PRINTED: 01/05/2018 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_			С
		345441	B. WING			12/	14/2017
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AL EVAND	DIA DI ACE			17	770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			G	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
		e cited as a result of the CI /2017 NC00128719, Event					
F 689 SS=D	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F (689			1/11/18
	as free of accident has §483.25(d)(2)Each resupervision and assist accidents. This REQUIREMENT by: Based on staff and reference of two perwhich resulted in a faresidents reviewed for Findings included: Resident #37 was ad 11/3/09 and his most facility was on 5/2/17 included heart failure	are that - sident environment remains azards as is possible; and esident receives adequate stance devices to prevent - is not met as evidenced esident interviews and fility failed to provide the son staff with transfers Il without injury for 1 of 2 or falls. (Resident #37) mitted to the facility on recent re-admission to the . His active diagnoses , hypertension, diabetes hia, Parkinson's disease, hid depression.			Alexandria Place's response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it is required by law. A. Address how corrective action will accomplished for each resident found to be affected by the deficient practice an what led to this deficiency being cited. It is the policy of Alexandria Place to ensure that residents who are unable to carry out independent transfers received the necessary services to prevent accidents. Resident #37 was assessed falls and level of assistance with transferior to 12/08/17. It was determined that	be to d o e	
	assistance with trans assessed to be at hig	fers. Resident #37 was h risk for falls.			Resident #37 needs to have a two pers assist with transfers. It has been determined that on 12/8/17 nurse aide		
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Electronically Signed 12/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′				ATE SURVEY DMPLETED
			A. BOILDI	_			С
		345441	B. WING _				12/14/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2017
					770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE				GASTONIA, NC 28054		
					T		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 689	Continued From page	ge 1	F	689			
	Review of Resident	#37's most recent minimum			did not consult the resident care sheet		
	data set (MDS) ass	essment dated 10/20/17			provided to all nursing assistants every	y	
	revealed he was as	sessed as cognitively intact.			shift. Therefore nurse aide #1 did not		
	Resident #37 requir	red extensive, two person			have another nurse aide with her to as	sist	
	physical assistance	with transfers. Resident #37			the resident with a transfer as was not	ed	
		ive impairment in his range of			to be required per the resident care sh		
	motion on both side	es of his lower extremities.			The resident care sheet informs the nu		
					aides of the level of care each residen		
		#37's care plan updated			to receive and should have been revie		
		he resident had a care plan			by nurse aide #1 at the start of the shift		
		required assistance from staff			All nurse aides will be retrained and in		
		interventions included to			serviced on the usage of the care shee		
	provide assistance	with all transfers as needed.			provided to them by Alexandria Place	as	
	Dovious of a purco's	note dated 12/8/17 revealed			well as the proper way to transfer residents needing two persons		
		ed Nurse #1 that Resident			assistance.		
		e shower when transferring			B. Address how corrective action will	l he	
		air to his wheelchair. Both the			accomplished for those residents havin		
		wer chair were locked and in			potential to be affected by the same	ig u	
		. Resident #37 attempted to			deficient practice.		
		e shower chair and fell. Nurse			Because all residents receiving physic	cal	
	Aide #1 told the Nu	rse #1 that Resident #37 did			assistance with two persons assist		
		she was standing by for			transfers are potentially affected by the	Э.	
		ne fall occurred. Resident #37			alleged deficient practice, on 12/27/17		
	was assessed for in	ijury and none were noted. He			Director of nursing assessed all reside	nts	
	was assisted back i	nto his wheelchair. Resident			that require two persons assistance wi	th	
	#37 denied pain and	d the Physician, the Director of			transfers. All nurse aides will be retrair	ned	
	Nursing and family	were notified.			and in serviced on the usage of the ca	re	
					sheets provided to them by Alexandria	i	
		nt report dated 12/8/17			Place as well as the proper way to		
		#37 sustained a fall without			transfer residents needing two persons	3	
		ring from the shower chair to			assistance. The Director of Nursing		
		wheelchair and shower chair			completed the retraining and in servici	ng	
		nd in their correct positions.			on 12/29/17. The nurse managers	for-	
		pted to transfer himself and			observed all two person assisted trans	iers	
		se Aide #1 was documented to			on 12/27/17. No other residents were		
		supervision when the fall			affected.		
	when the fall occurr	ne only staff member present			C. Address what measures will be pu	ıt	
	Willow the fall booten	ou.	1		1 C. Addices what incasures will be pu	46	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '				SURVEY PLETED
						(С
		345441	B. WING _			12/	14/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AL EVAND	DIA DI AOF			17	70 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			G	ASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From particles and interview Resident #37 stated shower room because while he was transfer were two nurse aided but one left to get state the nurse aided help him transfer to wheelchair moved be wet and he slipped his wheelchair and from the fall. He state they used a lift to get wheelchair. He furth get any more shower there were normally was being transferred surveyor observation. During an interview Nurse Aide #1 stated was with Resident #3 She stated he had detransferring from the wheelchair. Nurse Aide her he could transferring supervision.	ge 2 on 12/11/17 at 4:29 PM d that last week he fell in the use the wheelchair slipped erring. He stated that there es providing him his shower comething. He further stated who remained attempted to his wheelchair. He stated the coack because the floor was to a sitting position in front of denied having any injuries atted that the nurse came and et him back into his mer stated he did not want to ears because he did not like the room. Resident #37 stated of two staff present when he ed. Resident #37 declined on of his transfers. on 12/13/17 at 11:02 AM and she was the nurse aide who staff when he fell in the shower. Completed his shower and was a shower chair to his laide #1 stated Resident #37 ansfer himself so she was on. She stated when he put his	TAG	689	into place or systematic changes made ensure that the deficient practice will no occur To enhance currently compliant operations and under the direction of the Director of nursing, resident care sheed will be updated weekly and as needed reflect the correct transfer technique. These sheets will be given out to each nurse aide at each shift. The Director of Nursing will also perform weekly observations of two persons assisted transfers. These observations will be reported to the monthly Quality Assurant meetings. D. Indicate how the facility plans to monitor the measures to make sure the solutions are sustained. The facility mudevelop a plan for ensuring that corrections are achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC must be integrated into the Quality Assurance system of the facility. On a weekly basis The Director of Nurs will report observations of transfer techniques for residents with falls to the weekly falls committee meetings. The	e to ot ne ts to of nce at ust d. e	DATE
	the floor being wet a stopping the wheeld #1 further stated sh in the room because for the day. Nurse A Resident #37 slide into a seated position Nurse #1 to assess	Ichair it slipped back due to and the break not fully chair from moving. Nurse Aide e was the only staff member e her partner had gone home aide #1 continued, stating down in front of his wheelchair on and Nurse Aide #1 called the resident. She further			weekly observations will be completed days a week for 2 weeks, 3 days a week for 2 weeks, once a week for 2 weeks a finally monthly for 6 months. The Direct of nursing will report these random observations that were completed for the month to the Quality Assurance committee. If no issues are identified be the Quality Assurance Committee, the Director of nursing will report the	ek and tor he	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	ELE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345441	B. WING			C 12/14/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		1271472017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 689	Aide #1 stated he app transferring by himse was usually on the stated for Resident #3 concluded she had not assessments and har #37 was assessed to person assistance with During an interview of Nurse #2 stated she knew him well. She freextensive assistance required two staff preshower. During an interview of Nurse #1 stated that the shower room and while attempting to the shower room and while attempting to the shower injuries or constated they brought the wheelchair. She shows the only staff med During an interview of Director of Nursing stated they staff would perform the staff was the staff woul	p into his wheelchair. Nurse beared comfortable of the further stated she tower team and had not so to seen his care plan or do not been aware Resident require extensive two the transfers. In 12/13/17 at 11:24 AM cared for Resident #37 and curther stated he needed due to his condition and he sent during transfers in the In 12/13/17 at 11:28 AM Nurse Aide #1 called her to told her Resident #37 fell ansfer from the shower chair the further stated when she was sitting in front of the for. Nurse #1 stated he did complaints of pain. Nurse #1 the lift and got him back into curther stated Nurse Aide #1 mber present at the fall. In 12/13/17 at 1:43 PM the stated it was her expectation rovide assistance with the the resident 's assessed the further stated that did two person assistance where should have been two is transfer on 12/8/17 when	F 68	observations on a quarterly Quality Assurance Committee Quality Assurance committee charged with the responsibilithat the correction is achieved substantiated.	ee. The e will be ity to ensure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345441	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	343441		STREET ADDRESS, CITY, STATE, ZIP CODE	12/14/2017
				1770 OAK HOLLOW ROAD	
ALEXAND	PRIA PLACE		I	GASTONIA, NC 28054	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 812	Continued From page	e 4	F 812	2	
F 812 SS=E	l	tore/Prepare/Serve-Sanitary 2)	F 812	2	1/11/18
	§483.60(i) Food safe The facility must -	ty requirements.			
	state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store,	red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent produce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ance with professional			
	by: Based on observation facility failed to provide eat foods or silverwal hands for 2 staff men #4) during 3 of 3 dining #9, #21, #22 and #16 The findings included 1. During an observation PM, Nurse Aide (NA) Resident #9. Resident two pieces of bread silices on the top piece.			Alexandria Place's response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute ar admission that any stated deficiency accurate. We are submitting the POG because it is required by law. A. Address how corrective action was accomplished for each resident foun be affected by the deficient practice what led to this deficiency being cited it is the policy of Alexandria Place to ensure that all safe food handling practice are carried out. All nurse aides have	vill be d to and d. o actice

			TE SURVEY MPLETED				
			A. BOILDI	_			c l
		345441	B. WING _			1) 14/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	71-72017
				1	770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			G	GASTONIA, NC 28054		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	l	(X5)
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI: TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 812	Continued From pa	age 5	F	812			
	with a fork and mo	ved the bottom piece of bread			retrained on the proper handling of re-	ady	
	from under the top	piece of bread with his fingers.			to eat foods and the handling of clean		
	An interview with N	IA #4 was conducted on			silverware on 12/29/17. This training h	nas	
	12/11/2017 at 6:00	PM. The NA stated he had			been done by the Director of Nursing.	For	
		nad touched the bottom piece			resident #9, nurse aide #4 was		
		and. The NA stated he usually			immediately re-educated and made a		
		fork to move the pieces of			of the mishandling of ready to eat food		
		ted food should not be touched			For residents #21, #22 and #16, nurse		
	with bare hands.				aide #3 was immediately re-educated		
	0= 10/10/2017 =+	10:11 DM the Dietem Meneger			made aware of the mishandling of rea	•	
		12:14 PM the Dietary Manager			to eat food and the mishandling of cle		
		or any ready to eat food item dled with bare hands.			silverware by the Director of Nursing. negative outcomes were noted by the		
	Should not be hand	ned with bare names.			alleged deficient practice. It has been		
	On 12/14/2017 at 1	12:22 PM the Director of			determined that the alleged deficient		
		ted it was her expectation that			practice was caused by nurse aides w	/ho	
		bread with bare hands.			were not following safe handling polic		
					of Alexandria Place.		
	2. During an obser	vation in the dining room on			B. Address how corrective action wi	ll be	
		PM Nurse Aide (NA) #3 was			accomplished for those residents have	ng a	
	observed assisting	resident #21 with his meal set			potential to be affected by the same	_	
	up. NA #3 was ob	served to remove the bread			deficient practice.		
	from the paper bre	ad bag by placing her bare			Any resident has the potential to be		
	hand into the bag a	and removing the bread.			affected by this practice. All current		
					nursing staff will be in serviced on the		
		wed on 12/13/17 at 8:15 AM.			proper way to serve ready to eat food	S	
		d touched the bread when she			and the proper way to handle clean		
		e bag but she had not realized			silverware on 12/29/17 by the Director		
	it was not the corre	ect way to handle the bread.			Nursing. All future hires will be observ		
	0:- 40/40/47 -+ 40:-	AA DM the Dieter Menero			demonstrating proper safe food handl	ing	
		14 PM the Dietary Manager			techniques during their week of floor	aro	
		or any ready to eat food item dled with bare hands.			orientation to ensure that they are award and are proficient in using proper food		
	SHOULD HOLDE HALL	dieu willi bale Hallus.			handling techniques by the Director of		
	On 12/14/17 at 12	22 PM the Director of Nursing			Nursing. The Dietary manager will		
		s her expectation that staff not			conduct weekly observations for prop	≏r	
	touch bread with th	•			food and silverware handling. These	. ,	
	Coon broad will li	ion salo harido.			observations will be recorded on a Qu	ality	
	3. During an obser	vation in the dining room on			Assurance form.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	((X3) DATE SURVEY COMPLETED
		345441	B. WING _			C 12/14/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	12/11/2011
				1770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	
F 812	Continued From pag	e 6	F 8	12		
F 812	12/13/17 at 12:28 PM assisting resident #2 was observed to rempaper bread by placibag and removing the NA #3 was interview. She stated she had tremoved it from the lit was not the correct On 12/13/17 at 12:14 (DM) stated bread or should not be handled. On 12/14/17 at 12:22 (DON) stated it was touch bread with the 4. During an observed 12/14/17 at 8:10 AM assisting Resident #3 was observed to rempaper bread bag usinheld the bread in her the bread. NA #3 was interview. She stated she had the removed it from the lit was not the correct with the correct was not the correct with the literature.	A NA #3 was observed 2 with her meal set up. She love the bread from the ing her bare hand inside the e bread. ed on 12/13/17 at 8:15 AM. ouched the bread when she bag but she had not realized a way to handle the bread. A PM the Dietary Manager any ready to eat food item and with bare hands. PM the Director of Nursing her expectation that staff not in bare hands. At the bread from on NA #3 was observed in with his meal set up. She love the bread from the ing her bare hand. She then in hand as she applied jelly to be don 12/13/17 at 8:15 AM. ouched the bread when she bag but she had not realize it way to handle the bread. A PM the Dietary Manager	F8	C. Address what me into place or systema ensure that the deficie occur The dietary manager checks of ready to eathe handling of clean weekly checks will be week for 3 weeks, 3 tweeks, once a week monthly for a year. The form will be submitted Quality assurance correview. D. Indicate how the monitor the measures solutions are sustained develop a plan for encorrections are achied. The plan must be improcorrective action eval effectiveness. The Pointegrated into the Quaystem of the facility. The dietary manager checks of ready to eathe handling of clean weekly checks will be week for 3 weeks, 3 tweeks, once a week from will be submitted Quality assurance collective action and the submitted Quality assurance collections.	tic changes made ent practice will not will conduct weekly to food handling and silverware. These done 5 times a simes a week for 2 for 2 weeks and the Quality assurant to the monthly mmittee meeting for a facility plans to be to make sure that we done the facility must be sure that we done to make sure that we done to make sure that we done to make sure that we done that we done that we done that we done that we will conduct weekly to food handling and silverware. These done 5 times a meek for 2 for 2 weeks and the Quality assurant to the monthly mmittee meeting for the silverware to the monthly mittee meeting for the silverware to the silverware	to t y d ce or t y d
	should not be handle			review. If no issues an Quality Assurance Comanager will report the	ommittee, the Dieta ne observations on	ary a
		2 PM the Director of Nursing her expectation that staff not ir bare hands.		quarterly basis to the Committee. The Qual committee will be cha	ity Assurance	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SUF	OMPLETED	
		345441	B. WING		C 12/14/	2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	12/17/	2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE C	(X5) OMPLETION DATE	
F 812 F 867 SS=E	5. During an observa 12/14/17 at 8:15 AM assisting resident #10 was observed to rem silverware bag and with eating ends of the hands. NA #3 was interviewed She stated she was deating end of the silvitial slipped through her it on the resident 's to the resident's to the resident's to the resident's to the eating any ready to eat food with bare hands. On 12/14/17 at 12:22 (DON) stated it was to touch the eating part QAPI/QAA Improvem CFR(s): 483.75(g)(2) \$483.75(g) Quality as \$483.75(g)(2) The quassurance committee (ii) Develop and implication to correct iden This REQUIREMENT by:	tion in the dining room on NA #3 was observed with her meal set up. She ove the silverware from the while doing so she touched exilverware with her bare and on 12/13/17 at 8:15 AM. Unaware of touching the erware but she may have as a hand while she was placing ray. PM the Dietary Manager g part of the silverware and item should not be handled at PM the Director of Nursing her expectation that staff not of the silverware. Hent Activities (iii)	F 86	responsibility to ensure that the cor is achieved and substantiated.	1/1	11/18	
	facility's Quality Asse (QAA) Committee fai	ssment and Assurance led to maintain implemented itor interventions previously		survey report does not constitute agreement with the statement of deficiencies; nor does it constitute a			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	L COV		OMPLETED	
		345441	B. WING _			C 12/14/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12/1-7/2017	
				1770 OAK HOLLOW ROAD			
ALEXAND	RIA PLACE			GASTONIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 867	Continued From pag	ge 8	F 8	67			
F 867	put in place followin 10/19/16. This was originally cited in Oc subsequently recited survey of 12/14/17. In the area of Food facility's continued for survey showed a part sustain an effective Findings included: F812: Based on obstitute facility failed to pready to eat foods of bare hands for 2 stand #4) during 3 of (Residents #9, #21, This tag is cross refined to pready to eat foods of the facility was cited for ice machine in clear air dry plastic cups a storage. An interview was contained to the following the recertific facility was cited for ice machine in clear air dry plastic cups a storage.	g the recertification survey of for one deficiency that was stober of 2016 and d on the current recertification. The repeated deficiency was Safety Requirements. The ailure during the recertification attern of the facility's inability to QAA program. Servations and staff interviews provide a barrier between a silverware and the server's aff members (Nurse Aids #3 dining observations #22 and #16). Serenced to: Serenc	F 8	admission that any stated defice accurate. We are submitting the because it is required by law. A. Address how corrective accaccomplished for each resident be affected by the deficient practive accomplished for each resident be affected by the deficiency being It is the policy of Alexandria Pla Quality Assurance Committee to least quarterly and to include the Administrator, Director of Nursian Pharmacist, Medical director are three other staff members. This achieved by meeting monthly a reviewing all quality assurance completed by each department. While this tag denotes a repeat deficiency, the citation noted in different deficiency than was cit year. The Quality Assurance plainitiated for the prior year citation been effective in ensuring that the corrections initiated for that definitiated for the fact that the deficiency was not cited again of	tion will be found to ctice and g cited. In the comment at the com		
	the QAA committee were addressed by responsible for the of heads oversee the r to the QAA committer revisions. She state	ministrator who also headed She stated deficiencies the department heads deficiencies. The department monitoring and bring findings ee for discussion and d it was unfortunate for nother citation due to nurse		survey. Alexandria Place will ac corrections noted in our respon F812 to our Quality Assurance ensure that these correct ions a effective and sustained. B. Address how corrective ac accomplished for those residen potential to be affected by the s deficient practice. Any resident has the potential traffected by this practice. All cur	se for tag process to are also tion will be ts having a same o be		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345441	B. WING			C	
	ROVIDER OR SUPPLIER	345441	B. WING	STREET ADDRESS, CITY, STATE, ZIP 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	· CODE	12/14/2017	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIA	DATE
F 867	Continued From page	ge 9	F8	proper way to serve ready and the proper way to has silverware on 12/29/17 by Nursing. All future hires we demonstrating proper saft techniques during their worientation to ensure that and are proficient in using handling techniques by the nursing. The Dietary man weekly observations for public silverware handling. These will be recorded on a Quaform. C. Address what measure into place or systematic of ensure that the deficient proccur. The dietary manager will checks of ready to eat foot the handling of clean silverweekly checks will be dorn week for 3 weeks, 3 times weekly checks will be dorn week for 3 weeks, 3 times weeks, once a week for 2 monthly for a year. The Commonthly for a year. The Commonthly for a year of the facility assurance commitments are sustained. In develop a plan for ensuring corrections are sustained. The plan must be implemed corrective action evaluate effectiveness. The POC reintegrated into the Quality system of the facility.	ndle clean by the Director of civill be observed fe food handling week of floor they are awar g proper food ne Director of nager will cond proper food and se observation ality Assurance week will be put changes made practice will no conduct weekl od handling an erware. These ne 5 times a s a week for 2 weeks and Quality assurant the monthly ittee meeting for illity plans to make sure tha The facility mus ng that and sustained nented and the ed for its must be	d ag	

		(X3) DATE SURVEY COMPLETED				
						С
		345441	B. WING			12/14/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALEXAND	PRIA PLACE			1770 OAK HOLLOW ROAD GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 867	Continued From page	e 10	F 8	The dietary manager will cond checks of ready to eat food ha the handling of clean silverwar weekly checks will be done 5 the week for 3 weeks, 3 times a work weeks, once a week for 2 week monthly for a year. The Quality form will be submitted to the manager will be submitted to the manager will report the observanterly basis to the Quality A Committee. A quarterly in servate completed with all nursing staffood handling techniques incluback demonstration. This in servite wed in the quarterly Quality Assurance meeting. The Quality Assurance committee will be a correction is achieved and subsequently and subsequently in the submittee will be considered with all nursing staffood handling techniques incluback demonstration. This in servite well in the quarterly Quality Assurance committee will be considered and subsequently and subsequently the submittee will be considered and subsequently as a considered and subse	andling and re. These times a reek for 2 eks and y assurand nonthly meeting foied by the the Dieta rations on Assurance will be ff on proper unity ity charged wat the	ce or ary a e er rn be