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	345126	A. BUILDING _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

(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 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, and record review the facility failed to provide towels and washcloths in time for residents' AM care, and failed to provide washcloths of adequate size and washcloths without frayed edges and tears. Findings included: Review of Resident Council Minutes revealed on 06/18/13 and 09/17/13 housekeeping issues were discussed. Minutes from 10/15/13 documented residents complained that bath cloths were too small and that there were inadequate linens on two mornings. Minutes from 12/17/13 documented residents were concerned about the time it took to get clothes and linens back, and minutes from 02/18/14 documented that bathing issues were discussed. At 11:40 AM on 03/06/14 the facility's Social Worker (SW) and Activity Director (AD) stated residents complained in resident council meetings about not having adequate towels, washcloths, and linens for their AM care. They reported residents also had concerns about the size and condition of the towels and washcloths. Even after corporate addressed the resident council about three weeks ago, the SW and AD stated as of yet there was no resolution to these resident concerns.	F 254	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Mount Olive Center does not admit that the deficiency listed on this exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in leagl and/or regulatory or administrative proceedings the deficiency, statemens, facts, and conclusions that form the basis for the deficiency." 1. A complete linen inventory was conducted on 3/7/14 to determine status of linen supplies. The inventory showed a need for additional wash cloths and bath towels which were ordered on 3/10/14. 40 dozen wash cloths and 16 dozen additional bath towels were ordered and have been received. Housekeeping and Nursing staff will follow up with residents #145, #53, #61, #86, #60 to assure they are receiving and/or have access to an adequate supply of linens as needed. Staff assigned to conduct facility "Partner Program" rounds will also check with these residents weekly to assure they have adequate linens.	3/28/14

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

Electronically Signed | 03/26/2014

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F 254	Continued From page 1 Review of the facility's grievance log revealed on 02/03/14 a grievance was filed on behalf of Resident #107 (no longer present in the facility). There was concern because the resident had a GI upset over the weekend, and had no washcloths or linens on her bed. The grievance was resolved, and the housekeeping staff was to ensure all linens were out in the facility before leaving at the end of their shifts. At 10:18 AM on 03/03/14 Resident #145 stated it was very frustrating because there were frequently not enough towels, washcloths, and linens to carry out AM care. The resident reported it was not unusual for it to be after lunch before staff had enough linens to remake beds. The resident commented this problem with linen shortage was ongoing with examples as recently as last week. At 10:36 AM on 03/03/14 Resident #53 the quality of the washcloths was poor. The resident explained they were so small and ragged it often took two or three, if you could find that many, to wash up in the morning. The resident reported there were some mornings when the aides could not find any washcloths, and one end of a towel was used for washing and the other end was used for drying. The resident commented just last week there were problems with not enough washcloths and towels. At 10:48 AM on 03/03/14 a family member of Resident #61 stated there was frequently a shortage of towels and washcloths, and the washcloths were too small and frequently frayed, torn, and/or stained. At 11:54 AM on 03/03/14 Resident #57 stated as	F 254	2. Facility will maintain an adequate supply of linens to assure residents have access to clean and serviceable linens throughout the day. 3. Housekeeping/Laundry Supervisor in concert with facility Administrator has established linen par levels to assure an adequate supply of linens are on hand at all times. a. The Housekeeping/Laundry Supervisor will complete a linen inventory each month and additional linens will be purchased as necessary to maintain established par levels. b. The Activity Director and/or Social Worker will monitor the Resident Council and any linen concerns will be promptly reported to the Housekeeping Supervisor and Administrator for Corrective action. 4. The Administrator will review the monthly linen inventory to assure needed items are purchased promptly. Linen inventory and any grievances related to linen supplies will be reviewed by the QAPI Committee Monthly for three months.	

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recently as last week there was a problem with not enough towels and washcloths for baths in the mornings.

At 1:42 PM on 03/03/14 there were two washcloths in Resident #86's bathroom. Both were extremely small, approximately 4 1/2 inches x 4 inches, with one discolored and frayed all around the edges and the other torn in two places.

At 1:45 PM on 03/03/14 Resident #86 stated it was very difficult to get washcloths and towels when bathing in the mornings. The resident reported sometimes one towel could be found, and one end was used for washing while the other was used for drying.

At 2:40 PM on 03/03/14 Resident #60 stated if you were lucky enough to obtain any washcloths you had better hide a few so you would have something to bathe with in the mornings. The resident reported a couple of days last week there were no washcloths available for AM care, not being restocked until around 11:30 AM.

At 9:05 AM on 03/06/14 the Infection Control Nurse stated 24 residents in the building were exhibiting signs and symptoms of nausea/vomiting, diarrhea, and GI discomfort.

At 9:10 AM on 03/06/14 there were no towel or washcloths in the facility.

At 9:12 AM on 03/06/14 there were four washcloths and three towels which were folded on a clean linen cart in the laundry room. Two of the wash cloths were extremely small with ragged edges, and one washcloth was stained. One of

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the three towels was also tattered. At this time the Environmental Services Manager stated a linen cart was brought inside the facility at 10:45 PM on 03/05/14. She also reported she thought a linen cart was brought into the building at 7:30 AM on 03/06/14, but she was not sure what type of linens were on the cart.

At 9:32 AM on 03/06/14 Nursing Assistant (NA) #5 stated the washcloths were so small that it took three to clean one resident up with. The NA also reported that many of the washcloths were tattered and so thin you see through them, and frequently there were not enough towels and washcloths for AM care. The NA commented this was an ongoing problem.

At 9:42 AM on 03/06/14 NA #6 stated washcloths were too small, there were not enough of them, and they were in poor condition. During AM care the NA reported there were often no towel and washcloths in the building although there might be some on carts or in washers/dryers in the laundry room.

At 9:44 AM on 03/06/14 NA #7 stated it was not uncommon for it to be 11:00 AM before there were enough towels and washcloths to go around to complete AM care. The NA reported these towels and washcloths were in poor condition, and were so small that it took multiples to clean a single resident up. The NA commented this was an ongoing problem.

At 9:46 AM on 03/06/14 the resident council president stated it had been brought up multiple times in resident council meetings about not enough and the poor condition of towels and washcloths. He reported, basically in response to

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resident concerns, the group was told that that was just the way things were going to be.

At 9:48 AM on 03/06/14 NA #8 stated sometimes it was 10:30 AM before linens for AM care were brought into the building, and they were often squirreled away by staff and residents because of the shortage.

At 9:50 AM on 03/06/14 NA #9 stated there was not enough linen in the building, especially a shortage of towels and washcloths. The NA reported this was an ongoing problem.

At 9:55 AM on 03/06/14 a linen cart was brought into the building. It had five washcloths and five towels on it. Two of five washcloths were extremely small and tattered, and one of five washcloths was stained.

At 10:06 AM on 03/06/14 NA #10 stated towels and washcloths were too small and dingy.

At 10:10 AM on 03/06/14 NA #11 stated sometimes, including a couple of times last week, there were not enough towels and washcloths, some were torn and fraying around the edges, and some were not large enough.

At 10:14 AM on 03/06/14 NA #12 stated sometimes there were not enough towels, washcloths, and bed linens for AM care, and some of the washcloths needed replacing because they were in poor condition.

At 10:55 AM on 03/06/14 a linen cart entered the building it had eleven towels and eleven towels on it. Three of the washcloths were extremely small and frayed around the edges. At this time the

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F 254	Continued From page 5 Environmental Services Manager stated she pulled damaged linens, and used petty cash to go buy replacements. (Between 9:10 AM and 10:55 AM on 03/06/14 only twenty washcloths came into the building, and nine of those were extremely small, stained, torn, or frayed) The manager commented she thought she could use some more linen inventory.	F 254		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the nursing staff failed to administer insulin as ordered for one of one resident, Resident # 34. Findings included: A review of the Minimum Data Set (MDS) Assessment dated 01/07/14 revealed that Resident #34 was admitted to the facility on 12/31/13 with diagnoses which included anemia, hypertension, diabetes mellitus, thyroid disorder, and other fracture. This assessment also indicated that the resident was cognitively intact, and that she required extensive assistance with transfer, dressing, and personal hygiene. A review of the Physician's Orders revealed an	F 309	1. Resident # 34 received the ordered amount of insulin each day administered by medication nurse. 2. Residents that have orders for insulin to be administered have potential to be effected. Audit of physician orders for residents was performed on 3/25/14 by DNS and Supervisor to identify any resident with orders for insulin. Medication administration records were audited by (whom) on (date) to assure that insulin has been administered and documented by the medication nurse. Alert and oriented residents were interviewed by (whom) on (date) to verify	4/4/14

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F 309	Continued From page 6 ordered dated 02/21/14 for Resident #34 to receive Humulin N insulin, 25 units subcutaneously twice per day. (Humulin N is a crystalline suspension of human insulin which provides a slower onset of action and a longer duration of activity than regular insulin.) Additional review of the Physician's Orders revealed an order dated 02/24/14 for Resident #34 to also receive Novolin R insulin (a fast acting insulin which is structurally identical to human insulin) twice per day using the following parameters: For a finger stick blood sugar of 151-200, give 2 units For a finger stick blood sugar of 201-250, give 4 units For a finger stick blood sugar of 251-300, give 6 units For a finger stick blood sugar of 301-350, give 8 units For a finger stick blood sugar of 351-400, give 8 units For a finger stick blood sugar of 351-400, give 10 units For a finger stick blood sugar of 401-450, give 12 units Another Physician's Order dated 02/21/14 revealed the resident was to receive a blood sugar test (via finger stick) twice per day. A review of the Medication Administration Record (MAR) for February 2014 revealed initials to indicate Resident #34 had received 25 units of Humulin N insulin as ordered at 8:00 AM and 8:00 PM on 02/21/14 through 02/26/14. The MAR did not reflect initials to indicate the insulin	F 309	that insulin is being administered by the medication nurses. 3. Unit Manager #1 was reeducated on administering insulin at the time it was ordered or notifying the physician if there is a reason the insulin was not given by the DNS on 3/24/14. Nurse # 3 was reeducated on the procedure if the medication is not available in the center by the DNS on 3/24/14 Licensed nurses were re-educated on the procedure if medication is not available in the center and procedure if the nurse is unable to administer the medication on time or as ordered by the physician by the DNS on 3/24/14. Education on the procedure if medication is not available will be reviewed with any newly hired licensed nurse during the orientation process. Audits of medication administration records to monitor for blanks or indication that insulin was not administered to be conducted weekly for three months by the Director of Nurses, Nurse Practice Educator and/or Unit Managers. Four Licensed nurses will be observed weekly times one month administering insulin to assure that the amount of insulin drawn up is the amount the physician has ordered. 4. The finding of the medication record audit and the results of the observation of the licensed nurses administering insulin will be presented to the QAPI committee monthly for 3 months by the Director of Nursing.	

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was given on 02/27/14 at 8:00 AM. The 8:00 PM dose on 02/27/14 was initialed as given by Nurse #4. Further review of the MAR revealed that both the morning and the evening doses of Humulin N insulin, 25 units, were held (not administered) on 02/28/14.

Additional review of the MAR for February 2014 revealed that Resident #34's blood sugar check was held (not conducted) on the morning of 02/28/14.

In an interview with Resident #34, whose cognition was intact, she stated that she did not receive her Humulin N insulin on Friday, 02/28/14, and that she had missed a total of three doses. She also stated that when she asked the nurse why she was not getting her Humulin N as ordered, the nurse told her that the insulin was out of stock.

In an interview with Unit Manager #1 on 03/03/14 at 4:35 PM, she explained that she did not administer Resident # 34's Humulin N insulin on the morning of 02/28/14 because the resident was in the beauty shop during the time she would have normally received the Humulin N dose, and that she felt it was too late to give her the dose after her hair appointment was finished. She explained that it was already approximately 9:00 AM at that time and the Humulin N was scheduled to be given at 8:00 AM. She further stated that she did not make a notation in the nurse's notes to indicate the Humulin N was not given and that she did not contact the physician regarding the missed insulin dose.

An interview was conducted on 03/04/14 at 4:35 PM with the nurse who was on duty the evening

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of 02/28/14, Nurse #3. During the interview, Nurse #3 stated that the Humulin N insulin was out of stock on that date and that she could not give Resident #34 the Humulin N dose of 25 units at 8:00 PM. She stated she did not order a refill for the out of stock insulin because it had already been ordered. In addition, she stated that she did not contact the physician to notify him that the Humulin N insulin was not available or that the resident did not receive her Humulin N dose. She further explained that she gave the resident 10 units of the Novolin R sliding scale insulin to provide coverage for the missed Humulin N dose. The MAR revealed Resident # 34's blood sugar was 441 when Nurse #3 gave her the Novolin R dose on 02/28/14 at 8:00 PM.

A review of the Interdisciplinary Progress Notes/Nursing Notes revealed there were no nurse notes to indicate that the resident did not receive the prescribed Humulin N doses.

In an interview with the Director of Nursing on 03/03/14 at 4:50 PM, she confirmed it was her expectation for the nurse to follow up on any out of stock medication, including insulin, by contacting the facility's pharmacy, and that if the medication is out of stock at the facility's pharmacy, she would expect the nurse to obtain the necessary medication from the local back up pharmacy.

An interview was conducted via telephone with a representative from the medical records department of the facility's contract pharmacy on 03/06/14 at 10:00 AM. During the interview, the representative stated that a Fax order for a refill of Humulin N insulin was received from the nursing facility at

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F 309	Continued From page 9 7:30 AM on 02/28/14 at 7:30 AM. The representative also added that the prescription was filled and then delivered to the facility on 03/01/14 at 12:29 AM. She explained that typically, when prescription refills are ordered during the morning hours, the prescription is filled and delivered on the same day by 7:00 PM. She stated she was not certain why the re-fill was not made until 03/01/14. In addition, the representative confirmed that the request for the Humulin N was not a STAT (immediate) request. An interview was conducted on 03/06/14 at 4:00 PM with the nurse who was on duty the evening shift on 02/27/14, Nurse #4. During the interview, Nurse #4 stated that when she gave Resident #34 her 8:00 PM dose of Humulin N, there was not enough insulin left in the vial to administer the full 25 unit dose. She explained she administered all that was left in the vial to Resident #34, but she could not remember exactly how much it was. She stated that she was a new nurse, and that her trainer instructed her to go ahead and administer what was available and that more would have to be ordered. In a telephone interview with the training nurse, Nurse #5, on 03/06/14 at 4:12 PM, she stated there was enough Humulin N insulin to administer to Resident #34 on the morning of 02/27/14, and that she went ahead and placed an order for a refill at that time. She explained she had forgotten to initial on the Medication Administration Record that she gave the Humulin N dose of 25 units on that morning. She added that she did not work on 02/28/14, but when she came to work on 03/01/14 for her 7:00 AM to 7:00 PM shift, the Humulin N insulin refill still had not arrived at the facility. Nurse #5 stated that she	F 309		

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F 309	Continued From page 10 then called the facility's pharmacy to follow up, and that the pharmacy explained the insulin was on backorder. She stated she then told the pharmacy that the insulin was needed immediately and asked that it would need to be obtained by the local back up pharmacy. She further stated that the insulin finally arrived at the facility before the end of her shift on 03/01/14. In a second interview with Unit Manager #1 on 03/06/14 at 4:37 PM, she confirmed that she did not administer the Humulin N insulin on the morning of 02/28/14 that she did not notify the physician to report that she did not receive dose. In a second interview with the Director of Nursing on 03/06/14, she confirmed that she would expect the nurse on duty to call the pharmacy to re-order the Humulin N insulin, and that if it was on backorder, to obtain it from the local back up pharmacy.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		4/4/14

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F 325	Continued From page 11 by: Based on observations, record review, staff and physician interviews, the facility failed to ensure that new or recommended interventions were implemented for 3 of 4 sampled residents (Resident #61, #105 and #178) who had significant weight loss. Findings included: 1. Resident #61 was admitted to the facility on 01/23/13. Cumulative diagnoses included depression, dementia, diabetes mellitus and hypertension. A physician's order of 01/28/13 indicated Resident #61 was to receive Remeron 15 mg (milligrams) mg daily. A nutrition note 07/16/13 indicated Resident #61's weight on 06/19/13 was 172 pounds with a body mass index (BMI) of 25.4. The July 2013 weight was pending. The resident's intake was noted at an average of 39% for breakfast, 82% for lunch and 54% for dinner over the last 7 days. Resident #61 was receiving sherbet at bedtime for increased calorie needs with no other interventions in place. The plan was to continue to monitor. An interdisciplinary team (IDT) note of 08/12/13 at 1:41 PM indicated Resident #61 continued to trigger for significant weight loss. It was noted the resident's weight was down 15.5 pounds or 8.7% in 90 days. It was also noted that Resident #61's current weight was 162.5 pounds with a BMI of 23.9. The resident's intake had improved since the last note. It was documented that Resident #61 received sherbet at bedtime. Resident #61 also received protein powder and arginaid for wound healing of a pressure ulcer.	F 325	1. Residents #61, #105, #168 were evaluated by Dietitian to assure appropriate nutrition interventions are in place. Care plans were reviewed and updated to address nutrition related concerns. Changes in resident weights, meal intakes, nutrition interventions are discussed by the IDT (Interdisciplinary Team) during daily clinical meetings. 2. Resident weight records were reviewed for any significant weight loss for the last six months by the MDS Nurses on 4/2/14 along with their nutritional care plan to assure that the weight loss had been addressed. 3. Licensed nurses were reeducated on the weight management process by the SDC on 3/24/14 & 3/28/14 which included weighing resident weekly x4 after admission/readmission, obtaining reweights within 24 hours if there is a 5 pound variance, referring the resident to the Registered Dietitian for any significant weight loss in a month, 3 months, 6 months or a gradual weight change over a period of time. The Director of Nursing and/or Unit Manager will monitor weights for any variance weekly. The Registered Dietitian will complete an assessment of residents with significant variance in weight and present any recommendations to the physician for consideration and orders. Weight variances will be reviewed weekly by the Interdisciplinary Team and care plan implemented or reviewed/updated as needed. Dietitian	

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F 325	Continued From page 12 Her albumin was low at 2.2 indicating severe depletion likely related to the wound and not poor intake. It was documented there were no other interventions at this time as her needs were being met. The note indicated the plan was to continue to monitor. A medical nutrition therapy assessment of 08/26/13 indicated Resident #61 triggered for weight loss in the past 90 days. Resident #61's BMI was 23.9. Her current weight was 162.5 pounds with a 1.8% weight loss in 30 days, 8.7% in 90 days and 9.5% in 180 days. It was noted that Resident #61's nutritional requirements included 2216-1585 kcal (kilocalories), 111 grams of protein and 2216 ml (milliliters) of fluids. It was noted that she was tolerating the regular diet with protein powder and arginaid. It was also documented that Resident #61 had refused meals at times. This note indicated Resident #61's intake was adequate to meet her needs however she continued to be at risk for weight loss related to occasional meal refusals. The plan was to continue the protein supplements until her pressure ulcer healed and continue the current plan of care with no changes. The plan was to monitor Resident #61's weights, laboratory results and any other changes in her medical condition. A note from the previous registered dietician (RD) of 09/06/13 indicated a quarterly assessment was completed for Resident #61 on 08/26/13. The resident's BMI was 23.8 and her weight was down 1 pound this month with a current body weight of 161.5 pounds. Resident #61's intake was noted to be 55% at breakfast, 75% at lunch and 45% at dinner for the past 15 meals reviewed. It was noted that this was less than her	F 325	reviewed GHC Nutrition Care Process and monitors residents with nutrition concerns on a minimum of monthly basis. 4. The Director of Nursing will present the results of the weekly monitoring of weight variances to the QAPI committee for 3 months.	

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estimated needs. The plan was to continue the protein powder, arginaid and the sherbet. It was documented that Resident #61 had a history of significant weight loss and the RD would continue to monitor with no further interventions to be added at this time.

A medical nutrition therapy assessment of 10/11/13 for Resident #61 noted she was receiving a regular low lactose diet with intake of 55% at breakfast, 54% at lunch and dinner. She was receiving sherbet as a bedtime snack as well as arginaid and protein powder twice daily for wound healing. Her BMI was noted at 25 with a current weight of 172 pounds indicating a 3.9% increase over the last 90 days. Intake was noted to be 75% to meet her nutritional requirements. The plan was to monitor Resident #61.

A TSH (thyroid stimulating hormone) blood level was done on 10/30/13. It was slightly elevated at 4.63 uIU/mL with the normal range being 0.35 to 4.5.

According to the weight charting in Resident #61's electronic record, the weight on 11/08/13 was 179 pounds.

An IDT note of 11/10/13 from the RD indicated an assessment had been completed for Resident #61 on 10/11/13. It was noted the RD was reviewing the chart due to a significant weight gain with a current body weight of 179 pounds. The plan was to continue to monitor. The RD did not request a reweigh.

According to the electronic weight history in Resident #61's chart, she had lost 5% in the past 30 days and weighed 164 pounds on 12/11/13.

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Another IDT note of 12/13/13 at 9:05 AM indicated Resident #61 had triggered for a significant weight loss over the past 30 days. The resident ' s weight was down 15 pounds indicating an 8.4% weight loss. Resident #61's last weight was 164 pounds on 12/11/13. It was documented that Resident #61 had an elevated TSH (Thyroid stimulating hormone) level which may be contributing to weight fluctuations. The plan was to continue to monitor with no changes to the nutrition plan at this time.

A note of 12/19/13 at 1:18 PM indicated that Resident #61 had been reviewed in the care meeting due to weight loss. It was noted that the resident has lost 15 pounds in the past 30 days with current weight of 164 pounds. It was noted she previously had a weight gain. The plan was to continue Remeron and snacks.

A physician's note of 12/27/13 indicated Resident #61 had decreased independence with feeding and decreased intake by mouth. She was noted over the last several days to have decreased intake and found to most likely have a urinary tract infection (UTI).

The Quarterly MDS of 12/31/13 indicated Resident #61 had significant weight loss with weight noted at 164 pounds.

Blood work collected on 01/28/14 indicated Resident #61 had an elevated TSH of 4.799 ulU/mL. Her sodium level was low at134 mEq/L.

The Annual Minimum Data Set (MDS) assessment of 02/17/14 indicated the resident was cognitively impaired. Resident #61 required

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staff assistance with meals. No weight loss was noted. The resident weighed 162 pounds. According to the Care Area Assessment (CAA) detail, nutrition would be addressed in the care plan.

A nutrition therapy assessment by the RD of 02/18/14 indicated Resident #61 had adaptive equipment which consisted of a grip handle spoon, a left angle fork and a plate guard. It was noted she was receiving Remeron for increased appetite. It was documented that upon admission Resident #61 weighed 198 pounds. The resident's current weight was 162 pounds which indicated a 4.4% weight loss in the past 30 days. Resident #61's weight was down 9.5% over the past 90 days. Resident #61's BMI was 23.9 and her desired body weight was 145 pounds. It was noted that the resident consumed 50-75% of meals with no refusals. The resident was receiving snacks twice daily along with protein and arginaid to help meet needs due to an unhealed pressure ulcer. The plan was to continue the diet and supplements with no concerns at this time.

According to Resident #61's meal intake for March 2014, the resident was independent for eating with an average intake of 50% for breakfast, 50-75% for lunch and 50% for dinner.

Resident #61's care plan, last revised on 03/04/14, identified a problem with having a potential for alteration in nutrition due to a history of weight loss and a history of gradual weight loss. Interventions included notification of the physician of significant weight loss, to feed the resident as needed and to notify the nurse and the RD with 3 or more meal refusals.

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F 325	Continued From page 16 A laboratory report dated 03/05/14 indicated Resident #61 had a low TSH level of 2.939 ulU/mL. According to the electronic weight history in Resident #61's chart, the resident weighed 161.5 pounds on 02/05/14 indicating a 7.5% weight loss in 90 days. During an observation of Resident #61 on 03/04/14 at 1:15 PM, a plate guard was noted sitting on her lunch tray. A visitor was sitting on her bed and stated she told staff she would place it on her plate. Resident #61 was observed sitting in bed with the breakfast tray placed on the over bed table at 9:00 AM on 03/05/14. The resident was not eating. During the lunch meal observation, on 03/05/14 at 12:45 PM, Resident #61 was observed sitting in bed with her tray in front of her. She was not eating. Resident #61 was observed again on 03/06/14 at 9:00 AM. She was eating using the built up spoon and the plate guard was in place. During an interview with Nurse #2, on 03/06/14 at 9:20 AM, she stated Resident #61 usually fed herself after set up. She stated she was not aware of any dietary supplements being used during medication pass. Nurse #2 was not aware that Resident #61 had lost weight. During another interview with Nurse #2, on 03/06/14 at 2:20 PM, she stated she did not	F 325		

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review weights unless there was a physician ' s order for Lasix (a diuretic) and the resident was to be weighed on a frequent basis. She added that the UM was responsible for tracking residents for weight loss.

During an interview with Nurse Aide #3 (NA #3) on 03/06/14 at 12:10 PM, she stated she had not worked with Resident #61 but a few times. She reported that Resident #61 fed herself breakfast but was not feeling well and didn't eat very much of breakfast or lunch.

NA #4 was interviewed about Resident #61 on 03/06/14 at 12:10 PM. She stated at times Resident #61 would feed herself and at times staff had to feed her. She added that when she was assigned to Resident #61 she always went back and forth to check on her. NA #4 commented that Resident #61 loved ice cream.

The Unit Manager (UM #1) was interviewed on 03/06/14 at 2:55 PM. She reported that the previous RD was responsible for tracking and trending the resident's weights. She stated she trended for 5% weight loss in 30 days and 10% weight loss in 180 days. The UM commented that the previous RD did not trend for weight loss in 90 days. She stated a resident would be re-weighed if there was a 3 pound fluctuation in the weight. The UM also stated the previous RD made recommendations for any supplements that she felt were needed. She commented the new RD would be reviewing the charts for weight loss within the 30 days and the 180 days. The UM also stated the physician was informed weekly in regard to those residents who had weight loss. She stated weight loss was reviewed weekly during the IDT meetings. The UM reviewed

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Resident #61's electronic charting and stated the last time supplements were given to her was back in July 2013.

During an interview with the Director of Nurses (DON), on 03/06/14 at 3:35 PM, she stated the RD was the person responsible for actually running the IDT meetings and weight losses were discussed at that meeting routinely. She stated the RD was new and was in the process of reviewing everyone's charts.

During a telephone interview with the RD on 03/06/14 at 4:50 PM, she stated she had been employed for only a short time period. She stated when she reviewed a resident's chart she also reviewed the previous RD's notes. The RD stated she prints out the weight exception report monthly and reviews to see if residents lost or gained weight. She stated she talks with the staff to see how the resident was doing with their intake and also speaks with the resident if they were capable of answering questions. The RD reported she reviews the activities of daily living (ADL) book and reviews the last 21 meals for intake percentage. She stated she would make recommendations on an individual basis based on the resident's BMI as well as the medical condition. When questioned about Resident #61, she stated she would prefer to monitor to see if she continued to lose weight even though she had triggered numerous times in the past for weight loss.

Resident #61's physician was interviewed on 03/06/14 at 5:40 PM. He stated he was relatively new with the facility and was in the process of making some changes in the process for staff to communicate changes to him. He stated there

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F 325	Continued From page 19 was a communication book for staff to place any issues that he needed to address. Upon discussion about Resident #61, he stated he was not aware that she had lost a significant amount of weight and felt the weight loss needed to be reviewed. The physician commented that he did not feel that an elevated TSH blood level would cause a resident to lose weight. He also commented he would have expected a re-weigh back in November 2013 when the resident gained weight to 179 pounds. He reported he did not use the resident's BMI as an indicator for adding or not adding supplements for weight loss and supplements would be implemented on an individual basis. The physician also commented that even if a resident was over weight and had a high BMI he might not want that resident to lose weight and would review that resident for possible weight loss interventions. 2. Resident #178 was admitted to the facility on 10/11/13. The resident's documented diagnoses included dementia, hypertension, arthritis, and aphasia. The resident's electronic weight record documented she weighed 140.2 pounds on 10/14/13 and 139 pounds on 10/18/13. Resident #178's 10/20/13 Admission Minimum Data Set (MDS) documented her cognition was severely impaired, she required extensive assistance by a staff member for eating, and she	F 325		

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had not experienced any significant weight loss.

The resident's 10/21/13 care plan identified her as being at risk for weight loss due to advanced dementia.

A 10/21/13 medical nutrition therapy assessment documented Resident #178 was on a dysphagia puree diet, was occasionally refusing meals, ice cream was added to her tray slips as a preference, and her average meal intake was 73%.

The resident's electronic weight record documented she weighed 139 pounds on 10/28/13 and 138.4 pounds on 11/06/13.

A 11/20/13 registered dietitian (RD) interdisciplinary progress note documented Resident #178 had a wound, and her meal intake was 77%. The RD recommended house supplement daily to help increase caloric intake and protein intake to promote wound healing.

A 11/24/13 physician order started the resident on a house supplement (shake) daily.

The resident's electronic weight record documented she weighed 133.5 pounds on 12/11/13 and 126.5 pounds on 01/06/14. On 01/06/14 the electronic system flagged the resident as having significant weight loss--over a 5% change in 30 days with a 5.2% loss of 7 pounds and over a 7.5% change in 90 days with a 9.8% loss of 13.7 pounds.

Resident #178's Significant Change MDS documented the resident's cognition was severely impaired, she was dependent on a staff member

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for eating, she experienced a significant weight loss of greater than or equal to 5% in the last month or a significant weight loss of greater than or equal to 10% in the last six months, and the she was receiving a mechanically altered therapeutic diet.

In a 01/14/14 medical nutrition therapy assessment the RD documented Resident #178 was tolerating her dysphagia puree diet well, but her appetite at the evening meal was poor, and her total meal intake had dropped to 59%. The RD's recommendation was to increase the house supplement to twice daily (BID).

However, review of the resident's January, February, and March 2014 medication administration record (MAR) revealed Resident #178 was still only receiving a house shake once daily at 9:30 AM. The MARs documented the resident's average intake of the daily shakes was 100%.

The resident's care plan was revised on 01/20/14 to identify "Alteration in Nutrition Status: refuses meals at times, advanced dementia. Resident has experienced significant weight loss of 5% in past 30 days" as a problem. Interventions to this problem included "Provide supplements as ordered".

A 01/23/14 RD interdisciplinary progress note documented Resident #178 was reviewed in a resident care meeting due to weight loss, with a current weight of 126.5 pounds (obtained on 01/22/13). The RD documented the resident was assessed on 01/14/14, and the resident was to continue with the house supplement (shakes).

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The resident's electronic weight record documented she weighed 124.5 pounds on 02/09/14 and flagged the resident as having significant weight loss--over a 10% change in 180 days with a 11.2% loss of 15.7 pounds.

A 02/19/14 RD interdisciplinary progress note documented Resident #178 had a stage II pressure ulcer to her right heel, her body mass index (BMI) indicated she was in an overweight status, the resident was receiving house supplement daily (QD), and was consuming 100% of her house shake on most days. There were no new nutritional recommendations.

The resident's electronic weight record documented she weighed 124.5 pounds on 03/02/14.

At 2:28 PM on 03/06/14 the dietary manager (DM) stated, according to his computer records, Resident #178 was currently receiving a shake (house supplement) between breakfast and lunch at 9:30 AM.

At 2:40 PM on 03/06/14 nursing assistant (NA) #8 stated she had worked with Resident #178 on both first and second shifts. She reported she had not seen the resident receive a shake between lunch and supper, but she thought the resident might receive a shake or ice cream sometimes as an evening snack. According to NA #8, Resident #178 used to eat about 75% of her breakfast and lunch meals, but that intake had dropped to about 50% of meals in the last two months. She commented the resident had to be fed, and the resident did like beverages and sweets which made the shakes ideal.

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At 2:50 PM on 03/06/14 Nurse #1 stated Resident #178's appetite had declined to about 50% in the last couple of months. He reported the resident drank liquids well, and almost always drank 100% of her shake between breakfast and lunch.

At 2:52 PM on 03/06/14 Unit Manager #1 stated the RD only trended weight losses of 5% in 30 days or 10% in 180 days. She reported the RD was in the building daily, and when she made recommendations they were given to the unit managers who presented them to the physicians for orders. She commented the physicians were good about approving whatever interventions the RD thought were best for the residents. According to the unit manager, residents with significant weight loss were followed by the interdisciplinary team (IDT) which met weekly. She also commented Resident #178 still had a pressure ulcer to her right heel which presented as hard eschar surrounded by softer necrotic tissue.

At 4:10 PM on 03/06/14 Nurse #3 stated Resident #178 was only eating 50% of her supper meal, but she had seen the resident drink shakes and eat ice cream sometimes.

At 4:22 PM on 03/06/14 NA #12 stated Resident #178 ate 50 - 75% of her supper meals, liked sweets, and had to be fed. She reported when the resident was having a bad evening she sometimes started the supper meal by feeding the resident something sweet, and then the resident would eat some of her other foods.

At 4:50 PM on 03/06/14, during a telephone conversation, the RD stated she recorded her recommendations on a sheet which was

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MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(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 325	Continued From page 24 forwarded to the unit managers who in turn obtained physician orders to put them in place. 3. Resident #105 is a 74 year old with cumulative diagnoses including hypertension, diabetes mellitus, aphasia, and dementia. Review of the Minimum Data Set, (MDS) Assessment dated 11/29/2013 revealed Resident #105 was totally dependent for bed mobility, personal hygiene, dressing, locomotion, and bathing; however, he was independent for eating with set up assistance only. A review of the resident Nursing Care Plan which was initiated on 04/16/10 and last revised on 01/27/14 revealed that interventions were in place to address the resident's cognitive impairment and the need for assistance with activities of daily living. Interventions for these problems included the following: Nursing staff will anticipate and meet resident's needs due to his aphasia, will cue the resident regarding eating at times, and at other times feed him as needed due to his severely impaired cognition. Further review of the same Nursing Care Plan revealed interventions related to an alteration in the resident's nutritional status. The care plan indicated that the resident had significant weight loss, continued to lose weight, and had a weight loss of 5% in the past 30 days. The goal related	F 325		

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to the alteration in nutritional status was that weight loss would slow and stabilize as evidenced by no further weight loss. Interventions included: assisting the resident with eating as needed, continuing supplements as ordered, notifying the physician and the responsible party of any significant weight loss, an evaluation by a registered dietician, providing a mechanically soft diet, cueing the resident to have a meal intake of 75-100%, providing verbal cues for self feeding, provide adequate time for self feeding, and doing weight assessment as ordered.

A review of the resident's weight assessments revealed the following:

On 06/19/13 - weight of 127 pounds
On 07/19/13 - weight of 123.5 pounds
On 08/07/13 - weight of 124.5 pounds
On 09/05/13 - weight of 121 pounds
On 10/10/13 - weight of 119 pounds
On 11/07/13 - weight of 123.5 pounds
On 12/11/14 - weight of 121.4 pounds
On 01/06/14 - weight of 111.5 pounds
On 01/15/14 - weight of 114.5 pounds
On 01/21/14 - weight of 115 pounds
On 01/28/14 - weight of 111.5 pounds
On 02/06/14 - weight of 113 pounds

An Interdisciplinary Progress Note dated 10/18/13 stated that the resident continued to gradually lose weight and had lost 7 pounds in the past 180 days. The same note indicated, "Continue supplements as ordered."

Another Interdisciplinary Progress Note dated 01/30/14 revealed the resident's weight loss was reviewed by the facility's interdisciplinary team for weight loss and that he had a 7.5% weight loss

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over the past 90 days. The note was signed by Unit Manager #1.

Another Interdisciplinary Progress Note dated 02/24/14 written by the facility's Registered Dietician (RD) also indicated that the resident had a significant weight loss of 5% over the past 30 days, and a 7.5% weight loss over the past 90 days. The note indicated the resident's Body Mass Index (BMI) was 18.6 which was within normal limits. According to the note, the resident's diet order was a dysphagia puree diet with nectar thickened liquids, along with a House Supplement everyday. The note further indicated that the number of daily calories provided for the resident was approximately 1775 kilocalories, which was adequate to meet the resident's caloric needs, and that the resident's current diet and supplement would continue.

A review of the Meal Intake Record fluctuated between 50% to 75% for most days during the months of November 2013, December 2013, January 2014, and February 2014.

A review of the Medication Administration Record (MAR) revealed Resident #105 received the House Supplement daily during the months of December 2013, January 2014, and February 2014, except for 2 days.

On 03/05/14 at 9:10 AM the resident was observed lying on his left side in bed with his eyes open. Upon verbal stimulation, the resident did not respond except for making a grunt. There was no breakfast tray noted in his room at that time.

On 03/05/14 at 1:20 PM, the resident was sitting

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F 325	Continued From page 27 up in his bed eating his lunch without staff assistance. Approximately 25 % of his meal had been consumed, and the resident nodded when he was asked if he would eat more of his meal. The meal tray included a pureed green item and a pureed light orange item, and one cup of thickened orange liquid, and one cup of clear thickened liquid By 1:32 PM, the resident had eaten approximately 2/3 of the meal and continued to eat. In an interview with Unit Manager #1 on 03/06/14 at 2:54 PM, she stated that dietary recommendations are typically made by the RD who then gives the recommendation to one of two unit managers. She explained that the unit manager then gets the recommendation approved by the physician. She also stated that the RD just recently started working at the facility about one month earlier and that she is in the facility on a daily basis. Unit Manager #1 confirmed that she had given Resident #105 his House Supplement that morning, and that he ate it all. She described the House Supplement as frozen shake. A telephone interview was conducted with the RD on 03/06/14 at 4:50 PM. During the interview, she stated that she did not think about adding any additional supplements for Resident #105 because she felt his weight was stabilizing. After further discussion with the RD regarding the resident's significant weight loss, she agreed that he should have additional supplements.	F 325		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	F 366		3/28/14

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F 366	Continued From page 28 Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to offer an alternate vegetable of the same nutritive value as the scheduled vegetable on the menu for a lunch meal. Findings included: During an observation of preparation for the lunch meal sweet potatoes, which had been baked, were observed on top of the oven at 10:20 AM on 03/04/14. Review of the menu for the lunch meal on 03/04/14 revealed chicken dijon, diced white potatoes, and carrots were being served. At 12:43 PM on 03/04/14 Resident #63 was observed eating lunch. He had carrots identified as a dislike on his tray slip. He had both diced white potatoes and a baked sweet potato on his meal tray. The resident remarked that he received a lot of potatoes for lunch. Record review revealed the resident's documented diagnoses included diabetes. At 9:42 AM on 03/05/14 the AM cook stated that she had baked sweet potatoes as an alternate for carrots during her 03/04/14 lunch meal. At 9:45 AM on 03/05/14 the dietary manager (DM) stated that sweet potatoes would not be a comparable alternate for carrots because nutritionally sweet potatoes were considered a	F 366	1. Resident #63 has not received any improper food substitutions since the issue was identified during the survey. a. In-service and training was provided by the FSD on 3/7/14 and 3/26/14 for cooks and relief cooks about proper menu substitutions (difference between vegetables and starches). 2. Improper food substitutions have the potential to affect all residents. a. In-service and training was provided by the FSD on 3/7/14 and 3/26/14 for cooks and relief cooks about proper menu substitutions (difference between vegetables and starches). 3. A Food Substitution Log has been put into place to be used on a daily basis. a. Cooks and Relief Cooks will need to have substitutions approved by either the Food Service Director or Registered Dietitian before service to residents. 4. The Substitution Log will be reviewed by the Food Service Director or Registered Dietitian daily for 30 days and then weekly for 3 months. The Food Substitution Logs will be reviewed by the facility QAPI Committee monthly for 3 months and the PIP plan will be updated as necessary to address any continuing	

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F 366	Continued From page 29 starch and carrots were considered a vegetable. He explained residents at the 03/04/14 already had white potatoes as one starch, and they did not need sweet potatoes for a second starch at the same meal.	F 366	systemic problems.	
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 use good sanitation skills to prevent cross contamination during the preparation of raw chicken, failed to maintain the three compartment system sanitizing sink at the proper strength, and failed to repair a drain problem at the three compartment sink which resulted in particles drying on the kitchen floor. In addition the facility failed to allow kitchenware to completely dry before stacking it in storage, failed to keep kitchen surfaces/floors/equipment clean, and failed to label and date opened food items in storage. Findings included: 1. During food preparation observation at 9:55 AM on 03/04/14 raw chicken in a strainer was being rinsed under running water in one sink of	F 371	1. There we were no specific residents identified as having been affected by the stated deficient practices but such practices had the potential to affect all residents. a.In-service and training was provided by the FSD on 3/7/14 and 3/26/14 for all Dietary Staff covering Safe Food Handling Techniques, Hand Washing, Thermometer Calibration, Internal Safe Cooking Temperatures, Proper Food Service, Proper Cleaning and Sanitation, Proper Cleaning and Sanitation of 3-Compartment Sink, and Proper Labeling and Storage of Dry, Frozen, Refrigerated Foods, and Proper Storage of Pans and Dishes prior to use.	3/28/14

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F 371	Continued From page 30 the two compartment sink system, and raw chicken soaking in stagnant water was in the other sink in the system. At 10:24 AM on 03/04/14 the AM cook picked the strainer up with gloved hands, removed it from the two compartment sink, and slid her gloved hands in oven mitts to remove cooked chicken from the oven, transferring it from the baking pans into tray pans using tongs. The cook then removed the oven mitts, laid them on a food preparation counter, and proceeded to remove the tray pans from the draining board of the two compartment sink system. At 9:32 AM on 03/05/14 the dietary manager (DM) stated in the approximate month that he had supervised the kitchen the dietary staff had received a couple in-services about good sanitation in food handling practices and the prevention of cross contamination. He reported topics such as handwashing and the proper handling of kitchenware and food at sinks were covered. According to the DM, placing gloved hands, contaminated by raw chicken, inside of oven mitts, which might later be used by the same cook or other cooks who were not wearing gloves, was a source of cross contamination which had the potential of making residents sick. At 2:36 PM on 03/06/14 the PM cook stated the dietary staff was trained to wash hands and apply clean gloves before handling raw meat and surfaces contaminated by raw meat, to remove those gloves immediately after contact was completed, and to wash hands before handling any kitchenware or before starting any other food preparation tasks.	F 371	b.Food Service Director has developed specific cleaning assignments for kitchen staff that went into effect 3/7/14. This assignment includes cleaning of the ice machine. c.Facility was in the process of resolving the identified problem with the floor drain that would back up on the kitchen floor. Contractors located and replaced a broken drain line with all repairs completed on 3/11/14. d.Maintenance has cleaned the light fixtures throughout the kitchen and has them on a scheduled for routine cleaning. 2.The stated deficient practices had the potential to affect all residents of the facility. a.In-service and training was provided by the FSD on 3/11/14 and 3/26/14 for all Dietary Staff covering Safe Food Handling Techniques, Hand Washing, Thermometer Calibration, Internal Safe Cooking Temperatures, Proper Food Service, Proper Cleaning and Sanitation, Proper Cleaning and Sanitation of 3-Compartment Sink, Proper Labeling and Storage of Dry, Frozen, Refrigerated Foods, and Proper Storage of Pans and Dishes prior to use. b.Food Service Director has developed specific cleaning assignments for kitchen staff that went into effect 3/7/14. This assignment includes cleaning of the ice machine. c.Facility was in the process of resolving the identified problem with the floor drain that would back up on the kitchen floor. Contractors located and replaced a	

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F 371	Continued From page 31 2. At 9:55 AM on 03/04/14 a pot, a pitcher, and assorted utensils were soaking in the sanitizing section of the three compartment sink. A strip used to check the quaternary sanitizing solution only registered 0 - 50 parts per million (PPM). The dietary aide stated the solution was supposed to register 200 PPM. At 10:24 AM on 03/04/13 a pot, tray pan, and plastic storage container were soaking in the sanitizing section of the three compartment sink. A strip used to check the quaternary sanitizing solution only registered 100 PPM. The dietary aide stated the solution was supposed to register 200 PPM. At 10:46 AM on 03/04/13 the cook ran the Robot Coupe and a spatula through the three compartment sink system. A strip used to check the quaternary solution in the sanitizing sink only registered 0 - 50 PPM. At this time the dietary manager (DM) reported he told the dietary staff to run kitchenware through the dish machine rather than through the three compartment sink system. At 9:32 AM on 03/05/14 the DM stated approximately a week ago the service representative adjusted the dispensing system for the the sanitizing solution at the three compartment sink, and at that time the solution was registering 200 PPM. He reported, obviously, the fix was temporary or new problems arose which prevented the dispensing system from working properly. At 2:36 PM on 03/06/14 the PM cook stated she realized the sanitizing solution rose slowly in the dispensing tubes at the three compartment sink so she watched the solution carefully, and made	F 371	broken drain line with all repairs completed on 3/11/14. d.Maintenance has cleaned the light fixtures throughout the kitchen and has them on a scheduled for routine cleaning. 3. A Sanitation Checklist has been put into place that will be completed by the Food Service Director each week and the Administrator each month. Any deficient practice or item identified during weekly inspections will be immediately addressed and corrected. The checklist is thorough and addresses each of the items identified in the original deficiency. 4.Sanitation Checklists and the completed Staff Cleaning Assignments Checklist will be reviewed by the facility QAPI Committee monthly for 3 months and the PIP plan will be updated as necessary to address any continuing systemic problems.	

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sure she allowed extra time before engaging the system and starting the flow of the solution into the sink water.

3. 12/27/13 Quality Improvement (QI) Committee Minutes documented a drain problem in the kitchen was being addressed by maintenance.

01/14/14 QI Committee Minutes documented the drain problem in the kitchen continued, and a bid was obtained for the repairs.

Review of a 01/14/14 health department sanitation inspection revealed the kitchen drain at the three compartment sink system was not operating properly. The inspector documented this posed a potential health hazard because waste and water was running on the floor, and a correction "must be made."

02/11/14 QI Committee Minutes documented the drain problem in the kitchen continued, and the maintenance manager (MM) was going to try and rent equipment to "scope out" the kitchen drain.

During initial tour of the kitchen, beginning at 4:03 PM on 03/02/14 revealed there were dried particles under the three compartment sink and around the drain. There was a slightly sour/decomposed odor coming from this area.

A 03/03/04 document from another repair company provided a bid which was later approved by the facility's corporate management team.

At 11:37 AM on 03/04/14 as the three compartment sink was being drained, water

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poured up out of the drain, and flowed onto the floor. This water had food particles in it.

A 03/04/14 e-mail confirmed the corporate acceptance of the bid provided on 03/03/14.

At 10:30 AM on 03/05/13 the MM stated the kitchen pipes were old and deteriorating. He reported approximately two to three months ago when he snaked the clogged kitchen drain servicing the three compartment sink system and hit mud, he realized he was going to need outside help. He commented the following week he started getting bids, but the first was too high. According to the MM, he obtained about six other bids, and just received word from corporate that work could begin on the repairs.

At 2:36 PM on 03/06/14 the PM cook stated the kitchen drain at the three compartment sink had been a problem for at least three years. However, she reported she had learned to release the water from the sink system slowly rather than all at once. She commented if there was overflow she immediately mopped the area.

4. During initial tour of the kitchen, beginning at 4:03 PM on 03/02/14 two of six tray pans stacked on top of one another in storage had moisture trapped in them. The cook stated she thought these tray pans were stacked in storage after that day's lunch meal.

During a follow-up tour of the kitchen, at 9:50 AM on 03/04/14, one of six tray pans stacked on top of one another in storage had moisture trapped inside of it. The cook stated she was unsure whether this tray pan was stacked wet that morning or the evening before.

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F 371	Continued From page 34 At 9:32 AM on 03/05/14 the dietary manager (DM) stated kitchenware should be completely air dried before stacking it in storage. At 2:36 PM on 03/06/14 the PM cook stated kitchenware had to be dry before being stacked in storage. 5. During initial tour of the kitchen, beginning at 4:03 PM on 03/02/14, there was a pink/gray film on the back panel of the ice machine, the face of the wall fan blowing between the dish machine area and the steam table was dusty, light bulbs above the dish machine and steam table were dusty, the top of the microwave was covered with dried food, and the kitchen floor was sticky and was littered with food debris. During a follow-up tour of the kitchen, beginning at 9:50 AM on 03/04/14, there was a pink/gray film on the back panel of the ice machine, the face of the wall fan blowing between the dish machine area and the steam table was dusty, light bulbs above the dish machine and steam table were dusty, the top of the microwave was covered with dried food, and the kitchen floor was sticky, littered with food debris/condiment wrappers/strips used to check sanitizer strength. In addition, a thick red syrup was present on the outside and inside of a utensil drawer, there were food crumbs in a cart where sectional plates were turned face down, and food preparation counters presented with dried food, food crumbs, smear of butter, a half opened can of crushed pineapple, an opened bag of cheese snacks, and used gloves. At 9:32 AM on 03/05/14 the dietary manager	F 371		

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(DM) stated the pink/gray build up on the back panel of the ice machine could contaminate the ice with mold, and food and kitchenware could be contaminated by dust on light bulbs and the wall fan, and a dirty microwave could contaminate foods being heated in it. He commented kitchen surfaces were to be kept clean and sanitized as needed, and the kitchen floor was to be mopped a couple times a day. According to the DM, maintenance was supposed to clean kitchen lights and fans, but he had not had a chance to coordinate that cleaning yet.

At 2:36 PM on 03/06/14 the PM cook stated the dietary staff was supposed to follow a cleaning schedule which would prevent contamination by dirt, dried food particles, bacteria, or mold. She reported kitchen surfaces were supposed to be cleaned and sanitized with bleach water. She explained food preparation counters were supposed to be cleaned and sanitized after completing a preparation task, before moving on to a new task. The cook commented maintenance cleaned fans and lights in the kitchen.

6. During initial tour of the kitchen, beginning at 4:03 PM on 03/02/14, opened food items were found in storage areas without labels and dates. In the dry storage room a 15-ounce box of raisins, a 10-pound bag of elbow macaroni noodles, a 10-pound bag of spaghetti noodles, a bag of rigatoni noodles, a foil package of cherry gelatin mix, a 40-ounce box of grits, a 28-ounce box of enriched farina, a 32-ounce foil package of pudding mix, and a 16-ounce bag of marshmallows were all opened, but without labels and dates. Also in the dry storage room 14 bowls of prepoured cereal were undated, and bins of

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rice and Japanese bread crumbs were undated. In the walk-in refrigerator a 5-pound bag of shredded mozzarella cheese, a bag containing sliced orange cheese, and a bag of French bread were opened, but without labels and dates. In the walk-in freezer three bags of chicken and a bag of riblets were removed from original packaging and placed in storage without labels and dates.

During a follow-up tour of the kitchen, beginning at 9:50 AM on 03/04/14 there were opened food items in storage without labels and dates. In the dry storage room a foil package of cherry gelatin, a 28-ounce box of cream of wheat, a bag of confectioner's sugar, and a bag of toasted oat cereal were opened, but without labels and dates. Also in the dry storage room 8 bowls of prepoured cereal were undated, and bins of rice and Japanese bread crumbs were undated. A bag of opened dinner rolls was found in the walk-in freezer without a label and date.

At 9:32 AM on 03/05/14 the dietary manager stated the cooks checked the storage areas regularly to make sure opened food items, food items removed from original packaging, and leftovers were labeled and dated. He added that he also checked these storage areas when his schedule allowed.

At 2:36 PM on 03/06/14 the PM cook stated it was the responsibility of all dietary employees to monitor storage areas. She commented the stock person specifically had this responsibility when working. She explained all dietary staff had a pen with which they were supposed to date opened food items, leftovers, and food items removed from their original packaging.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

(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 372	Continued From page 37	F 372		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to remove food debris from the outside and door track of dumpsters in an attempt to reduce the chance of insect and rodent infestation. Findings included: At 4:42 PM on 03/02/14 there was dried food matter covering the outside of two dumpsters below the sliding doors. In addition, there was a thick orange sauce embedded in the sliding door track of one dumpster. Both dumpsters were filled with bagged garbage. At 1:04 PM on 03/05/14 both of the facility's dumpsters had been emptied. However, there was still dried food on the outside of the dumpsters and a thick orange sauce embedded in the sliding door track of one of the dumpsters. At 2:36 PM on 03/06/14 the dietary manager (DM) stated it was the dietary department's responsibility to make sure garbage from the kitchen was bagged before being placed in the dumpster area and to make sure the sliding doors of the dumpsters remained closed when not in use. He reported the maintenance department was responsible for hosing the dumpsters down periodically. However, he commented he did not think the dumpster were hosed down on a set, regular schedule. According to the DM, the	F 372	1. Dumpsters have been cleaned to remove dried food residue from door tracks and exterior. 2. Dumpsters are being checked frequently to assure they are being kept free of food spills. 3. Dietary Staff received in-service training by the FSD on 3/11/14 regarding their responsibility to immediately clean up any spills that occur when they are placing refuse into the dumpster. The Food Service Director and Maintenance Director will make daily inspections of the dumpsters to assure they are clean. a.Maintenance Staff will pressure wash the exterior of the dumpsters at least once a month or more frequently if required b.The Administrator will make periodic inspections to assure compliance. 4. Food Service Director and Maintenance Director are completing a Dumpster Inspection report on a daily basis and report results will be reviewed by the facility QAPI Committee monthly for 3 months.	3/21/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

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F 372	Continued From page 38 dumpster area should be kept free from food debris because the debris could cause insects, rodents, and vermin to breed in the area. At 10:28 AM on 03/06/14 the maintenance manager (MM) observed the dumpsters, and stated that they needed to be hosed off because of the food matter on the outside and in the door track. He reported that the dumpsters usually remained fairly clean so they were not hosed down on a set, regular schedule.	F 372		