

received 1/2/13

PRINTED: 12/18/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/13/2012
NAME OF PROVIDER OR SUPPLIER GLENFLORA			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360	
(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 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview the facility failed to maintain dish machine final rinse temperatures at or above 180 degrees Fahrenheit, failed to keep a food made with milk and butter out of the danger zone of 41 degrees to 134 degrees Fahrenheit during the operation of the trayline, and failed to keep foods which were cooling, and not to be reheated, covered with a fly in the kitchen. Findings include:</p> <p>1. Dish machine observation began at 9:37 AM on 12/12/12.</p> <p>Final rinse temperatures were sustained at or above 180 degrees Fahrenheit until 10:10 AM on 12/12/12 when two racks were run through the dish machine, and the final rinse temperatures only reached 165 degrees Fahrenheit. The two dietary employees at the dish machine were not monitoring the gauges. After surveyor intervention, two more racks were run through the dish machine, and the final rinse temperatures only reached 162 degrees Fahrenheit.</p>	F 371	<p><u>DISCLAIMER</u></p> <p>RESPONSE PREFACE:</p> <p><i>GlenFlora</i> acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance.</p> <p><i>GlenFlora's</i> response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, <i>GlenFlora</i> reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
David Thomas Smith
TITLE
Executive Director
(X6) DATE
12/26/2012

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 371	<p>Continued From page 1</p> <p>At 10:18 AM on 12/12/12 one of the dietary employees emptied the dish machine and refilled it. Attempts were made to run two more racks of kitchenware through the dish machine. The final rinse temperatures only reached 160 degrees Fahrenheit.</p> <p>The dietary employees allowed the dish machine to sit until 10:28 AM on 12/12/12. At that time eight more racks were run through the dish machine, with the final rinse temperatures reaching or exceeding 180 degrees Fahrenheit.</p> <p>At 11:42 AM on 12/13/12 the dietary manager (DM) stated the dietary staff was trained to watch the dish machine gauges the whole time the dish machine was running. She reported a service representative was in yesterday to assess the problem with the final rinse temperatures. According to the DM, a problem was identified with the booster system, and a part was ordered.</p> <p>At 11:50 AM on 12/13/12 a cook stated the dietary staff was trained to watch the temperature gauges on the dish machine during the entire dishwashing process. If the final rinse temperature did not reach 180 degrees Fahrenheit, the cook reported they were trained to drain the dish machine and refill with hot water. If the final rinse temperature still did not reach the required temperature, then the cook commented the DM was to be notified so she could involve the maintenance department in helping to resolve the problem.</p> <p>At 11:58 AM on 12/13/12 the Maintenance Manager stated the service representative found</p>	F 371	<p>F-371 Plan of Correction</p> <p>Following observation of inadequate temperatures the DM immediately notified the Executive Director and Plant Operations Director. The Executive Director contacted the vendor for immediate service. The vendor responded to the call on the same date, 12/12/2012, and determined a problem within the heater booster. The vendor then ordered the appropriate parts to be installed upon receipt. The dishwasher was removed from operation on the afternoon of 12/12/2012. On 12/18/2012 the vendor repaired the heat element booster and, following successful temperature checks, the operation was resumed.</p> <p>Following observed lower temperature of puree bread on 12/13/2012 the dietary staff took action to insure proper temperature prior to serving.</p> <p>After shared concern regarding preparation of spice cake and rolls on 12/12/2012 dietary staff took the action of covering to insure sanitary condition.</p>	1/10/2013

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F 371	<p>Continued From page 2</p> <p>there was an element not functioning correctly in the booster system of the dish machine so a new element was ordered to replace the defective one.</p> <p>2. Trayline began operation at 11:55 AM on 12/12/12. Puree bread in small plastic dessert bowls was being removed one tray at a time from a warmer (with about six bowls on a tray), and left on a shelf above the steam table.</p> <p>At 12:04 PM on 12/12/12 a new tray with bowls of puree bread was removed from the warmer and placed above the steam table.</p> <p>At 12:12 PM on 12/12/12 a calibrated thermometer was used to check the temperature of one of the bowls of puree bread above the steam table. The thermometer registered 122 degrees Fahrenheit. At this time the cook stated she made the puree bread with bread, water, milk, and butter.</p> <p>At 11:42 AM on 12/13/12 the dietary manager (DM) reported her staff was supposed to keep puree bread above 135 degrees Fahrenheit during the operation of the trayline because it was made with milk. She stated staff made the puree bread using milk and butter, kept the finished product in the steamer, and then transferred it to the warmer closer to the time the trayline began operation. She reported the puree bread lost temperature when it was removed from the warmer and set on the shelf above the steam table. According to the DM, she preferred the staff to leave the puree bread in the warmer and remove individual bowls as they were needed.</p>	F 371	<p>The dietary staff was in-serviced on 12/20/2012 regarding proper dishwashing temperature, proper food preparation and temperature checks.</p> <p>The dish machine temperature log will be maintained and completed during each meal and will be reviewed by the DM and administration with results being reported to the Quality Assurance Committee. The DM instructed staff to utilize production guide temperature recommendations and signature sheets in regards to temperature administration. The production guide logs will be monitored by DM daily. The logs will also be reviewed by the Quality Assurance Committee.</p> <p>The DM instructed dietary staff to follow the safety and sanitation form during all operations. The dietary staff will complete the safety and sanitation form daily and the DM will monitor safety and sanitation procedures with weekly physical audits as well as reviewing the completed form weekly. The results will be reviewed by the Quality Assurance Committee.</p>	

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F 371	<p>Continued From page 3</p> <p>At 11:50 AM on 12/13/12 a cook stated she made puree bread using chopped bread, butter, and milk. She commented the puree bread was supposed to remain at 160 degrees Fahrenheit during the operation of the trayline. In order for this to be accomplished, the cook remarked the puree bread should be kept in the warmer and removed one bowl at a time as needed.</p> <p>3. During food preparation observation on 12/12/12 spice cake was removed from the oven at 9:30 AM, and rolls were removed from the oven at 9:41 AM. Both of these foods were placed, uncovered, into an open rolling rack to cool.</p> <p>At 10:42 AM on 12/12/12 a fly was observed in the kitchen</p> <p>At 10:43 AM on 12/12/12 the rolls and the spice cake were still in the rolling rack without being covered.</p> <p>At 11:42 AM on 12/13/12 the dietary manager (DM) stated in September 2012 she reviewed with the dietary staff the importance of covering cooked food items. The DM stated she preferred the staff to cover hot products with aluminum foil to keep them safe from flies and gnats while cooling.</p> <p>At 11:50 AM on 12/13/12 a cook stated she was trained to cover cooked and cooling food items with aluminum foil or a pan lid/cover to keep flies and gnats off the food. She reported covering foods was extremely important when those foods would not be reheated to kill any bacteria or germs to which they may have been exposed</p>	F 371	<p>F-441 Plan of Correction</p> <p>Contact precautions resolved for elder #80 after follow-up information received from urology related to a negative urinalysis. Contact precautions for elder #70 resolved as facility received eye culture results on 12/13/2012 revealing MRSA resolution.</p> <p>GlenFlora's infection control policy changed effective 12/14/2012 to reflect SPICE recommendations related to signage/posting of information in main entry way/doorway regarding isolation. Facility-wide in-servicing held on 12/26/2012 to educate staff regarding signage/posting for elders on isolation.</p> <p>Infection control will monitor facility performance for adherence to policies whenever an elder is placed on isolation. Infection control will record and report findings on monthly infection control reports and report in quarterly meetings.</p>	1/10/2013	

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F 371	Continued From page 4 during the cooling process.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441			

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F 441	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to post the approved Statewide Program for Infection Control and Epidemiology (SPICE) isolation signs outside the resident's door (Resident #70 and Resident #80) for 2 of 2 observed rooms. Findings include: A review of the facility Infection Control Policy updated 11/22/11 entitled Notice of Isolation showed it was the policy of the facility to post an isolation notice at the room entrance doorway and above the resident's bed when isolation precautions were ordered. A review of the facility Infection Control Policy updated 11/22/11 entitled Visitation During Isolation showed that "Visitors must follow instructions issued by the charge nurse and/or as outlined on the appropriate isolation notice posted at the entrance to the resident's room." A review of the Issues in Infection Control for Nursing Homes provided by SPICE showed that isolation signs must be posted on the door to the resident's room. The SPICE program has been considered a standard by the Centers for Disease Control (CDC) as a tool for communicating the procedures that healthcare workers, family and visitors should follow to prevent cross transmission. A review of the isolation sign for Contact Precautions read, "Visitors must report to Nursing	F 441			

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F 441	<p>Continued From page 6</p> <p>Station before entering." There were two interventions listed (wash hands and gloves) and the directive of "when entering the room" was next to the interventions. The isolation sign was orange and approximately a half sheet of paper in size.</p> <p>An observation on 12/10/12 at 9:45 AM during the initial tour of the facility did not show any isolation signs posted on resident doorways.</p> <p>In an interview on 12/12/12 at 3:30 PM the Infection Control Nurse stated that two residents (Resident #70 and Resident #80) were on isolation precautions during the survey.</p> <p>In an interview on 12/12/12 at 3:35 PM Nurse Aide (NA) #1 stated that one resident on her hall was on isolation. She indicated that isolation signs were hung over the resident's bed and were orange in color.</p> <p>In an observation on 12/12/12 at 3:40 PM Resident #70 and Resident #80's rooms were inspected and Contact Isolation signs were noted hung over their beds.</p> <p>In an interview on 12/12/12 at 4:40 PM NA #2 stated she had one resident on isolation on her hall. She indicated that isolation signs were hung over resident's beds and not placed on the door to the resident's room.</p> <p>In an interview on 12/12/12 at 5:56 PM Nurse #2 indicated that isolation signs were kept over the resident's beds.</p> <p>In an interview on 12/12/12 at 6:12 PM Nurse #3</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>indicated that isolation signs were kept at the head of the bed in the resident's rooms.</p> <p>In an interview on 12/13/12 at 9:39 AM NA #3 indicated isolation signs were placed over the bed on a board. She stated that the nurse would also let the aides know if anyone on their assignment was on special precautions.</p> <p>In an interview on 12/13/12 at 9:47 AM Housekeeper #1 stated that isolation signs were kept over the resident's bed. She indicated that she would start cleaning when she walked into the room and might not see what precautions were needed right away.</p> <p>In an interview on 12/13/12 at 11:00 AM the Infection Control Nurse stated that isolation signs were not placed on the door to the resident's room. The signs were placed above the beds for residents needing precautions. She indicated that there was also a sheet kept at the desk to show which residents were on isolation. She stated it was her expectation that staff would know which residents were on isolation by looking at the signs over the beds and the sheet kept at the desk</p> <p>In an interview on 12/13/12 at 2:00 PM the Director of Nursing (DON) indicated that isolation signs were hung over the head of the resident's bed. She stated isolation signs were not hung on resident doors to make it more "homelike".</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER GLENFLORA			STREET ADDRESS, CITY, STATE, ZIP CODE 5701 FAYETTEVILLE ROAD LUMBERTON, NC 28380	
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system.</p> <p>The deficiencies determined during the survey are as follows:</p>	K 000	<p>DISCLAIMER RESPONSE PREFACE: <i>GlenFlora</i> acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. <i>GlenFlora's</i> response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, <i>GlenFlora</i> reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.</p>	3/1/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE *Executive Director* (X6) DATE 1/31/2013

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K 000	Continued From page 1	K 000	K-018 - Plan of Correction <ul style="list-style-type: none"> Plant operations director opened up/expanded strike plates to ensure proper closure/latching on doors in both room 316 & kitchen environmental service door. Plant operations director will conduct quarterly audits on each corridor including non-resident room doorways. Plant operations will immediately fix any deficient doorways to ensure proper closure. He will then report findings to GlenFlora's Quality Assurance Committee. 	3/1/2013
K 018 SS=E	<p>42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: door to resident room 316 and Environmental Service door in kitchen did not close and latch for smoke tight seal.</p> <p>42 CFR 483.70(a)</p>	K 018		

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NAME OF PROVIDER OR SUPPLIER GLENFLORA			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 FAYETTEVILLE ROAD LUMBERTON, NC 28360	
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K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: fire/smoke barrier wall on 300 hall and at wall separating nursing home side from HA side. Both walls have hole/penetration that was not sealed to maintain the required fire resistance rating of the fire/smoke barrier.</p> <p>42 CFR 483.70(a)</p>	K 025	<p>K-025 - Plan of Correction</p> <ul style="list-style-type: none"> Plant operations director to place fire caulking in holes/wall penetrations to maintain compliance on both the 300 hall (at barrier wall) and wall between HA and SNF areas. The plant operations director and administrator will follow up on all additional maintenance/projects requiring caulking to ensure fire-rated caulking in place. Additionally, plant operations director will conduct facility-wide inspection to ensure all caulking in place is approved fire-rated caulking. Plant operations director will report any deficient findings to the Quality Assurance Committee and discuss corrective action. 	3/1/2013
K 038 SS=E	<p>42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038		

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

PRINTED: 01/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345194	(X2) MULTIPLE CONSTRUCTION A. BUILDING 1A - MAIN BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2013
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K 038	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey, facility could not identify and locate breaker for Delayed Egress locks (could not check doors for loss of power). 42 CFR 483.70(a)	K 038	K-038 – Plan of Correction <ul style="list-style-type: none"> On January 16th, 2013 the vendor tied all mag locks into a central switch located behind nursing station on 300 hall. Facility staff to be in-serviced on location and operating switch on February 6th, 2013. Annual in-servicing calendar will include review of release switch with all staff. Plant operations director to report in-service/review to the Quality Assurance Committee. K-045 – Plan of Correction <ul style="list-style-type: none"> One light fixture in both Lavender Terrace (100 hall sun room) and the 200 hall sun room will be placed on the non-switch, life safety circuit. Plant operations director will conduct monthly checks to ensure lights are working properly. Plant operations director will ensure proper functionality or take corrective action (replacing bulbs). All monthly inspections will be compiled and reported to the Quality Assurance Committee. 	3/1/2013
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: Lavender Terrace room on 100 hall and Sun room on 200 Hall would leave the patient in darkness. 42 CFR 483.70(a)	K 045		