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	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

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WHITE OAK MANOR - TRYON	**70 OAK STREET TRYON, NC 28782**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigations. Event ID OMEZ11.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/17/18

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

Electronically Signed | 08/13/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair scratched doors in resident bathrooms (#201 and #213) failed to repair a scratched closet in resident room (#203), failed to repair torn laminate on closet in resident room (#213) and failed to repair holes in bathroom doors in resident rooms (#204 and #213) on 1 of 4 resident hallways. The findings included: 1. Observation on 07/17/18 at 12:32 PM of the private bathroom of resident room #201 revealed both sides of the lower half of the bathroom door had multiple scratches. Subsequent observations on 07/19/18 at 8:56 AM and 07/20/18 at 5:06 PM revealed the condition of the door remained unchanged. 2. Observation on 07/17/18 at 11:53 AM of the shared bathroom of resident room #213 revealed the lower half of the inside bathroom door of room #213 had multiple scratches. Subsequent observations on 07/18/18 at 9:31 AM and 07/19/18 at 8:35 AM revealed the condition remained unchanged. Observation on 07/17/18 at 11:53 AM in resident room #213 revealed an approximately 11 inch X 5.5 inch area on the bottom of the right side of the	F 584	White Oak of Tryon provides a safe, clean, comfortable, and home like environment for the residents, staff, and visitors. Room 201 and 213 bathroom doors with scratches were repaired. Room 203 closet door with scratches was repaired. Room 213 laminate on closet that was torn was repaired. Room 204 and 213 bathroom doors with holes were replaced. The damages to the closet and bathroom doors are a result of the use of lifts in the room, moving beds within or out of the room, and the use of electric wheel chairs and inconsistent communication to the Maintenance Department that repairs need to be made. Maintenance repair needs will be better communicated to the Maintenance Department, and consistent rounding from the Maintenance Department to identify areas in need of repair. The facility staff	

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F 584	Continued From page 2 closet door had torn laminate. Subsequent observations on 07/18/18 at 9:31 AM and 07/19/18 at 8:35 AM revealed the condition remained unchanged. Observation on 07/17/18 at 11:53 AM of resident room #213 revealed an approximately 6 centimeter (cm) hole in the room side of bathroom door. Subsequent observations on 07/18/18 at 9:31 AM and 07/19/18 at 8:35 AM revealed the condition remained unchanged. 3. Observation on 07/17/18 at 12:38 PM in resident room #203 revealed the right side of the closet wall had multiple scratches. Subsequent observations on 07/19/18 at 8:58 AM and 07/20/18 5:03 PM revealed the condition remained unchanged. 4. Observation on 07/17/18 at 2:01 PM in resident room #204 revealed an approximately 6 cm hole in the room side of the bathroom door. Subsequent observations on 07/18/18 at 10:52 AM and 07/19/18 at 8:35 AM revealed the condition remained unchanged. An interview with the Maintenance Assistant (MA) (the Maintenance Supervisor (MS) was on vacation) on 07/20/18 at 4:41 PM was conducted. The MA stated the work order system the facility currently utilized was that the aides and the nurses wrote a note and put it in the box that was mounted on the wall on the way out of the front of the building by the Administrator's office. The MA explained he checked the box twice a day and prioritized the work orders in the order they came in. The MA further stated the Administrator, MS and he made walking rounds about every other day and he would document the repairs that	F 584	was re-educated on reporting any damage or area that needs to be repaired to the Maintenance Department no later than 8/17/18 by the SDC (Staff Development Coordinator) and new orientees will receive training on reporting any environmental damages to maintenance during their orientation by the SDC or the head of their department if not nursing. The Maintenance Department was re-educated on making consistent facility rounds to identify repair needs by the Administrator and was completed prior to 8/17/18. Newly hired Maintenance employees receive this education during their job specific orientation with the Maintenance Director. The Maintenance Department will make weekly rounds in the facility to identify any areas that needs to be repaired, needed repairs are communicated to the Administrator. The Administrator will monitor the facility environment regarding maintenance by rounding weekly for 4 weeks, then monthly for 4 months and as needed thereafter. The identified trends are discussed during morning QI meetings Monday-Friday and discussed with the QA Committee with recommendations made for system changes as indicated. The Administrator and the Maintenance Director are responsible for the continued	

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	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - TRYON	70 OAK STREET TRYON, NC 28782

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F 584	Continued From page 3 needed to be made. During an environmental tour with the MA on 07/20/18 at 4:55 PM he explained they (Administrator, MS and he) talked about the holes in the doors a couple of weeks ago and hopefully when he (MS) returned from vacation they could change them. The MA stated the bathroom doors could be sanded to remove the scratches and he was not sure what the Administrator and MS had decided what to do about the scratched and torn closets. An interview was conducted with the Administrator on 07/20/18 at 8:15 PM who confirmed there were no definite plans for the facility to go through renovations. The Administrator stated he expected his Maintenance Department to conduct rounds through the resident rooms and make repairs as needed. The Administrator further stated he expected the residents' living quarters to be homelike.	F 584	compliance of F584.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately code the Minimum Data Set assessments for 2 of 4 sampled residents reviewed for falls (Residents #6 and #58) and 3 of 5 sampled residents reviewed for medications (Residents #1, #22 and #27.)	F 641	White Oak of Tryon assessments will accurately reflect the resident's status which includes falls and medications. Resident #1 MDS has been corrected and coded for a diuretic medication.	8/17/18

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WHITE OAK MANOR - TRYON	70 OAK STREET TRYON, NC 28782

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F 641	Continued From page 4 The findings included: 1. Resident #1 was admitted to the facility 10/07/13 and readmitted to the facility 8/27/17 with diagnoses which included Alzheimers, arthropathy, pain, hypertension, hypothyroidism, diabetes, anxiety, depression, atrial fibrillation and pain. Review of physician orders and the July 2018 Medication Administration Record noted Resident #1 was administered 12.5 milligrams of Hydrochlorothiazide (HCTZ-a diuretic) every day at the time of the Minimum Data Set assessment. An annual Minimum Data Set (MDS) dated 07/12/18 for Resident #1 did not code Resident #1 on a diuretic. On 07/20/18 at 4:40 PM MDS Nurse #2 stated the HCTZ should have been coded as a diuretic on the 07/12/18 annual MDS for Resident #1 and it was an oversight that it was not coded correctly. On 07/20/18 at 8:00 PM the Director of Nursing stated she expected the MDS to be coded accurately and noted the HCTZ should have been coded as a diuretic on the 07/12/18 MDS for Resident #1. On 07/20/18 at 8:05 PM the administrator stated he expected the MDS to be coded accurately,. 2. Resident #27 was admitted to the facility 08/30/12 with diagnoses which included depression, pain in hip, alzheimers, arthritis left hip, hemiplegia and psychosis.	F 641	Resident #27 MDS has been corrected and coded for anti-anxiety and antibiotic medications. Resident #58 MDS has been corrected and coded for falls. Resident #6 MDS has been corrected and coded for a fall. Resident #22 MDS has been corrected and removed coding for an anticoagulant and a diuretic. The facility has a new MDS nurse that is still undergoing training. These coding mistakes were oversights and she is being randomly audited by our corporate MDS consultant for accuracy. An audit was completed on 7/27/18 of current residents' most recent MDS assessment to assure MDS is coded accurately for medications and falls. Audit was completed by the MDS Consultant with corrections made by 8/1/18. The facility's MDS nurses were re-educated on the accuracy of coding the MDS by the Corporate MDS Consultant on 7/26/18. Newly hired MDS nurses will receive this education during their job specific orientation with the corporate consultant. The MDS assessments will be monitored for accuracy of medications and falls coding by the Director of Nursing (DON) and/or MDS nurses weekly for 4 weeks,	

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F 641	Continued From page 5 Review of the June Medication Administration Record and physician orders noted Resident #27 took a daily dose of 500 milligrams of Penicillin (an antibiotic) every six hours as well as 1 milligram of Valium (an anti-anxiety medication) at bedtime. The quarterly Minimum Data Set (MDS) dated 06/05/18 did not code Resident #27 on an anti-anxiety or antibiotic medication. On 07/20/18 at 4:40 PM MDS Nurse #1 reviewed the 06/05/18 quarterly MDS for Resident #27 and stated the Penicillin should have been coded as an antibiotic and the Valium should have been coded as an anti-anxiety medication. MDS Nurse #1 stated it was an oversight that the two medications were not coded correctly on the 06/05/18 MDS for Resident #27. On 07/20/18 at 8:00 PM the Director of Nursing stated she expected the MDS to be coded accurately. The Director of Nursing stated the 06/05/18 quarterly MDS for Resident #27 should have coded the resident was taking an anti-anxiety and antibiotic at the time of the assessment. On 07/20/18 at 8:05 PM the administrator stated he expected the MDS to be coded accurately. 3. Resident #58 was admitted to the facility 01/10/12 with diagnosis which included chronic obstructive pulmonary disease, edema, hypothyroidism, depression, osteoarthritis, anxiety, diastolic heart failure, hypokalemia, polyneuropathy and Parkinsons.	F 641	then 5 assessments monthly for 3 months, and as needed thereafter. The identified trends are discussed during morning QI meetings Monday-Friday and discussed with the QA Committee for recommendations if needed. The DON is responsible for the ongoing compliance of F641.	

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F 641	Continued From page 6	F 641		

Review of the medical record of Resident #58 noted 2 falls with details as follows:
5/6/18 6:30 AM-Resident #58 was sitting on her walker in the bathroom and slipped off the walker onto the floor. No complaints of pain were noted. She had on polyester pants which were slick and most likely reason she slipped.
6/11/18 3:35 PM-Resident #58 fell over her walker. Resident #58 was found on the floor, lying on her back, with her head next to the dresser. Resident #58 complained of severe head pain and had a lump on the back of the right side of her head as well as complaints of lower back pain.

The quarterly Minimum Data Set (MDS) dated 07/10/18 for Resident #58 coded Resident #58 had no falls since the prior assessment (which was dated 04/19/18.)

On 07/19/18 at 3:50 PM MDS Nurse #1 stated she kept a hand logged book in her office of resident falls to utilize when an MDS was completed. MDS Nurse #1 looked at the book and stated it did not include the 05/06/18 and 06/11/18 falls for Resident #58 which resulted in an error when the quarterly MDS was coded for Resident #58. MDS Nurse #1 stated not coding the 2 falls on the 07/10/18 quarterly MDS for Resident #58 was an oversight.

On 07/20/18 at 8:00 PM the Director of Nursing stated she expected the MDS to be coded accurately and the 07/10/18 quarterly MDS for Resident #58 should have noted the 2 falls since the prior assessment.

On 7/20/18 at 8:05 PM the administrator stated

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F 641	Continued From page 7	F 641		

he expected the MDS to be coded accurately.
4. Resident #6 was admitted to the facility on 01/27/18 with diagnoses that included hemiplegia (paralysis on one side of the body), muscle weakness and dementia.

Review of Resident #6's medical record revealed she had an unwitnessed fall on 04/01/18 at 2:15 PM while in the courtyard of the facility. Further review revealed Resident #6 sustained a skin tear to her right hand as a result of the fall.

Review of the quarterly Minimum Data Set (MDS) dated 05/01/18 indicated Resident #6 had no falls since the prior MDS assessment which was dated 02/03/18.

During an interview on 07/19/18 at 5:45 PM MDS Nurse #1 revealed she reviewed the fall occurrence reports and manually logged them into a fall book that she referenced when completing a MDS. MDS Nurse #1 confirmed Resident #6 had a fall on 04/01/18 and the MDS dated 05/01/18 was coded incorrectly. MDS Nurse #1 added not coding the fall on 04/01/18 was an oversight and a corrected MDS would be submitted to accurately reflect Resident #6 had a fall.

During an interview on 07/20/18 at 7:40 PM the Director of Nursing stated she would expect for the MDS to be accurately coded.

5. Resident #22 was admitted to the facility on 08/20/13 with diagnoses that included heart failure, hypertension, Parkinson's disease, Alzheimer's, and depression.

Review of Resident #22's physician orders and

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	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - TRYON	70 OAK STREET TRYON, NC 28782

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F 641	Continued From page 8 Medication Administration Record (MAR) for May 2018 revealed no anticoagulant (blood thinner) or diuretic (promoted increased production of urine) was ordered or administered to Resident #22. Review of the quarterly Minimum Data Set (MDS) dated 05/22/18 indicated Resident #22 received an anticoagulant and diuretic daily during the 7-day assessment period. During an interview on 07/19/18 MDS Nurse #1 revealed she referenced the MAR when coding medications on the MDS. MDS Nurse #1 reviewed the May 2018 MAR for Resident #22 and confirmed no anticoagulant or diuretic was ordered or adminstered. MDS Nurse #1 stated it was possible she had reviewed another resident's MAR by mistake which caused the incorrect coding of medications on Resident #22's MDS dated 05/22/18. MDS Nurse #1 added a corrected MDS would be submitted to accurately reflect Resident #22 did not receive anticoagulants or diuretics. During an interview on 07/20/18 at 7:40 PM the Director of Nursing stated she would expect for the MDS to be accurately coded.	F 641		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		8/17/18

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F 812	Continued From page 9 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff the facility failed to ensure the reach in freezer containing single serve ice cream/sandwiches maintained food in a frozen state, failed to store buckets of ice cream off the floor of the walk in freezer, failed to refrigerate individual servings of salad dressing consistent with manufacturer recommendations and failed to ensure cottage cheese, fresh mozzarella cheese and single service cartons of milk were not stored beyond expiration. The findings included: 1. During the initial tour of the facility kitchen on 07/17/18 from 10:55 AM-11:20 AM the following concerns were identified: -The temperature of food stored in a box reach in freezer was noted to be 24 degrees Fahrenheit when tested by the Assistant Food Service Director (AFSD). Stored inside the box reach in freezer at the time the temperature was taken was a box of single serve vanilla sandwiches which were completely melted and five boxes of single serve ice cream cups. All the boxes were stored directly on the bottom of the freezer and	F 812	White Oak of Tryon stores, prepares, distributes, and serves food in accordance with professional standards for food service safety. The food items (single serving ice cream/sandwiches) in the reach in freezer were discarded during survey. The reach in freezer's temperature was corrected under warranty on 7/20/18 and will be checked daily by the dietary manager or cook to insure it is maintaining the correct temperature for 2 weeks then monthly for 2 months and periodically thereafter. The employee responsible for opening the kitchen and checking the freezer temps did not check the temperature on the day of the deficiency. All dietary personnel were inserviced on the importance of monitoring and reporting malfunctioning equipment by 8/13/18. Newly hired dietary staff receive this education during their job specific orientation with the dietary manager. Removed ice cream buckets off the floor	

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F 812	Continued From page 10 when the lid of several of the single serve ice cream cups was lightly touched the product inside pooled out over the cup. The AFSD was present at the time of the observation and noted the box reach in freezer was new and had recently been moved within the kitchen because of problems with maintaining temperature. The AFSD explained the reach in freezer had been located close to the warming unit and they thought the heat from the warming unit might have been the problem with maintaining the freezer temperature. The AFSD stated she did not think staff had opened the reach in freezer box that morning and the product inside had not been from a recent delivery. The AFSD stated she was not aware the products inside the reach in freezer were not frozen. The AFSD reviewed the daily temperature log and noted staff had not checked the temperature of the reach in freezer that morning. -Two, 5 quart plastic buckets of ice cream were observed stored under shelving, on the floor of the walk in freezer. The AFSD was present at the time of the observation and stated no food products were supposed to be stored on the floor of the walk in freezer. The AFSD stated the 5 quart plastic buckets belonged to the activity department and they stored them in the kitchen walk in freezer for resident use at activities. The AFSD stated she was not sure who placed the 5 quart buckets of ice cream under shelving in the walk in freezer. -One, 5 pound unopened container of lowfat cottage cheese with a manufacturer stamped expiration date of 07/02/18 was stored, ready for use on shelving in the walk in refrigerator. The AFSD was present at the time of the observation and stated the coolers were checked on stock days (Tuesday/Friday) for any outdated items and	F 812	of the walk in freezer during survey, and further ice cream buckets will be stored appropriately. The Activity department's freezer is not large enough to store the large ice cream containers so they were stored in the kitchen's walk in freezer in the kitchen. On the day of the deficiency, we received a large stock shipment of frozen food that was to be stored in the walk in freezer. Dietary staff placed the ice cream on the floor; with the food shipment we just received to make room on the shelves to fit the new stock. The ice cream buckets were never picked back up and placed on the shelf after the stock had been loaded into the freezer. The ice cream buckets that were placed on the floor during the survey have been discarded. Activity staff and dietary staff will be inserviced regarding proper storage of all food by 8/17/18. Newly hired dietary staff and activity staff receive this education during their job specific orientation with the respective department head. Discarded identified individual servings of salad dressing during survey and will be stored consistently with manufacturer recommendations. The AFSD (Assistant Food Service Director) ordered the wrong individual servings of honey mustard salad dressing. The AFSD was re-educated by the FSD (Food Service Director) on 7/20/18 regarding ordering the appropriate dressing. All stocking personnel will be inserviced no later than 8/17/18 by the FSD to verify all incoming inventory with temperature requirements	

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	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 11 were supposed to be checked all other days by all staff for any outdated items. The AFSD could not explain why the 5 pound container of lowfat cottage cheese with a 07/02/18 expiration date remained ready for use on shelving in the walk in refrigerator. -One, 3 pound unopened container of fresh mozzarella cheese with a manufacturer stamped best by date of July 15th was stored, ready for use on shelving in the walk in refrigerator. The AFSD was present at the time of the observation and stated the coolers were checked on stock days (Tuesday/Friday) for any outdated items and were supposed to be checked all other days by all staff for any outdated items. The AFSD could not explain why the 3 pound container of fresh mozzarella cheese with a July 15th expiration date remained ready for use on shelving in the walk in refrigerator. On 07/19/18 at 11:40 AM the Food Service Director (FSD) stated she expected frozen food items to be stored frozen. The FSD stated even at the highest setting the reach in box freezer was still not working and they were not going to use it again until it was serviced. The FSD stated staff should be checking the walk in refrigerator five days a week for any items out of date and couldn't explain why the expired cottage cheese and fresh mozzarella had not been removed prior to 07/17/18 by dietary staff. The FSD stated the activity staff brought the buckets of ice cream to the kitchen the week prior and asked if they could be stored in the walk in freezer. The FSD stated she was not sure who placed the buckets of ice cream in the freezer but expected all food to be stored on shelving, not on the floor of the walk in freezer.	F 812	will be stored in the appropriate location. Newly hired stocking personnel receive this education during their specific job orientation with the FSD. The expired food items identified during survey (cottage cheese, fresh mozzarella cheese and singling serving cartons of milk) were discarded, and no food items will be stored after expiration date. The Dietary staff were re-educated on the storage and removal of food items on 8/10/18 by the Dietary Manager. Staff were educated to discard and report any food that has met its expiration or used by date by the Dietary Manager or SDC. Refrigerators on the nursing units will continue to be monitored daily by the Dietary Aides for any and all expired items, the Kitchen Supervisor will also monitor on inventory days (Mondays and Thursdays), the stock personnel will monitor on delivery days (Tuesdays and Fridays) to ensure all food items are stored appropriately and not placed on the floor and or placed in the freezer/cooler when the manufacturer recommends, and the Dietary Manager will monitor the freezer temperatures weekly during her compliance rounds. Newly hired dietary staff will receive this education during their specific orientation with the Kitchen Supervisor and the SDC (Staff Development Coordinator) for the newly hired nursing staff for the nursing unit refrigerators. The identified trends are discussed during	

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	345127	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - TRYON	70 OAK STREET TRYON, NC 28782

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F 812	Continued From page 12 2. On 07/17/18 at 12:00 PM 5, 1/2 pints of whole milk with a manufacturer expiration date of 07/16/18 were stored inside a pantry refrigerator which was located adjacent to the 400 hall. On 7/18/18 at 9:42 AM 5, 1/2 pints of whole milk remained in the pantry refrigerator located adjacent to the 400 hall. In addition, there were also 2, 1/2 pint containers of lowfat milk with a manufacturer expiration date of 07/17/18. On 7/18/18 at 11:00 AM a dietary aide stated someone from the dietary department checked each nourishment pantry every day to replenish stock and remove any outdated items. The dietary aide stated the 5, 1/2 pints of whole milk with an expiration date of 07/16 should have been discarded two days prior and the 2, 1/2 pints of lowfat milk with an expiration date of 07/17 should have been discarded the day prior. The dietary aide stated she was not sure who checked the nourishment pantries 07/16/18 and 07/17/18. On 07/19/18 at 11:40 AM the Food Service Director stated dietary staff should remove any outdated food items from the pantry refrigerators when they were stocked each day. 3. On 07/18/18 at 11:15 AM a wicker basket housing individual servings of salad dressing was observed in the Benson dining room. A dietary aide present at the time of the observation stated the individual servings of salad dressing were stored in the wicker basket for resident use when a salad was served to residents. Inside the basket were five, 1.5 ounce servings of honey mustard salad dressing which had marked on the label by the manufacturer "keep refrigerated." The five, 1.5 ounce servings of honey mustard	F 812	morning QI meetings Monday-Friday and discussed with the QA Committee with recommendations be made for system changes if needed. The Dietary Manager is responsible for continued compliance of F812.	

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F 812	Continued From page 13 salad dressing all felt at room temperature. On 07/19/18 at 11:20 AM observations were made of the tray line for the lunch meal. Included on the pre-planned lunch menu was salad and a large container of salad was observed on the tray line. Also on the tray line was a container of assorted individual salad dressings. The FSD was present at the time of the observation and stated the individual assorted salad dressings were for resident use when a salad was on the menu. Inside the container were 5, 1.5 ounce servings of honey mustard salad dressing which had marked on the label by the manufacturer "keep refrigerated." The 5, 1.5 ounce servings of salad dressing all felt at room temperature. The FSD stated the single serve honey mustard salad dressing was pulled from a box stored in dry storage. The FSD obtained the box containing 18 singe serve honey mustard salad dressings off shelving in dry storage and noted the manufacturer instructions outside the box "must be refrigerated." The FSD stated she wasn't aware the single serve honey mustard dressing needed to be refrigerated. The FSD stated she thought the Assistant Food Service Director (AFSD) only bought shelf stable salad dressings. The AFSD was present at the time of the interview and stated she was not aware the honey mustard salad dressing needed to be refrigerated. On 07/20/18 at 8:00 PM the Administrator stated he expected frozen foods to be stored frozen, food that required refrigeration to be refrigerated and food not stored beyond the manufacturer expiration date.	F 812		