

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345550	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/04/2015
NAME OF PROVIDER OR SUPPLIER WHITE OAK OF WAXHAW			STREET ADDRESS, CITY, STATE, ZIP CODE 700 HOWIE MINE ROAD WAXHAW, NC 28173	
(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 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure a Nurse Aide had renewed her Nurse Aide certification when her certification expired for 1 of 5 personnel files reviewed for abuse prohibition. (NA #1).</p> <p>The findings included:</p> <p>A review of a facility policy titled Plan for the Prevention of Elder Abuse that was not dated indicated in part the facility would conduct state licensure and registry board verification.</p> <p>A review of personnel files on 06/04/15 at 9:11 AM revealed Nurse Aide (NA) #1 was hired by the facility on 02/03/15. A document inside the file titled North Carolina Nurse Aide I Registry indicated the registry listing for NA #1 had expired and the listing expiration date was 05/31/15.</p> <p>During an interview on 06/04/15 at 9:12 AM the Human Resource Manager verified the North Carolina Nurse Aide I Registry listing indicated the NA certification for NA #1 had expired. She explained the Staff Development Coordinator was in charge of ensuring that licenses and certifications were up to date.</p>	F 226	<p>White Oak of Waxhaw has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>NA#1 was taken off the active work schedule during the survey and has remained off the work schedule until their NA certification was renewed. NA #1's certification was renewed and is now active as of 6/11/2015.</p> <p>An audit of all the current NAs was completed on 6/3/2015 by Director of Nursing, to assure all NAs have current active certification. If a certification has expired the employee will not be permitted to work until the renewal has occurred and been verified by Staff Development Coordinator (SDC) or Human Resources (HR).</p> <p>The current system of utilizing a notebook to track licenses and certifications will continue to be used. The SDC, HR, or Director of Nursing (DON) will monitor - giving a 30 day reminder to the NA prior to</p>	7/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/25/2015

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 226	<p>Continued From page 1</p> <p>During an interview on 06/04/15 at 9:27 AM the Director of Nursing verified NA # 1's certification had expired on 05/31/15. She explained the Staff Development Coordinator was responsible for checking licenses and certifications and was to follow up with staff before their certification expired. She stated it was her expectation that prior to the end of each month certifications would be checked to ensure that every staff had an up to date certification.</p> <p>During an interview on 06/04/15 at 9:38 AM the Staff Development Coordinator confirmed she was responsible for reviewing licensure and certifications on a monthly basis but did not realize NA #1's certification had expired until after the expiration date. She explained when staff were hired the human resources department staff printed a copy of the license or certification for her and she filed them in a notebook. She stated she had a section labeled for nurses and a separate section labeled for Nurse Aides (NAs) and the notebook was divided by month and she highlighted who was due for renewal of their license or certification. She explained when the time came for renewal, NAs usually brought their paper work to her so she could complete a section that verified the number of hours they had worked and NAs were responsible for mailing the paper work to the North Carolina Nurse Aide I Registry. She stated most of the time NAs told her they had sent their paper work to the registry and then she checked their website and printed the renewed certification for their personnel file. She explained NA #1 had not brought her paper work to her and when she asked her why her certification had expired NA #1 stated she had forgotten to send her paper work in to the registry and that's why it had expired.</p>	F 226	<p>their certification expiration date. The SDC and HR will validate the renewal of the certification prior to the expiration date, printing the new renewal for the notebook. If the renewal period lapses the employee will not be permitted to work until the certification has been renewed and verified by HR or SDC. This process will be ongoing.</p> <p>A re-education for certified staff, NAs, to review the renewal process was given on 6/23/2015 and completed by 7/02/2015 by Administrator. All newly hired licensed staff certifications will be verified by SDC or HR before job offer is made and will receive renewal process education at job specific orientation.</p> <p>Identified trends are reviewed in the morning QI (Quality Improvement) meeting Monday thru Friday for 3 months, then as trends are identified thereafter, with recommendations made as indicated.</p> <p>The Administrator and DON are responsible for ongoing compliance of F226.</p>		

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F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two entrée items at a temperature of 140 degrees or above before plating and failed to use the steam table to help ensure foods remained above 140 degrees before plating for three entrée items and for gravy on 1 of 4 halls (300 hall/Maple Terrace).</p> <p>The findings included: On 06/03/15 at 5:30 PM the 300 hall food dinner service was observed. Dietary Aide #1 was plating food from a portable steam table. There were also 4 food items that were observed on the cart for the steam table. These food items were in uncovered metal containers beside the steam table; they were not on or being warmed by the steam table. Dietary Aide #1 was observed preparing a plate for a resident which included one of the food items not on the steam table (regular diet pork entrée). Interview with Dietary Aide #1 at this time revealed these food items had been off the steam table for the entire meal service. She added that they were not on the</p>	F 371	<p>White Oak of Waxhaw does 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.</p> <p>300 Hall/ Maple Terrace receives food that is at or greater than the revised Food Code recommendation. The foods that require the use of the steam table are placed on the steam table.</p> <p>Additional steam tables have been purchased and were put in to use on 6/12/2015.</p> <p>The Dietary Manager, Dietary Supervisor or Cook will monitor food temperatures at the point of service daily for 3 months, then monthly thereafter.</p> <p>The Dietary Consultant will monitor the use of the steam tables and the food</p>	7/2/15	

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F 371	<p>Continued From page 3</p> <p>steam table because it was full and she did not have room for them.</p> <p>On 06/03/15 at 5:40 PM the Dietary Supervisor measured the temperature of the 4 food items not on the steam table. The following was observed: Regular diet pork entrée (145 degrees F/Fahrenheit) Puree shrimp (135 degrees F) Ground pork (the thermometer was observed to stay at a temperature of 98 degrees however was left in without observation of the temperature reading for approximately an additional 15 seconds) Gravy (temperature was not measured) Interview with the Dietary Supervisor at this time revealed the ground pork temperature reached a maximum of 112 degrees F. She stated that the food items that were not on the steam table should have been on the steam table and that if she had arranged the food items herself they would have been.</p> <p>Interview with the Dietary Manager on 06/03/15 at 6:00 PM revealed that it was his expectation that all foods that should be kept warm (above 140 degrees F) prior to plating should be on the steam table. He added that the foods that had not been on the steam table were above 140 degrees F prior to leaving the kitchen but acknowledged that at least two of the food items that were not on the steam table did not maintain a temperature of above 140 degrees F, according to the temperatures observed with the Dietary Supervisor.</p> <p>Interview with the Dietary Consultant on 06/04/15 at 9:30 AM revealed that the facility had taken steps to ensure all foods that should be</p>	F 371	<p>temperatures at the point of service on her routine visits every other month for 4 months.</p> <p>The dietary staff have been reeducated on using the steam tables and on monitoring the food temperatures at the point of service by the Dietary Manager and will be completed by 7/02/2015.</p> <p>Identified trends are discussed during the morning Quality Improvement meeting Monday thru Friday for 3 months then monthly for 3 months, with recommendations made as indicated.</p> <p>The Dietary Manager is responsible for compliance of F371.</p>		

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F 371	Continued From page 4 maintained above 140 degrees F prior to plating would fit on the steam table. She added that the foods that had not been on the steam table had not been under 140 degrees F for an amount of time that would be considered hazardous.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		7/2/15	

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F 431	<p>Continued From page 5 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to label a medication syringe with the medication name, date of dispensing, and/or expiration date in 1 of 4 medication refrigerators (400 hall medication refrigerator) reviewed for medication storage and labeling.</p> <p>Findings included:</p> <p>On 06/04/15 at 2:45 PM an observation was made of the medication refrigerator on the 400 resident hall. The controlled medications used for the residents on the 400 hall were kept together in a locked refrigerator. One medication syringe with 0.1 cubic centimeters (cc) of a clear liquid was found in a pill crushing bag with a resident's first initial and last name (Resident #107) written on the bag. Nurse #1, who was present in the medication room when the syringe was discovered, stated "it may have fallen out of her box or an old box and was not noticed."</p> <p>A record review of Resident #107's Physician Order Sheet revealed a medication order for 0.1 cc Lorazepam (Ativan) SL q 12 h PRN (sublingual every twelve hours as needed for anxiety).</p> <p>On 06/04/15 at 3:46 PM, Nurse #2 reported that Resident #107's Ativan was scheduled for 1st shift, and she had never administered a dose of Ativan to Resident #107. Nurse #2 reported that the dispensing dropper for the liquid Ativan was</p>	F 431	<p>White Oak of Waxhaw does assure that drugs and biological used in the facility are labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>The medication syringe found during the Survey with a clear liquid substance was discarded at that time per the facility policy by the Director of Nursing (DON).</p> <p>The license nurses were reeducated on Medication storage and labeling by the DON and completed by 7/02/2015 by Director of Nursing. Newly hired nurses receive this education during their job specific orientation with Staff Development Coordinator (SDC).</p> <p>Nursing Administration (DON, SDC, Nursing Supervisors, treatment Nurse) have completed a review of the items stored in the Medication Rooms by 7/02/2015. Any item found stored inappropriately or that has expired will be discarded per facility policy.</p> <p>The Nursing Administration will monitor the 4 medication rooms weekly for 4 weeks, then monthly for 2 months. The consultant Pharmacist will continue to</p>		

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F 431	<p>Continued From page 6</p> <p>attached to the top, or lid, of the medication bottle. She stated that if she administered a dose she would replace the lid containing the dispensing dropper back into the bottle. Nurse #2 reported she would have wasted, with another nurse, a dose of Ativan that had been pulled up in a syringe and not administered.</p> <p>On 06/04/15 at 3:30 PM, an interview was conducted with the Director of Nursing who stated, "I don't know that it (the clear liquid) is a medication in the syringe. They (the nurses) rinsed the syringe. It might just be water. That might have been a syringe that fell out of the box of Ativan. The syringe was most likely inserted into the pill crusher bag to keep the syringe clean, or it could have been from an old box. If a nurse pulls a medication, but doesn't give it they should dispose of it or waste it."</p>	F 431	<p>monitor the medication rooms every other month to ensure ongoing compliance to F431.</p> <p>Identified trends or concerns are discussed in the morning Quality Improvement meetings Monday thru Friday for 4 weeks, monthly for 2 months, then as needed for recommendations.</p> <p>The DON is responsible for compliance to F431.</p>		