

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

PRINTED: 08/29/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345432</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTERN NORTH CAROLINA BAPTIST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>213 RICHMOND HILL DRIVE</b> <b>ASHEVILLE, NC 28806</b>		
(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  No deficiencies were cited as a result of the complaint investigation Event ID#2ITQ11 - 8/19/16.	F 000	A) 24 Hour and 5 Day reports will be reported to the Health Care Personnel Investigations (HCPI), regarding any suspected Abuse or Injuries of unknown origin. Abuse is defined as any willful infliction of injury, unreasonable confinement, and intimidation or punishment with resulting physical harm, pain or mental anguish.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	B) 24 Hour and 5 Day Reports will be reported to the HCPI for any and all allegations of suspected Physical Abuse and or Injuries of Unknown Origin. All Nursing documentation with in the past 90 days were audited to ensure our compliance.  C) The entire staff including the Director of Nursing and the Administrator will be inserviced by the Vice President of Operations as to the importance of and the step by step procedures of communicating and documenting any and all suspected abuse issues and or Injuries of Unknown Origin to their immediate supervisor, the Director of Nursing and the Administrator/Abuse Officer.  D) The Quality Assurance team ( The Medical Director, Director of Nursing, Care Plan coordinator, Administrator, Dietary Manager, and the Activity Director) will audit and discuss any and all 24 Hour and 5 Day Reports regarding Physical Abuse and or Injuries of Unknown origin. And will track the results of and the effectiveness of the changes in the individual care plans as well as the interventions implemented, monthly. The 24 hour and 5 day reports of the past 90 days were audited as to our compliance.  E) 09-09-2016		

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

*Christopher A. Elmer*

TITLE

Administrator

(X6) DATE

09-06-2016

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 225	<p>Continued From page 1</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, resident, family, physician and staff interviews the facility failed to submit a 24 hour and 5 day report to the Health Care Personnel Investigations (HCPI) and failed to investigate an allegation of physical abuse for 1 of 1 sampled Residents (Resident # 2) who reported an allegation of physical abuse and for 1 of 1 sampled Residents (Resident #19) who had an injury of unknown origin.</p> <p>Findings Included:</p> <p>1. Resident # 2 was admitted to the facility on 07/03/2014.</p> <p>Review of the Minimum Data Set (MDS) annual assessment dated 06/02/2016 revealed Resident # 2 to be intact of cognition with no behaviors. Continued review the MDS assessment for Activity of Daily Living (ADL), revealed, Resident # 2 required extensive assistance with 2 person physical assist for bed mobility.</p> <p>During an interview with Resident # 2 on 08/16/2016 at 10:08am, she explained an incident with NA # 1 and Nurse # 3 that work on the 11pm-7am shift. Resident # 2 stated she was trying to get out of the bed and explained to NA #1 that she wasn't well, but stated NA #1 "pushed her and she fell backwards and hit the</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>bed rail on the lower part of her neck and back causing her pain for more than 2 weeks." Resident # 2 stated that she reported the incident to her responsible party. Resident #2 could not recall the exact date that the incident occurred.</p> <p>A review of the nurse's notes for Resident #2 revealed an entry dated 4/16/2016. The notes indicated, Nurse #3 overheard NA #1 telling Resident #2, " please don't climb out of the bed as you may fall on the floor. " The note indicated that Nurse #3 went into the resident's room at that time. The notes further indicated that Nurse #3 was present in the resident's room and that she and NA #1 assisted Resident #2 back into the bed. Nurse #3 documented in the notes that Resident #2 stated that NA #1 handled her in a rough manner.</p> <p>A review of the facility grievances revealed that a grievance was made by the responsible party for Resident # 2, dated 4/18/2016 to the Director of Nursing (DON). The grievance revealed that Resident # 2 stated to him that someone threw her onto the bed rails, causing the resident to strike an area on her face and neck.</p> <p>During an interview with the DON on 08/17/2016 at 10:03am, she revealed that there was no abuse investigation for the grievance with Resident #2. She further stated that "it was not a reportable incident."</p> <p>An interview was conducted with NA #1 on 8/17/2016 at 3:36PM. During this interview, NA #1 indicated that she did recall the incident on 4/16/2016 with Resident #2. She stated that she was assisting Resident #2 back to her bed, and stated Resident #2 became upset and stated the</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>staff were treating her like trash. She stated that she made sure the resident was comfortable and left the room. She stated that she did not talk further to anyone about the incident, and that the DON nor any other Administration staff ever came to her to question her about Resident #2's concerns of care and treatment.</p> <p>An interview was conducted with Nurse #3 on 8/17/2016 at 5:39PM. During this interview, Nurse #3 indicated that she did recall the incident on 4/16/2016 with Resident #2. She stated that while NA #1 was assisting Resident #2, the resident became upset and stated that staff were "treating her like trash." Nurse #3 stated that she did not talk to the DON about the concerns, until after the Responsible Party reported the concern.</p> <p>An interview was conducted with the Responsible Party for Resident #2 on 8/17/2016 at 5:55PM. During this interview, the Responsible Party stated that Resident #2 reported to him on 4/18/2016 that she had been handled roughly and was thrown into the bed rails by a staff on third shift. The Responsible Party stated that he reported the allegation to the DON.</p> <p>An additional interview with DON on 08/18/2016 at 1:10pm, revealed that the facility no longer had a Social Worker. She stated that the Social Worker position was the Abuse Coordinator for the facility. The DON explained the positions now in charge of reviewing abuse allegations and grievances are the Activities Director, Administrator, and the DON.</p> <p>During an interview with Administrator on 08/18/2016 at 5:03pm, he stated that he was the</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>Abuse Officer and responsible for reporting all allegations of abuse. When shown the grievance for Resident #2, he indicated that he did review the grievance when it was filed. He stated it was a reportable incident and that, "it should have been reported and it was overlooked."</p> <p>2. Resident #19 was admitted to the facility on 10/10/12 with a diagnosis of closed fracture of humerus, generalized muscle weakness, abnormal coagulation, chronic pain, hypertension, osteoporosis, protein calorie malnutrition, edema, vitamin D deficiency, coronary artery disease and congestive heart failure. The most recent Minimum Data Set (MDS) assessment dated 5/31/16 indicated Resident #19 required extensive assistance with bed mobility with 2 person assistance. The MDS further indicted Resident #19 was coded on the MDS as being cognitively intact as evidenced by a brief interview for mental status (BIM ' s) score of 12. Review of the facility incident report/fall log from 5/1/16 through 7/1/16 revealed no incidents or falls for Resident #19. Review of Resident #19 ' s nursing note dated 5/8/16 revealed at 11:00am this shift nursing assistant (NA) notified the nurse of a bruise and swelling of right lower extremity (LE). Large bruise noted just below right knee with swelling in same area. The note continued with Resident #19 was able to perform range of motion (ROM) without difficulty at hip joint and ankle joint. Resident# 19 expressed feeling pain with ROM of the right knee. The note revealed Resident #19 stated she was " dropped from sling last night " . Nurse notified nursing supervisor and nursing supervisor notified medical doctor (MD). The note continued with an order was received for</p>	F 225			

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F 225	Continued From page 5 portable x-ray of Resident #19 ' s right knee and tibia/fibia (2 views) as well as administration of tramadol for pain. At 12:15pm x-ray arrived to x-ray resident #19 ' s right lower extremity (RLE). Review of Resident #19 mobile x-ray dated 5/8/16 revealed lateral views of the right knee were presented for evaluation. There was a posttraumatic deformity in the lateral superior portion of Resident #19 ' s tibia without evidence of displacement. The x-ray report stated, " Most likely this reflects old trauma " . " An old insufficiency fracture could look like this " . The section identified as " Impression " stated deformity of the lateral portion of the tibia without displacement; moderate degenerative changes. Computed tomography (CT) imaging should be considered for follow up. Review of Resident #19 ' s nursing note dated 5/18/16 at 5:36pm revealed resident leg continued to be discolored and resident complained of intermittent pain. Review of Resident #19 ' s nursing note dated 5/19/16 stated, " according to the assigned nursing assistants (NA ' s) during the 11-7 shift on 5/6/16, 5/7/16, 5/9/16, and 5/11/16 this resident was not transferred out of bed and she did not walk in her room or in corridor and she did not locomote on the unit or off the unit; during 3-1 shift on 5/9/16 she was totally dependent for transfers (a mechanical lift was used); she did not ambulate any in her room, did not locomote off the unit and was totally dependent for locomotion on the unit during 3-11 shift on 5/7/16. " Review of Resident #19 ' s nursing note dated 5/20/16 at 1:21pm revealed during an am shower Resident #19 was noted that resident had a nodule on the side of her right knee. Power of Attorney (POA) was present and aware. The note continued with another x-ray was requested and a	F 225			

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F 225	<p>Continued From page 6</p> <p>call was place to the physician.</p> <p>Review of Resident #19 mobile x-ray results dated 5/20/16 indicated 2 views of the right knee were presented for evaluation. The note continued with severe osteopenic changes were seen. There was an impacted insufficiency fracture of the proximal tibia which was similar to the May 8, 2016 study. The section identified as " impression " included 1) impacted insufficiency fracture of the proximal tibia with mild posttraumatic deformity of the proximal fibula. The x-ray report continued with the findings weren ' t changed from the May 8, 2016 x ray report.</p> <p>Review of nursing note dated 5/20/16 at 5:54pm stated x-ray results reviewed and the findings were reviewed with the medical doctor.</p> <p>Review of Resident #19 ' s nursing note dated 5/20/16 at 9:05pm revealed Resident #19 ' s x-ray result were received with results of a positive impacted insufficiency fracture to her right tibia . Medical Doctor (MD) was notified and gave order to send resident #19 to the emergency department (ED) for possible CT scan, treatment, and evaluation by an orthopedic MD. Emergency medical services (EMS) arrived and transported Resident #19 to the emergency department (ED) at 7:00pm.</p> <p>Interview with the Director of Nursing (DON) on 8/18/16 at 1:23pm the DON stated the information would have been provided to her in the facilities electronic medical record system as a 24 hour report. She further indicated that she had not completed a 24 hour report for the bruise identified 5/8/16 or when it was identified Resident #19 received results of a positive impacted insufficiency fracture of her tibia on 5/20/16. The DON stated Resident #19 had changed her story of how the incident occurred.</p>	F 225			

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F 225	Continued From page 7 Resident #19 had first stated she had fallen from a lift and then stated she had hit on a bedrail when being put back into bed. It was unknown how Resident #18 sustained the injury. She indicated the facility felt as though it was unlikely the resident had a fall from the lift. The DON revealed the facility did not complete a 24 hour working reports unless they felt as though it was warranted. She revealed they typically looked at medications that may cause bruising to include other clinical factors. The DON further stated unless they saw the injury as a problem they wouldn ' t do a report. The facilities time line on reporting varied upon the staff that was being involved. The Administrator was the facilities abuse officer and complaints reviewer and did not indicate a 24 hour report was required. The DON indicated she interviewed staff members but was unable to communicate their names. She revealed she interviewed the nurse that was present. The DON stated the facility nursing assistants were interviewed and indicated they knew nothing about the resident falling from a lift or possibly hitting her leg. The DON was unable to produce an internal investigation. Review of document provided by the DON on 8/18/16 at 2:45pm stated, " 5/8/16: received call from RN supervisor reporting resident noted to have swelling and bruising to right lower leg and is complaining of pain in area. The supervisor stated resident complained of right toe pain during the previous evening (5/7) and was assessed and was noted at that time to have a small bruised area on right lower leg and denied pain. Resident stated to supervisor that her leg must have smacked the lift when she was being put to bed. Supervisor stated that she instructed residents nurse to monitor bruised area for changes and complaints of pain. Supervisor	F 225			



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F 225	<p>Continued From page 8</p> <p>stated that she had spoken with staff and residents roommate and no fall had occurred. POA and physician have been notified and x-rays will be obtained today. " The note continued with " 5/8/16: received call from RN supervisor. X-rays were negative for fracture. Doctor had ordered antibiotics for cellulitis. No further action warranted. The DON indicated this document was her notes in regards to the incident dated 5/8/16. "</p> <p>Interview with the administrator on 8/18/16 at 3:10pm revealed he was the facilities abuse officer and complaint reviewer. The Administrator indicated injuries of unknown origin were investigated as soon as possible. He further indicated it was 24 hours or less. He indicated an internal investigation had been conducted in response to Resident #19 ' s injury. He further revealed he had not observed an internal investigation and was unable to locate an internal investigation. He stated the nurse was contacted because the facility had picked up on bruising. The x-ray were negative and the physician put the resident on antibiotics due to cellulitis. The Administrator stated Resident #19 ' s account of the incident varied from a fall from a lift and putting her back into bed. The Administrator stated the second x-ray said something to the effect that the injury was probably an old fracture. He indicated no 24 hour working report nor a 5 day working report were completed for injury of unknown origin. The administrator indicated Resident #19 ' s injury was not an injury of unknown origin.</p> <p>Interview with the facility physician on 8/18/16 at 4:30pm revealed it was unknown how the injury occurred with Resident #19. He stated that he was made aware the resident had bruise to the knee and she was complaining of pain. The</p>	F 225			

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F 225	Continued From page 9 physician stated it was unlikely the resident had a fall from the lift due to the angle the resident ' s injury. He indicated if she had fallen form the lift she would have mostly face planted due to the location of Resident #19 ' s fracture. The Physician indicated the injury would have had to come from hard standing, a drop, bumping. He continued with would have occurred with a blow to the front of Resident #19 ' s knee. The physician indicated initially it was thought to have been an old injury due to the first x-ray results. Resident #19 continued to have pain and an additional x ray was taken. Resident #19 was sent out to the emergency room where we could get a more definitive x-ray. He recalled being present for a facility meeting in which the mechanisms of the incident were asked of him. He the bruising he observed appeared to be from an acute incident. The physician indicated the order for antibiotics was not in regards to the resident ' s knee. The area that indicated the use for an antibiotic was receiving treatments in regards to cellulitis in a different area of the leg.	F 225			
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F 226	<p>Continued From page 10</p> <p>the areas of reporting, protection and investigation for 1 of 1 sampled resident (Resident #2) who reported an allegation of physical abuse.</p> <p>Findings Included:</p> <p>A review of the facility policy titled " Elder/Dependent Adult Abuse Assessment and Reporting " dated July 30, 2011, read in part: It is the policy of this facility to report any suspected cases of elder abuse or dependent adult abuse. Employees subject to the reporting requirements include any employee who provides resident direct care and any other employee whose official duties require him/her to regularly work directly with elders or dependent adults. Mandatory Reporting: When an employee is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse.</p> <p>Procedure: Instances of physical abuse shall continue to be reported to the long term care state authorities and local law enforcement agency when it is alleged to have occurred in a long term facility. The Healthcare Administrator shall be notified immediately. The administrator will have the ultimate responsibility to guide the investigation and report to any agencies or authorities.</p> <p>It is the policy to guarantee the safety of all residents during an investigation, including but not limited to supervising all involved Employees pending outcome of the investigation.</p> <p>A review of the nurse's notes for Resident #2 revealed an entry dated 4/16/2016. The notes indicated, Nurse #3 overheard NA #1 telling</p>	F 226	<p>A) 24 Hour and 5 Day reports will be reported to the Health Care Personnel Investigations (HCPI) for any suspect Abuse. Abuse is defined as any willful infliction of injury, unreasonable confinement, and intimidation or punishment with resulting physical harm, pain or mental anguish.</p> <p>B) 24 hour and 5 Day reports will be reported to the HCPI for any suspected physical abuse. All grievance logs/nursing notes were audited for any suspected physical abuse for the past 90 day period.</p> <p>C) The entire staff will be inserviced by the Vice President of Operations including the Director of Nursing and the Administrator as to the importance of and the step by step procedures regarding communicating and documenting any suspected physical abuse to their immediate supervisor, the Director of Nursing, the Care Plan Coordinator and the Administrator/Abuse Officer.</p> <p>D) The Quality Assurance Team (the Medical Director, Director of Nursing, Care Plan Coordinator, Administrator, Dietary Manager, and the Activity Director) will audit and discuss all 24 Hour and 5 Day reports regarding suspected Physical Abuse and track the results and the effectiveness of the changes in the individual care plans as well as the effectiveness of the interventions implemented. All grievance logs/nursing notes were audited for any suspected abuse for the past 90 days.</p> <p>E) 09-09-2016</p>		

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F 226	<p>Continued From page 11</p> <p>Resident #2, "please don't climb out of the bed as you may fall on the floor." The note indicated Nurse #3 went into the resident's room. The notes further indicated Nurse #3 was present in the resident's room with NA #1 and helped assist Resident #2 back into the bed. The Nurse (#3) note continued with Resident #2 had told her NA #1 handled her in a rough manner.</p> <p>A review of the facility grievances revealed a grievance was made by the responsible party for Resident # 2, dated 4/18/2016 to the Director of Nursing (DON). The grievance revealed Resident # 2 stated to him someone threw her onto the bed rails, causing the resident to strike an area on her face and neck.</p> <p>During an interview with Resident # 2 on 08/16/2016 at 10:08 AM, she explained an incident with NA # 1 and Nurse # 3 working the 11 PM-7 AM shift. Resident # 2 stated she was trying to get out of the bed and explained to NA #1 she wasn't well, but stated NA #1 " pushed her and she fell backwards and hit the bed rail on the lower part of her neck and back causing her pain for more than 2 weeks." Resident # 2 stated she reported the incident to her Responsible Party. Resident #2 could not recall the exact date the incident occurred.</p> <p>During an interview with the DON on 08/17/2016 at 10:03 AM, she revealed there was no abuse investigation for the grievance with Resident #2. She further stated, "It was not a reportable incident." The DON was unable to provide any investigation into the abuse allegation made by Resident #2.</p> <p>An interview was conducted with NA #1 on</p>	F 226			

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F 226	<p>Continued From page 12</p> <p>8/17/2016 at 3:36 PM. During this interview, NA #1 indicated she did recall the incident on 4/16/2016 with Resident #2. She stated she was assisting Resident #2 back to her bed, and stated Resident #2 became upset and stated the staff were treating her like trash. She stated she made sure the resident was comfortable and left the room. She stated she did not talk further to anyone about the incident, and the DON nor any other Administration staff ever came to her to question her about Resident #2's concerns of care and treatment.</p> <p>An interview was conducted with Nurse #3 on 8/17/2016 at 5:39 PM. During this interview, Nurse #3 indicated she did recall the incident on 4/16/2016 with Resident #2. She stated while NA #1 was assisting Resident #2, the resident became upset and stated staff were, "treating her like trash." Nurse #3 stated she did not talk to the DON about the concerns, until after the Responsible Party reported the concern.</p> <p>An interview was conducted with the Responsible Party for Resident #2 on 8/17/2016 at 5:55 PM. During this interview, the Responsible Party stated Resident #2 reported to him on 4/18/2016 she had been handled roughly and was thrown into the bed rails by a staff on third shift. The Responsible Party stated he reported the allegation to the DON.</p> <p>An additional interview with DON on 08/18/2016 at 1:10 PM, revealed the facility no longer had a Social Worker. She stated the Social Worker position was the Abuse Coordinator for the facility. The DON explained the positions now in charge of reviewing abuse allegations and grievances are the Activities Director,</p>	F 226			

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F 226	Continued From page 13 Administrator, and the DON.  During an interview with Administrator on 08/18/2016 at 5:03 PM, he stated he was the Abuse Officer and responsible for reporting all allegations of abuse. When shown the grievance for Resident # 2, he indicated he did review the grievance when it was filed. He stated it was a reportable incident and, " it should have been reported and it was overlooked."	F 226			
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 discard expired food items and failed to date opened food items in 2 of 2 nourishment rooms (ground floor and first floor). The findings included: An observation of the first floor nourishment room on 8/18/16 at 8:48 AM revealed that the refrigerator contained a jar of beets labeled with a resident's name. The jar of beets was opened and there was no date present on the jar. Additionally, an open jar of blackberry jam labeled with a resident's name was discovered in the	F 371	A) All refrigerators and food storage areas were inspected and all food items that were not dated, that were out of date (must have had a current date and be within the past 3 days) and or that did not have a name were discarded.  B) All refrigerators and food storage areas will be inspected daily to ensure all expired food items are discarded as well as any food items that are not properly marked (they must have a name a date and the date must be with in a current 3 day period), to ensure compliance.  C) The entire staff will be inserviced by the Administrator as to the importance of all food items having names and dates within a current 3 day period. There is a sign off sheet attached to the refrigerator that will be signed daily by the dietary staff member who performs the daily inspection to ensure compliance.  D) All refrigerators and food storage areas and the daily sign off sheets will be inspected by the Dietary Director and the Administrator weekly to ensure compliance. The Quality Assurance Team ( the Medical Director, Director of Nursing, Care Plan Coordinator, Administrator, Dietary Manager, and the Activity Director) will be informed of the results of the daily sign off sheets and the weekly inspections performed by the Dietary Manager and the Administrator at the monthly Quality Assurance meeting.  E) 09-09-2016		

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F 371	<p>Continued From page 14</p> <p>refrigerator, a date was not present on the container. The manufacturer 's use by date was November 9, 2015. Additionally, a plastic cup of corn flakes covered with plastic cling wrap dated 3/7 (year not included) was found in the cereal cabinet by the sink.</p> <p>An observation of the ground floor nourishment room on 8/18/16 at 9:06 AM revealed that the refrigerator contained a jar of mayonnaise labeled with a resident's name, a date was not present on the jar. Observation of a lower cabinet revealed a 33.9 ounce container of Ground Coffee, no resident's name or date of opening was recorded on the container. The manufacturer's date on the bottom of the container indicated best if used by June 14 2014. A 10.5 ounce container of House Blend Ground Coffee was also discovered that did not contain a resident's name or date of opening.</p> <p>An interview conducted with Nurse # 2 on 8/18/16 at 9:19 AM revealed that the person placing a resident' s food item into the refrigerator was responsible for labeling and dating the item. Nurse # 2 indicated that dietary staff are responsible for checking dates and discarding items that are expired. Nurse # 2 revealed that the coffee under the cabinet belonged to a resident. Nurse # 2 indicated that the coffee canister did not have the resident's name or a date of opening. When asked to look at the use by date, Nurse # 2 replied June 14, 2014. She reported that she was not aware that coffee had been put under the cabinet.</p> <p>An interview conducted with Nurse # 1 on 8/18/16 at 9:27 AM, revealed that dietary staff are responsible for discarding expired food items from the refrigerator in the nourishment room. Nurse # 1 indicated that the person who put a food item into the refrigerator would be</p>	F 371			

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F 371	<p>Continued From page 15</p> <p>responsible for labeling the item with the resident's name and date. When asked to look at the blackberry jam in the refrigerator she acknowledged a resident' s name was present on the jar but the date was missing. When asked to check the manufacturer 's expiration date Nurse # 1 replied, " It was expired and it should be thrown away. " Nurse # 1 confirmed that the beets had no date recorded on the label and should also be discarded. When asked about the cornflakes dated 3/7 Nurse # 1 indicated the corn flakes probably came down on a snack cart. She replied, " They are way too old to be in here, and they should be thrown away. "</p> <p>An interview conducted with the Dietary Manager (DM) on 8/18/16 at 9:49 AM revealed that dietary staff are responsible for cleaning out refrigerators and cabinets located within the nourishment rooms. DM indicated she was not aware resident food/beverage items were being stored in the cabinets. DM revealed that dietary staff check each nourishment room on a daily basis. Dietary staff ensure that resident food items are labeled with the resident's name and date of opening. Dietary staff also check to ensure that resident food items are not expired. When asked about the expired items that were located in each nourishment room, the DM indicated her expectation was that dietary staff check to ensure that any food that was not labeled with resident's name, date of opening, or was expired was discarded. DM further indicated that dietary staff should monitor manufacturer expiration dates as well.</p> <p>An interview conducted with the Director of Nursing (DON) on 8/18/16 at 10:01 AM revealed that the responsibility for cleaning out refrigerators and cabinets falls on dietary staff.</p>	F 371			



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F 371	Continued From page 16 The DON indicated it was her expectation that any food items stored within the nourishment room should be checked to ensure it was labeled with the resident's name and date. She further indicated food items should also be checked for expiration date. The DON also revealed nursing staff should check resident food items to ensure they are labeled with a resident's name and date. The DON indicated that dietary staff should be checking resident food items for labels and dates, and throwing out any food item that was expired. An interview with the Administrator on 8/18/16 at 10:17 AM revealed that he expected the nourishment room to be checked and any expired or unlabeled food item to be discarded.	F 371		