STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345445	A. BUILDING ______ B. WING ______	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENAIRE	4000 GLENAIRE CIRCLE CARY, NC 27511

(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 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. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) to reflect results of the Level II Preadmission Screening and Resident Review (PASRR) determination for 1 of 1 *residents* identified as Level II PASRR (Resident#7).	F 278	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. 1. <u>What corrective action will be accomplished for residents affected?</u> The affected resident's comprehensive and significant change MDSs, for the last three years, have been corrected and re-submitted. The Social Worker will speak with the regional PASR office to review the resident's significant change assessment from April of 2016 by 6-29-2016. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents in the facility on 6-14-2016 were reviewed for presence of Level II PASR by the MDS coordinator, Director of Nursing, and Social Worker. No other Level II's were identified. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The Social Worker will be responsible for identifying new admissions with Level II's and she was in-serviced on 6-28-2016 by the Director of Nursing to recognize and monitor these admissions. If the resident is Level II then the Social Worker will notify the Director of Nursing, MDS Coordinator, the Medical Records Coordinator and the facility Billing Specialist.	06-29-2016

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

TITLE: EXECUTIVE DIRECTOR

(X6) DATE: 7/13/16

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			06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENAIRE	**4000 GLENAIRE CIRCLE** **CARY, NC 27511**

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F 278	Continued from page 1 The findings Included: Resident #7 was re-admitted to the facility on 6/1/11 with cumulative diagnoses which included personality disorder, generalized anxiety disorder, depressive disorder, and reactive confusion. A review of Resident #7 ' s annual Minimum Data Set (MDS) assessment (Section A) dated 4/1/16 indicated the resident was not considered A Significant Change MDS assessment dated 4/11/16 also indicated Resident #7 was not considered to be Level II PASRR. Determination of a Level II PASRR resident is made by an in-depth evaluation. The results of this evaluation are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care. A review of the facility ' s list of Level II PASRR residents revealed that Resident #7 was named on the list. A review of Resident #7 ' s records included an FL-2 (Medicaid Program Long Term Care Services) dated 9/24/04. Resident #7 ' s Level II PASRR number included the letter code " B. " An interview was conducted on 6/9/16 at 10:05 AM with the facility ' s Director of Nursing (DON). The DON reported that she herself was the Registered Nurse who assumed responsibility for verifying accuracy of the facility ' s Minimum Data Set (MDS) assessments. During the interview, the DON confirmed Resident #7 was determined to be a Level II PASRR.	F 278	The Director of Nursing created a QA audit tool, implemented on 6-28-2016, that will capture admissions and their PASR Level and will be completed upon each new admission. The Director of Nursing or her designee will monitor admissions for the next three months. The Director of Nursing or her designee will bring this monitoring tool to QA for three months and cease doing so upon the decision of the Interdisciplinary Team. 4. <u>How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</u> All residents with a Level II PASR will be reviewed weekly in our Medicare A meeting to check for presence of significant change assessment and notification to state authorities as necessary. Checking the status of residents with Level II PASR has been added to the weekly agenda for the Medicare A meeting. An audit form has been created to record weekly status check and upon each new admission to the facility. These audit forms will be reviewed in QA monthly for three months to ensure continued compliance. The Interdisciplinary Team will meet after three months to determine if the continuation of these audit tools is necessary.	

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F 278	Continued From page 2 An interview was conducted on 6/9/16 at 10:10 AM with the facility ' s SW. Upon inquiry, the SW also confirmed Resident #7 was determined to be a Level II PASRR. When asked how this information was shared among team members, she reported it would have been verbally shared in team clinical meetings. A follow-up interview was conducted on 6/9/16 at 10:15 AM with the facility ' s DON. Upon inquiry, the DON indicated that her expectation was for the Level II PASRR determination to be coded accurately on a resident ' s MDS assessment. She indicated coding the resident as a Level II PASRR on the MDS assessments had been missed.			
F371 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 observations and staff interviews the facility failed to remove dented cans of applesauce in 1 of 1 dry storage area and failed to wear hair restraints for 2 of 2 staff who had beards which were not covered. The findings included: 1) During the initial tour of the main kitchen on 6/7/16 at 9:50 AM an observation of the dry storage area revealed a dented can of applesauce in the same location as the other cans of applesauce which were ready for use. On 6/7/16 at 9:55 AM the Production Manager stated the dented can should not have been in with the others. He stated it should be removed and placed in the area specified for dented cans so that it would not be used. 2) During initial tour of the main kitchen on 6/7/16 at 9:50 AM 2 food service staff members were observed to have a beard. They were not wearing a beard restraint while they were working in the food production area. On 6/9/16 at 4:45 PM the Production Manager stated beard covers were available and he expected staff to wear them while working in the kitchen.	F 371	The facility must - Procure food from sources approved or considered satisfactory by Federal, State or local Authorities; and store, prepare, distribute and serve food under sanitary conditions. 1. What corrective action will be accomplished for residents affected? The two preparation cooks were in-serviced on 6-30-2016 regarding proper use of hair/beard nets, and all dietary staff on 7-06-2016 by the Director of Dining services about wearing hair/beard nets and retrained on facility policy and procedure regarding proper use of hair nets in the kitchen. An area outside of the dry food storage area has been designated to temporarily store dented or damaged dry food until discarded by the authority of the Production Manager, Director of Dining Services, or the designated director of that shift. All Dietary Staff were in-serviced on proper dry food storage procedures by 7-06-2016 and informed of the new storage area for dented or damaged dry goods. The Director of Dining Serviced and the Assistant Director inspected the dry food storage room to ensure there were no dented or damaged dry food storage products on 6-30-2016 and any products found to not be in compliance were discarded immediately.	07-06-16

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F 371		F 371	2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? At the start of each shift the Production Manager, Director of Dining Services, or the designated director will check, observe, and monitor the dietary staff to ensure they are following proper hair net policy on all shifts, including weekends, for three months. The Directors will in-service staff members who violate this policy and implement employee disciplinary procedures for staff who continually violate this policy. Any violations of policy that require disciplinary action will be brought to the immediate attention of the Administrator. 3. What measures will be put into place to ensure this practice does not recur The Directors or their designee will instruct dietary staff to discard dented or damaged dry food storage products upon delivery. The Directors or their designee will create a QA tool that will be completed by the Directors or their designee on stock delivery days and it will be brought to the monthly QA and continue for three months. An in-service of all dietary staff regarding hair net policy and procedure will be completed by 7-06-2016. The Directors or their designee will check, observe, and monitor the dietary staff to ensure they are following proper hair net policy and procedure. The Directors or their designee will utilize a QA tool that they will monitor on every shift which include weekdays and weekends and it will continue for three months and be brought monthly to QA for review by IDT. Any dietary staff who violates policy will be in-serviced by the Directors or their designee and continual violations will result in disciplinary action and immediate notification to the Administrator.	07-06-16

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		F 371	4. How corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Directors or their designee will design and complete weekly a Quality Assurance tool that will track and monitor the dry food storage room on each delivery day. The Directors or their designee will in-service all dietary staff about dented cans and damaged dry foods. The Directors or their designee will discard any dented or damaged dry food and inspect the dry food storage room after each delivery for three months and bring this form to QA monthly. IDT will evaluate the process and determine whether or not to continue monitoring this process after three months. The Directors or their designee will create and complete daily a QA monitoring tool for hair nets and bring that to monthly QA for three months to be evaluated by IDT. This tool will be completed daily, on every shift including weekends. IDT will evaluate and determine whether or not to continue the QA monitoring tool after three months. The Directors or their designee will continue to inservice staff who violate this policy and document on the QA tool for evaluation by the IDT at the monthly QA meeting.	