| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345545 | A. BUILDING _____ B. WING _____ | 12/16/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN LAKES COMMUNITY MEMORY CARE | 3701 WADE COBLE DRIVE BURLINGTON, NC 27215 |

| (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 |
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| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review the facility failed to secure the tubing of an indwelling catheter on 1 of 1 sampled residents, Resident #17.<br>Findings Included:<br>Resident #12 was admitted on 12/2/15 with the diagnoses in part of right hip fracture, and benign prostatic hypertrophy with urinary retention.<br>Review of the physician order dated 12/11/15, revealed in part,<br>1. D/C (discontinue) I & O cath (in and out catheter)<br>2. Insert catheter d/t (due to) retention<br>During an observation and interview of indwelling urinary catheter care on 12/17/15 at 10:18 AM, the blanket was pulled back and it was noted that there was no urinary securing device applied to the tubing and the thigh of Resident #17. During observation of care, no skin irritation was noted. Nurse Aide #1 indicated Resident #17 doesn ' t use a catheter securing device. Aide #2 indicated no catheter securing device was ordered. Nurse #1 indicated the catheter secure straps were | F 315 | Plan of Correction for F315<br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>• A strap to secure the tubing of the indwelling catheter was immediately added to Resident#17.<br><br>Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:<br><br>• In-services are being completed with all nursing staff on Catheter Care Policy and Procedure. In addition, nursing staff will be reminded that any variation from policy and procedure, due to a potential contraindication should be accompanied by an order from the physician.<br>In-services will be completed by January 16, 2016. | 1/16/16 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/30/2015 |

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

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| F 315 | Continued From page 1<br>available for use and Resident #17 didn ' t require the use of a catheter strap, he was not ambulatory. The nurse told us when to use a catheter strap.<br>During interview on 12/16/15 at 11:27 AM, the director of nursing (DON) indicated Resident #17 had not required a catheter strap. He was non ambulatory and he had not pulled at the tubing. Residents who used a urinary leg bag used the securing strap to the leg. | F 315 | • The charge nurse on duty will be required to verify a strap to secure the catheter tubing is in place and initial the Treatment Administration Record weekly.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:<br><br>• In addition to training on Catheter Care Policy and Procedure, the nurse in charge will now be required to verify placement of the strap and initial the Treatment Administration Record on a weekly basis.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility:<br><br>• The Director of Nursing will monitor ongoing compliance with Catheter Care Policy and Procedure. The Director of Nursing, or appointed charge nurse, will verify placement of a strap to secure tubing each week when the catheter bag is changed. This practice will be validated on the Treatment Administration Record.<br><br>Include dates when corrective action will be completed: | |

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| F 315 | Continued From page 2 | F 315 | This corrective action will be completed by January 16, 2016. | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews and review of kitchen cleaning checklist, the facility failed to maintain sanitary conditions in the kitchen, by 1) not cleaning the pellet warmer 2) cleaning the plate warmer, 3) cleaning the dry storage containers, 4) removing and cleaning up the opened food from the shelves of the dry storage room and 5) removing the dented cans.<br><br>The findings included:<br><br>1. During an observation on 12/14/15 at 9:50AM, the pellet warmer had a high volume of grease, food and dried food build up on the inside and outside. There was also a wash cloth and bottom plate cover on the inside next to the heating coils. There was also some clean bottom covers inside the warmer touching the grease/dirty hood surface. | F 371 | Plan of Correction for F371:<br>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br>• The Pellet warmer was cleaned inside and out as well as the covers, and oven mitt and pellet were removed from the unit during cleaning on 12/14/15.<br>• In-service was complete on 12/18/15 with all dietary staff regarding completing weekly and daily cleaning lists, and in-services will be done quarterly and reviewed by Food Service Director, Assistant Food Service Director, and or Chef<br>• New Weekly Cleaning Sheets were posted starting 12/21/15 and are checked by AM and PM Chef's to ensure completion prior to end of day. Follow up | 12/18/15 |

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| F 371 | Continued From page 3<br>During an interview on 12/14/15 at 9:50AM, the dietary manager indicated staff was expected to clean all kitchen equipment as the spills occur and then perform the weekly deep cleaning of all the kitchen equipment. In addition, complete the tasks on the daily checklist.<br><br>2. During an observation on 12/14/15 at 9:50AM, the plate warmer inside and outside had a large volume of grease, dried food on the inside of the lid the touches the plates. The dirty lids were touching the clean surfaces of the plates.<br><br>During an interview on 12/14/15 at 9:50AM, the dietary manager indicated staff was expected to clean all kitchen equipment as the spills occur and then perform the weekly deep cleaning of all the kitchen equipment. In addition, complete the tasks on the daily checklist.<br><br>3. During an observation on 12/14/15 at 9:50AM, the sugar, flour dry storage containers had a large volume of dried foods/liquids on the inside around the rims of the lids and outside very dirty and there was scoop stored in the flour.<br><br>During an interview on 12/14/15 at 9:50AM, the dietary manager indicated staff was expected to clean all kitchen equipment as the spills occur and complete the tasks on the daily checklist.<br><br>4. During an observation on 12/14/15 at 9:50AM, the storage room shelving had opened cereal and other dry food products spilled all over the shelves and on the floor.<br><br>During an interview on 12/14/15 at 9:50AM, the dietary manager indicated the stock person was responsible for ensuring the storage area was | F 371 | by the Food Service Director<br>• Plate warmer was cleaned inside and out on 12/14/15 and in-service was completed with all staff 12/18/15 regarding cleaning<br>• Shelves and cans were cleaned on 12/14/15, all cereal spilled and floors were swept<br>• Both Flour and Sugar ingredient bins were dumped and cleaned inside and out and a new lid was purchased for the flour bin on 12/14/15 In-service was completed regarding cleaning up spills as they are made, cleaning ingredient bins bi-weekly inside and out<br>• Dented cans were removed from the stock room 12/15/15, and placed in dietary office for credit. In-service with new Dented Can Policy was complete on 12/18/15<br><br>Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice:<br><br>• All items found to be dirty , pellet warmer, plate warmer, ingredient bins were immediately cleaned and in-services were done 12/18/15.<br>• The Dented Can Policy was reviewed and changed and in services were completed 12/18/15, and all dented cans were disposed of and removed from the stock room.<br>• The stock room was cleaned of all cereal / food stuffs spilled and in services | |

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| F 371 | Continued From page 4<br>clean and swept out daily in accordance to the kitchen checklist.<br><br>5. During an observation on12/15/15 at 11:20AM, 7 dented cans of apple fruits and 2 large cans of tomato soup were stored on the shelves in the dry storage room.<br><br>During an interview on 12/15/15 at 11:30AM, the dietary manager indicated that the cans should be checked prior to placement on the shelves. When staff find there are dented cans they should be removed and placed in her office to be returned to the vendor. She further stated that all staff were responsible for completing the opening and closing checklist daily. The cook supervisor was responsible for monitoring and checking behind staff to ensure the task of the checklist were being done.<br><br>During an interview on 12/15/15 at 11:35AM, the cook supervisor indicated that she was responsible for overseeing and checking the kitchen staff to ensure they were following the opening and closing checklist. | F 371 | were completed on 12/18/15<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:<br><br>• The weekly cleaning list will include all equipment in the kitchen and posted with the daily cleaning list In-services will be completed quarterly on sanitation and cleaning of equipment and will all new employees on hire and quarterly thereafter. Follow up will be done by Food Service Director or Assistant Food Service Director Copies will be kept on file in the dietary office for one year<br>• Dented can policy will be posted on all stock room doors and in services will be held quarterly and will all new employees on hire and each quarter thereafter. These will be kept in the dietary office for one year and the opening and closing check list will be followed up by the Chef, Assistant Food Service Director and Food Service Director<br>• All spills will be cleaned up as they happen and in-services will be done quarterly and with new employees on hire and every quarter thereafter. Chef, AFSD, and FSD will follow up<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC | |

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| F 371 | Continued From page 5 | F 371 | is integrated into the quality assurance system of the facility:<br>• The Chef/supervisor or the Assistant Food Service Director (AFSD), and or Food Service Director (FSD) will monitor daily to insure all cleaning is being done of equipment and that all spills are being cleaned up appropriately and immediately as they happen.<br>• A weekly list and opening and closing cleaning list will be posted and checked daily by the Chef/ supervisor and or the AFSD or FSD.<br>• Dented cans will be disposed of after removing from stock room or prior to putting up stock and we will follow up by checking daily on the opening and closing check sheet and monitored by the AFSD, FSD, and Chef.<br>• The FSD or AFSD will report the results of the corrective actions on the sanitation of equipment, dented cans, and ingredient bins in the Quality Assurance Meeting quarterly for the next two quarters and then evaluate for further action if needed<br><br>Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State:<br><br>• Cleaning of equipment, plate warmer, pellet warmer, ingredient bins was complete 12/15/15 and first of quarterly in services was complete on 12/18/15<br>• The dented can policy was revised on 12/18/15 and all dented cans were removed on 12/14/15, first completed | |

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| F 371 | Continued From page 6 | F 371 | quarterly in-service was 12/18/15<br>• The cleaning of spills and revised opening and closing cleaning list and weekly cleaning list were revised on 12/18/15 and first quarterly in-service was complete on 12/18/15 | |