishwashing/prior to service. Staff instructed to remove any tableware not cleaned in rinsing/dishwashing process and report to DM. Dietary staff re-educated on pre-dishwashing rinsing process. The DM will perform an audit five times a week in order to inspect	2/28/2014

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F 371	Continued From page 2 At 3:36 PM on 01/29/14 the dietary manager (DM) stated it was the responsibility of the dietary employee placing kitchenware, sanitized by the dish machine, into storage to check for dried food particles. She explained if kitchenware was found with dried food particles on it, it was to be scrubbed and re-run through the dish machine until clean. She reported the facility was supposed to use a dipping solution every Thursday to remove stains and residue from kitchenware. At 3:48 PM on 01/29/14 the PM cook stated it was the responsibility of the dietary employee placing kitchenware into drying racks or final storage to check and make sure that it was free from dried food particles. She also commented the DM would check behind the staff sometimes. The cook reported that kitchenware was supposed to be de-stained every Thursday, or on Saturdays or Sundays if the task could not be accomplished on Thursdays.	F 371	tableware completed in the dishwasher cycle prior to being placed into service. The DM will provide a detailed report of the tableware audit quarterly to the Quality Assurance Committee. The Quality Assurance Committee will review for any trends. Any negative audit results will be reported to the administrator timely immediately following findings. Upon discovery of stained kitchenware (sectional plates and coffee mugs) the DM removed from service and immediately began de-staining process. The dietary staff was in-serviced on de-staining kitchenware on 2/12/2014. The dietary department will increase the de-staining process for kitchenware from one to three times a week. Dietary staff members will record the completion of each task in a log (Attachment II). The DM will be responsible for maintaining the log and insuring de-staining process has been completed, at a minimum, three times each week. The log will be reviewed quarterly during GlenFlora's Quality Assurance Committee meetings. Negative trends will be reported to the facility administrator.	2/28/2014

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	345194	A. BUILDING 1A - MAIN BLDG B. WING	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

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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 protected construction , one story with a complete automatic sprinkler system. The deficiencies determined during the survey area as follows:	K 000	**DISCLAIMER** RESPONSE PREFACE: ***GlenFlora*** acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. ***GlenFlora's*** response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, ***GlenFlora*** reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	4/3/2014 3/25/2014
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 — TITLE — (X6) DATE

David Thomas Ferrell — Executive Director — 3/12/2014

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: double doors going into rehab. were being held open with rubber wedges. 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 9:00 am onward, the following items were noncompliant, specific findings include: smoke wall in attic at director of nursing office, has unsealed openings that are not seal properly to maintained the rating of smoke wall.	K 018	**K-018 – Plan of Correction** • Administrator removed door wedges immediately and informed therapy staff that the doors could not be held/propped open at any time. • Plant operations director will check fire rated doors to insure compliance during routine inspections. • Plant operations director will immediately fix any deficient doorways for proper closure. • He will then report findings to GlenFlora's Quality Assurance Committee. **K-025 – Plan of Correction** • Plant operations director to place fire caulking in holes/wall penetrations to maintain compliance on both the 300 hall (at barrier wall) and wall between HA and SNF areas. • The plant operations director and administrator will follow up on all additional maintenance/projects requiring caulking to make sure fire-rated caulking in place. • Additionally, plant operations director will conduct facility-wide inspection to make	4/3/2014 3/25/2014
K 025 SS=E		K 025		
K 029 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 2 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 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 9:00 am onward, the following items were noncompliant, specific findings include: soiled linen door at main nurse station has a hole that is open(door is not 3/4 rated with hole).	K 029	certain all caulking in place is approved fire-rated caulking. • Plant operations director will report any deficient findings to the Quality Assurance Committee and discuss corrective action. **K-029 – Plan of Correction** • On Wednesday, March 5th the plant operations director covered the one inch hole w/ 1/16" steel plates and used a fastener with 1/4" bolts, lock washers and nuts. • Facility will ensure future maintenance and installation of fire doors will, in no manner, negate fire rating.	4/3/2014 03/25/2014
K 062 SS=E	42 CFR 483.70(a) 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: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following	K 062	**K-062 – Plan of Correction** • Plant operations director manually cleaned sprinkler heads in noted locations on March 4th and re-glued excutcheon plate cover. • Plant operations director will accompany fire protection/equipment vendor during biannual inspections to ensure sprinkler heads are clean/lint and dust free. • Inspections will be reported to GlenFlora's Safety and Quality Assurance Committees.	

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K 062	Continued From page 3 items were noncompliant, specific findings include: 1. sprinkler heads in laundry room have excess lent on head. 2. sprinkler head at exit by Olender Place(outside) had excess lent and spider weed on head. 3. storage closets in Rehab. office were missing escutcheon plate cover. 42 CFR 483.70(a)	K 062		