STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #1ENG11.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair 7 resident room doors with broken and splintered laminate and wood on the lower edges of the doors (Room #201, #202, #302, #304, #307, #311 and #315) on 2 of 5 skilled resident hallways (200 and 300 halls), failed to repair 4 bathroom doors with broken and splintered laminate (Rooms #201, #209, #302 and #314) on 2 of 5 skilled resident hallways (200 and 300 halls) and failed to repair the day room door on the 200 hall with broken and splintered laminate on the middle and lower edges of the door) on 1 of 5 skilled resident hallways. The findings included: 1. a. Observations of Room #201 on 12/12/16 at 4:12 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and were rough to touch. Observations of Room #201 on 12/14/16 at 11:53 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and were rough to	F 253	F83.15 The facility corrected the deficient practice by repairing the identified doors to rooms 201,202,302,304,307,311 &315 in addition to the bathroom doors in rooms 201,209,302 and 314 along with the dayroom door on the 200 hall. Completion date: 12/16/2016. In efforts to assure that others were not impacted the Project Manager, along with maintenance department personnel inspected all facility doors on 12/19/2016, identifying ones in need of repair. Repairs of other identified doors were completed on 12/23/2016. Staff were reeducated in regards to the facility work order process and the expectation of reporting potential hazards, including broken and splintered doors, immediately. This re-education was completed on 1/12/2017. A door monitoring audit tool will be utilized by a member of the maintenance team to inspect 25% of all doors throughout the	1/12/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/12/2017

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F 253	Continued From page 1 touch. Observations of Room #201 on 12/15/16 at 9:51 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and were rough to touch. b. Observations of Room #202 on 12/13/16 at 11:18 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and had large splinters on the edges of the hinge side of the door. Observations of Room #202 on 12/14/16 at 11:55 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and had large splinters on the edges of the hinge side of the door. Observations of Room #202 on 12/15/16 at 9:52 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door and had large splinters on the edges of the hinge side of the door. c. Observations of Room #302 on 12/12/16 at 3:25 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to the touch. Observations of Room #302 on 12/14/16 at 11:44 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to the touch. Observations of Room #302 on 12/15/16 at 9:59 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to	F 253	facility. This audit process will be under the direction and supervision of the facility Project Manager. Any identified damage will be immediately scheduled for repair. This audit tool will be completed monthly for four months. The first review by the QA committee was on 1/11/2017 with no current concerns identified. The results of the door audit tool will be reported monthly to the QA committee through the QAPI process. The QA committee will evaluate the effectiveness of the intervention and will recommend changes if necessary. The first review by the QA committee was on 1/11/2017 with no current concerns identified.	

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F 253	Continued From page 2	F 253		

the touch.

d. Observations of Room #304 on 12/12/16 at 3:26 PM revealed the door of the resident's room had broken and splintered laminate on the hinge side edges of the bottom half of the door with rough edges to the touch.
Observations of Room #304 on 12/14/16 at 11:45 AM revealed the door of the resident's room had broken and splintered laminate on the hinge side edges of the bottom half of the door with rough edges to the touch.
Observations of Room #304 on 12/15/16 at 10:00 AM revealed the door of the resident's room had broken and splintered laminate on the hinge side edges of the bottom half of the door with rough edges to the touch.

e. Observations of Room #307 on 12/12/16 at 3:27 PM revealed the door of the resident's room had broken and splintered laminate on the of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.
Observations of Room #307 on 12/14/16 at 11:46 AM revealed the door of the resident's room had broken and splintered laminate on the of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.
Observations of Room #307 on 12/15/16 at 10:02 AM revealed the door of the resident's room had broken and splintered laminate on the of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.

f. Observations of Room #311 on 12/12/16 at 3:30 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations of Room #311 on 12/14/16 at 11:47

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F 253	Continued From page 3	F 253		

AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations of Room #311 on 12/15/16 at 10:01 AM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.

g. Observations of Room #315 on 12/12/16 at 4:15 PM revealed the door of the resident's room had broken and splintered laminate on the hinge side of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.
Observations of Room #315 on 12/14/16 at 11:48 AM revealed the door of the resident's room had broken and splintered laminate on the hinge side of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.
Observations of Room #315 on 12/15/16 at 10:05 AM revealed the door of the resident's room had broken and splintered laminate on the hinge side of the bottom half of the door with sharp edges to the touch where laminate and wood were broken out.

2. a. Observations of Room #201 on 12/12/16 at 4:12 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch.
Observations of Room #201 on 12/14/16 at 11:53 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch.
Observations of Room #201 on 12/15/16 at 9:51 AM revealed the bathroom door inside the

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	345401	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 253	Continued From page 4	F 253		

resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch.

b. Observations of Room #209 on 12/12/16 at 4:02 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch. Observations of Room #209 on 12/14/16 at 11:58 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch. Observations of Room #209 on 12/15/16 at 9:55 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with edges that were rough to touch.

c. Observations of Room #302 on 12/12/16 at 3:25 PM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to the touch. Observations of Room #302 on 12/14/16 at 11:44 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to the touch. Observations of Room #302 on 12/15/16 at 9:59 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the door with rough edges to the touch.

d. Observations of Room #314 on 12/12/16 at 4:13 PM revealed the bathroom door inside the resident's room had broken and splintered

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F 253	Continued From page 5	F 253		

laminate on the edges of the bottom half of the inside of the door with rough edges to the touch. Observations of Room #314 on 12/14/16 at 11:42 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the inside of the door with rough edges to the touch. Observations of Room #314 on 12/15/16 at 10:00 AM revealed the bathroom door inside the resident's room had broken and splintered laminate on the edges of the bottom half of the inside of the door with rough edges to the touch.

3. Observations of the day room door on the 200 hall on 12/13/16 at 10:40 AM revealed broken and splintered laminate below the door handle on the edges of the door that was rough to the touch. Observations of the day room door on the 200 hall on 12/14/16 at 11:43 AM revealed broken and splintered laminate below the door handle on the edges of the door that was rough to the touch. Observations of the day room door on the 200 hall on 12/15/16 at 10:07 AM revealed broken and splintered laminate below the door handle on edges of the door that was rough to the touch.

During an interview and environmental tour on 12/15/16 at 1:55 PM with the Project Manager who was also in charge of the Maintenance Department he confirmed the facility utilized a work order system for any repairs that needed to be made. He explained they utilized a paper system and the work orders were kept on a clipboard at each nurse's station and at the reception desk. He further explained any staff could fill out work orders and they were also available to the public to write down any repairs they felt needed to be made. He stated work orders comprised a wide variety of issues and

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	345401	A. BUILDING _____ B. WING _____	C 12/15/2016

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F 253	Continued From page 6	F 253		

maintenance staff collected the work orders off the clipboards as they made rounds throughout the day. He further stated he preferred for staff to document needed repairs on the work orders rather than reporting them verbally to maintenance staff so they would have a record of them. He explained he went over the process to complete work orders during the first day of orientation for new employees and he instructed staff to write down anything they saw that they felt needed to be repaired but if it was a safety issue staff were expected to tell their supervisor immediately. He explained there were 3 maintenance staff that covered the skilled nursing units and they were on call 24 hours a day, 7 days a week and they were expected to immediately address any safety issues staff reported. He confirmed there was damage to doors where laminate had been broken out or splintered during the environmental tour. He stated housekeeping staff did routine staining on doors as needed and maintenance staff assisted. He further stated it was his expectation for all staff to report damage to doors to the maintenance staff through the work order system. He verified he had not received any work orders related to damage of doors.

During an interview on 12/15/16 at 2:08 PM with the Chief Executive Officer (CEO) who had also been present during the environmental tour she stated housekeeping staff were responsible for putting stain on doors. She explained they had a container of stain and went from room to room to stain areas of wood as needed. She stated it was her expectation for housekeeping staff to report to the Maintenance Department if they saw splintered or damaged laminate or wood on doors and maintenance staff should repair the doors.

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F 253	Continued From page 7 During an interview on 12/15/16 at 4:22 PM with the Administrator he stated had been made aware of the damaged doors observed during the environmental tour by the CEO and Project Manager who was in charge of the maintenance department. He stated it was his expectation for staff to report any damage that could cause injury to a resident to the maintenance staff immediately. He further stated it was his expectation for the maintenance staff to repair the damage to doors.	F 253		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to monitor the internal temperature of cold fruit to ensure it was served at a safe temperature below 41 degrees Fahrenheit, ensure expired food was not stored for use in 1 of 3 nourishment refrigerators, monitor freezer temperature in 1 of 3 nourishment freezers and have a system for monitoring thawed fortified supplements within the manufacturer's recommended use by date.	F 371	F483.35 1. (a). The facility corrected the impact of the deficient practice on 12/14/2016 by completing the following actions. The cantaloupe was pulled from the service line at a temp of 41°. The pureed fruit cocktail presented with a temp of 66.7° and was immediately pulled from delivery and removed from the service area. Completion date 12/14/2016	1/11/17

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	345401	A. BUILDING _____ B. WING _____	C 12/15/2016

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WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 371	Continued From page 8 The findings included: 1 a. On 12/14/16 at 11:30 AM observations were made of the lunch meal service. The Food Service Director was present for the observations. The lunch menu included cut cantaloupe for dessert and pureed fruit cocktail for dessert. On 12/14/16 at 11:42 AM the cook used a digital thermometer to check the internal temperature of food items for the lunch meal. The cook did not check the temperature of the cut cantaloupe or the pureed fruit cocktail. On 12/14/16 at 12:06 PM the cook began serving cut cantaloupe and pureed fruit cocktail for residents' lunches. Cut cantaloupe and pureed fruit cocktail were plated, placed on food carts and sent to the halls for delivery. On 12/14/16 at 12:18 PM when prompted the internal temperature of the cantaloupe was checked using a digital thermometer by the Registered Dietitian. The temperature of the cantaloupe was 41 degrees Fahrenheit. The internal temperature of the pureed fruit cocktail was checked and noted to be 66.7 degrees Fahrenheit. The facility's Registered Dietitian (RD) pulled the cantaloupe and pureed fruit cocktail from the tray line. On 12/14/16 at 12:25 PM the cook was interviewed and reported he did not check the temperature of the cantaloupe because the cantaloupe was being cut when he was taking temperature of food items. The RD was interviewed at the same time and stated the usual	F 371	(b). Milkshakes found partially thawed and not labeled with thaw or expiration dates were discarded immediately. Completion date 12/12/2016 (c). the freezer temperature in the 400/500 hall nourishment room refrigerator was identified as having no recent recorded temps and no thermometer was in place on 12/12/2016. The food in the freezer was discarded, a thermometer was placed, and a corrected monitoring log indicating separate freezer and refrigerator temps was put in place immediately. On revisit the freezer temp was found within acceptable range. Completion date 12/12/2016 (d). On 12/12/2016 the expired soymilk found in the nourishment room refrigerator was removed and discarded immediately. Completion date 12/12/2016 2. (a). During the survey process, fruit identified at temps outside of acceptable range were removed from service for all residents. No resident received or consumed fruit above acceptable range. All staff present on 12/14/2016 were immediately educated regarding acceptable temperature levels during food service and all kitchen staff received this training prior to 12/16/2016. (b). During the survey process, all nutritional milkshakes found thawed with no identifiable thaw or expiration dates were removed, preventing them from potentially being served to all residents. All staff present on 12/12/2016 were immediately educated on proper thawing and labeling protocols for shakes, and all	

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WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 371	Continued From page 9 protocol was for the cook's assistant to check the temperature of food items before tray line meal service but offered no explanation for the change in protocol. The RD stated the temperature of the fruit items should have been checked prior to meal service. On 12/15/16 at 1:41 PM the Food Service Director (FSD) was interviewed and explained the dessert was prepared too late not allowing enough time to cool the cantaloupe and pureed fruit cocktail. He added his expectation was that all cold food items were to be served below 41 degrees Fahrenheit. b. On 12/12/16 at 9:54 AM observations were made of the facility's kitchen with the Food Service Director (FSD). During the observations 4 boxes of thawed nutritional shakes were stored in the walk-in cooler. The nutritional shakes were marked with manufacturer's recommendations that cartons were only good for consumption 14 days once thawed. The FSD was interviewed about the boxes of thawed nutritional shakes and stated the box and/or cartons should be dated to monitor nutritional shakes for 14 days. The FSD offered no explanation why 4 boxes of thawed nutritional shakes stored ready for use were not dated or labeled with thaw date and/or use by date. The FSD was not aware of when the shakes were thawed or when they should be discarded. On 12/12/16 at 10:07 AM 8 cartons of thawed nutritional shakes were stored for use in the facility's remote kitchen refrigerator. The cartons were not labeled and/or dated with a use by date. The FSD was present for the observations and	F 371	kitchen staff received this training prior to 12/16/2016. (c). Ice cream and other items found in the untempt 400/500 hall nourishment room had the potential to affect all residents. Upon discovery on 12/12/2016 all items in the affected freezer were discarded immediately. No resident consumed these products. Freezer temperatures recorded upon placement of thermometer were within acceptable range. All staff present on 12/14/2016 were immediately educated regarding acceptable freezer temperatures and continuous monitoring for compliance. All kitchen staff received training prior to 12/16/2016. (d). The presence of the expired soymilk had the potential to affect residents. It was discarded on 12/12/2016 before being served to any resident. All staff present on 12/12/2016 were immediately educated regarding the correct procedures for checking each nourishment room at least daily for out of date or expiring products and discarding any found immediately. All kitchen staff received training prior to 12/16/2016. 3(a). The Food Service Director on 12/14/2016 reviewed systemic procedures which could impact staff's ability to assure prepared food temperatures are received and recorded accurately. New prep/pull guidelines were implemented and discussed with kitchen staff on 12/16/2016. A new Manager's Daily Check List was implemented on 12/14/2016 to include a daily manger's check of recorded tray line temperatures.	

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F 371	Continued From page 10 removed the cartons. The FSD stated a cook's assistant was responsible for daily checks to remove any items not labeled and/or dated. c. On 12/12/16 at 10:18 AM observations were made of the facility's nourishment rooms. The 400/500 hall nourishment pantry's freezer was observed and noted to have ice cream stored for resident use. Items stored in the freezer for resident use included an ice cream sandwich and 3 cartons of ice cream; the items were noted to be soft to touch. Additional observations of the freezer revealed there was no thermometer to monitor the unit's internal temperature. The FSD reported the temperature was monitored daily by nutrition services' staff. Review of the monthly temperature log for the refrigerator/freezer unit revealed the temperature of the freezer had not been monitored for the month of December. The FSD stated he was unaware the temperature was not being monitored for the freezer and stated it was an oversight. d. On 12/12/16 at 10:20 AM additional observations of the 400/500 hall nourishment pantry's refrigerator were made that revealed a ½ gallon of soymilk stamped with an expiration date of 11/18/16 was stored for use. The FSD was present for the observation, removed the item and stated the expired ½ gallon of soymilk should have been removed. The FSD explained a staff member was expected to check all food stored in refrigerators daily to remove expired items.	F 371	This will be reviewed and signed by the FSD at a minimum of 3 times weekly for 6 weeks to assure compliance. Managers have been instructed to remove any food product not presenting at correct temperature from the tray area immediately and discard. On 1/11/2017 check lists reviewed by the Administrator found 100% compliance. (b). The Food Service Director developed and educated staff on a thaw procedure system for milkshakes on 12/14/2016. Labels for all mighty shakes placed in the refrigerator were printed. Labels consist of thaw date and use by date. Managers are checking milkshake labels daily on Manager's daily check list. These will be reviewed by the FSD a minimum of 3 times weekly for 6 weeks to assure compliance. On 1/11/2017, check lists reviewed by the Administrator found 100% compliance. (c). A new freezer temp log was placed on all freezers/refrigerators on 12/14/2016. Temp log review has been added to the daily managers check list. These will be reviewed by the FSD a minimum of 3 times weekly for 6 weeks to assure compliance. On 1/11/2017, check lists reviewed by the Administrator found 100% compliance. (d). All freezers/refrigerators on 12/14/2016 were inspected for outdated food items. No other instances were identified. Inspection of refrigerator/freezers for out of date items was added to the manager's daily checklist. These will be reviewed by the FSD a minimum of 3 times weekly for 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345401	A. BUILDING _____ B. WING _____	C 12/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES SENIOR VILLAGE	204 OLD BRICKYARD ROAD NORTH WILKESBORO, NC 28659

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F 371	Continued From page 11	F 371	weeks to assure compliance. On 1/11/2017, check lists reviewed by the Administrator found 100% compliance. 4(a). The facility plans to continue to monitor the food temperatures via the QAPI process. The Food Service Director will review daily manger checklist 3 times weekly for 6 weeks. In addition, he will perform random audits 2 times per week for 4 weeks and 4 times monthly for 3 months following the initial 4-week period. He will report discrepancies, if identified, to the QA committee monthly. The QA committee will review monthly findings evaluating the effectiveness of this monitoring process and will recommend and implement changes if deemed necessary. The first review by the QA committee was on 1/11/2017 with no current concerns identified. (b). The facility plans to continue to monitor nutritional shake labeling protocol through the QAPI process. In addition to a checklist review, the Food Service Director will perform random audits 1 times per week for 4 weeks and 2 times monthly for 3 months following the initial 4-week period. The FSD will report his finding monthly to the QA committee who will evaluate the effectiveness of this intervention and recommend changes if necessary. The first review by the QA committee was on 1/11/2017 with no current concerns identified. (C). The facility plans to continue to monitor the refrigerator/freezer temperature monitoring process through	

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F 371	Continued From page 12	F 371	QAPI. In addition to monitoring the implemented daily manager's checklist, the Food Service Director will conduct inspections of each nourishment room refrigerator/freezer 1 times weekly for 4 weeks and 2 times monthly for 3 months following the initial 4-week period ensuring required thermometers are in place, temperatures are within acceptable range and accurate up to date logs are in place and maintained. The FSD will report his finding monthly to the QA committee who will evaluate the effectiveness of this intervention and recommend changes if necessary. The first review by the QA committee was on 1/11/2017 with no current concerns identified. (d). The facility plans to continue to monitor its intervention for out of date food items through its QAPI process. In addition to monitoring the manager's daily checklist, the Food Service Director will conduct inspections of nourishment room refrigerators 1 time weekly for 4 weeks and 2 times monthly for three months following the initial 4-week period. The FSD will report his finding monthly to the QA committee who will evaluate the effectiveness of this intervention and recommend changes if necessary. The first review by the QA committee was on 1/11/2017 with no current concerns identified.	