	-	D HUMAN SERVICES MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345386	B. WING _			08/14/2014	
NAME OF PROVID	ER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			•	
WILKES REGIO	NAL MEDICAL CTF	R SN			370 WEST D STREET ORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG				(X5) COMPLETION DATE
SS=E STC The (1) con autt (2)			F 37				9/2/14
by: Bas facii to d The An i of tr obs reve was con dish Obs dus alor On wer roor thic and					Corrective Action for F-371 Dust accumalation on the oscillating far the end of the dishline. Due to the high moisture content relate to steam in the dishroom and the increased accumlation of debris on the fans as a result; those fans were cleane immediately on August 14,2014.Beginn on August 14,2014 the cleaning was to started bi-weekly. The fans remain on t weekend cleaning list and were immediately added to the mid-week cleaning list. Documentation of the mid-week cleaning began on September 1,2014. Those records will be turned in weekly to the Office Manager and will b overseen and monitored by the Office Manager and Department Director weekly.These results will be reviewed quarterly in the SNF QAA meeting. We continue to educate staff on food servic priciples (including sanitation standard and expectations) in our daily department	ed hing be he er oe will ce s	
inse	erts as they exited	the dish machine. The			meetings. These meetings have been		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/02/2014

PRINTED: 09/09/2014

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

Electronically Signed

CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		345386	B. WING		08/14/2014
NAME OF PROVIDER OR SUPPLIER WILKES REGIONAL MEDICAL CTR SN			•	STREET ADDRESS, CITY, STATE, ZIP CC	DE
				1370 WEST D STREET NORTH WILKESBORO, NC 28659)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIO IE APPROPRIATE DATE
F 371	Continued From page 1		F 37		
		are were left in front of the		ongoing in our department a	
		e observations two dietary n the dish room. Dietary aide		attendance is logged. On Au 15th the expectation of sanit	-
		and reported that he had a		impressed upon the staff as	
		cleaning that included		survey results. There were r	
		d walls of the dish room.		affected by the deficient pra-	ctice.
		interviewed and explained			
	the drying process for	ing fan was used to quicken			
		d that the fans in the kitchen			
	-	weekend. He reported that			
	-	oscillating fan the weekend			
		n accumulated dust after a			
	-	needed more frequent ed the fan and reported that			
	-	nd needed to be cleaned.			
		PM the Registered Dietitian d and reported that oscillating			
		ere cleaned weekly. She			
	explained that all kitc	hen equipment was on a			
		it she expected that at			
		quipment was identified dirty			
		mber should clean the item that the large oscillating			
	•	for being a problem for			
		dishware because the fan			
		quickly. The RD stated that			
	÷ .	ion was that items in the			
	kitchen were cleaned	1 ao 1100000.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 943561

If continuation sheet Page 2 of 2