PRINTED: 01/23/2017 FORM APPROVED OMB NO. 0938-0391

	(X3) DATE SURVEY COMPLETED	
345316 B. WING 12/15	15/2016	
NAME OF PROVIDER OR SUPPLIER SENIOR CITIZENS HOME SENIOR CITIZENS HOME STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderfy, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with family members, residents and facility staff, the facility failed to repair and/or replace furniture with marred tops and/or broken drawers for 10 of 30 samples residents (Residents # 41,9,11,14,18,45,46,56,57 and 65) whose rooms were observed. Findings includet: During the initial tour of the facility, beginning on 12/12/16 at 9:30 AM, the furniture in the rooms for Residents 1, 9, 11, 14, 18, 45, 46, 56, 57 and 65 were noted to have the veneer pealed off the top and off of some edges of the furniture. Residents # 1 and 9 had bedisdle tables with drawers that were broken and would not close properly. On 12/13/16, 12/14/16 and 12/15/16, it was noted the worn and/or broken furniture had not been repaired or replaced. 1. The Quarterly Minimum Data Set (MDS) for Resident #9, dated 10/25/16, indicated Resident #9 had short and long term memory impairment with severely impaired cognitive skills for daily decision making. On 12/14/16 at 10:30 AM, the Responsible Party ABDRATORY DIECTORS OR PROVIDENSUPPLIER REPRESENTATIVES SIGNATURE 1// The furniture for residents 1, 9, 11, 14, 14, 14, 44, 46, 46, 65, 57 and 65 have been repaired and the edigings have been scheduled to be painted or repaired. All of the residents 1, 9, 11, 14, 14, 18, 44, 46, 56, 57 and 65 have been chard to have deen checked on 1-12-17 and furniture that have been found to have deen ended to have deen checked on 1-12-17 and furniture that have been found to have deen grapited or replaced. On a monthly basis, for 90 days, the Administrator will check all bedeside tables with a resident printiture Audit form. Any bedside tables with one of the part	1/12/17	

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

Electronically Signed 12/30/2016

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345316	B. WING	·····		12/15/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 253	stated she thought the adding she had been condition of the tops taken contact paper a furniture herself. She furniture in such disremoment, the facility witherefore, she would to be in better shape. To one of Resident #9 week, but she had not administration, knowing Resident #9 had been. The Administrator was 3:06 PM. The Administrator was 3:06 PM. The Administrator stated there were no available Administrator stated there were no available Administrator stated the added if drawers were not working, he either him or the main Observations were most working, he either him or the main Observations were most working, he either him or the main Observations were most working he would was on 12/15/16 at 8:25 interviewed. She stafacility where the dan found, had the oldest She stated the furniture at least a year. The him of the stafacility was a facility where the dan found, had the oldest She stated the furniture at least a year. The him of the stafacility was a facility	was interviewed. She e furniture was in disrepair, so disturbed by the of the furniture she had and recovered Resident #9's e added she would not have epair in her home and at the was her mother's home so have expected the furniture The RP added the drawers by nightstands fell apart last of reported this to ing that staff that assisted in aware. Is interviewed on 12/14/16 at istrator stated furniture was based on looking bad or if ole parts for repairs. The ine had received no concerns its, staff or family members. Its of dressers and nightstands expected staff to report to intenance supervisor. Indee of the resident's room indeed furniture had been in shape and it was not and in his house. AM, Housekeeper #1 was ited residents on that end of inaged furniture had been if furniture in the building. In had been in disrepair for inousekeeper stated it was ited residents or decide if the indeed.	F 25	Developer. Any negative findin the Audits will be forwarded to t two quarterly QA Meetings until resolved.	he next		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345316	B. WING		12/15/2016		
	NAME OF PROVIDER OR SUPPLIER SENIOR CITIZENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	12102010		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 253	Supervisor was intereported the poor of Administrator or the reported furniture is Maintenance Super lot of rounds in the not aware of the coobserved the condinamed resident's rothe would not want stated at times, due furniture it was use nothing at all. 2. Resident # 57 was 8:15 AM. He stated had no problems we furniture. His Administrator was 3:06 PM. The Administrator was needed there were no avail Administrator stated werbalized by reside the added if drawer were not working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were with the Administrator stated working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working, reither him or the machines of the problems were not working.	erviewed. He stated he condition of furniture to the es Social Worker when staff issues to him. The roisor stated he did not make a facility and therefore he was indition of the furniture. He tion of the furniture in the boms at this time and stated the furniture in his home. He es to lack of replacement what was in the room or have as interviewed 12/15/16 at disince he had poor vision, he with the condition of the ssion MDS, dated 11/11/16, as cognitively intact. Was interviewed on 12/14/16 at inistrator stated furniture was dispassed on looking bad or if able parts for repairs. The dish had received no concerns the staff or family members. In the staff of family members are to dressers and nightstands are expected staff to report to contend to the resident's room tor. He acknowledged the gh shape and it was not	F 25:	3			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345316	B. WING		12/15/2016	
	NAME OF PROVIDER OR SUPPLIER SENIOR CITIZENS HOME			TREET ADDRESS, CITY, STATE, ZIP CODE 275 RUIN CREEK ROAD IENDERSON, NC 27536	,	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 253	up to the maintenar furniture was replaced. At 8:35 AM on 12/15. Supervisor was interported the poor or Administrator or the reported furniture is Maintenance Super lot of rounds in the not aware of the corobserved the condit named resident's rothe would not want to stated at times, due furniture it was use nothing at all. 3. The Annual MDS 10/28/16, indicated cognitively impaired the resident was into not want to use the furniture looked so In the Administrator was 3:06 PM. The Administrator was 3:06 PM. The Administrator stated verbalized by reside the added if drawers were not working, heither him or the mac Observations were with the Administrator.	housekeeper stated it was ace supervisor to decide if the sed. 5/16, the Maintenance serviewed. He stated he condition of furniture to the social Worker when staff sues to him. The visor stated he did not make a facility and therefore he was notition of the furniture. He cion of the furniture in the soms at this time and stated he furniture in his home. He to lack of replacement what was in the room or have 6 for Resident #65, dated the resident was moderately 1. On 12/15/16 at 8:15 AM, erviewed and stated he would furniture in his home since the	F 253			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED	
		345316	B. WING _			12/15/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	'	12/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 253	interviewed. She st facility where the da found, had the older She stated the furni at least a year. The up to the maintenar furniture was replaced. At 8:35 AM on 12/13 Supervisor was intereported the poor conditional control of the cond	5 AM, Housekeeper #1 was tated residents on that end of amaged furniture had been st furniture in the building. It ture had been in disrepair for the housekeeper stated it was not accessive to decide if the sed. 5/16, the Maintenance enviewed. He stated he condition of furniture to the social Worker when staff	F 2				
	46, who shared a rong Resident #45, who moderately cognitive stated he would like Resident #46, who cognitively intact on 12/7/16, that if he has furniture looked so the top of the nights. The Administrator was 3:06 PM. The Administrator was 100 PM.	had been assessed as ely impaired on 11/25/16, ethe furniture replaced. had been assessed as his quarterly MDS, dated ad been at home and his bad, he would have sanded stand and refinished it by now.					

AND DUAN OF CODDECTION INTERIOR NUMBER.		1 ' '	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED	
		345316	B. WING	 	12/	15/2016
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 253	Administrator stated verbalized by reside He added if drawers were not working, heither him or the ma Observations were with the Administrat furniture was in roug anything he would voon 12/15/16 at 8:25 interviewed. She st facility where the dafound, had the older She stated the furniture was replaced at least a year. The up to the maintenant furniture was replaced At 8:35 AM on 12/18 Supervisor was interported the poor condaministrator or the reported furniture is Maintenance Super lot of rounds in the finot aware of the corrobserved the conditionamed resident's round he would not want the stated at times, due furniture it was use	able parts for repairs. The I he had received no concerns ants, staff or family members. Is to dressers and nightstands are expected staff to report to an intenance supervisor. I had been shape and it was not want in his house. If AM, Housekeeper #1 was ated residents on that end of imaged furniture had been st furniture in the building. I ture had been in disrepair for the housekeeper stated it was not increase when	F 25	53		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3		ATE SURVEY DMPLETED
		345316	B. WING		,	12/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2275 RUIN CREEK ROAD HENDERSON, NC 27536		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 253	room. The nightstar holding the television areas of the veneer of missing. The drawer not open or close professional transfer of the Administrator was 3:06 PM. The Administrator stated there were no available Administrator stated verbalized by resider He added if drawers were not working, he either him or the main Observations were mith the Administrator furniture was in rough anything he would was On 12/15/16 at 8:25 interviewed. She stated the furniture at least a year. The fup to the maintenance furniture was replaced At 8:35 AM on 12/15. Supervisor was interviewed the poor con Administrator or the State of the control of rounds in the far not aware of the control of th	dition of the furniture in her and in the resident's room, and was observed to have large on the top of the nightstand ers of the nightstand would operly. It is interviewed on 12/14/16 at a sistrator stated furniture was pased on looking bad or if the parts for repairs. The the had received no concerns and the staff of family members, and to dressers and nightstands expected staff to report to antenance supervisor. The acknowledged the fine shape and it was not east in his house. AM, Housekeeper #1 was ted residents on that end of anged furniture had been a furniture in the building. The had been in disrepair for thousekeeper stated it was be supervisor to decide if the d. In the Maintenance wiewed. He stated he addition of furniture to the Social Worker when staff	F 25	53		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE COMP		
		345316	B. WING		12/	15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	, .=	.0.20.0
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253	named resident's roche would not want the stated at times, due furniture it was use woothing at all. 6. The Annual MDS 9/9/16, indicated the term memory impair cognitive skills for day of the term memory impair cognitive skills for day as observed as breakfast. The NA shis family member, want the furniture in had been in poor repadded he had report the furniture out of her had the furniture out of her had the furniture out of her had the mandal and th	for Resident #11, dated resident had short and long ment with severely impaired aily decision making. AM, Nursing Assistant (NA) sisting Resident #11 with her stated Resident #11 with her stated Resident #11 was also NA #2 added he would not his room; adding the furniture pair for at least 6 months. He ed the condition of the top of maintenance man. NA #2 would have thrown the ouse a long time ago. As interviewed on 12/14/16 at histrator stated furniture was based on looking bad or if ble parts for repairs. The he had received no concerns ints, staff or family members. To dressers and nightstands a expected staff to report to intenance supervisor. In ade of the resident's room or. He acknowledged the h shape and it was not	F 25	3		

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		345316	B. WING	 	12	2/15/2016
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	She stated the furnitat least a year. The up to the maintenant furniture was replace. At 8:35 AM on 12/18 Supervisor was intereported the poor condition of the reported furniture is Maintenance Superlot of rounds in the finot aware of the condition of the condition of the condition of the would not want the stated at times, due furniture it was used furniture in the furniture in her maintenance superlock of the furniture in her mainten	st furniture in the building. ture had been in disrepair for housekeeper stated it was use supervisor to decide if the ed. 5/16, the Maintenance rviewed. He stated he ondition of furniture to the Social Worker when staff sues to him. The visor stated he did not make a facility and therefore he was ndition of the furniture. He ion of the furniture in the oms at this time and stated the furniture in his home. He to lack of replacement what was in the room or have d been assessed on her 0/21/16 with short and long ment with moderately skills for daily decision making. comment on the condition of oom which included furniture	F 25	53		

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345316 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345316	B. WING		12/15/2016	
	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536		,	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 253	furniture was in rou anything he would On 12/15/16 at 8:2 interviewed. She s facility where the dround, had the olded She stated the furniat least a year. The up to the maintenant furniture was replaced to the poor of the control of the control of the control of the control of the would not want stated at times, due furniture it was use nothing at all. 8. Resident #56's indicated the resident term memory impaired cognitive Resident #56 was she felt about the volaries would not here.	tor. He acknowledged the 1gh shape and it was not 1gh shape and it was 1gh shape and it was 1gh shape and 1gh sh	F 253			
	3:06 PM. The Adm	ninistrator stated furniture was d based on looking bad or if				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED
		345316	B. WING _			12/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	·	
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F 253	Administrator stated verbalized by resided He added if drawers were not working, he either him or the mai Observations were no with the Administrator furniture was in roug anything he would working he added he working he work	ble parts for repairs. The he had received no concerns hts, staff or family members. to dressers and nightstands expected staff to report to intended of the resident's room or. He acknowledged the h shape and it was not ant in his house. AM, Housekeeper #1 was ated residents on that end of maged furniture had been t furniture in the building. ure had been in disrepair for housekeeper stated it was be supervisor to decide if the ed. /16, the Maintenance viewed. He stated he indition of furniture to the Social Worker when staff	F 2	53		
F 371 SS=E	named resident's roo he would not want the stated at times, due furniture it was use ve nothing at all.		F3	71		1/12/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED	
		345316	B. WING		12/	15/2016	
	ROVIDER OR SUPPLIER		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1275 RUIN CREEK ROAD HENDERSON, NC 27536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food	F	371			
	by: Based on observation interviews the facility and stove top free of opened food items straintain the dish manabove 180 degrees a member from touching bare hands. 1) An observation of the one of 12/12/16 at 9:30 And build up around the boven beside the stove burnt debris along the oven was ½ inch thic stated the stove and cleaned to remove the when the oven was can be calculated in aluminum foil was the reach in refrigeration present. The Dietary item was ham left from stated the food item is date on it. 3) An observation of the one 12/12/16 at 10:00	the surface of the gas stove all revealed black debris urners. The convection e also had a buildup of black to bottom. The debris in the k. The Dietary Manager the oven needed to be to buildup. He did not state leaned. 5 AM a food item wrapped be beserved on the top shelf of tor. It did not have a label Manager stated the food m a previous meal. He should have a label with a state less washing machine.			Dietary Staff has been inserviced on the process and policy for marking and data all foods and the use by dates on 12-16-16. Dietary staff will be inserviced monthly and the topics will be dish machine, marking/dating and cleaning. Dissolvable marking labels were ordered on 12-13-16 and received on 12-15-16. The Dietary Manager and or Head Codwill monitor the proper food storage protocols, including labeling for dates, used by and pull for thawing utilizing the Marking and Dating Foods Audit form monitoring tool daily times 4 weeks, then 3 times a week for 4 weeks, then week times 4 weeks then monthly times 12 months to ensure proper storage has occurred. Opportunities will be correct daily by the Dietary Manager as identificating these audits. The District Dietar Manager will monitor the proper food storage protocols, including labeling for dates, used by and pull for thawing we times 6 weeks then 2 times per month 4 weeks, then monthly for 12 months. In negative findings from the audits will be forwarded to the next quarterly OA	ting ed ed S. bk ee en ely ed ry r ekly for Any	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			12/15/2016	
NAME OF PROVIDER OR SUPPLIER SENIOR CITIZENS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2275 RUIN CREEK ROAD HENDERSON, NC 27536	'		
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F 371	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIA			

Facility ID: 923449

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345316	B. WING _			12/15/2016	
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F 371	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F3	PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPI			