

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

PRINTED: 10/22/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/31/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MARYFIELD NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1315 GREENSBORO ROAD</b> <b>HIGH POINT, NC 27260</b>
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F 000	INITIAL COMMENTS  No deficiencies were cited as a result of the complaint investigation survey completed 8/27/18-8/31/18. Event ID #HBM911.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally	F 585		8/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  10/01/2018
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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 585	Continued From page 1 (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a	F 585			

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F 585	<p>Continued From page 2</p> <p>summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility's grievance policy failed to include the business address and email of the grievance official, the contact information of independent entities with whom grievances may be filed, ensuring that written grievance decisions meets documentation requirements, taking corrective action in accordance with State law if the grievance is confirmed by the facility or an outside entity having jurisdiction and maintaining evidence of the result of all grievances for no less than three years.</p> <p>Findings included:</p> <p>A review of the employee handbook policy revised 11/2/2017 and titled "Supporting the Right</p>	F 585	<p>Pennybyrn at Maryfield Annual Recertification Survey Plan of Correction F 585 cited for Non-compliance found 8/30/2018 Return to compliance: 8/30/2018</p> <p>Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>We have not be able to identify any current or past residents affected by the wording of a policy that they have not seen nor would have reason to use. The deficient practice has the potential of affecting all current residents in the</p>		

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F 585	Continued From page 3 of Residents to Voice Grievances" was provided by the Administrator on 8/29/18 at 11:00 AM. The policy stated, "Residents, their legal representative, and family have the right to express a grievance or complaint about care and services provided by this community. They may also do so anonymously. Each grievance or complaint is to be handled with respect and in a timely manner." Further review of the policy revealed the following elements: "1. It is the responsibility of all employees within the community to listen respectfully when a resident or family member expresses a concern. 2. Residents and families are encouraged to bring concerns about the operation of the household to the household team. 3. The employee who takes the complaint should, orally or in writing, notify household leadership including the household coordinator and nurse mentor and/or Vice President of Health Services, Director of Nursing or Assistant Healthcare Administrator and Grievance Officer. 4. The leader notified of the complaint will notify and/or work with the Assistant Administrator/Grievance Officer (name and phone number were listed) who will be responsible for the completion of the remainder of the grievance process including: a. leading the investigation while maintaining confidentiality, b. issuing official decisions to the resident, c. report and coordinate with state and federal agencies, d. prevent further violations while the investigations are in process, e. complete all documentation, f. meeting all applicable state and federal laws and regulations. 5. It is expected that all employees of the household and community will be open to self-examination and be sensitive to the perspective of residents and their families."  A review of the facility's grievance policy revealed	F 585	facility.  On 8/30/2018 immediately following the conversation between the administrator and the lead surveyor, the policy in question was updated by the grievance officer match the language in F 585 of the elements which the surveyor had contented were not listed out as separate and matching the language in 585 to include.  <ul style="list-style-type: none"> <li>• business address and email of the grievance official,</li> <li>• the contact information of independent entities with whom grievances may be filed,</li> <li>• ensuring that written grievance decisions meets documentation requirements for example the date the grievance was received, a summary statement, steps to investigate the grievance and a summary of the pertinent findings and conclusion, a statement where the grievance was confirmed or not, any corrective action taken by the facility and the date the decision was made. taking corrective action in accordance with State law if the grievance is confirmed by the facility or an outside entity having jurisdiction and maintaining evidence of the result of all grievances for no less than three years.</li> </ul> Resident will continue to receive upon admission and through on-going communication (such as the weekly		

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F 585	<p>Continued From page 4</p> <p>it did not include the business address and email of the grievance official or the contact information of independent entities with whom grievances may be filed. The grievance policy also did not include information that ensured written grievance decisions met documentation requirements, how corrective action would be implemented in accordance with State law if the grievance was confirmed by the facility or an outside entity that had jurisdiction or how the facility maintained evidence of the result of all grievances for no less than three years.</p> <p>On 8/30/18 at 11:54 AM an interview was completed with the Administrator. She stated the grievance policy was included in the staff handbook. She said that although the policy had not included all the required elements outlined in the regulation the facility maintained the intent of the regulation. The Administrator reported the facility had provided information to residents and families on how to file grievances. She said information about the Ombudsman and State Agency were posted in the facility.</p>	F 585	<p>newsletters at least quarterly , written communications from the Administrator which are sent to all resident/POA's at least twice annually, prominent postings, and verbal communication such introduction/identification of the grievance officer as well as all other leadership staff at the annual resident meeting typically hosted each summer) where all the elements required of 585 as stated in the attached policy are provided.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same practice:</p> <p>We are not aware of any residents who were negatively impacted by the language in the policy in question. Leadership staff have spoken to families and residents and found no one who reports any concern in this area.</p> <p>As previously stated, to our knowledge there was no residents affected by the deficient practice and we have not been able to identify other residents affected.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice does not occur?</p> <p>Prior to survey, we had attempted to match intent of the regulation to our policies, referencing the specific F tag(s) related to the policy rather than the utilizing all and/or the exact language</p>		

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F 585	Continued From page 5	F 585	<p>contained in an F tag. All policies will be reviewed by the Assistant Administrator at least once each calendar year and at the time of any updates received from CMS to ensure continued compliance and utilization of the precise language of the F tags whenever possible.</p> <p>The particular policy in question [Grievance] was updated immediately (8/30/2018) and provided to the survey team to include the following:</p> <ul style="list-style-type: none"> <li>• business address and email of the grievance official,</li> <li>• the contact information of independent entities with whom grievances may be filed,</li> <li>• ensuring that written grievance decisions meets documentation requirements for example the date the grievance was received, a summary statement, steps to investigate the grievance and a summary of the pertinent findings and conclusion, a statement where the grievance was confirmed or not, any corrective action taken by the facility and the date the decision was made. taking corrective action in accordance with State law if the grievance is confirmed by the facility or an outside entity having jurisdiction and maintaining evidence of the result of all grievances for no less than three years.</li> </ul> <p>How does the facility plan to monitor its performance to make sure that solutions are sustained and ensuring the correction achieved and integrated into the Quality Assurance Systems of the facility?</p>		

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F 585	Continued From page 6	F 585	<p>All policies will continue to be reviewed by the Assistant Administrator within each calendar year to attempt to make certain the policy contains the required language of the F tag to eliminate any misunderstanding.</p> <p>Compliance with requirements of Grievance under resident rights will continue to be the responsibility of the identified Grievance Officer including review all grievances as they are reported, maintenance of records including logs, investigations, outcomes and any other information and/or reporting required based on the circumstances of the grievance, for a period no less than three years. The grievance officer will provide assistance with investigations. Grievances will be tracked and will be reviewed at the quarterly QA meetings to ensure grievances are continuing to be addressed and that there is no indication grievances are not being identified or properly and promptly addressed. Any concerns found through the quarterly review will be investigated in more detail to ensure resolution and intervention as necessary. The Grievance Officer will and respond within the appropriate time as identified by the circumstance, including within 24 hrs. as required by regulation with communication of finds in writing to the appropriate parties within 5 days.</p> <p>We will also continue the following practices that were existing prior to</p>		

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F 585	Continued From page 7	F 585	<p>survey:</p> <ul style="list-style-type: none"> <li>• Building relationships with residents and their families so that they are comfortable sharing concerns.</li> <li>• Providing easy access to information on who and how they can share information in openly viable places.</li> <li>• Addressing issues as soon as we are aware, hopefully before they become a grievance. (For example looking for a missing sweater at the time the resident notices it is missing. Laundry is done in the household and can often be immediately located rather than residents having to take this issue to a social worker.)</li> <li>• Monthly meetings in each separate household for the approximately 20 residents who reside within that house, creating an opportunity for them to speak up and share concerns on an on-going basis to raise awareness of and provide opportunities for residents to continue to make us aware of concerns rather than waiting for resident to reach a point of dissatisfaction that forces them to comes to us.</li> <li>• Continue the practice of inviting in our local Ombudsman at least annually to attend a meeting of her choice and offer us feedback.</li> <li>• Continuing to routinely suggest families and residents utilize the services of the ombudsman so that they feel they truly have an advocate that is not attached to the facility.</li> </ul>		
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		9/28/18	



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F 812 SS=D	Continued From page 8 CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interview, the facility failed to ensure the final rinse cycle of a dish machine reached and maintained a minimum temperature of 180 degrees Fahrenheit to sanitize food service and food preparation dishware; and, by not ensuring employees washed hands and donned clean gloves when handling soiled then clean items.  Findings included:  1. During a tour of the Hughes satellite kitchen on 8/30/18 at 11:00 a.m., the high temperature dishwashing machine was observed in operation with staff actively washing dishes in the machine.	F 812	Pennybyrn at Maryfield Annual Recertification Survey Plan of Correction F 812 cited for Non-compliance found 8/30/2018 Return to compliance: 8/30/2018 (Dishwasher) 9/28/2018 (Gloves)  Per 2567 received 9/17/2018: Facility failed to ensure the final rinse cycle of the dish machine reached and maintained a minimum temperature of 180 degrees Fahrenheit to sanitize food service and food preparation dishware and by not ensuring employees washed hands and donned clean gloves when handling soiled then clean items.		

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F 812	<p>Continued From page 9</p> <p>The machine's temperature gauge for the final rinse temperature only reached 175 degrees Fahrenheit. Upon request, the cycle was repeated. During this cycle the machine's final rinse temperature reached a maximum temperature of 176 degrees Fahrenheit. The operating instructions posted on the wall next to the dishwashing machine revealed the machine's final rinse cycle temperature should reach a minimum of 180 degrees Fahrenheit.</p> <p>During an interview on 8/30/18 at 11:10 a.m., CDM#1 (certified dietary manager) stated that the final rinse temperature of the dishwashing machine should reach 180 degrees Fahrenheit, but would sometimes range between 175-180 degrees Fahrenheit. She revealed that once each day the rinse temperature was recorded on the monthly dishwasher temperature log which she signed with her initials.</p> <p>Review of the Daily Dishwasher Temperature Log posted in the Hughes satellite kitchen revealed documented, final rinse temperatures less than 180 degrees Fahrenheit on August 2, 7, 9, and each day from August 12 to August 30, 2018.</p> <p>On 8/30/18 at 11:20 a.m., during a third observation of staff actively washing dishes in the dishwashing machine in the Hughes satellite kitchen the machine's final rinse temperature only reached a temperature of 172 degrees Fahrenheit. Staff was observed to store the dishes/utensils/plates that were washed in the dish machine for use.</p> <p>2. During the continuous observation of the Hughes satellite kitchen on 8/30/18 at 11:30 a.m.,</p>	F 812	<p>Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>We have not be able to identify any current or past residents affected by the two issues cited. There has been no known or suspected food borne illness or sickness related to the two concerns presented under F 812</p> <p>On 8/30/2018 immediately following the conversation regarding dishwashers between the surveyor and dietary/operations staff, Eastern Food Equipment was contacted to conduct a diagnostic on the dishwasher in concern. Diagnostics were performed and the dish machine in question within a few hours. The machine was found to be in proper working order with no concerns. After diagnostics were completed, the machine was run 12 consecutive times, all times exceeding 180 degrees.</p> <p>There was no corrective action possible at the time of the potential alleged contamination because the staff member whose actions are in question were not made aware by the surveyor at the time of the reported incident she states she witnessed. Because of delay in notification there was no opportunity provided to the person present to address any surfaces reported later that were potentially contaminated. The kitchen was cleaned as scheduled prior to and</p>		

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F 812	Continued From page 10 CDM#1 (certified dietary manager) was observed wearing plastic gloves while cleaning a cart with a damp cloth, then placing dirty dishware in a dish rack. When the dishwashing machine completed the final rinse cycle, CDM#1 (wearing the same plastic gloves) removed the dishware from the dishwashing machine and placed/stored each of the beverage glasses in the cabinets in the front serving area of the kitchen. CDM#1 continued wearing the same soiled, plastic gloves as she used a large serving spoon to stir a pot of cooking noodles. CDM#1 then returned to the dishwashing machine area, removed the soiled, plastic gloves, washed her hands, and then donned a clean pair of plastic gloves. CDM#1 never acknowledged that she should have put clean gloves on prior to storing the clean glassware and stirring the cooked noodles.	F 812	after the incident was reported, but the only way to have accomplished corrective action for the residents potentially being served at that time would have been to notify staff present so any area that was believed to have been contaminated could have been cleaned at that time.  Address how the facility will identify other residents having the potential to be affected by the same practice:  We do not have reason to believe any residents were affected by either the dishwasher concern or the concern related to the gloves.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice does not occur? (all completed by 9/28/2018)  <ul style="list-style-type: none"> <li>Staff were retrained on utilizing gauges and test strips (like the one utilized during survey) to eliminate confusion.</li> <li>New dials were ordered to provide clear gauges for reading that reduces the potential for an inaccurate reading of the gauge.</li> <li>Routine checks will be conducted by a contracted service with Eastern Food Equipment and by our operations team to continue to ensure the equipment is functioning properly</li> <li>Any equipment not found functioning properly or in question of functioning properly will be taken out of service immediately.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/31/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MARYFIELD NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1315 GREENSBORO ROAD</b> <b>HIGH POINT, NC 27260</b>		
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F 812	Continued From page 11	F 812	<ul style="list-style-type: none"> <li>New tools for recording temperatures have been developed in coordination with the county health inspector and training provided to ensure the understanding of the difference of the requirement of 180 degrees at the manifold and 160 degrees at the plate.</li> <li>Pennybyrn will continue the practice of requiring all kitchen staff to undergo and maintain current their Serve Safe certification. In addition, we will continue to require Certified Dietary Mangers (such as the person who is in question) to keep current their CDM certification in good standing, which includes re-education for the require CE credits. We will also continue the practice of requiring all Homemaker staff to attend education at least annually that includes the ability to demonstrate competency in the areas indicated within F 812 as they pertain to their roles at a minimum annually. If any concern is found within the year, staff will individually or together be re-educated.</li> </ul> <p>How does the facility plan to monitor its performance to make sure that solutions are sustained and ensuring the correction achieved and integrated into the Quality Assurance Systems of the facility?</p> <p>Each household kitchen, which serves approximately 20 residents, will continue to be inspected individually by the Guilford County Health Inspector and continue to receive an individual and separate grade/rating based on that area alone. The Health Inspector will make us aware of any issues he finds during his routine</p>		

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

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F 812	Continued From page 12	F 812	<p>and on-going inspections through reporting that is public record and shared with us at the time of inspection.</p> <p>The Registered Dietician will report on random checks/audits that she does between meetings at each quarterly QA meeting. She will ask for and receive assistance with training and/or equipment concerns she identifies immediately upon identification of a problem supported by the Administrator and Operations Leader. She will continue to consult with and round with the Health Inspector as he inspects the nine individual kitchens on our property. Nursing leadership present in each household have also been made aware to monitor for concerns.</p>		