DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM							M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	345001		B. WING			C		
NAME OF PROVIDER OR SUPPLIER				STREE	TADDRESS, CITY, STATE, ZIP CODE	03/	22/2017	
					V PETTIGREW STREET			
HILLCRES	ST CONVALESCENT CE	NTER			IAM, NC 27705			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 371 SS=E	483.60(i)(1)-(3) FOOI STORE/PREPARE/S	ERVE - SANITARY	F 37	71			4/19/17	
		rom sources approved or ry by federal, state or local						
	(i) This may include for from local producers, and local laws or regu							
	(ii) This provision doe facilities from using p gardens, subject to co safe growing and foo							
		es not preclude residents s not procured by the facility.						
		, distribute and serve food in essional standards for food						
	foods brought to resid visitors to ensure safe handling, and consum	egarding use and storage of dents by family and other e and sanitary storage, nption. T is not met as evidenced						
	Based on observatio facility failed to label a food items, failed to d their use-by date and	ns and staff interviews the and date previously opened liscard left over foods past failed to store previously ts appropriately which were		de of	his plan of correction constitutes my ritten allegation of compliance for the eficiencies cited. However, submission the Plan of Correction is not an dmission that a deficiency exists or the	on		
	stored in one of two v one kitchen walk-in fr reach-in refrigerators			C re	ne was cited correctly. This Plan of orrection is submitted to meet quirements established by state and deral law.			
	The findings included	:						
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE	
	cally Signed						04/14/2017	

Electronically Signed

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.

PRINTED: 04/27/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUILDING	B	CO	COMPLETED	
	245224				С		
345001		B. WING			3/22/2017		
NAME OF PROVIDER OR SUPPLIER HILLCREST CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
				1417 W PETTIGREW STREET DURHAM, NC 27705			
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	(X5) COMPLETION DATE		
F 371	Continued From page	e 1	F 37	1			
1 371			F 37		lillereet		
		foods stored in the kitchen's n 03/20/2017 at 09:20 AM		[F 371] It is the policy of I Convalescent Center (Hill			
	revealed the following			with the food safety guide			
				in the FDA Food Code, C			
	a. A container of prur	nes which was labeled and		North Carolina Health De	partment. This		
		container of diced green		Statement of Deficiency of			
	peppers dated 3/16/1	7.		food that, per our policy, v			
	During on interview	with Cook #1 on 02/22/2017		been served to residents,			
		vith Cook #1 on 03/22/2017 1 indicated that any food		attests and the lack of doo makes clear that any othe			
		-made or canned and		this regulation are not und			
		ainer, the label on this food					
		oduct name, current/today's		Immediately after the insp	ection, the		
	date and a use by da	te of 3- 4 days. Cook #1		Assistant Administrator co	onducted a		
		ould be discarded after the		thorough survey of the kit			
	use by date.			were no other concerns n	oted.		
		s "Food Discarding Policy"		Those items in question w	vere immediately		
		ated opened food items will		discarded per our policy,			
	be discarded within s	even days of opened date.		have been either that sam	•		
	h. Thusa transport	an and have containing		deep cleaning day 48 hou	irs after the		
	lettuce and two open	opened bags containing		inspection.			
		at were not dated when		Since these items at issue	e were not		
	-	nager indicated that the		delivered to any resident			
		beled with date when		residents were identified b	by the survey		
	opened.			team as voicing complain			
				individual corrective action	n could be		
	03/20/2017 at 09:35	vith the Dietary Manager on AM, Dietary Manager		accomplished.			
		duce in the refrigerator when		It is important to note that			
	opened was used wit	hin 7 days of opening.		recent County Departmen			
	2 An Observation of	the kitchen's walk in freezer		reports researched conclu			
	on 03/20/2017 at 09:	the kitchen's walk-in freezer		concerns, and both of the Health Specialists who co			
	following:			surveys noted no concern			
	a. A previously opene	ed bag of French fries that		The Dietary Department v	vas in-serviced		
		opened. A plastic bag with a		on the results of the surve			

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

Facility ID: 943259

If continuation sheet Page 2 of 4

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/27/2017 RM APPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345001		B. WING			C 03/22/2017			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HILLCRES	HILLCREST CONVALESCENT CENTER			1417 W PETTIGREW STREET				
				D	DURHAM, NC 27705			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 371	Continued From page 2 sliced meat patty with no label or date. Interview with the Dietary manager, at the time of the observation revealed the sliced meat was an uncooked veal patty. b. Observations of the kitchen's walk-in freezer revealed a large plastic bin on top of the cart. Observations revealed the large plastic bin contained the following meat products which were not labeled or dated and had been removed from their original containers/boxes. A previously opened bag of raw shrimp, a bag of previously opened meat patties, previously opened bag of raw meat, a bag of pepperoni which was previously opened, and a previously opened bag of breaded meat patties. Interview with the Dietary manager, at the time of the observation, revealed the breaded meat patties were chicken strips. During an interview with the Dietary Manager on 03/20/2017 at 09:35 AM, Dietary Manager indicated that the meat products were used in past meals and the leftover products should have		F	371	of the following plan of correction was included in the in-service. Staff have also been in-serviced on the importance of properly labeling and sealing stored items, and not simply rolling down the tops of the bags. Weekly, unannounced inspections by Registered Dietitian or her designee at taking place using an existing, but rev Hazard Surveillance form. The goal of this exercise is to continue a weekly inspection until three consecutive inspections indicate no issues of con- and then to maintain this process on monthly unannounced basis. This pla- correction will be reviewed in the nex- regularly scheduled Quality Assurance meeting and the dates are subject to vote of this interdisciplinary committer	ce. serviced on the labeling and nd not simply f the bags. inspections by the her designee are existing, but revised rm. The goal of inue a weekly onsecutive o issues of concern his process on a basis. This plan of wed in the next uality Assurance are subject to the		
	3. An observation of trefrigerator on 03/20/ container of leftover of During an interview w 03/20/2017 at 09:35 / indicated that the left within 48 hours and the should have been dise During an interview w	17 at 09:30 AM revealed a green beans dated 3/11/17. with the Dietary Manager on AM, the Dietary Manager overs were usually used the leftover green beans						

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

Facility ID: 943259

If continuation sheet Page 3 of 4

PRINTED: 04/27/2017

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/27/2017 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345001		B. WING			_	C 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
HILLCRES	ST CONVALESCENT CEN	ITER			1417 W PETTIGREW STREE DURHAM, NC 27705	ĒT		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 371	leftover food were sto discarded after the us Review of the Storing 08/03/04 read in part: up to three days with day one. During an interview w 03/22/2017 at 1:58 Pl leftover prepared food and used within 5 to 7 preparation. She indic were discarded after was her expectation t and label foods accur that it was her expect	by date. She indicated that bred for 3-4 days and	F	371				

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

Facility ID: 943259

If continuation sheet Page 4 of 4