DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM AP CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 09									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		X3) DATE COMP	TE SURVEY MPLETED				
345559		B. WING _		C 08/0	; 6/2015				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
HOMEST	EAD HILLS			2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ie Ate	(X5) COMPLETION DATE			
F 371 SS=E	The facility must - (1) Procure food fro considered satisfac authorities; and	SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 37	71		8/28/15			
	This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of the kitchen procedures, the facility failed to maintain sanitary conditions in the kitchen by 1) ensuring that fresh produce was removed from spoiled/rotten produce in 1 of 1 walk in refrigerator 2) failed to clean and remove food debris from meal carts 3) failed to clean and remove food and liquid debris from steam table and warmer box 4) clean and remove food debris from dry storage containers 5) failed to label and date dry food products 6) clean and stored dishes on clean surfaces 7) failed to air dry 5 serving pans 8) failed to clean and remove food and grease debris from dome covers 9) ice scoop left in ice machine and 10) remove thawed food products from the floor. The findings included: 1. During an observation on 8/3/15 at10:40AM,			 F371 1. The Director of Dining Services removed all spoiled rotten food remo from fresh produce, cleaned and rem debris form the meal carts, cleaned aremoved debris from the steam table warmer box, cleaned and removed d form the dry storage containers, laber dated dry food products, cleaned and stored dishes on clean surface, clean and air dried serving pans appropriatic cleaned and removed grease and deform dome covers, removed the ice s from the ice machine and stored it properly and removed thawed food products from the floor. 2. For resident having the potential to affected by the same deficient practice the Sous Chef audited all refrigerator freezer and dry storage containers its for labeling and dates, audit all products 	noved and e and debris el and d ned tely, ebris scoop o be ce, rs, ems				
	tomatoes mixed wit	itor had a box of fresh h spoiled and rotten tomatoes e was brown and mushy. On		ensure that the rotten/spoiled production been separated from the fresh on Au	ce has ugust				
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE			

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

08/24/2015

PRINTED: 08/26/2015

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.

Electronically Signed

	-	I AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>	T			APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345559				IPLE CONSTRUCTION	Сом	E SURVEY PLETED	
		345559	B. WING			C 26/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COL	E	•	
HOMESTEAD HILLS							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 371	Continued From pa	-	F 37		the second		
	lemons mixed with	there was also a box of fresh spoiled and rotten lemons.		3, 2015. A sanitation check of kitchen will be conducted by A 2015. A general cleaning base	ugust 28, ed on the		
	kitchen supervisor for checking the pro discard the spoiled	v on 8/3/15 at 10:40AM, the indicated he was responsible oduce upon delivery and /rotten produce. The dietary firmed this expectation during		sanitation cleaning for clean and air dry serving pans, dome covers, ice scoop, meal carts, steam table and warmer box, clean and stored dishes on clean surfaces,dry storage containers and			
	the tour.			thawed food products on the f	loor.		
	2 meals carts used dirty with large volu On 8/5/15 at 11:10/ another meal cart v dirty with large volu on the surfaces. In	ervation on 8/3/15 at 10:40AM, I for meal service delivery was imes of dried foods and liquids. AM, in the walk in refrigerator was stored in the refrigerator imes of dried food and liquids addition, 2 tray pans of as lying on the surfaces of the		3. The facility added a system that included a daily audit tool sure that the deficient practice occur. The Sous Chef or his d his absence the Executive Ch for labeled food items in the re freezer and dry storage, spoile produce is removed from fres steam table and warmer box f check the dry storage for debi	to make e will not esignee in ef will check efrigerator, ed/rotten h, check the or debris,		
	8/5/15 at 11:10AM, DM both indicated cleaned according shift. In addition, de	on 8/3/15 at 10:40AM and the kitchen supervisor and the meal carts should be to the kitchen checklist each esserts and food should be cart before being place in the		pans are air dried, check for or stored dishes on clean surface dome covers are free of greas debris, ice scoop is to in the ic and stored properly and thave products are not on the floor.	es, the se and food se machine ed food		
	the warmer box and volume of dried for	ervation on 8/3/15 at 10:40AM, d steam table had a large ods, liquids and grease build up outside of warmer box and		4. This audit will be conducted per week for four weeks, and for four weeks and/or a patter compliance is established. Th this audit will be noted and rev monthly Quality Assurance Co	then weekly n of e results of <i>r</i> iewed in the		
	kitchen supervisor kitchen equipment accordance to kitch	on 8/3/15 at 10:40AM, the and DM both confirmed the should be cleaned daily in nen check list. The DM e responsibility of the Kitchen					

Facility ID: 110427

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		AND HUMAN SERVICES				FORM	08/26/2015 APPROVED 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		345559	B. WING _			C 08/06/2015			
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-			
HOMEST	EAD HILLS		2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 371	 Supervisor to ensur completing the clear daily. 4. During an obset the dry storage con (flour, sugar, bread volumes of dried for and outside of the control of the contr	ervation on 8/3/15 at 10:40AM, tainers used for dry products crumbs, corn meal) had large ods and liquids on the inside containers. Ton 8/3/15 at 10:40AM, the and DM indicated the the kitchen staff to clean and tainers daily and ensure there products found in each of the anot designated. ervation on 8/3/15 at 10:40AM, teal and brown sugar were ated in the dry storage area. Ton 8/3/15 at 10:40AM, the and DM confirmed the items in a should be labeled and dated ed. ervation on 8/3/15 at 10:40AM, found dirty with dried foods d edges. The plates were also od preparation table that had a case and food on the surfaces. Ton 8/3/15 at 10:40AM, the and DM indicated the dishes ly cleaned and free of food d. The surface should also be cordance to the kitchen	F 37	71					

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		AND HUMAN SERVICES				FORM	08/26/2015 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
	345559		B. WING			C 08/06/2015			
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
HOMEST	EAD HILLS		2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 371	Continued From pa	ige 3	F 3	571					
	 During an observation on 8/3/15 at 10:40AM, 5 silver pans were stacked wet on the dry storage rack. 								
	kitchen supervisor a were wet and indica	on 8/3/15 at 10:40AM, the and DM confirmed the pans ated the pans should have be ed in a staggered formation.							
	8. During an observation on 8/3/15 at 10:40AM, 29 silver dome covers were stacked on the dry storage rack with a large volume of dried food and heavy build-up of grease on the inside and outside of the domes.								
	kitchen supervisor a and grease build-up indicated that the d	on 8/3/15 at 10:40AM, the and DM confirmed the food p on the dome and both omes should be cleaned in cleaning checklist and kitchen							
	and 8/5/15 at 11:10	ervation on 8/3/15 at 10:40AM AM, the ice scoop was e on the inside of the machine chen.							
	dietary aide (DA) in been placed on the ice for a long time.	on 8/3/15 at 11:00AM, the dicated that the scoop had inside of the machine in the The DA indicated she was of be stored inside the							
	kitchen supervisor	on 8/5/15 at 11:10AM, the confirmed the scooped was e on the inside of the machine.							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 09									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		345559	B. WING		C 08/06/2015				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
HOMEST	TEAD HILLS		2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103						
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 371	The supervisor indi located on the outs the inside. 10. During an obset several boxes of sp the kitchen floor, wi running on the floor boxes had a foul of the boxes, while op stored on the shelf During an interview kitchen supervisor foods and produces immediately after it refrigerator. The old have been discard. the refrigerator was foods that could no been discard and n During an interview administrator indicat the DM was respon of the kitchen meet	age 4 cated the scoop should be ide of the machine and not in ervation on 8/5/15 at 11:10AM, poiled produce, chicken was on here the chicken juice was r and the produce that was in dor. Staff was stepping over bened/spoiled bread was with the clean dishes. on 8/5/15 at 11:10AM, the and DM confirmed the spoiled s should have been discarded was removed from the d spoiled bread should also The DM indicated that one of s being repaired and all the t be salvaged should have not placed on the floor. on 8/6/15 at 2:10PM, the ated the kitchen supervisor and hsible for ensuring the quality t the standards and sanitary dance to the regulations.							

Facility ID: 110427

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