### SUMMARY STATEMENT OF DEFICIENCIES

**F 371**

**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 discard expired food in the kitchen cooler and freezer, maintain sanitary conditions of the hood vents in the kitchen, failed to label and date foods in one of two nourishment refrigerators (station 1) and failed to monitor freezer temperatures in two of two nourishment refrigerators that contained food items for residents. The findings included:

- On 6/15/15 at 10:25AM, a tour of the kitchen was conducted with Administrative staff #1. There was a package of provolone cheese in the kitchen cooler labeled with an expiration date of 6/10/15. The following items were noted in the kitchen freezer: 16 vanilla ice cream opened with some of the containers of ice cream melted, 18 chocolate ice cream opened with some of the containers melted. Ice was noted around all of the containers. There was also a package of thirty-six (36) Danish with an expiration date of 6/1/15.

- On 6/15/15 at 10:30AM, Administrative staff #1

It is the practice of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and to store, prepare, distribute and serve food under satisfactory conditions.

**Criteria One:**

No residents were found to have been affected by the alleged deficient practice.

**Criteria Two:**

All residents had the ability 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.

Effective immediately, three times a day,
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<th>F 371</th>
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<td></td>
<td>The North Building refrigerators and freezer will be audited for accurate labeling and dating of food products by the Director of Dining Services or the Chef Manager. Any expired or unlabeled products will be discarded. A tracking log will be kept outside the coolers and freezer for auditing purposes. Chef Manager or Dietician will bring audits to be reviewed during the monthly QAPI meeting. Monitoring for the labeling and dating of food products will be a permanent part of the monthly QAPI process.</td>
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</table>

2. On 6/15/15 at 10:30AM, the hood vents above the cook area (sixteen in number) were noted to have a coating of dust. Two or three of the hood vents had dust and a black material noted covering the vent.

On 6/17/15 at 9:50AM, a tour of the kitchen was conducted with Administrative staff #1. An observation of the hood vents revealed the following: a total of 16 vents (8 on each side of the cooking area) was observed to be dusty with a greasy-type appearance. Also there were two--three hood vents black in appearance. Administrative staff #1 stated the hood vents were on the cleaning schedule and were done monthly. He said they were last cleaned in May 2015. He stated the hood vents were dusty and dirty and should have been cleaned.

3. On 6/17/15 at 10:00AM, a tour of the nourishment refrigerator on station two was conducted. There was not a thermometer in the freezer section of the refrigerator to monitor the temperature of the freezer.

On 6/17/15 at 10:10AM a tour of the nourishment refrigerator on station two was conducted with Administrative staff #2. She stated she expected nursing staff to have a thermometer in the freezer and to check the temperature daily. She stated, if there was not a thermometer in the freezer, she should be notified so one could be obtained. The facility policy titled "Refrigerator temperature monitoring" dated July 2, 2013 was reviewed.
### SUMMARY STATEMENT OF DEFICIENCIES

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<tr>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 371</td>
<td>Continued From page 2</td>
<td>with Administrative staff #2 who stated she was unaware they did not have a policy about the freezer temperatures and only checked and documented the refrigerator temperatures.</td>
<td>F 371 Dietician for all dining services staff, to include full time, part time and as needed (PRN) staff on 6/15/15 and 6/26/15. These in-services will be repeated weekly for three months then monthly thereafter for 9 months to ensure problem does not recur. All documentation of the training will be kept with the Healthcare Administrator and reviewed during monthly QAPI meeting.</td>
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<th>ID PREFIX TAG</th>
<th>(X2)</th>
<th>MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td><strong>NAME OF PROVIDER OR SUPPLIER</strong></td>
<td>PENICK VILLAGE</td>
<td><strong>STREET ADDRESS, CITY, STATE, ZIP CODE</strong></td>
<td>500 EAST RHODE ISLAND AVENUE</td>
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<tr>
<td><strong>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</strong></td>
<td></td>
<td><strong>DATE SURVEY COMPLETED</strong></td>
<td>06/18/2015</td>
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#### F 371

4. A facility policy titled "Labeling food in nourishment refrigerators" dated March 2015 stated it was the policy of (name) nursing staff that all personal food that belonged to a resident was labeled prior to placing in refrigerators in nourishment rooms and must be labeled with resident name, date and room number.

On 6/17/15 at 10:00AM, a tour of station one nourishment refrigerator was conducted. There was not a thermometer in the freezer section of the refrigerator to monitor the temperature of the freezer. Also, there were two (2) plates of salad (chicken or tuna salad) on a bed of lettuce with fresh fruit unlabeled and undated.

On 6/17/15 at 10:10AM a tour of the nourishment refrigerator on station one was conducted with Administrative staff #2. She stated she expected nursing staff to have a thermometer in the freezer and to check the temperature daily. She stated, if there was not a thermometer in the freezer, she should be notified so one could be obtained. Administrative staff #2 stated she expected staff to label and date all resident food items that were in the refrigerator. The facility policy titled "Refrigerator temperature monitoring" dated July 2, 2013 was reviewed with Administrative staff #2 who stated she was unaware they did not have a policy about the freezer temperatures and only checked and documented the refrigerator temperatures.

Criteria Four:

The corrective action will be monitored as

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**Note:** This text appears to be a page from a Medicare and Medicaid survey report, detailing deficiencies found in a facility's nourishment and refrigerator temperature monitoring practices. The report includes a summary statement of deficiencies, specific actions taken to address these deficiencies, and a plan for ensuring compliance in the future.
Penick Village's Healthcare Committee Board will review at its meetings held quarterly, the documented reports and action items that are created by CEO and/or Healthcare Administrator.

The DON will report on monitoring of the refrigerator and freezer temperature logs during the monthly QAPI meeting.

The Plan of Correction (POC) will be reviewed monthly during the QAPI meeting and minutes will be signed off by the Chief Operating Officer or the Chief

For the first three months, for the North Building kitchen refrigerators and freezer, the Healthcare Administrator will do five random checks per week for accurate dating and labeling of food products. The Chief Executive Officer (CEO), or Chief Operating Officer (CCO), the Healthcare Administrator or Director of Nursing (DON), and the Director of Dining Services or Chef Manager will inspect three times weekly for accurate dating and labeling of food products. If deemed appropriate after 3 months, the Healthcare Administrator will do three random checks per week and the CEO or COO will inspect once a week for the next 9 months the accurate dating and labeling of food products. All results and follow up action items will be documented and shared with the Quality Assurance Performance Improvement Committee (QAPI) monthly.

Penick Village's Healthcare Committee Board will review at its meetings held quarterly, the documented reports and action items that are created by CEO and/or Healthcare Administrator.

The DON will report on monitoring of the refrigerator and freezer temperature logs during the monthly QAPI meeting.

The Plan of Correction (POC) will be reviewed monthly during the QAPI meeting and minutes will be signed off by the Chief Operating Officer or the Chief
### PROVIDER'S PLAN OF CORRECTION

**ID**

**PREFIX**

**TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID**

**PREFIX**

**TAG**

**COMPLETION DATE**

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<td>F 371</td>
<td>Continued From page 4</td>
<td>F 371</td>
<td>6/19/15</td>
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<tr>
<td>F 431</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>F 431</td>
<td>6/22/15</td>
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**Executive Officer. Monitoring will continue through next standard survey to ensure continued compliance.**

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 431</td>
<td>Continued From page 5 be readily detected.</td>
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<td>F 431</td>
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<td>Criteria One: For the resident found to have been affected by the alleged deficient practice: No resident was found to have been affected by the alleged deficient practice.</td>
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<td>Criteria Two: For other residents who may have been affected by the deficient practice: All residents with medication stored in the refrigerator had the potential to have been affected by the alleged deficient practice.</td>
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<td>Criteria Three: The following systemic changes will be put into place to ensure the deficient practice does not recur: Medication refrigerators for Station One and Station 2 have been replaced as of 6/22/15.</td>
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This REQUIREMENT is not met as evidenced by:

Based on observations, record review and staff interview, the facility failed to maintain medication storage refrigerator temperatures according to manufacturer recommendations for safe drug storage for 1 of 2 nursing station refrigerators (Refrigerator #1). Findings included:

Medication storage review was conducted on 6/16/15 at 11:30 AM. The log of the June 2015 refrigerator temperatures at Nursing Station 2 showed 10 consecutive days of temperatures below the manufacturer recommended storage temperature of 36-46 degrees Fahrenheit (June 6 - 35 degrees, June 7 - 33 degrees, June 8 - 34 degrees, June 9 - 32 degrees, June 10 - 34 degrees, June 11 - 34 degrees, June 12 - 32 degrees, June 13 - 34 degrees, June 14 - 33 degrees, June 15 - 32 degrees).

It was noted that a handwritten note at the top of the log stated "Temp Range is 36 degrees - 46 degrees F".

Medications observed in the refrigerator included Lorazepam injections, Humalog and Novolog insulins, Promethazine suppositories, Gabapentin oral suspension, and lactobacillus oral tablets, all of which are to be stored at a temperature range of 36-46 degrees Fahrenheit per manufacturer recommendations. Logs for April and May were requested and noted to be outside of the manufacturer recommended range for 15 days in April and for 3 days in May 2015.

Nurse #1 was interviewed on 6/16/15 at 11:45 AM. He indicated that temperatures are checked...
F 431 Continued From page 6

Nursing staff to include full time, part time and as needed (PRN) staff, received in-service training by the Director of Nursing (DON) on 6/18/15 -6/19/15 on the range for refrigerator temperatures and action to be taken when a temperature is below or above the recommended temperature of 36 to 46 degrees Fahrenheit. Licensed staff will monitor and record medication refrigerator temperatures nightly on 7p-7a shift and needed adjustments reported to (DON).

Criteria Four:
The corrective action will be monitored as followed:

The DON or Admissions Coordinator will complete an audit weekly x 4 weeks, monthly x 4 months and quarterly to ensure proper documentation of medication refrigerator temperatures. All audit results will be presented by the DON at the monthly QAPI committee for continued monitoring.

6/22/15

F 456 SS=E

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 456</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the kitchen freezer in good working order as evidenced by a large build-up of ice and an observation of cartons of previously melted ice cream with large amounts of ice in the boxes of ice cream noted in the kitchen freezer. The findings included: On 6/15/15 at 10:25AM, a tour of the kitchen was conducted with Administrative staff #1. The following items were noted in the kitchen freezer: 16 vanilla ice cream opened with some of the containers of ice cream melted, 18 chocolate ice cream opened with some of the containers melted. Ice was noted around all of the containers. Ice build-up was noted near the top of the ceiling of the freezer and ice was noted in the boxes of ice cream. On 6/15/15 at 10:30AM, Administrative staff #1 stated there had been problems with the freezer leaking when it was in the defrost mode. He stated there had been several maintenance requisitions filled out for freezer repair. Administrative staff #1 stated if there was something that needed repair in the kitchen, he would fill out a maintenance slip, keep a copy and give a copy to the maintenance personnel. A review of the maintenance repair requisitions revealed the following repair requisitions were sent to maintenance for repair: 3/12/15--Freezer drains out on floor; 4/20/15--leak in freezer, drips on during defrost; 5/17/15--freezer leak, pile of ice on floor.</td>
<td>F 456</td>
<td></td>
<td>Criteria One: For the resident found to have been affected by the alleged deficient practice. No one resident was found to have been affected by the alleged deficient practice. Criteria Two: For other residents who may have been affected by the alleged deficient practice. All residents had the potential to have been 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: The freezer was defrosted on 6/19/15 by our on-site heating and cooling technician. The pipe in question was wrapped in insulation and will be monitored daily for leaks by the Director of Dining Services or Chef Manager with any leaks being reported immediately to the Healthcare Administrator who will advise maintenance of problem. Synder Refrigeration, INC. serviced the freezer on 6/26/15. Old caulking was removed along with insulation, ice melted per torch, leak was located, pipe replaced where leak occurred along with new</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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**PROVIDER'S PLAN OF CORRECTION**

**EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

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**NAME OF PROVIDER OR SUPPLIER**

**PENICK VILLAGE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**500 EAST RHODE ISLAND AVENUE**

**SOUTHERN PINES, NC  28387**

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

**345111**

**(X2) MULTIPLE CONSTRUCTION**

**A. BUILDING _____________________________**

**B. WING _____________________________**

**(X3) DATE SURVEY COMPLETED:**

**06/18/2015**

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**BUILDING.**

**ID**

**PREFIX**

**TAG**

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**SYNOPSIS STATEMENT OF DEFICIENCIES**

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**On 6/17/15 at 10:45AM, a tour of the freezer was conducted with Administrative staff #1 who stated someone had come on 6/16/15 and repaired the freezer. There was no ice buildup noted in the freezer.**

**On 06/18/2015 9:55:16 AM, Administrative staff #4 stated if something needed repair, there was a work order form that would be completed. It would be given to one of the maintenance personnel or put under the maintenance office door for repair for the next day. If it was an emergency, the kitchen staff might directly call the service contractor for repair. The kitchen freezers and coolers were part of a monitoring system so maintenance received an automated phone call at any time if one of the freezers or coolers malfunctioned. Administrative staff #4 stated the facility had an on-site heating and cooling technician as well as an outside service contract. Maintenance personnel were in the building from 8:00AM-4:30PM and on call seven days a week.**

**On 6/18/15 at 11:30AM, Administrative staff #4 stated he could not find any responses to the March requisition or the requisition cone on 5/17/15. He stated maintenance checked the freezer on 4/20/15, 4/21/15 and the contract company repaired the freezer on 4/22/15.**

**On 6/18/15 at 12NOON, Administrative staff #3 stated she was not aware of any problem with the freezer and had not been informed of any problems with the freezer by dietary or maintenance staff. She stated she expected dietary or maintenance staff to let her know of any kitchen freezer problems whenever caulking and insulation was secured with a roll of pipe insulator tape. According to Synder Refrigeration, Inc., "dripping has stopped".**

**Scheduled maintenance for the freezer will be done by our on-site heating and cooling technician every month for three months, then every 6 months thereafter.**

**Monitoring for leaks in the freezer will be added to the five random checks to be done by Healthcare Administrator per week. The CEO or COO, and Dining Services Director or Chef Manager will inspect three times weekly for one month, then monthly for three months, then every 6 months through next survey.**

**Criteria Four:**

**The corrective action will be monitored as follows:**

**The Dining Services Director or Chef Manager will report findings to the QAPI committee monthly through next survey.**

**6/26/15**
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tbody>
<tr>
<td>F 456</td>
<td>Continued From page 9 problems/repairs were needed for the kitchen freezer.</td>
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On 06/18/2015 at 12:37PM, Administrative staff #5 stated the repair on the kitchen freezer was done by facility staff in March and the problem was fixed. He stated he did not have a record of the May 17, 2015 requisition and didn’t have any record of servicing the unit in May, 2015.

F 520 | 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.
continued from page 10

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interviews, the facility’s Quality Assessment and Assurance Committee failed to implement, monitor and revise as needed the action plan developed for the 5/1/14, 2/7/13, 12/15/11 and 11/5/10 recertification surveys in order to achieve and sustain compliance. The facility had a pattern of repeat deficiencies on proper labeling, dating and the disposal of expired food items (F371) on the 5/1/14, 2/7/13, 12/15/11 and 11/5/10 recertification surveys. The findings included:

This tag is cross referenced to F 371. Based on observation and staff interviews, the facility failed to discard expired foods in the kitchen cooler and freezer, maintain sanitary condition of the hood vents in the kitchen, failed to label and date foods in one of two nourishment refrigerators (station one) and failed to monitor freezer temperatures in two of two nourishment refrigerators that contained food items for residents.

An interview was conducted with the Administrative Staff #3 and Administrative Staff #1 on 6/18/15 at 12:07 PM. She stated a new dietary manager was hired in March 2015 and the kitchen staff had been educated on proper labeling, dating and disposal of food items. Administrative Staff #3 did not indicate that the Quality Assessment and Assurance Committee had been monitoring the labeling, dating and disposal of expired foods. Administrative Staff #3 stated revision of their operational system would be needed to correct the problem.

Criteria One:
For the resident found to have been affected by the alleged deficient practice:

No resident was found to have been affected by the alleged deficient practice.

Criteria Two:
For other residents who may have been affected by the alleged deficient practice:

All residents had the potential to have been affected by the deficient practice.

Criteria Three:
The following systemic changes will be put into place to ensure the alleged deficient practice does not recur.

Penick Village has a monthly QAPI Meeting, held the last Thursday of each month. In addition to the monthly QAPI meeting, the Healthcare Administrator will meet weekly with the CEO to review and track progress for all action items in the POC and QAPI Committee recommendations for six months. At this time, if the CEO and Healthcare Administrator determine monitoring systems are effective, monitoring will continue by-weekly for the next three months and monthly thereafter. Documentation of actions required will be maintained by Healthcare Administrator. In the absence of the CEO and/or Healthcare Administrator, the COO and DON will be responsible for monitoring of
**Criteria Four:**
The corrective action will be monitored as follows:

Penick Village's Healthcare Committee Board will review at its meetings held quarterly the documented reports and action items that are created by the POC and QAPI committee.

The POC will be reviewed monthly during the QAPI meeting and minutes will be signed off by the Chief Operating Officer or the Chief Executive Officer. Monitoring will continue through next standard survey to ensure continued compliance.

6/19/15