

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2015
NAME OF PROVIDER OR SUPPLIER MOORESVILLE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(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 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain kitchen equipment in a clean and sanitary manner to prevent food borne illness by failing to clean the walk in freezer floor, a steam table shelf and a fan in the dish room. The findings included: A review of the Food and Nutrition Services, Master Cleaning Schedule Revised 4/01/14 listed " Freezer (Walk In) weekly / monthly, Floors, wet mopping/light scrub-monthly. Steam table-weekly and Fans weekly. " 1. During the initial kitchen tour with the Dietary manager on 10/27/15 at 8:25 AM the Walk in freezer was observed. Underneath the freezer shelving on the left side the floor was observed with bits of cardboard and paper debris, frozen food particles, ice chips and dark moist spills near the shelving legs. A second observations of the freezer floor on 10/28/15 at 2:32 PM revealed the freezer floor on the left side was observed with bits of cardboard and paper debris, frozen food particles, ice chips and dark moist spills near the shelving legs. A third observation of the walk in freezer on</p>	F 371	<p>Corrective action for those affected: The walk in freezer, the steam table cover and the fan were cleaned on 10/29/15.</p> <p>Corrective action for those potentially affected: The walk in freezer, the steam table cover and the fan were cleaned on 10/29/15.</p> <p>Systemic changes: The walk in freezer, the steam table cover and fan were added to the daily and weekly cleaning schedules. The FSD or designee will assure the daily and the weekly cleaning has occurred and the cleaning spreadsheets are signed accordingly. Dietary staff were educated on the cleaning schedule additional items, that the FSD or designee will check the cleaning schedules daily, and they will not be allowed to leave until their assignments are complete and documented. Any items not complete will be complete prior to employee leaving for the day. The</p>	11/11/15	

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

TITLE

(X6) DATE

Electronically Signed

11/06/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2015
NAME OF PROVIDER OR SUPPLIER MOORESVILLE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(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 371	<p>Continued From page 1</p> <p>10/29/15 at 10:51AM revealed the freezer floor was observed in the same unclean condition. During an interview with the Dietary Manager on 10/29/15 at 10:53 AM she stated that at the end of each shift she asked staff if they completed their cleaning but did not really check behind staff. She stated that she had just hired someone as kitchen manger to concentrate on the kitchen staff and cleaning.</p> <p>2.During an observation of the kitchen on 10/28/15 at 2:36 PM the steam table was observed. Observations underneath the 5 foot shelf was revealed it was covered with dried dark food particles. During a second observation of the steam table on 10/29/15 at 10:52 AM the underside of the steam table shelf was again observed to be covered with dried dark food particles.</p> <p>In an interview with the Dietary manager on 10/29/15 at 10:53 AM she stated that there was a cleaning schedule but it did not address cleaning underneath the steam table shelf. She stated that she would add the underside of the shelf to the cleaning schedule.</p> <p>3.During an observation of the dish machine on 10/28/15 at 2:28 PM a large wall fan was observed blowing directly onto the drying rack of clean dome lids that was less than 8 inches from the fan. The fan cage was observed covered with dark gray dust balls and the fan blades were observed with gray dust build up.</p> <p>During an interview with the Dietary manager on 10/28/15 at 10:53 AM she stated that she thought the maintenance man had cleaned the fan but did not remember when it had last been cleaned. She indicated that she would add cleaning the fan to the cleaning schedule.</p> <p>In an interview with the maintenance man on 10/28/15 at 2:42 PM he stated he could not</p>	F 371	<p>cleaning signature sheets will be complete and validated by the FSD or designee.</p> <p>QA and monitoring: The FSD or designee will review the cleaning schedules daily for completion. Any staff member who has not completed their assignments and documented will complete the work prior to their leaving for the day. The FSD or Designee will complete daily audits times 2 weeks, weekly audits times 4 weeks, monthly audits times 3 months and quarterly audits times 3 quarters. The results of the audits will be brought to the monthly QA meetings.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/29/2015
NAME OF PROVIDER OR SUPPLIER MOORESVILLE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(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 371	Continued From page 2 remember when he had last taken a brush and brushed down the fan in the kitchen dish room area.	F 371			