STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	;
		345478	B. WING		07/0	1/2020
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT WOODS NURSING AND REHABILITATION CENTER				604 LUCAS ROAD DUNN, NC 28334		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETIO
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE AF		DATE
E 000	Initial Comments		E 00	0		
	was conducted on 0 found in compliance related to E-0024 (b	OVID-19 Focused Survey 7/01/20. The facility was with 42 CFR §483.73)(6), Subpart-B-Requirements Facilities. Event ID#				
F 000	INITIAL COMMENT	S	F 00	ט ער גער גער גער גער גער גער גער גער גער ג		
	Control and Compla conducted on 07/01, compliance with 42 regulations and has Centers for Disease	OVID-19 Focused Infection int Investigation Survey was /20. The facility was found in CFR §483.80 infection control implemented the CMS and Control and Prevention d practices to prepare for D #Z0M811.				
	1 of 1 complaint alle Event ID #Z0M811.	gations was unsubstantiated.				
F 812 SS=F	Food Procurement, CFR(s): 483.60(i)(1)	Store/Prepare/Serve-Sanitary (2)	F 81	2		7/16/20
	§483.60(i) Food safe The facility must -	ety requirements.				
	approved or conside state or local author (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using gardens, subject to	food items obtained directly s, subject to applicable State gulations. es not prohibit or prevent produce grown in facility compliance with applicable				
	(iii) This provision do	od-handling practices. bes not preclude residents ds not procured by the facility.				

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.

07/13/2020

	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 07/29/2020 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		345478	B. WING			07/01/2020	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HARNETT	WOODS NURSING AND	REHABILITATION CENTER			04 LUCAS ROAD JUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From page 1		F	812			
PREFIX TAG (EACH DEFICIENCY M REGULATORY OR LSG F 812 Continued From page 1 §483.60(i)(2) - Store, pr serve food in accordance standards for food served This REQUIREMENT i by: Based on observation a facility failed to keep a f blowing toward the steat preparation area of the included: During an observation of at 11:38 AM a large floot blowing into the kitchen about ten feet in front o The face, blades, and b coated with a thick laye of dust. At this time the stated she thought envi- responsible for cleaning couple of weeks, but sh unsure about the last tir cleaned. During an interview with Environmental Services she stated environment responsible for keeping kitchen clean. She com department would be m fans. During a follow-up obse 07/01/20 at 1:18 PM the oscillating and blowing was located about ten fe table unit. The face, blades		nice with professional rvice safety. is not met as evidenced in and staff interview the a floor fan clean which was eam table and into the food he kitchen. Findings in of the kitchen on 07/01/20 oor fan was oscillating and en. The fan was located on the steam table unit. I back of the fan were yer of dirt and long strands he Dietary Manager (DM) invironmental services was ing kitchen fans every she reported she was time this particular fan was			Harnett Woods acknowledges receip the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of resider The Plan of Correction is submitted as written allegation of compliance. Harnett Woods's response to this Statement of Deficiencies does not denote agreement with the Statement Deficiencies nor does it constitute an admission that any deficiency is accur Further, Harnett Woods reserves the to refute any of the deficiencies on thi Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F812 On 7/1/2020 the dietary manager wipe down the identified fan. On 7/1/2020 the maintenance director removed the identified fan from the kitchen to break down and perform functe cleaning. On 7/2/2020 the dietary manager add	e Its. s a rate. right s ed	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345478		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		B. WING		C 07/01/202	0	
NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP 604 LUCAS ROAD DUNN, NC 28334	•	
(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	TION SHOULD BE COMPL THE APPROPRIATE DA	ETION
F 812	At this time the DM st fan as best as she co Manager (MM) could clean it better. The D to keep all kitchen far blow dust and dirt into preparation surfaces, cross-contamination. During an interview w 07/01/20 at 2:52 PM department was resp mechanical part of the condition and clean. were not on his clean he commented he tho these fans be cleaned prepared would not b stated he thought the mainly in the dish ma	tated she wiped down the build until the Maintenance break the fan down and DM reported it was important ns clean so they would not o food and onto food causing with the facility's MM on he stated the maintenance onsible only for keeping the	F 81	 2 fan cleaning to the Food S schedule. An in-service with 100% of maintenance, central suphousekeeping staff was in 7/6/2020 on topics of ensequipment is clean, to incregulation 483.60. The incompleted 7/10/2020. The maintenance director supervisor, or central supconduct an audit of the kit week x4 weeks, then 3x p weeks utilizing the food set schedule audit tool to ensecteanliness. Any issue with be immediately addressed manager or lead cook. The Administrator will revise the food service cleaning tools weekly x 6 weeks for and to ensure all areas of been addressed. The Executive QAPI commonthly and review the reservice cleaning schedule address any issues, concord trends and to make change to include continued frequemonitoring x 3 months. 	of dietary, bly, and bitiated on uring all kitchen lude fans, and service was c, housekeeping ply clerk will cchen fan 5x per wer week x2 ervice cleaning ure its h cleanliness will d by the dietary ew and initial schedule audit r compliance concern have mittee will meet esults of the food e audit tools and erns and/or ges as needed,	

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