

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

PRINTED: 04/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345394</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/07/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BROOK STONE LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573</b>
--	---

(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 -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews the facility failed to maintain kitchen equipment in a clean and sanitary condition by failing to clean one of two kitchen fans that was observed dirty. The findings included:</p> <p>During a follow up kitchen visit with the Certified Dietary Manager (CDM) on 4/5/16 at 8:49 AM a small portable fan was observed on the end of the dish machine drying shelf. The face of the fan cage was observed to have dark gray dust balls 1/8 inch diameter. The fan was observed to be on and blowing towards the clean, wet dishes that were pulled from the dish machine.</p> <p>In an interview with the CDM on 4/5/16 at 8:52 AM he stated that the fans were not on any cleaning schedule that staff cleaned on an as needed basis. The CDM then removed the fan from the kitchen.</p> <p>In an interview with the Administrator on 4/7/16 at 11:48 AM she stated that she expected the kitchen staff to remove the fan and be In-serviced immediately.</p>	F 371	<p>1) Re-inservice all dietary staff on having fan on line</p> <p>2) Clean all fans on Wednesday on 2nd shift</p> <p>3) Dietary manager to monitor and keep weekly record</p> <p>4) Evaluate compliance through monthly QA x 3months</p>	4/18/16
---------------	--	-------	--	---------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>04/18/2016</b>
--	-------	--------------------------------

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.