STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code on the Minimum Data Set (MDS) assessment to reflect PASRR (Preadmission screening and Resident Review) level 2 (two) for 1 of 1 resident in the sample reviewed for PASRR. (Resident #11)	F 278	The assessment referenced in the 2567 for resident #11, was modified on 9/22/2016, to reflect the correct level II PASRR status of this resident (“no” was modified to “yes”). The most current MDS assessment for resident #11, with an	9/23/16

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

Electronically Signed | 09/23/2016

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F 278	Continued From page 1 Findings included: Resident #11 was admitted on 11/8/2012 with cumulative diagnoses which included disorder of psychological development, cerebral palsy and pseudobulbar palsy. Review of PASRR (Preadmission Screening and Resident Review) Determination notification form revealed that Resident #11 was determined to be a PASRR level 11 since November 2012 with no expiration date. Review of the Annual Minimum Data Set (MDS) assessment dated 10/1/2015 revealed Section A of the MDS was not coded to reflect PASRR determination. During an interview with Social Worker on 8/30/2016 at 2:44PM who stated that she was responsible for completing the PASRR section on the MDS assessment. SW revealed that she should have coded the resident# 11 status for PASRR " yes " and not no. During an interview with MDS Coordinator on 8/31/2016 at 10AM she stated that it was the social worker responsible to code section A for PASRR level. That "we (referring to herself and the social worker) did not code section A correct. " During an interview with the Director of Nursing (DON) on 8/31/2016 at 11:50AM revealed her expectation for the MDS coordinator was to make sure the coding was accurate for all residents before the MDS ' s are in the system. During an interview with the Administrator on 8/31/2016 at 12 PM revealed his expectations were the MDS Coordinator completed and code the MDS accurately.	F 278	assessment date of 8/31/2016, is correctly coded in reference to the PASRR selection of section A1500. (PASRR Level II was coded “yes”). The Director of Social Services and MDS Coordinator audited all other MDS assessments for residents with a level II PASRR. Based on an audit completed 9/23/2016, all other MDS assessments were found to be correctly coded for residents with level II PASRR. The Director of Social Services will create and maintain a log, the “Level II PASRR Log;” this log will be updated for residents entering the facility with a level II PASRR, or when a resident’s status changes to or from a level II PASRR. The Director of Social Services maintains the log; she will distribute the “Level II PASRR Log” to the MDS Coordinator, Care Plan Nurse, Social Worker, and Administrator. The Level II PASRR Log will be used to ensure accurate coding of MDS assessments, specific to PASRR. A check list, the “MDS Assessment PASRR Check List” has been created to ensure MDS assessments are completed accurately, specifically in reference to the PASRR selection of section A of the MDS assessment. The list will be used for all MDS assessments for residents with a level II PASRR for 12 months from the date of corrective action. The MDS Coordinator and/or Social Services Director will report any findings of miscoded MDS Assessments at the	

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F 278	Continued From page 2	F 278	Executive QA Committee at the quarterly meetings for 12 months from the date of corrective action. The next Executive QA Committee meeting is scheduled October 18, 2016. The facility alleges full compliance with this plan of correction as of 9/23/2016.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to follow the care plan approach to assess Resident # 121 ' s arteriovenous (AV) fistula for the thrill and bruit. This was evident in 1 of 1 resident reviewed for dialysis services. Findings included: Record review revealed two residents in the facility received hemodialysis. Resident # 121 was admitted to the facility on 2/25/16 with cumulative diagnoses which included end stage renal disease which required hemodialysis three times a week. Review of the significant change Minimum Data Set (MDS) assessment dated 6/6/16 revealed Resident # 121 was alert and oriented. The MDS	F 282	An order was written for resident #121 to receive thrill and bruit checks every shift; the order was written to the MAR. Upon review on 9/21/2016, resident #121 received thrill and bruit checks each shift since the order was written. An audit was performed to ensure thrill and bruit is checked every shift, for any resident with an AV fistula. Upon investigation, there were no other residents with an AV fistula following the survey. A resident admitted on 9/3/2016 with an AV fistula. An order was written to this resident's MAR; thrill and bruit checks of the AV fistula have been performed. No other residents were found to have an AV fistula in the facility.	9/28/16

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F 282	Continued From page 3 indicated the resident required limited assistance for activities of daily living for mobility except for dressing, personal hygiene and locomotion. Review of the care plan dated 6/7/16, updated 8/4/16 and 8/11/16 revealed a goal for Resident #121 be free from complications related to hemodialysis. One of the approaches included the assessment of the fistula for the thrill and the bruit. The bruit was an audible sound generated by turbulent flow of blood in an artery and may be heard using a stethoscope. The thrill was the pulsation of the shunt. The thrill and the bruit assessment can assist in the determination of a blocked fistula or whether there was adequate blood flow. Review of the medical record revealed no documentation that the assessment of the bruit and thrill had been done since 6/7/16. Multiple attempts to interview Resident #121 were unsuccessful. Interview on 08/30/2016 at 2:01PM with Nurse #1 and Nurse #2 was conducted. Both nurses indicated they had not assessed Resident #121 ' s fistula for the thrill and the bruit , were not aware of the facility ' s protocol for checking the thrill and bruit or where to document the results. Nurse #1 indicated no one informed her about assessing the bruit and thrill because it was not written on the Medication Administration Record (MAR). Interview and review of the MAR on 08/30/2016 at 3:35 PM with the Unit Manager who stated a doctor ' s order should have been written to check the bruit and thrill so that it would be documented on the MARS. The unit manager confirmed there	F 282	The Wound Care Nurse was educated of the facility protocol for ensuring proper placement and function of AV fistulas. The Wound Care Nurse is responsible for writing an order to check for thrill and bruit of the AV fistula for any new residents, or for any resident's that may obtain an AV fistula. A procedure has been written and included in the Nursing Policy & Procedure manual to ensure no further deficient practice occurs. Nurses were in-serviced of the importance of checking for thrill and bruit of residents with AV fistulas. Nurses have signed acknowledgement of this in-service, or will have signed the in-service at their next shift. The Wound Care Nurse will audit charts weekly for three months, then monthly for six months to ensure nurses are checking for thrill and bruit of all residents having AV fistulas. Findings from these audits will be reported to the Executive QA Committee at quarterly meetings for the duration of the audits. The next Executive QA Committee meeting is scheduled October 18, 2016. The facility alleges full compliance with this plan of correction as of 9/28/2016.	

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F 282	Continued From page 4 was no evidence or documentation that Resident #121's shunt was checked for the thrill or bruit. Interview on 08/31/2016 at 2:33: PM with Nurse #3 who stated she checked the thrill and bruit once last month (referring to July) but could not remember the exact time. Interview on 08/31/2016 at 3:18 PM with Nurse #4 revealed she was assigned to worked with resident only 2 -3 time and had not checked the thrill and bruit on 8/27/16. Interview on 08/31/2016 at 6:38 PM with the Administrator, Unit manager and Director of Nurses (DON) was conducted. The DON indicated her expectation was for staff to implement the approaches stated in the care plan.	F 282		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to administer an antibiotic and antiviral medication as ordered for Resident #121. This was evident in 1 of 1 resident reviewed for dialysis services. Findings included: Resident # 121 was admitted to the facility on 2/25/16with cumulative diagnoses which included end stage renal disease which required	F 333	Both medication treatments (Levaquin and Valtrex) for resident #121 were completed prior to the survey. A Medication Error Report was completed for these medications; MD was notified through the medication error reporting process. An audit was completed of all current residents' new medication orders from	9/28/16

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F 333	Continued From page 5 hemodialysis three times a week. Review of the significant change Minimum Data Set (MDS) assessment dated 6/6/16 revealed Resident # 121 was alert and oriented. The MDS indicated the resident required limited assistance for activities of daily living for mobility except for dressing, personal hygiene and locomotion. Review of the Nurse Practitioner ' s orders dated 8/9/16 revealed orders for Levaquin 750 milligrams (mg) by mouth (po) for a one time dose then 500 mg every 48 hours (2 days) for 5 doses. Levaquin is the brand name for levofloxacin, a prescription antibiotic drug used to treat a variety of bacterial infections. Review of the nurses ' notes dated 8/9/16 revealed Resident #121 refused all po meds which included Levaquin. On 8/10/16 Resident #121 accepted the Levaquin. The next doses of Levaquin scheduled to be given on 8/12/16, 8/14/16,8/16/16.8/18/16 and 8/20/16. Review of the Medication Administration Record (MAR) revealed the Levaquin order was transcribed onto the MAR by Nurse #1. Review of the transcribed order revealed the Levaquin 750 mg dose was blocked off for 8/9/16 and 8/10/16 for the medication to be administered. Further review of the MAR revealed Levaquin 500 mg po every 48 hours was blocked off and written in the block to be administered on 8/13/16, 8/16/16, 8/19/16, 8/22/16 and 8/25/16. These days indicated Levaquin would be administered every 72 hours (3 days) instead of the ordered every 48 hours (2 days). Interview on 08/31/2016 at 2:33 PM with Nurse	F 333	8/9/2016 through 9/26/2016 to ensure medications were administered, timely. Any issues identified were corrected, related to this previously deficient practice. Nurses were in-serviced to ensure medications are transcribed and administered, as ordered, timely. Nurses were also in-serviced to contact the pharmacy in the event a medication is unavailable through the in-house emergency drug supply (PYXIS). Nurses have signed acknowledgement of this in-service, or will have signed the in-service at their next scheduled shift. To prevent further deficient practice, the facility has since implemented an electronic medical record (EMR) system; implementation of the EMR system has been completed. This system will prevent transcription errors related to administration as times will be automatically filled as ordered. Back up pharmacy procedure has been adjusted and clarified with appropriate staff. Effective 9/28/2016, the facility will audit a minimum of 10 MD orders (if number of orders allows) for QA purposes, audits will occur daily for 3 months, then weekly for 6 months, to ensure timely medication management. Any medications identified during the above mentioned monitoring will be addressed and then reported to the Executive QA Committee, quarterly, for the duration of the monitoring. The next Executive QA Committee Meeting is scheduled October 18, 2016.	

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F 333	Continued From page 6 #3 (who worked on 8/12/16) stated the Levaquin was not administered on 8/12/16 because of the way the order was transcribed onto the MAR. Nurse #3 stated she administered the Levaquin on 8/19/16 and 8/25/16 because of the way the order was transcribed. Interview on 08/31/2016 at 3:01 PM with Nurse #1 (who transcribed the order) revealed the resident would not take the Levaquin on 8/9/10/16. Nurse #3 gave the medication on the 10th. Nurse #1 stated she wrote the 1st set of numbers/date on the MAR, then thought it was wrong and transcribed a 2nd number of days for the Levaquin to be administered. Interview and record review on 08/30/2016 at 3:35 PM with the Unit Manager revealed the dose of 750 mg of Levaquin should have been administered on 8/9/16 and given the 500 mg po dose 48 hours afterwards for 5 doses. Nurse #4 worked on 8/13/16 and 8/14/16 was no longer employed at the facility and was unable to be contacted. Interview on 08/31/2016 at 6:38 PM with the Administrator, Unit Manager and Director of Nurses (DON) was held. The DON indicated the prescribed medications should have been transcribed and administered as ordered. 2. Record review revealed nurse practitioner ' s telephone orders dated 8/19/16 for Diflucan 150 mg po for 1 time dose. Diflucan was an antifungal medication used to treat a variety of fungal infections. In addition Valtrex 500 mg po daily for 7 days was ordered. Valtrex is an antiviral drug.	F 333	The facility alleges full compliance with this plan of correction as of 9/28/2016.	

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F 333	Continued From page 7 Review of the Medication Administration Record (MAR) revealed the order for Valtrex was transcribed onto the MAR with an error drawn to 8/21/16. The scheduled administration time was 8 AM. Further review of the MAR revealed the resident missed 2 doses of the Valtrex (one dose 8/19/16 and one dose on 8/20/16). Interview on 08/31/2016 at 2:15 PM with the Unit manager revealed the facility had a backup pharmacy to be contact should the need arise. Interview on 08/31/2016 at 2:33PM with Nurse #3 who stated that the resident complained of itching and pain between the legs so the nurse practitioner was notified. Nurse #3 stated she obtained the order about 6 PM and that she did not attempt to use the backup pharmacy to obtain the Valtrex. Interview on 08/31/2016 at 2:15 PM and again at 3:35 PM with the Unit manager revealed the orders were faxed into the regular pharmacy after the cut off time for filling orders. The Unit manager indicated the medication delivery time to the facility was in the evening and Valtrex was delivered late evening on 8/20/16. Further interview with the Unit manager revealed the facility had a backup pharmacy to be contacted should the need arise. Interview on 08/31/2016 at 6:38 PM with the administrator, unit manager and Director of Nurses (DON) was held. The DON indicated her expectation for staff were to contact the back -up pharmacy.	F 333		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		9/23/16

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F 356 SS=C	Continued From page 8 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post the staffing information for 1 of 5 days of the survey conducted on 8/27/16 to 8/31/16.	F 356	Staffing hours were posted, during the survey on 8/28/2016, immediately following an interview with the Director of Nurses.	

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F 356	Continued From page 9 Findings included: On 8/28/16 at 12:27 AM, the daily nursing staffing sheet was observed posted on the wall on the left near the main entry to the facility. The staffing information posted was dated 8/26/16. The staffing information for 8/26/16 included the date, shift, census, number of staff members and number of staff hours (including totals). Observations revealed there was no staffing information posted for 08/27/16. The Director of Nursing (DON) was interviewed on 8/28/16 12:30 AM. She stated the staffing information was updated and posted daily. The DON further explained the medical records staff member updated and posted the staffing sheet daily and she was not sure who updated the staffing sheets on the weekend. The DON looked through the other staffing sheets that were behind the staffing sheet dated 8/26/16 and was unable to find the staffing sheet for 8/27/16. The DON was interviewed again on 8/30/16 at 4:42 PM. She stated that her expectation would be for the staffing information to be posted every day. They were going to have medical records staff post the staffing information through the week and weekend.	F 356	Staffing hours have been posted daily, since 8/28/2016 to include: facility name; the current date; the total number and the actual hours worked by RNs, LPNs, and CNAs; and resident census. The facility adjusted the process for posting staffing hours. A new tool has been created. The Concierge (Receptionist) will post hours as provided from the Staffing Coordinator. Staffing hours for Saturday, Sunday, and Monday, will be posted prior to the close of business on Friday. Staffing hours for Tuesday, Wednesday, Thursday, and Friday will be posted the prior day at to the close of business. Holiday hours will be posted in advance, as necessary. Hours will be adjusted, as necessary, to reflect the most current staffing hours and facility census. Staffing hours for each day will be maintained for at least a period of 18 months, per the facility record retention policy. Staffing hours posting will be reviewed by the Administrator monthly for 9 months to ensure daily staffing hours were posted, maintained, and accurate. Any findings of un-posted staffing hours will be reported in the Executive QA Committee meetings for the duration of monthly reviews. The next Executive QA Committee meeting is scheduled October 18, 2016. The facility alleges full compliance with this plan of correction as of 9/23/2016.	

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and record review the facility failed to maintain the floors free from the accumulation of trash, dust and stained floor tiles. The facility failed to maintain clean stove and oven. The facility failed to use label and date stored food items. The facility failed to discard food items that exceed the use by date. This was evident in 2 of 3 observations in the kitchen. The facility failed to maintain a repair free and clean nourishment refrigerator. This was evident on 3 of 3 resident care units. (Cooper River, Ashley River and Low Country) Findings included: Review of the facility policy titled " Food Storage Guide " dated 4/28/10 read in part: Under section " Food Dating and Labeling Guidelines " b. The use by date is the date the product should be used by or discarded if not consumed. 5. Keep floors, walls, shelves and equipment in storage, free from spills and in good repair. 6. Keep food at least 6 inches off the floor Observations during the initial tour of the kitchen with the Food Service Manager (FSM) on 8/27/16	F 371	Issues listed from survey observations were corrected either at that time they were identified or as repairs and corrections were possible. All items identified during the survey have been corrected or supplies ordered as of 9/27/16. The facility changed the process for monitoring the kitchen; the kitchen is now audited by the Administrator and a dietary management representative on a weekly basis. This collaboration was initiated and completed on 9/13/16 and will continue as a corporate expectation for a minimum of the next quarter and then a minimum of each month. To prevent future problems in the identified dietary areas, the facility initiated a 100% re-training in-service with dietary personnel for all areas of previous deficient practice. This in-service was directed by the facility's executive chef	9/28/16

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THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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F 371	Continued From page 11 at 11:30 PM through 8/28/16 at 12:10 AM revealed the following: A. 1. The ventilation grate in the freezer area had a heavy accumulation of a brown colored substance. There was an accumulation of dust and trash on the floor between the freezers. 2. In the dry storage area a. There was a box of 3-12 pound bags of coffee stored on the floor. b. Under the shelves in the storage room there was an accumulation of a brown colored substance in the floor corners of the room. There was dust noted along the base of the floors. c. There were orange and brown colored stained floor tiles. Observations on 8/29/16 at 11:25 AM in the kitchen revealed: The ventilation grate in the freezer area had been removed. The accumulation of dust and trash on the floor between the freezers remained. Under the shelves in the storage room there the accumulation of a brown colored substance in the corners of the room remained. The dust noted along the base of the floors remained. The orange and brown colored stained floor tiles in the dry storage room remained. A hole was noted in the wall in the dry storage area. B. The stove top has an accumulation of black colored food burned food debris. One of the grate was broken Inside the 2 ovens was an accumulation of burned food debris at the base of the stove. Stored above the stove was a plastic wrapped white disposable plate containing cooked sausage and bacon. C. 1. In refrigerator #3 a. An onion wrapped in plastic was unlabeled and undated. b. A chopped brown colored substance stored in	F 371	and dietary manager. Retraining and monitoring of compliance will be under the direction of a newly formed QA Team, The Dietary Experience QA Team. Representatives on this Committee include the Administrator, Executive Chef, Dietary Manager, a Dietary employee, Maintenance Director, and COO. A minimum of 3 of the representatives of this group will meet weekly to complete a kitchen round/inspection and to monitor compliance with this plan of correction. The facility formed the aforementioned QA team to address the issues identified in the survey. A minimum of 3 of the representatives of this group will meet weekly to complete a kitchen round/inspection and to monitor compliance with this plan of correction. Documentation will be completed at that time to validate compliance. Any areas identified during these weekly rounds will be brought back to the QA team and will be addressed as/when needed. This QA team which will be chaired by the NHA will report to the Executive QA Committee. The next Executive QA Committee meeting is scheduled October 18, 2016. The facility alleges full compliance with this plan of correction as of 9/28/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345330	A. BUILDING _____ B. WING _____	C 08/31/2016

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a bowl identified by the FSM as mechanically altered sausage was unlabeled and undated.
2. In refrigerator #2
a. An opened container of cottage cheese was labeled as opened 7/14/16. The container lid indicated the best use by date as 8/15/16.
b. An open ½ gallon of chocolate milk was labeled as opened 7/5/16. The container had a use by date of 8/25/16.
c. There were 2 (4) ounce containers of cottage cheese stored out of their original containers that were undated and unlabeled.
d. An 8 ounce glass of an orange color liquid identified by the FSM as orange juice was unlabeled and undated.
Interview on 8/29/16 at 12:00 PM with Supervisory Cook (SC) #1 who stated the policy within the facility was to have dietary staff label and date all opened food items prior to storage.
Interview on 8/29/16 at 12 noon with SC #2 revealed once a food item was opened it is stores in a smaller container and that container must be labeled dated.
D. In refrigerator #3 there were (1) gallon size open containers of creamy Italian dressing, mustard, mayonnaise and relish. The tops and sides of the containers were sticky with a dried spilled substance around the opening of the containers.
E. Inside refrigerator #3 there were multiple cracks in the base of the refrigerator with an accumulation of a dried brown colored substance.
Interview on 8/31/16 at 5:30 pm with the Administrator, FSM and Executive Chef (EC) was held. The EC stated his expectations were to have staff label and date items stored in the refrigerator or freezer, staff to dispose of items past the use by date and clean staff clean the kitchen and equipment as needed. The

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Administrator indicated his expectations were to have an orderly, clean dietary environment with food items dated and labeled when stored.

F. Nourishment Refrigerators

Observation on 08/28/2016 at 11:24 AM of the nourishment refrigerator located in the Cooper River Unit revealed a missing thermometer in the refrigeration section. One of two refrigerator bins had standing pink colored fluid in the bottom.

Observation on 08/28/2016 at 11:40 AM of the nourishment refrigerator located in the Ashley River revealed the lowered drawer bottom had a dried sticky brown colored substance.

Observation with Nurse #5 on 08/28/2016 at 11:48 AM of the nourishment refrigerator located on the Low Country Unit revealed peeling white color interior with a missing bar handle off the refrigerator door. The freezer section had an accumulation of ice in the freezer section that covered almost the entire freezer section. There was an embedded plastic bag with 2 wooden sticks exposed. An attempt to remove the embedded plastic bag was unsuccessful. The seal around the door frame was partially detached.

Interview on 08/28/2016 at 2 PM with Housekeeper (HK) #1 who stated the HK staff clean the refrigerators everyday inside and out but our department never defrosted the refrigerators.

Interview on 08/30/2016 at 7:39 AM with the Housekeeping Supervisor who stated the housekeepers actually cleaned the refrigerators weekly but check every day. The supervisor indicated that a log was used to confirm the

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F 371	Continued From page 14 cleaning. A review of the Low country log revealed the refrigerator had not been checked daily. The housekeeper assigned to Low Country was out on leave and was not available for interview. At 9:08 AM on 8/30/16 with the HK Supervisor revealed no one was able to check the low country refrigerator because there was no staff available to let the housekeeper in the locked room where the refrigerator was located. Further interview on 08/31/2016 at 6:05: PM HK supervisor revealed the floor technicians were responsible for defrosting the refrigerator. The HK supervisor indicated she expected that the refrigerators be kept clean.	F 371		