STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews the facility failed to apply a privacy cover to a urinary catheter bag for 1 of 1 resident with an indwelling urinary catheter (Resident # 35). Findings included: Resident # 35 ' s diagnoses included urinary obstruction/retention, chronic kidney disease, asthma, diabetes mellitus, and hypertension. The Minimum Data Set from 9/26/13 described the resident as cognitively intact. Physician orders on 10/10/2013 prescribed an indwelling urinary catheter for the resident with instructions to change monthly. Instructions for catheter care as per the care plan dated on 3/4/2014 instructed staff to " provide privacy bag cover when bedside drainage bag is used " , among other catheter care instructions. Upon observations made on 4/28/ 2014 at 6:27 PM, 4/29/2014 at 9:00 AM and 2:23 PM, and 4/30/2014 at 8:53 AM the catheter bag was noted to be hanging on the lower left side of the resident ' s bed in full view from the hallway and the door to the resident ' s room. The bag was moved to the right side of the bed, which faced the wall of the resident ' s room on 4/30/14 around 11:00 AM. At this time the bag was not visible from the hallway or the doorway to the	F 241	F241 It is the practice of the facility to provide our residents with dignity and privacy. Criteria One: For the resident found to have been affected by the alleged deficient practice: For resident #35, the care plan has been updated and a privacy bag provided for the resident to ensure privacy and dignity. Criteria Two: For other residents who may have been affected by the alleged deficient practice: There were no other residents identified by the deficient practice however, all residents with orders for an indwelling catheter have been reviewed, care plans updated, and a privacy bag provided for dignity. Criteria Three: The following systemic changes will be put into place to ensure the alleged deficient practice does not recur.	5/26/14

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

Electronically Signed | 05/21/2014

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F 241	Continued From page 1 room, but was noted to be draining yellow urine without an affixed privacy cover. The catheter was again observed to be uncovered on the same side of the bed on 5/1/2014 at 8:55 AM. During an interview with the resident on 5/1/2014 at 8:55 AM, the resident was questioned about her feelings regarding an uncovered catheter bag. She indicated that she had limited range of motion and was therefore not aware of the exposure of the catheter bag but stated her desire to have it covered immediately. She further said that she would like to have the catheter covered at all times for privacy. During an interview with the DON and Administrator at 9:09 AM on 5/1/2014, both were made aware of the uncovered catheter bag. The DON indicated that she was not aware of the need to cover catheter bags and said that she believed that the facility did not have any privacy covers to offer the resident at the moment. The Administrator said that they will be sure to order catheter covers and understands that the issue is one of dignity. An interview with Nursing staff # 1 at 9:16 AM on 5/1/14 revealed that she was aware that catheter bags need a " black cover " but could not provide a reason as to why Resident # 35 ' s bag was uncovered. She further stated that she thought a cover was needed for the sake of infection control; she denied knowing that it was for the principle of dignity. Nursing staff # 2 at 9:23 AM on 5/1/14 said that "dignity is a big part of a resident's life" and indicated that he was aware that catheter bags should be covered. He further stated that he had not worked since Monday (4/28/14) and therefore	F 241	Educational training will be provided by the Healthcare Administrator (HCA)or Director of Nursing(DON)to all PRN,PT/FT licensed and certified nursing staff to insure privacy bags are provided for residents using indwelling catheters. Criteria Four: The corrective action will be monitored as follows: The DON or Charge Nurse will audit weekly times 4 weeks then monthly times 3 months to ensure use of privacy bags for indwelling catheters. Audits to be taken to QA monthly for review and continuation as needed. 5/26/14	

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F 241	Continued From page 2 is not sure why the catheter bag had remained uncovered for the past four days of the survey. He also believed most members of the nursing staff knew to provide a privacy cover but re-educating the staff may prove beneficial.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, the facility failed to remove a personal care alarm while in bed and failed to remove a fall mat for 1 (Resident # 41) of 1 alert and oriented residents, who had been informed of the reason for these devices but said she did not want to use them. The findings included: Resident #41 was admitted on 3/13/14 with diagnosis including status post fall, right leg pain, and history of acute renal failure due to dehydration. Review of the Nursing Admission Note dated 3/13/14 revealed " verbalizes needs, speech clear and easily understood, order obtained for chair/bed alarm r/t (related to) decreased safety awareness, resident attempting to transfer self without assistance, resident understood when this nurse explained the use of the call bell and to ask for assistance to prevent falls and for her safety. "	F 242	F242 It is the practice of the facility to provide our residents with safety equipment when the assessment indicates such need. Criteria One: For the resident found to have been affected by the alleged deficient practice: For resident #41 the personal care alarm and fall mat were removed per resident request. Criteria Two: For other residents who may have been affected by the deficient practice: Each resident with a personal alarm and or fall matt have been reassessed, and	6/2/14

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F 242	Continued From page 3 Review of the resident ' s medical record from her admission date of 3/13/14 - 4/29/14 indicated Resident #41 did not have any falls during this time. The Admission Minimum Data Sat (MDS) Assessment dated 3/20/14 revealed Resident #41 was cognitively intact and required limited assistance for transfers and walking. The Falls Care Area Assessment completed for this MDS revealed that Resident # 41 had a fall prior to admission in the facility and that an order was obtained for a bed and chair alarm as the resident " forgets to ring for assistance with toileting and transferring " . Review of the Care Plan dated 3/21/14 revealed a plan of care for the following problem statement " I had an actual fall related to instability, dehydration " . Interventions included " I need a mobility monitor on my bed and chair, check functioning every shift " . Review of the Nursing Notes from 3/21/14 - 4/28/14 revealed: 3/21/14 - " Resident refuses to have mat at bedside. Several attempts made to keep at bedside but resident adamant about not having mat. Resident is A/O x 3 (alert and oriented to person, place and time). Bed alarm is on and functioning. " 4/19/14 - " Observed resident removing bed alarm and placing it under her pillow, staff replaced alarm x 2, spoke with resident and explained that the alarm was in place for her safety related to her history of falls, resident verbalized understanding. " 4/23/14 - Observed resident removing alarm, staff spoke with resident and explained why she had an alarm and she verbalized understanding " . On 4/29/13 at 10 AM Resident # 41 was interviewed and stated that when she went to bed	F 242	care plans updated to reflect residents right to make choices about aspects of his or her life in the facility significant to the resident. For those resident s unable to make the choice, the Power of Attorney or significant other has been contacted for approval with care plan for personal care alarm and or fall matt. Criteria Three: The following systemic changes will be put into place to ensure the deficient practice does not recur: All licensed and certified nursing staff will be in-serviced by the Healthcare Administrator or DON on the right of residents to make choices about aspects of his or her life in the facility, that are significant to the resident and to inform the Charge Nurse or Director of Nursing if a resident voices a need to make changes in their plan of care, by 5/26/14. All new admissions will be assessed for choices by day 21 of admission for choices and who to notify if they need to make changes. Criteria Four: The corrective action will be monitored as followed: The DON or Charge Nurse will complete an audit weekly x 4 weeks, monthly x 4 months and quarterly during care plan on those residents who have the personal care alarm and or fall matt to ensure choice for continued use. These audits will be reviewed during monthly QA for	

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F 242	Continued From page 4 at night the Nursing Assistant (NA) would always attach an alarm to her. The resident stated that she did not want this alarm and that every night she would tell the NA that but they always told her she had to have it and put it on anyway. The resident stated that she did not like the alarm because it would go off and wake her up. She added that she knew staff put it on because they were worried she would fall, and she should probably have it, but she just didn ' t want it. Resident # 41 said she also did not like the fall mat beside her bed. On 4/30/14 at 4 PM during an interview with the Director of Nursing she indicated that she had not been aware that Resident #41 did not want the personal care alarm on while in bed. She also said that if the resident did tell a Nursing Assistant (NA) she did not want the alarm it should have been reported to the nurse and then shared in the daily interdisciplinary team meeting (stand-up meeting) for review. Interview with NA # 1 on 4/30/14 at 5:40 PM revealed that Resident #41 had told her in the past she did not want the personal alarm put on while she was in bed and that she had reported this to the nurse. NA #1 said that the nurse told her to check the care plan and if it was in the care plan the resident needed to have it, so then she would advise the resident of this and put the alarm on. Interview with NA #2 on 4/30/14 at 5:45 PM revealed that Resident #41 had told him she did not like the alarm. He stated that he had worked with her the previous night and did put the alarm on but he does it in a way that it won ' t ring if she just turns over so she would let him do it. He also said that when she said she did not want it he would remind her that she could take it off herself but he needed to put it on. NA #2 also said that	F 242	continued compliance. 5/26/14	

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F 242	Continued From page 5 Resident #41 did not like the fall matt beside her bed.	F 242		
F 371 SS=F	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 interviews, the facility failed to label and date food items in the refrigerator, walk-in cooler and freezer and discard out of date meat in the walk-in cooler. The facility also failed to maintain the dishwashing rinse temperature at 180 degrees F (Fahrenheit). The findings included: A facility policy titled "Use of leftovers" version date 2010 stated, in part, "Procedure: 2. Leftovers will be covered, labeled, and dated; then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service. 4. Leftovers that have not been properly stored will be discarded. 5. Any food that is leftover will be handled as noted above and may be used as follows: Use leftovers within three (3) days or discard." 1. On 4/28/14 at 6:19 PM, the initial tour of the	F 371	F371 It is the practice of the facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities, and store, prepare, distribute and serve food under sanitary conditions. Criteria One: For the resident found to have been affected by the alleged deficient practice. No resident was been found to be affected by this alleged deficient practice. Criteria Two: For other residents who may have been affected by the alleged deficient practice.	5/26/14

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F 371	Continued From page 6 kitchen was conducted. The double door kitchen refrigerator contained the following items: one stainless steel container of ground brown meat unlabeled and undated and one half (1/2) box of two ounce sausage patties opened and undated. In the walk-in cooler, the following items were noted: two eight ounce cups of milk undated, one five pound plastic bag of clam meat 1/3 full opened and undated, one white container approximately 1/3 full of unknown food item unlabeled and undated, one package of beef pieces (stew beef pieces) wrapped in plastic undated and one package of opened turkey breast slices opened and dated 4/20 with use by 4/25/14. In the freezer, the following items were noted: four frozen waffles wrapped in plastic and undated, 1/3 pecan pie wrapped in plastic and undated and one package of blueberries opened and undated A second observation was made on 4/30/14 at 10:30 AM with the Dietary Manager. The walk-in cooler was entered and the following items were observed: one five pound plastic bag of clam meat 1/3 full opened and undated and one white container approximately 1/3 full of unknown food item unlabeled and undated. The Dietary Manager acknowledged she was not sure what was in the container, opened the container and observed raw scallops in the container. The freezer was entered and the following items were observed: four frozen waffles wrapped in plastic and undated, 1/3 pecan pie wrapped in plastic and undated and one package of blueberries opened and undated. On 4/30/14 at 11:00 AM, the Dietary Manager stated she expected expired foods to be discarded and opened foods to be labeled and	F 371	No other residents have been found to be affected by the alleged deficient practice. Criteria Three: The following systemic changes will be put into place to ensure the deficient practice does not recur: All Dining staff to include PRN/PT/FT and the Certified Dietary Manager have been in-serviced on 5/5/14 by the District Manager for Sodexo,GB, on Food Safety Product and Labeling & Dating and sanitation of pots, pans, and other equipment and utensils using the HACCP Manual guidelines. Criteria Four: The corrective action will be monitored as followed: The Healthcare Administrator and/or DON will audit the refrigerator; walk-in cooler, freezer, and dish washing machine daily x one week, 3 times per week for 4 weeks, and weekly as needed. A member of the Executive Team Chief Executive Officer (CEO) or Chief Operational Officer (COO) will audit weekly x 3 months then monthly beginning June 2014. Audits to be taken to QA monthly, through 2015 recertification survey to ensure continued compliance. 5/26/14	

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F 371	Continued From page 7 dated. On 5/1/14 at 8:15 AM, the Dietary Manager stated it was the cook's responsibility to label and date food items and ultimately it was the Dietary Manager's responsibility to check and make sure that items were labeled, dated and discarded if expired. 2. On 4/30/14 at 9:18 AM, an observation of the dishwashing machine was conducted with the Dietary Manager. The temperature of the water for the rinse cycle was noted to be 172 degrees F. The Dietary Manager stated the dish machine had a booster and the booster might need to be reset. She reset the machine and the temperature of the water for the rinse cycle was noted to remain at 172 degrees F during the rinse cycle. On 4/30/14 at 9:14 AM, dietary staff #1 stated the water temperature for the rinse cycle should be 180 degrees F. He said he had been told that it could be ten degrees under 180 degrees F and it would be all right. A review of the facility policy titled " Resource: Sanitation of Dishes/ Dish Machine "version date 2010 stated, in part, "High Temperature Dishwasher Final rinse temperature or sanitization-180 degrees F". The Dishwashing/ Ware Washing Machine Temperature Log for April 2014 was reviewed with the Dietary Manager and revealed the following: 4/2/14 (lunch) rinse temperature-175 degrees F 4/3/14 (lunch) rinse temperature-165 degrees F and (dinner)-160 degrees F	F 371		

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F 371	Continued From page 8 4/4/14 (breakfast) rinse temperature-165 degrees F and (lunch)-170 degrees F 4/5/14 (lunch) rinse temperature-155 degrees F 4/6/14 (breakfast) rinse temperature-175 degrees F, (lunch)-172 degrees F 4/7/14 (dinner) rinse temperature-158 degrees F 4/8/14 (breakfast and lunch) rinse temperatures 170 degrees F, (dinner)-160 degrees F 4/10/14 (breakfast) rinse temperature-155 degrees F 4/11/14 (lunch) rinse temperature-170 degrees F 4/17/14 (breakfast) rinse temperature-170 degrees F, (lunch)-165 degrees F 4/22/14 (breakfast) rinse temperature-175 degrees F, (dinner)-177 degrees F 4/23/14 (breakfast) rinse temperature-175 degrees F, (dinner)-168 degrees F 4/24/14 (dinner) rinse temperature-170 degrees F 4/25/14 (breakfast) rinse temperature--175 degrees F, (lunch)-170 degrees F,(dinner)-174 degrees F 4/26/14 (breakfast and lunch) rinse temperatures-175 degrees F,(dinner)-170 degrees F 4/27/14 (breakfast and dinner) rinse temperatures-170 degrees F 4/28/14 ((breakfast and lunch) rinse temperatures-170 degrees F 4/29/30 (breakfast, lunch, dinner) rinse temperatures-170 degrees F. On 4/30/14 at 11:00 AM, the Dietary Manager stated she was aware that the rinse cycle temperature should be at or above 180 degrees F and she had not been informed by any dietary staff that the temperatures had been below 180 degrees F. She did not indicate if she monitored/ reviewed the temperature log on a regular basis.	F 371		

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F 371	Continued From page 9 The Dietary Manager said she expected the dietary staff to inform her when the temperatures were not what they were supposed to be.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain effective monitoring practices through their quality assessment and assurance committee (QAA) over the calendar	F 520	F520 It is the practice of the facility to maintain a quality assurance and assessment	5/26/14

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F 520	Continued From page 10 year to prevent noncompliance with labeling and dating food items and discarding expired food items in the kitchen. The findings included: Also see F tag 371. On 5/1/14 at 9:18AM, the Administrator and Director of Nursing stated the facility had not continued to monitor, on an ongoing basis, the effectiveness of their plan of action regarding the issues that had been identified during the last two recertification surveys in relation to the labeling, dating and discarding of expired food items. The Administrator stated he thought the kitchen problems were resolved for a period of time but, unfortunately, the action plan did not become a part of the dining service leadership's ongoing daily checklist.	F 520	committee to develop and implement appropriate plans of action to correct identified quality deficiencies. Criteria One: For the resident found to have been affected by the alleged deficient practice: Corrective action has been implemented for those residents identified in tags F241 and F242 to ensure compliance with identified deficient practices. Criteria Two: For other residents who may have been affected by the alleged deficient practice: No other residents have been identified to have been affected by the alleged deficient practice. Criteria Three: The following systemic changes will be put into place to ensure the alleged deficient practice does not recur. As of 5/19/14, a new Healthcare Administrator has been appointed and will initiate monthly QA meetings to include the Director of Nursing, the Medical Director, and 3 other members of the facility staff, to assist in identifying possible deficient practice and implement corrective action and monitoring systems to ensure compliance with Federal and State regulations. The QAA Committee will be conducted by the HCA or DON.	

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F 520	Continued From page 11	F 520	Monitoring of North Dining facility will continue weekly through 2015 recertification survey to assure continued compliance with F371. Criteria Four: The corrective action will be monitored as follows: The Healthcare Administrator and or DON will report monthly in writing to the CEO and/or the COO, the actions of the QA Committee for on-going compliance. 5/26/14	