STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	10/27/2016

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OCEAN TRAIL HEALTHCARE & REHAB CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #SOBS11	F 000		
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	F 278	F278-This plan of correction is provided	11/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/14/2016

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F 278	Continued From page 1 facility failed to accurately code the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening and Resident Review (PASRR) determination for 3 of 7 residents (Residents #10, #37, #76) identified as a Level II PASRR resident. Findings included: 1. Resident #10 was admitted to the facility on 5/21/15 and was most recently readmitted on 8/5/15 with a diagnoses including Schizophrenia, Bipolar Disorder, Borderline Personality Disorder, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of Resident #10's PASRR level II, dated on 9/30/13, revealed that the resident had a permanent number. Review of the Annual MDS, dated on 5/10/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review 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. During an interview with the MDS Coordinator on 10/27/16 at 2:30 PM, she stated that she would find out who was a level II PASRR by looking on the chart or calling the social worker if it was not on the chart. The MDS Coordinator stated that she was responsible for entering this information into the MDS and that the PASRR information is supposed to be on the initial, annual, and change	F 278	as a necessary requirement of continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice. For those residents found to have been effected by the alleged deficient practice the following corrective action was taken: The Social Worker printed out the list of all those residents identified during the survey who were level II PASRR. The MDS for those residents were reviewed and corrections made as needed by the MDS nurse (completion date 10/28/16). The social worker placed all PASRR in the medical records in the social section. (completion date 10/28/16) All residents with a level II PASRR have the potential to be effected by the same alleged deficient practice. A list of residents with level II PASRR was printed by the social worker, reviewed by the MDS nurse with changes made as needed. Copies of those PASRR were then placed in the residents chart in the social section (completion date 10/28/16). To ensure that the alleged deficient practice will not recur the following measures were put into place: The social worker will place a copy of all PASRR in the patients medical record as part of the social section. The social worker will print a list of all level II PASRR in the building on a monthly basis and distribute a copy of this list to the MDS nurse. The social worker will complete	

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F 278	Continued From page 2 of condition MDSs and all Level II PASRR residents should be coded as such. In an interview with the Director of Nursing (DON) on 10/27/16 at 3:25 PM, she stated that she would expect all level II PASRR residents to be coded appropriately on the MDS. She also stated that it would be the expectation, moving forward, that the social worker would be responsible for entering this information in the MDS. 2. Resident #37 was admitted to the facility on 1/21/09 with diagnoses including Psychotic Disorder with Hallucinations. Review of Resident #37's PASRR level II, dated on 12/09/2009 revealed that the resident had a permanent PASSAR level II number. Review of Resident #37's Annual MDS, dated on 4/1/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review 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. During an interview with the MDS Coordinator on 10/27/16 at 2:30 PM, she stated that she would find out who was a level II PASRR by looking on the chart or calling the social worker if it was not on the chart. The MDS Coordinator stated that she was responsible for entering this information into the MDS and that the PASRR information is supposed to be on the initial, annual, and change of condition MDSs and all Level II PASRR	F 278	that section on the MDS. The MDS nurse will audit both the medical record and the printed list to ensure proper coding of PASRR levels on the minimum data set. A PASRR audit tool will be completed within 14 days of admission and then annually or at the time of a significant change. In order to ensure that the solutions are sustained this plan of correction will be integrated into our Quality Assurance program and reviewed by the QA committee at our monthly QA meetings for 3 months and then quarterly thereafter.	

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F 278	Continued From page 3	F 278		

residents should be coded as such.

In an interview with the Director of Nursing (DON) on 10/27/16 at 3:25 PM, she stated that she would expect all level II PASRR residents to be coded appropriately on the MDS. She also stated that it would be the expectation, moving forward, that the social worker would be responsible for entering this information in the MDS.

3. Resident #76 was admitted to the facility on 5/5/16 with diagnoses including Down Syndrome and Major Depressive Disorder.

Review of Resident #76's Admission MDS, dated on 5/13/16, indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review 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.
Review of the PASRR Level II number for Resident #76 revealed that it was a lifetime number with no level of care restrictions.

During an interview with the MDS Coordinator on 10/27/16 at 2:30 PM, she stated that she would find out who was a level II PASRR by looking on the chart or calling the social worker if it was not on the chart. The MDS Coordinator stated that she was responsible for entering this information into the MDS and that the PASRR information is supposed to be on the initial, annual, and change of condition MDSs and all Level II PASRR residents should be coded as such.

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F 278	Continued From page 4 In an interview with the Director of Nursing (DON) on 10/27/16 at 3:25 PM, she stated that she would expect all level II PASRR residents to be coded appropriately on the MDS. She also stated that it would be the expectation, moving forward, that the social worker would be responsible for entering this information in the MDS.	F 278		
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 a sanitizing solution at the strength required by the facility for adequate sanitization in 2 of 2 sanitation buckets and a three compartment sink and failed to maintain clean equipment for use in the preparation of meals for facility residents by not maintaining a clean microwave and deep fryer in the kitchen. Findings included: 1. At 10:55 AM on 10/25/16, the kitchen manager (KM) used a test strip, used to measure the strength of sanitation solution, in a red sanitation bucket that was located under the food	F 371	F371- This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medicaid Programs and does not in any manner constitute an admission to the validity of the alleged deficient practice. For those areas effected by the alleged deficient practice the following corrective action was taken: The microwave was properly cleaned on 10/27/16. The deep fryer was emptied, cleaned and fresh oil was added on	11/15/16

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F 371	Continued From page 5 preparation table. The strip did not register any sanitation solution. At 10:57 AM on 10/25/16, the kitchen manager used a test strip, used to measure the strength of sanitation solution, in a red sanitation bucket that was located on the end of the three compartment sink. The strip did not register any sanitation solution. In an interview on 10/25/16 at 10:58 AM, the kitchen manager stated that the test strips used were not the proper test strips for the sanitation solution that was in the buckets and that the kitchen staff could not locate or were out of the proper test strips needed to measure the sanitation solution. The kitchen manager was unable to say why the facility did not have the proper test strips for the sanitation solution being used. At 11:06 AM on 10/25/16, the kitchen manager emptied the two red sanitation buckets and replaced them with one red bucket and one green bucket with a bleach based sanitation solution. The Kitchen manager used the same test strips that had been used to test the sanitation solutions in the buckets that were dumped in the new sanitation buckets and both buckets registered that they contained an adequate amount of bleach solution for proper sanitation, at least 50 parts per million (PPM). At 11:10 AM on 10/25/16, the dietary manager (DM) stated that the facility had recently switched vendors for their sanitation solutions about 2 months ago and had only received a month supply of the test strips that should be used for the new sanitation solution. The DM reported they	F 371	10/27/16. The correct PPM strips were ordered and PPM reading will be recorded daily to ensure that the water in the 3 compartment sink and the red sanitizer bucket meets sanitization requirements (completion date 11/3/16). The hood was dusted on 10/28/16. All equipment in the kitchen, as well as sanitary solutions, has the potential to be effected by the same alleged deficient practice. The cleanliness of all kitchen equipment and the proper set up, use, and monitoring of proper sanitary solutions will be monitored by the food service manager or his designee. The equipment will be cleaned and sanitized as needed. The supply of PPM strips will monitored and additional strips will be ordered as needed to prevent depletion of the supply. The sanitary solution will be maintained at the proper PPM readings, and if not, will be corrected immediately (completion date 11/3/16). In order to assure that the same alleged deficient practices do not recur, the following systemic changes have been implemented. The food service manager or his designee will make daily rounds inspecting equipment and sanitation as well as monitoring sanitary solutions in the 3 compartment sink and in the sanitizer buckets for compliance. These rounds and their results will be documented/logged. Oil will be replaced	

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F 371	Continued From page 6 had been out of the appropriate test strips for about 3 weeks, but they had been using a bleach solution instead and had been testing their sanitation buckets using the strips that the KM had used earlier, which were appropriate for detecting PPM levels for bleach based sanitation solutions. At 11:15 AM on 10/25/16, the DM and KM searched for the PPM log to show that the facility had been testing the sanitation solution in the sanitation buckets and were unable to find the log or any other record that the sanitation buckets had been monitored regularly for the proper amount of sanitation solution. At 5:50 PM on 10/26/16, a dietary staff member, used a test strip to test the sanitation solution in the third compartment, or the sanitization compartment of the sink. The test strip did not register a minimum of 50 PPM of bleach based sanitation solution. At 5:53 PM on 10/26/16, the dietary staff member emptied the third compartment of the sink and stated that the solution may have gotten weak since the water had been used and more water had been added to the sink. The staff member reported that bleach would need to be used because of the facility not having the strips needed to test the sanitation solution that was supposed to be used for the sink. At 6:05 PM on 10/26/16, the dietary staff member used a test strip and tested the new water that had been filled into the third compartment of the sink and mixed with bleach. The test strip registered 75 PPM.	F 371	in the deep fryer as needed. Fryer oil was changed on 10/27/16. To monitor the performance of the dietary department to make that these corrections are achieved and sustained, an audit tool has been developed to review the cleaning and sanitation logs and the cleanliness of the equipment at our weekly meetings. Audits will completed daily for one month with the revision of audit frequency to be determined at each meeting. Subsequent audits will be integrated into the Quality Assurance program at our monthly QA meetings for the next 3 months. At these meetings the effectiveness of the corrective action will be reviewed and revised as needed to sustain the effectiveness of the plan of correction. The daily audits will begin on 11/15/16.	

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2. At 10:51 AM on 10/25/16, the microwave located on a table at the end of the tray line had dried and stuck on food debris on the bottom, sides, and top of the inside.

At 11:20 AM on 10/25/16, the DM stated that the microwave should be cleaned as needed throughout the day and each night.

At 5:20 PM on 10/26/16, the microwave was still dirty with dried and stuck on food debris on the bottom, sides, and top of the inside.

3. At 10:50 AM on 10/25/16, the grease in the fryer was dark brown to black in color, contained bits of old fried foods on top and around the edges of the fryer and smelled of burned food and oil.

At 11:20 AM on 10/25/16, the DM stated that the oil was changed and fryer was cleaned once a week.

At 5:49 PM on 10/26/16, the grease in the fryer was still dark brown to black in color, contained bits of old fried foods on top and around the edges of the fryer and smelled of burned food and oil.

In an interview with the DM at 1:55 PM on 10/27/16, he stated he understood the concerns regarding the PPM logs and the sanitation solution testing in the sanitation buckets and three compartment sink, the cleanliness of the microwave, and the changing of fryer oil and cleaning of the fryer. He reported that, moving forward, he would be maintaining a daily and weekly checklist of necessary cleaning items, including the microwave and that staff would be

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F 371	Continued From page 8 in-serviced about the importance of maintaining the cleanliness of the microwave and other food preparation equipment. The DM reported that the fryer oil had been changed on the morning of 10/27/16, which was a Wednesday, but was typically scheduled to be changed on Tuesdays after all meals were served for the day and he would stress to the staff the importance of changing the oil on an as needed basis if it was getting used more frequently and needed to be changed prior to the weekly scheduled time. He also reported that he had set up another PPM log for staff to begin using immediately for testing sanitation solution and that they would be using the bleach solution until they received the proper test strips to be used for testing the solution connected to the three compartment sink.	F 371		