STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE A. BUILDING			I AND HUMAN SERVICES E & MEDICAID SERVICES			-	APPROVE . 0938-039
345490 B. WING 08/14/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, 20° CODE 128 SNOW HILL ROAD AYDEN, NC 28513 ATOEN COURT NURSING AND REHABLITATION CENTER PRESX TAG SUMMARY STATEMENT OF DEPICIENCIES (EXCH DEPICIENCY WINT DE PERCENDER DE PRILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PREFX (CAD CORRECTION CONSTRUCT OF THE PERCENDER DE PRILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PREFX (CAD CORRECTION CORRECTION (CAD CORRECTION CONSTRUCT OF THE PERCENDER DE PRILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG PREFX (CAD CORRECTION CORRECTION (CAD	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		(X3) DAT CON	E SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AYDEN, COURT NURSING AND REHABILITATION CENTER 128 SNOW HILL ROAD AYDEN, KC 28513 (M) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) IPROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE (REACH DEFICIENCIES) IPROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IPROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE (REACH DEFICIENCIES) IPROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE (REACH DEFICIENCIES) F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of the complaint investigation. Event ID#3HNS11. F 325 SS=D UNLESS UNAVOIDABLE F 325 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 collician difficient when there is a nutritional problem. F 325 MD was notified by DON of resident #11 weight loss on 3/8/14 and order given to increase feeding to every 4 hours. Resident #11 was admitted to the facility on 11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. MD was notified by DON of resident #11 weight loss on 3/8/14 and order given to increase feeding to every 4 hours. Resident #11 weight loss and 12/1/14 to review weight monitoring program until weight loss to include tube feeders was completed by DON and methy fustoweight ad aging to 145 pounds (lbs), Resi			345490	B. WING			-
AYDEN COURT NURSING AND REHABILITATION CENTER AYDEN, NC 28513 (PAI) ID TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of the complaint investigation, Event ID#3HNS11. F 000 F 325 483.25(i) MAINTAIN NUTRITION TATUS UNLESS UNAVOIDABLE F 325 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. MD was notified by DON of resident #11 weight loss on 8/8/14 and order given to increase feeding to every 4 hours. Resident #111 westigated for weight loss. Findings included: Resident #111 received all nutrition through a feeding tube and wes totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weight on no person to receive that nourishment. Review of the weight bised in the electronic medical record showed Resident #11 weight	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRÉFIX TAG CEACH CORRECTUE ACTION BEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG CEACH CORRECTUE ACTION BHOULD BE CROSS-REFERENCE OT 1HE APPROPRIATE COMP DEFICIENCY) F 000 INITIAL COMMENTS F 000 No deficiencies were cited as a result of the complaint investigation, Event ID#3HNS11. F 325 F 2433.25(I) MAINTAIN NUTRITION STATUS SS=D F 325 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 concessible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement timely weight loss interventions for 1of 3 sampled residents (Resident #11) was damitted to the facility on 11/1/01/0 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. MD was notified by DON of resident #11 weight loss on 8/8/14 and order given to increase feeding to every 4 hours. Resident #11 weight loss stable. RD visit on 8/2/14 and agree with changes. Resident #11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. Resident #11's Quarterly Minimum Data Set (MDS). Resident #11 neceived all nutrition through a feeding tube and was totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weighed	AYDEN C	OURT NURSING AN	D REHABILITATION CENTER				
No deficiencies were cited as a result of the complaint investigation, Event ID#3HNS11. F 325 F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE F 325 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. F 325 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement timely weight loss. Findings included: Resident #11) investigated for weight loss. Findings included: Resident #11's Quarterly Minimum Data Set (MDS) dated 07/31/14 showed a weight of 145 pounds (Ibs). Resident #11 received all nutrition through a feeding tube and was totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weight MDW as notified by DON of resident #11 weight ND was notified by DON of resident #11 weight loss on 8/8/14 and order given to increase feeding to every 4 hours. Resident #11 was admitted to the facility on 11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. MD was notified by DON of Resident #11 weight loss with recommendations implemented timely. 100% weight audit of all residents with significant weight loss to include tube feeders was completed by DON and weight committee (DON, Administrator, DN, A	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETIO DATE
F 325 complaint investigation, Event ID#3HNS11. 483.25(i) MAINTAIN NUTRITION STATUS F 325 SB=D 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 scinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. MD was notified by DON of resident #11 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement timely weight loss interventions for 1of 3 sampled residents MD was notified by DON of resident #11 Resident #111 investigated for weight loss. Findings included: Resident #11 was admitted to the facility on 11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. Resident #11 received all nutrition through a feeding tube and was totally dependent for weight loss to include tube feeders was completed by DON and weight committee (DON, Administrator, DM, Adminis	F 000	INITIAL COMMEN	TS	F 00	D		
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 by: Based on record review and staff interviews the facility failed to implement timely weight loss interventions for 1of 3 sampled residents (Resident #11) investigated for weight loss. Findings included: Resident #11 vas admitted to the facility on 11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. Resident #11's Quarterly Minimum Data Set (MDS) dated 07/31/14 showed a weight of 145 pounds (lbs). Resident #11 received all nutrition through a feeding tube and was totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weighted Maintage and the status of the status of the status of the weights listed in the electronic medical record showed Resident #11 weighted Maintage and was totally dependent on one person to receive that nourishment.		complaint investiga 483.25(i) MAINTAI	ation, Event ID#3HNS11. N NUTRITION STATUS	F 32	5		9/11/14
by: Based on record review and staff interviews the facility failed to implement timely weight loss interventions for 1of 3 sampled residents (Resident #11) investigated for weight loss. Findings included: Resident #11 was admitted to the facility on 11/10/10 with cumulative diagnoses of aphasia, cerebral vascular accident (CVA), and hemiplegia. Resident #11's Quarterly Minimum Data Set (MDS) dated 07/31/14 showed a weight of 145 pounds (lbs). Resident #11 received all nutrition through a feeding tube and was totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weighed		assessment, the faresident - (1) Maintains acceptatus, such as boo unless the resident demonstrates that (2) Receives a them	acility must ensure that a ptable parameters of nutritional dy weight and protein levels, t's clinical condition this is not possible; and rapeutic diet when there is a				
through a feeding tube and was totally dependent on one person to receive that nourishment. Review of the weights listed in the electronic medical record showed Resident #11 weighedsignificant weight loss to include tube feeders was completed by DON and weight committee (DON, Administrator, DM, QA nurse, MDS nurse) on 7/22/14 to		by: Based on record r facility failed to imp interventions for 10 (Resident #11) inve Findings included: Resident #11 was a 11/10/10 with cum cerebral vascular a hemiplegia. Resident #11's Qua (MDS) dated 07/31	eview and staff interviews the blement timely weight loss of 3 sampled residents estigated for weight loss. admitted to the facility on ulative diagnoses of aphasia, accident (CVA), and arterly Minimum Data Set 1/14 showed a weight of 145		weight loss on 8/8/14 and order increase feeding to every 4 hour Resident family made aware by 8/8/14 and agree with changes. #11 placed on weekly weight mo program until weight loss stable. on 8/21/14 to review resident #1 loss with recommendations impl timely.	given to s. DON on Resident nitoring RD visit 1 weight emented	
		through a feeding to on one person to re Review of the weig medical record sho	tube and was totally dependent eceive that nourishment. hts listed in the electronic bwed Resident #11 weighed		significant weight loss to include feeders was completed by DON weight committee (DON, Admini DM, QA nurse, MDS nurse) on 7	tube and strator, 7/22/14 to	

Electronically Signed

08/29/2014

PRINTED: 09/03/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO.	<u>0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
					(C
		345490	B. WING			14/2014
IAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
YDEN CO	OURT NURSING AND	D REHABILITATION CENTER		128 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 325	Continued From pa	qe 1	F 32	25		
	and 148.3 lbs. on 0 Review of the Dieta 05/05/14 showed R requirement was 13 Resident #11 receiv Review of the Phys 05/22/14-08/07/14 s Resident #11. Review of the Regis Notes dated 05/28/ weight changes we received tube feedin Review of the RD P showed Resident # loss of 12.7 lbs. (7.9 #11 received nutrition provided 1200kcal of supplement was als another 100kcals for recommended on 0 feeding to every 4 h halt weight loss. Review of the Dieta 07/31/14 showed R requirement was 15 receiving 1300 calo Review of the Quali Review dated 08/08 weight to be 148.3 h with a gradual loss the RD recommend 08/07/14 (the recon 07/21/14).	7/18/14. 7/18/14. Ty Supplemental 4 dated resident #11's nutritional 389 calories each day. Ved 1300 calories each day. ician Telephone orders dated showed no diet changes for stered Dietician (RD) Progress 14 showed no significant re noted. Resident #11 ng nutrition 4 times each day. Progress Notes dated 07/21/14 11 had a significant weight 9%) over 90 days. Resident on 4 times each day which (calories). A protein so being given which added or a total of 1300kcals. The RD 07/21/14 to increase the tube hours (6 times each day) to ary Supplemental 4 dated tesident #11's daily calorie 545 calories. Resident #11 was aries. ity Improvement Weight 8/14 showed Resident #11's Ibs. and stable times 30 days over 90 days. The approval for dations to increase the se each day was received on nmendation was made on ician Telephone Orders dated		 for weight loss, MD/RP not referral to RD. Any issues addressed by DON and we committee. DON complete on 8/21/14 of all residents weight loss and ensured in were implemented timely, notification, and referral to DON and weight committe facility consultant on timely intervention, MD/RP notific referral on 8/29/14. To ensure that all weights a properly, the DON and weight for 4 weef for 3 months to review any include resident #11 that tr 5% (in 30 days), 7.5% (90 180 days) utilizing a weight tool. Interventions will be ir timely for all identified resid weight review will be docur DON in the progress notes resident. The MD, RD, and will be contacted as needed identification of any potentit. The RD will review all tube monthly for 3 months and to identify any potential cor will forward recommendati the MD to for review and ir recommended interventior. Administrator will review Q completion weekly for four 	identified were sight d weight review with significant terventions MD/RP RD. e inserviced by rweight loss ation, and RD are monitored ght committee (s and monthly residents to igger for a +/- days), 10% (in t committee nplemented dents. This nented by the for each resident family d upon the al concerns. feeders hen as needed noerns. DON ons from RD to nplement all s timely. I tool for	

Facility ID: 960259

If continuation sheet Page 2 of 16

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	CON	E SURVEY IPLETED
		345490	B. WING			C 14/2014
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 128 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 325 F 327 SS=D	there was no weigh indicated the weigh after she left and sh Resident #11's weig In an interview on 0 Director of Nursing charge of the weigh the purpose of the or resident weights. S weekly weight meet also be the monthly committee would re- for a weight loss or 180 days. She indicate about a greater tha stated she expecter weight was not four high calorie liquid s used to increase Re- In an interview on 0 Administrator stated breakdown in the st administrative staff, have requested Re- came in on 06/25/1 resident receiving r should not lose wei 483.25(j) SUFFICIE HYDRATION The facility must pri- sufficient fluid intak and health.	th for Resident #11. She th must have been entered he was not informed of ght loss. 18/14/14 at 2:53 PM the (DON) indicated she was in not committee. She stated it was committee to monitor trends in he indicated there were tings and one of those would and on eof those would and one of those would and one of those would and one of those would and the point of the point and and for review. She stated a upplement could have been esident #11's weight. 18/14/14 at 3:15 PM the d she felt there had been a and sten due to a change in the . She indicated the RD should sident #11's weight when she 4. The Administrator stated a mutrition through a feeding tube	F 325	meetings will be forwarded to the QI committee monthly for four mo review and follow up as deemed necessary for any potential trends determine the frequency and/or n continued monitoring. This will be completed by Septem 2014.	onths for s and to eed for	9/11/14

Facility ID: 960259

If continuation sheet Page 3 of 16

	-	AND HUMAN SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345490	B. WING			C 14/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		14/2014
AYDEN (OURT NURSING ANI	D REHABILITATION CENTER		128 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 327	Continued From pa	ge 3	F 32	27		
	and staff interviews system in place to r provided to 1 of 3 r had physician's ord Findings included: Resident #61 was r 02/03/14. Cumulati stage renal disease a failed renal transp A Significant Chang assessment of 02/1 be cognitively intact extensive to total as living but needed so According to the Ca for this MDS, he trig with other areas. A document entitled Assessment" was Resident #61. He v and wandering pred According to the ele #61's resident care pitcher in the room, identification bracel restrictions of 1500 A physician's order that Resident #61 v of 1500 ml daily. T	tion, record review, resident a, the facility failed to have a monitor and/or track fluids esidents (Resident #61) who ers for fluid restrictions. re-admitted to the facility on ve diagnoses included end e with hemodialysis, history of olant and hypertension. ge Minimum Data Set (MDS) 10/14 noted Resident #61 to t. The resident required ssistance with activities of daily et up only for eating. are Area Assessment (CAA) ggered in dehydration along d "At Risk Wandering completed on 05/02/14 for was identified as being at risk cautions were in place. ectronic charting, Resident guide included: no water wandering with an let in place and fluid ml (milliliters) daily. sheet for June 2014 noted was to have a fluid restriction here was no indication noted were to be divided between		Resident #61 was educated fluid restriction of 1500 ml on DON. Resident #61 fluid rest reviewed by DON and QA nu 8/29/14 for 16 days to ensure was not exceeding required r per MD order. Resident was exceed fluid restrictions durin Resident #61 MAR was upda 8/29/14 by DON and QA nurs and track fluid intake per requ restrictions. A 100% audit of all residentP fluid restrictions for 30 days w completed by DON and QA n 8/29/14 to ensure residents h exceeded required restriction order. No resident was found fluid restrictions per MD orde audit. Residents with fluid rest MARs were updated on 8/29/ and QA nurse to monitor and intake per required restriction <i>Constructions</i> . All CNAs will be inserviced by DON/QA nurse on document in electronic health record to restrictions. All licensed nursi be inserviced by 9/11/14 by D nurse on documentation of flu MAR and in electronic health on how to properly track and intake for fluid restrictions per All dietary staff will be inservity 9/11/14 by DON/QA nurse on	8/29/14 by rictions were rse on e resident estrictions not found to a audit. ted on se to monitor uired s fluids on vas urse on had not s per MD to exceed r during strictions '14 by DON track fluid s. / 9/11/14 by ation of fluids include fluid ng staff will DON/QA uid intake on record and monitor fluid r MD order. ced by	

Facility ID: 960259

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	0938-039 SURVEY PLETED
		345490	B. WING _			C 08/1	; 4/2014
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AYDEN (COURT NURSING ANI	D REHABILITATION CENTER			28 SNOW HILL ROAD YDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETIO DATE
F 327	••••••••••••••••••••••••••••••	-	F 32	27			
	Administration Rec. "FYI" (for your infor on a 1500 ml fluid r no fluid totals listed all of the date block According to the Ju sheet, Resident #6 1500 ml daily and h Novosource (protei daily. Upon review of the Administration Rec. "FYI" (for your infor on a 1500 ml fluid r no fluid totals listed all of the date block A Quarterly MDS as documented Reside A health status note indicated that Reside oriented and could noted that he ambu wheelchair and hac The August 2014 pl Resident #61 was t	ly 2014 physician's order 1 was on a fluid restriction of ad orders for 60 ml of n supplement) three times July 2014 Medication ord (MAR), it was noted as mation) that Resident #61 was estriction daily. There were as to dietary or nursing and			nursing staff, and dietary staff will be inserviced during orientation. DON a QA nurse will be inserviced by consu- on 8/29/14 regarding fluid restrictions how to properly track and monitor for residents with MD orders for fluid restrictions. CNAs will document actual fluid intal each shift for all residents to include resident #61 in the electronic health record. Licensed nursing staff will document fluid intake with med pass each resident to include resident #67 MAR and in electronic health record will notify MD if resident exceeds flui restriction per MD order. DON/ QA n will monitor fluid intake for residents fluid restrictions per MD order using tool for daily for five days, weekly for weeks, and monthly for three months DON will immediately address all identified areas of concern. The resu the fluid restriction monitoring will be forwarded to the facility QI committee monthly for four month for review an follow up as deemed necessary for a potential trends and to determine the frequency and/or need for continued monitoring. This will be completed by Septembe	and ultant s and r ke on s for 1 on and id id with a QA four s. The ults of e id any e	
	Administration Rec "FYI" (for your infor	August 2014 Medication ord (MAR), it was noted as mation) that Resident #61 was estriction daily. There were			2014.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C NAME OF PROVIDER OR SUPPLIER 345490 B. WING 08/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 128 SNOW HILL ROAD AYDEN, NC 28513 128 SNOW HILL ROAD AYDEN OF CORRECTION (X3) DATE SURVEY COMPLETED			AND HUMAN SERVICES				F	FORM	APPROVED 0938-0391
A: BUILDING C 345490 B. WING 08/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AYDEN COURT NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	TATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			(3) DATE	E SURVEY
345490 B. WING 08/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 128 SNOW HILL ROAD AYDEN COURT NURSING AND REHABILITATION CENTER 128 SNOW HILL ROAD AYDEN, NC 28513 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID FOR FOR COURT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETING DATE	ND PLAN OF CORREC	CTION	IDENTIFICATION NUMBER:	A. BUILD	ING				
AYDEN COURT NURSING AND REHABILITATION CENTER 128 SNOW HILL ROAD AYDEN, NC 28513 (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 (X5) COMPLETIC DATE			345490	B. WING					
AYDEN COURT NURSING AND REHABILITATION CENTER AYDEN, NC 28513 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETIC DATE	NAME OF PROVIDER	OR SUPPLIER							
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATECOMPLETIC DATE	AYDEN COURT N	IURSING AN	D REHABILITATION CENTER						
	PRÉFIX (EA	CH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE		COMPLETION
 F 327 Continued From page 5 all of the date blocks were left blank. During the lunch meal observation on 08/11/14 beginning at 12:20 PM, Resident #61 was observed eating lunch in his room. There were 2 styrofoam cups of liquids on his tray. When interviewed, the resident stated that he didn't have a water pitcher but did have his own personal coffee cup that he filled at will. Resident #61 also commented that none of the staff ever asked him how much he was consuming. He also commented that he did not receive water from staff unless the nurse was administering medications. Upon review of Resident #6's tray slip, it was noted that he was also noted on the tray slip that he was on a 1500 ml fluid restriction. Resident #61's care plan, last reviewed on 08/12/14, identified a problem with end stage renal cliesease and was at risk for complications due to hemodialysis. It was noted that his diet was as ordered with a 1500 ml fluid restriction. A problem was also identified as a potential for or actual fluid volume excess related to his non-compliance with Nurse Aide #1 (NA#1) on 08/12/14 at 4:50 PM, she stated Resident #61 was a little confused today. She stated he was a dialysis resident and went out for dialysis 3 times weekly. NA#1 stated he ad been identified as a wanderer and his picture was on the wander board in the employee lounge. She reported that Resident #61 needed assistance with personal care but could self transfer from the bed to the wheelchair. When questioned about fluid restrictions, she commented that he dank a lot of 	TAGREGF 327Continuall of the During beginni observe styrofoa intervie have a persona #61 als asked h also co from sta medica slip, it v diet with tray slipResider 08/12/1 renal di due to I was as problem actual f non-colDuring 08/12/1 was a li dialysis weekly. wander board in Resider care bu wheelch	ued From pa he date block the lunch m ing at 12:20 ed eating lur am cups of I ewed, the res water pitche al coffee cup so commented him how mu ommented th aff unless the ations. Upon was noted th h large porti- to that he was or t#61's care 14, identified isease and v hemodialysis ordered with m was also ie fluid volume mpliance with an interview 14 at 4:50 PI ittle confuse s resident an . NA #1 stat rer and his p n the employ at could self hair. When	age 5 ks were left blank. heal observation on 08/11/14 PM, Resident #61 was nch in his room. There were 2 liquids on his tray. When sident stated that he didn't er but did have his own p that he filled at will. Resident ed that none of the staff ever uch he was consuming. He hat he did not receive water he nurse was administering h review of Resident #6 's tray hat he was receiving a regular ions. It was also noted on the is on a 1500 ml fluid restriction. The plan, last reviewed on d a problem with end stage was at risk for complications is. It was noted that his diet th a 1500 ml fluid restriction. A identified as a potential for or excess related to his ith fluid intake. w with Nurse Aide #1 (NA#1) on M, she stated Resident #61 ed today. She stated he was a hd went out for dialysis 3 times ted he had been identified as a pocture was on the wander yee lounge. She reported that led assistance with personal transfer from the bed to the questioned about fluid	F 3		CROSS-REFERENCED TO THE APPRO			

Facility ID: 960259

If continuation sheet Page 6 of 16

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	09/03/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345490	B. WING			C 14/2014
NAME OF F	PROVIDER OR SUPPLIER	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
AYDEN (COURT NURSING AN	D REHABILITATION CENTER		28 SNOW HILL ROAD YDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 327	restricted. NA #1 a be on his resident of inside the closet do documented the flu trays at the end of e Resident #61 was of 08/13/14 at 1:00 PM of fluid on his tray. usually received a of coffee with his brea pointed to a silver of television and state on a regular basis. to another area in th Resident #61 states the mornings for re he helped himself. ever asked him how drinking. Upon obs was silver in color a approximately a 12 During an interview 2:35 PM, she states at the end of each s with orders for fluid any extra fluids. Sh fluid restriction was resident's care guid During an interview 4:20 PM, she states amounts in the corr to the residents who She also stated she ensure that the resi	added that if he was, it would care guide which was located oor. NA #1 also stated she uid consumed from his meal each shift. observed having lunch on M. There was an 8 ounce cup Resident #61 reported that he carton of milk and a cup of akfast meal. Resident #61 cup that was sitting beside the ed he filled that cup with coffee He also reported that he goes he building to get coffee. d the coffee pot was left out in esidents who wanted coffee so He commented that no one w much coffee he was servation, the personal cup and appeared to be 1-16 ounce cup. with NA #2 on 08/13/14 at d she documented fluid totals shift. She stated residents restrictions did not receive he also commented that the also included on the	F 327			

If continuation sheet Page 7 of 16

	KS FUR MEDICARE	& MEDICAID SERVICES	1			D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED
		345490	B. WING _		08	C 3/14/2014
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
YDEN C	OURT NURSING AN	D REHABILITATION CENTER		128 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 327	Continued From pa	-	F 32	7		
	reported that the n	which was Resident #61. She urse aides document in the now much Resident #61 s meal trays.				
	(DON) and Nurse # was reported that F non-compliant with ambulatory via a w nor Nurse #2 could Resident #61 abou stated currently the or monitoring the a resident was on a p	with the Director of Nurses #2 on 08/14/14 at 11:00 AM, it Resident #61 was the fluid restrictions and was heelchair. Neither the DON I remember educating t fluid restrictions. The DON ere was no system for tracking mount of fluids taken in if a obysician ordered fluid #2 commented that based on				
	her knowledge of fl facilities, she had s medication adminis indicating how muc much nursing prov the nurse aides do consumed from the aware that anyone	luid restrictions from previous seen totals noted on the stration records (MARs) ch dietary provided and how ided. The DON reported that cumented the amount of fluids e meal trays but she was not was monitoring or over seeing dents at this facility. The DON				
	reported that she w manager to discuss amounts to be prov department and the commented that sh	vould meet with the dietary s fluid restrictions and decide vided from the dietary e nursing staff. The DON also he would meet with nursing d restrictions and it would be				
	(DM) on 8/14/14 at approached about restrictions when s	with the dietary manager 2:45 PM, she stated she was how she wanted to handle fluid he was first hired. The DM ided 960 ml of fluids on the				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION (0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
					(С
		345490	B. WING _		0 8/ [,]	14/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AYDEN (COURT NURSING AN	D REHABILITATION CENTER		128 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 327 F 371 SS=E	restriction. Accordi restriction was note on the tray slips, an at each meal were The DM explained documented the ac in the care tracker of reported she was u fluid provided with as nutritional supple 483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and	ing to the DM, the fluid ed as a "for your information" ad the beverages to be offered documented on the tray slips. the nurse aides (NAs) tual intake of meal beverages electronic system but she nsure how nursing tracked medications and fluid provided ements. ROCURE, /SERVE - SANITARY	F 32			9/11/14
	by: Based on observat facility failed to follo safely thawing froze faces blowing into f onto sanitized kitch before providing it t food/beverage item contamination by in kitchenware before and failed to mainta sanitizing solution to	NT is not met as evidenced tion and staff interview the ow facility expectations for en meats, failed to clean fan ood preparation areas and enware, failed to wash fruit o a resident, failed to keep is covered to prevent sects, failed to air dry placing food/beverage into it, ain the strength of a quaternary used to wipe down meal carts ing rooms and resident halls.		 On 8/11/14, all thawed meat item were assessed to determine safety I (Dietary Manager). The thawed chic was discarded by DM due to not bei safe with blood in pans. Additional b of frozen chicken were pulled on 8/1 by DM and thawed properly for 8/12, meal by DM and cook. Barbeque wa dated and found safe for use by DM cook 8/11/14. All dietary staff were inserviced by D 	by DM ken ng oxes 1/14 /14 /14 is and	

Facility ID: 960259

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		AND HUMAN SERVICES				PRINTED: 09/03/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345490	B. WING			08/14/2014
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1
AYDEN C	OURT NURSING ANI	D REHABILITATION CENTER			28 SNOW HILL ROAD IYDEN, NC 28513	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 371	Continued From pa	ae 9	F	371		
	Findings included:	-			how to safely thaw frozen meats I 9/11/14. All new hired dietary staf	
	1. During initial tour of the kitchen on 08/11/14, beginning at 10:50 AM, two trays of thawed chicken and a tray of thawed barbeque were being stored in the walk-in refrigerator without labels which would indicate when the meats were				inserviced during orientation.	
					Dietary staff will thaw frozen mea properly by procedure. Dietary Ma Administrator will observe all thay	anager or
	pulled from the free	ezer and placed into in the thawing process. The			meats for five days, using the me tool, then weekly for four weeks, t	at audit
	two trays of thawed	chicken were full of blood. At			monthly for three months to ensu	re frozen
		v manager (DM) stated the que were pulled from the day, 08/06/14.			meats are thawed safely. Staff wi retrained by the Dietary Manager identification of any potential thaw safety concerns.	upon the
	barbeque pork platt residents for lunch	nenus revealed that a ter was being served to on 08/12/14 and baked was being served to residents 2/14.			The results of the safe thawing m audits will be forwarded to the fac committee monthly for 4 months review and follow up as deemed	ility QI
		3/14 two carts full of frozen ed in the walk-in refrigerator.			necessary for any potential trends determine the frequency and/or n continued monitoring.	
	At this time the coo such as 08/13/14, a were pulled from th	k explained on Wednesdays, a full week's worth of meats e freezer and placed in in the thawing process.			This will be completed by Septem 2014.	ber 11,
	At 10:00 AM on 08/	13/14 the DM stated the gue found in the walk-in			2. On 8/13/14, fans were cleaned dietary aid using fan cleaning pro-	
	refrigerator during i have been served a explained that the f frozen meats to beg	nitial tour were supposed to at meals on 08/12/14. She acility pulled a week's worth of gin thawing on Wednesdays.			All dietary staff were inserviced by how to properly clean fans in the by 9/11/14. All new hired dietary s be inserviced during orientation.	kitchen
	days for the chicker	would probably take a couple n and barbeque to completely r thawing, they should be ner couple of days.			Fans are scheduled to be cleaned and weekly according to procedur dietary aide. DM or Administrator observe all fans for five days, usir	re by will
	At 4:45 PM on 08/1	3/14, during a telephone			audit tool, then weekly for four we	

Facility ID: 960259

		(X2) MULTIP			E SURVEY		
F CORRECTION	IDENTIFICATION NUMBER:				PLETED		
	0.45.400				C		
	345490			08/	14/2014		
ROVIDER OR SUPPLIER							
OURT NURSING ANI	D REHABILITATION CENTER						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE		
Continued From pa	ae 10	F 371					
conversation, the conversation, the consultant stated it pull a week's worth begin the thawing protacceptable to provide the theory of the consecutive of the consecu	 a provide food service b process. She reported it was ull meats from the freezer on pook them until 08/12/14. c process. She reported it was ull meats from the freezer on pook them until 08/12/14. c process of being pulled from the days of being pulled from the wing. 4/14 the DM stated the dietary week's worth of frozen meats before she starting working in ported this practice had not 4/14 the PM cook stated she ut up stock and pull meats for month. She reported she sdays to pull all the meats in ppeared on a week's worth of ented she transferred these walk-in refrigerator where eing cooked and served to 	F 371	 then monthly for three months to that all fans are cleaned properly. staff will be retrained by the Dieta Manager upon the identification or potential concerns. The results of the fan cleaning au be forwarded to the facility QI conmonthly four months for review a up as deemed necessary for any trends and to determine the frequand/or need for continued monitor. This will be completed by Septem 2014. Dietary employee was discipling not proper fruit and vegetable was procedure by Dietary Manager an Administrator on 8/18/14. All dietary staff were inserviced by Manager on how to properly washing for the factor. 	Dietary ry f any dits will nmittee nd follow potential ency ring. dber 11, ed for erviced hing d			
strands of dust hanging off the back of the fan. During food preparation and dish machine observation, beginning at 9:30 AM on 08/13/14, a floor fan was blowing into the food preparation			 dietary staff will be inserviced duriorientation. Dietary staff will properly wash fruiproviding to residents per procedure Dietary Manager or Administratories observe dietary staff washing and providing fruit to residents for five using the audit tool, then weekly from the staff washing and the staff washing and the staff washing and providing fruit tool, then weekly from the staff washing and the staff washing and the staff washing and the staff washing and providing fruit tool, then weekly from the staff washing and the staff washing and the staff washing and providing fruit tool, then weekly from the staff washing and the staff washing and the staff washing and the staff washing and providing fruit tool, then weekly from the staff washing and the staff washing at the staff washing a	ing uit before ure. will l days, or four			
	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER COURT NURSING ANI SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From par conversation, the ci consultant stated it pull a week's worth begin the thawing p not acceptable to p 08/06/14 and not co According to the co be used within three freezer to being that At 2:10 PM on 08/1 staff was pulling a v to thaw at one time the facility. She rep been questioned. At 2:30 PM on 08/1 had been helping p thawing for about a was told on Wedne the freezer which a menus. She comme frozen meats to the they thawed until be residents sometime the food prepar fan had a coating o strands of dust han During food prepara	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345490 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 conversation, the corporate food service consultant stated it was not company policy to pull a week's worth of frozen meats at one time to begin the thawing process. She reported it was not acceptable to pull meats from the freezer on 08/06/14 and not cook them until 08/12/14. According to the consultant, frozen meats should be used within three days of being pulled from the freezer to being thawing. At 2:10 PM on 08/14/14 the DM stated the dietary staff was pulling a week's worth of frozen meats to thaw at one time before she starting working in the facility. She reported this practice had not been questioned. At 2:30 PM on 08/14/14 the PM cook stated she had been helping put up stock and pull meats for thawing for about a month. She reported she was told on Wednesdays to pull all the meats in the freezer which appeared on a week's worth of menus. She commented she transferred these frozen meats to the walk-in refrigerator where they thawed until being cooked and served to residents sometime during the coming week. 2. During initial tour of the kitchen on 08/11/14, beginning at 10:50 AM, a floor fan was blowing into the food preparation area. The face of the fan had a coating of dirt and dust on it with some strands of dust hanging off the back of the fan. <td <="" colspan="2" td=""><td>OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345490 B. WING</td><td>OF DEFICIENCIES F CORRECTION (X1) FROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 345490 B. 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Facility ID: 960259

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/03/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345490	B. WING	i			0 14/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
AYDEN C	OURT NURSING ANI	D REHABILITATION CENTER			28 SNOW HILL ROAD AYDEN, NC 28513		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ae 11	E :	371			
	off the back of the f	ans.			Manager upon the identification of a potential concerns.	any	
	wipe both fan faces this time the dietary utilized in the kitche cleaned every Wed the past couple of v A 2:10 PM on 08/14 person was respon- weekly, but she cor stock person left sh employee newly as responsibility of clea commented it had b the floor fans were dust and dirt from th food being prepared possibly making res At 2:30 PM on 08/1 with stock responsi putting up stock ab been told that part of the floor fans used 3. At 10:23 AM on 0 the kitchen door an	4/14 the PM cook/dietary aide bilities stated she began but a month ago, but had not of her new job was to clean in the kitchen. 08/13/14 an employee came to d told the dietary staff that a			 The results of the fruit washing aud be forwarded to the facility QI comm monthly for four months for review a follow up as deemed necessary for potential trends and to determine the frequency and/or need for continuer monitoring. This will be completed by September 2014. 4. On 8/13/14 tea urn was covered rolls were covered on tray line with paper by cook and dietary aid. All dietary staff were inserviced by I how to properly keep food/beverage covered to prevent contamination b insects by 9/11/14. All new hires will inserviced during orientation. Dietary staff will cover food/beverage during preparation to prevent contamination by insects. Tea urns covered with lid and food items will covered with wax paper or pre-bage 	nittee and any ne d er 11, and wax DM on e items y I be ge will be be ged.	
	A dietary employee from the walk-in ref side dish. The grap	tial request for fresh grapes. retrieved a bag of grapes rigerator and placed them in a bes were no washed prior to nember with the side dish.			Dietary Manager or Administrator w observe all tea urns and food on the line for five days, using the audit too weekly for four weeks, then monthly three months to ensure that all food	e tray ol, then y for I and	
	At 2:10 PM on 08/1 (DM) stated all dieta in-serviced on the in	4/14 the dietary manager ary staff were previously mportance of washing fresh as before serving them to			beverage items are properly covered prevent contamination by insects. It staff will be retrained by the Dietary Manager upon the identification of a potential safety concerns.	Dietary	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/03/2014 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		345490	B. WING			C 08/14/2014		
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE			
AYDEN C	OURT NURSING ANI	D REHABILITATION CENTER			28 SNOW HILL ROAD AYDEN, NC 28513			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	Continued From pa	ge 12	F3	371				
	Continued From page 12 residents. She reported washing fresh fruit and vegetables thoroughly helped cleanse away harmful bacteria which could make residents sick. At 2:30 PM on 08/14/14 the PM cook stated she remembered being in-serviced about the importance of washing fresh fruit and vegetables before serving them raw. She reported she was told that washing the fresh produce reduced the chance that residents could get foodborne illness. 4. At 10:32 AM on 08/13/14 a fly was observing hovering around the food preparation area. At 10:35 AM on 08/13/14 a canister of brewed tea was uncovered. At 11:57 AM on 08/13/14 rolls were removed from the warmer and placed at the trayline. The dietary aide working on the trayline bagged about five rolls, and left the rest of the pan uncovered. At 12:00 noon on 08/13/14 this tea canister still remained uncovered. At 12:15 PM on 08/13/14 a fly was hovering over food at the trayline, and half a large baking pan of rolls was still uncovered. At this time the dietary manager (DM) stated since she worked in the facility the dietary staff always bagged their							
	was to be dropped rolls there would be and could pose a here reported it was imp	4/14 the DM stated if fly feces in the tea or on the cooked no way to kill the bacteria, ealth risk for residents. She ortant to keep food and during food preparation and			for four weeks, then monthly for the months to ensure that all kitchenw dried properly before placing food/beverage in it. Dietary staff w retrained by the Dietary Manager u identification of any potential safet concerns.	are is ill be upon the		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/03/2014 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
345490			B. WING			08/14/2014			
NAME OF PROVIDER OR SUPPLIER AYDEN COURT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 128 SNOW HILL ROAD AYDEN, NC 28513						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 371	trayline operation secontaminated, espectively at temperatures At 2:30 PM on 08/12 was taught to keep so that flies and gna 5. At 10:12 AM on of kitchenware, 3 of wet inside. At this to stated the moisture was due to the hot 1 where they were sta At 12:12 PM on 08/14 the trayline operation cook from placing of side dish which had dish had been sittin steam table. This let touch. At 3:41 PM on 08/11 dietary employee from 25, 8-ounce cups word from 25, 8-ounce cups word them. At 2:10 PM on 08/12 kitchenware should food and beverage new cups which show and the same cups would no meal. The DM corror kitchenware could of At 2:30 PM on 08/14	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 trayline operation so they would not be contaminated, especially if they were not being kept at temperatures hot enough to kill bacteria. At 2:30 PM on 08/14/14 the PM cook stated she was taught to keep food and beverages covered so that flies and gnats could not land on them. 5. At 10:12 AM on 08/13/14, during an inspection of kitchenware, 3 of 17 plastic side dishes were wet inside. At this time the dietary manager (DM) stated the moisture formation inside these dishes was due to the hot ledge below the steam table where they were stacked. At 12:12 PM on 08/13/14, during observation of the trayline operation, the surveyor stopped the cook from placing okra for the lunch meal into a side dish which had moisture inside it. This side dish had been sitting on the ledge below the steam table. This ledge was very warm to the couch. At 3:41 PM on 08/13/14 the surveyor stopped a dietary employee from pouring unsweet tea into 25, 8-ounce cups which still had moisture inside		371	 The results of the kitchenware audii be forwarded to the facility QI commonthly for four months for review a follow up as deemed necessary for potential trends and to determine the frequency and/or need for continued monitoring. This will be completed by September 2014. 6. On 8/14/14 quaternary solution b were disposed of and new solution made according to procedure. All dietary staff were inserviced by I regarding proper procedures for prequaternary solution and how to main the strength of the solution used to down meal carts by 9/11/14. All new dietary staff will be inserviced during orientation. Dietary staff will prepare quaternary solution buckets at the beginning of shift using sanitizing sink solution or and water. Dietary staff will use Hyperse strip to check strength of solution. Solution must be at least 200 ppm. to cleaning meal carts, solution will checked using Hydrion strip to ensure strength is maintained to at least 200 ppm. Dietary Manager or Administration will observe the quaternary solution buckets for five days, using the aud then weekly for four weeks, then me for three months to ensure that quaternary solution buckets for five days. 				
	At 2:30 PM on 08/1	4/14 the PM cook stated she place food and beverage in			then weekly for four weeks, then me	onthly Iternary			

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		E & MEDICAID SERVICES	Τ		OMB NO.		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	`´сом	(X3) DATE SURVEY COMPLETED	
		B. WING _			C 08/14/2014		
			STREET ADDRESS, CITY, STATE, ZIP C		00/14/2014		
AYDEN (OURT NURSING AN	D REHABILITATION CENTER		128 SNOW HILL ROAD AYDEN, NC 28513			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 371	Continued From page 14 kitchenware which was completely dry.		F 37	is maintained. Staff will be retrained by th			
	6. During operation of the dish machine on 08/13/14, between 9:32 AM and 9:50 AM, multiple meal carts were emptied, and a dietary			Dietary Manager upon the identification any potential safety concerns. The results of the quaternary solution			
		loth from a red bucket to wipe		audits will be forwarded to the facility QI committee monthly for four months for review and follow up as deemed necessary for any potential trends and to determine the frequency and/or need for continued monitoring.			
	strength of the san bucket registered (quaternary sanitize	13/14 a strip used to check the itizing solution in this red 0 - 100 parts per million of er. At this time the dietary					
	solution from the the dispensing system	orted the quaternary sanitizing nree-compartment sink was always used in the red olution should register 200		This will be completed by S 2014.	eptember 11,		
	staff sanitized mea touched by multiple resident care areas	14/14 the DM stated her dietary Il carts because they had been e staff and had been rolled into s. She reported the red the quaternary sanitizing					
	solution were made was used to check were made up. Th the strength of the bucket was weake	e made up twice daily, and a strip check their strength each time they p. The DM explained she thought of the sanitizing solution in the red veakened by taking the cloths in and					
	out of the bucket so much. Therefore, she commented she thought just checking the strength of the sanitizing solution once, immediately after it was made up, was not frequent enough.						
	sanitizing the meal control practice and contamination in th	14/14 the PM cook stated carts was a good infection d prevented cross he kitchen. She reported she ap of bleach into a bucket filled					

If continuation sheet Page 15 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM API CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED				
		345490	B. WING				C 14/2014				
NAME OF PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE						
AYDEN C	AYDEN COURT NURSING AND REHABILITATION CENTER				128 SNOW HILL ROAD AYDEN, NC 28513						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE				
F 371		vater when making up the sanitizing meal carts and food	F 3	371							

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