STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255342	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MS CARE CENTER OF RALEIGH	309 MAGNOLIA DR/HIGHWAY 35 SOUTH RALEIGH, MS 39153

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and facility policy review it was determined the facility failed to serve food in a safe and sanitary condition to prevent the possible spread of infection and contamination, during one (1) of two (2) kitchen observation. The identified concerns placed all residents receiving food/nourishment from the kitchen at risk for foodborne illnesses. Findings include: A review of the facility's Food Service Operational Standards For Purchasing, Cooking and Storage policy, undated, revealed: This facility stores, prepares, distributes, and serves food under sanitary conditions to prevent the spread of food borne illness and to reduce those practices that result in food contamination and compromised food safety. Avoid overloading cooking surfaces. Wash, rinse, and sanitize all equipment and utensils before and after each use. Review of the facility's Hand Washing Policy, undated, revealed, handwashing would be done by all staff throughout their shift, and to reduce the transmission of organisms from resident to resident, and from the staff to the resident. A review of the facility's Cleaning and Sanitizing Equipment policy, undated, revealed: All equipment is kept clean and food contact surfaces are cleaned and sanitized. Remove food and soil from under and around the equipment. Remove detachable parts and manually wash, rinse, and sanitize or run through dish machine. Allow to air dry. Wash and rinse fixed food contact surfaces, then wipe or spray with a chemical sanitizing solution. Review of the facility's training record, titled Safety and Dietary Procedures, dated 02/26/2020, revealed the dietary staff was in-serviced on Food Storage, Food Preparation, Food Service/Sanitation, Safety, Food Temperature and other Safety Measures, which included cross contamination, handwashing, cleaning surfaces and proper refrigeration of leftovers. A review of the facility's Employee Sanitation Practices policy, undated, revealed, gloves are worn to protect food by creating a barrier between the hands and food. Gloves should be changed as soon as they become soiled or torn and before beginning a different task. An observation, during the initial tour of the kitchen, on 03/03/2020 at 9:15 AM, revealed the conventional oven was dirty with build-up of food on the inside walls of the oven. The aluminum foil, in the bottom of the oven, was dirty with food build up. The two (2) small ovens had food build up on the inside walls and on the aluminum foil in the bottom of the ovens. The door of the oven had food build up on it as well. During an interview, on 03/03/2020 at 9:35 AM, the Dietary Manager (DM) stated that all the ovens were dirty. The DM stated she had a schedule for when the ovens are supposed to be cleaned, and they were apparently not cleaned according to the schedule. The DM stated the food build-up on the ovens looked to be from several days of cooking. A review of the Cleaning Schedule #1, dated February 2020-March 01, 2020, revealed the small ovens were initialed as being last cleaned on February 27, 2020. The large oven was initialed as being last cleaned on February 29, 2020. During an observation, on 03/04/2020 at 10:56 AM, Dietary Worker #2 knocked a piece of white sandwich bread, that was in a paper sleeve, off of a serving cart onto the floor. Dietary Worker #2 picked the sleeve with the piece of bread in it, up off the floor, and placed it back on top of the cart with the other pieces of sandwich bread in sleeves. The sleeve with the piece of bread that had fallen to the floor, was taken off of the cart; however, the other sleeves of bread were served to the residents. Dietary Worker #2 did not remove her gloves or wash her hands after picking the sleeve of bread off the floor and placing it back onto the cart. Dietary Worker #2 went back to the food serving line, wearing the same gloves that she used to pick the bread up off the floor. During an observation, on 03/04/2020 at 11:02 AM, the Dietary Manager (DM) was assisting Dietary Worker #3 in calibrating the thermometer to check food temperatures. The DM, without wearing gloves, picked up the foam cup that was being used for calibration, went to the ice maker and dipped the foam cup into the ice machine to obtain more ice. During an interview on, 03/04/2020 at 11:04 AM, the DM stated that she used the foam cup to obtain ice from the ice machine, instead of using the scoop. The DM stated she shouldn't have done it, and that it was contamination. The DM revealed they did not discard the ice from the ice machine, nor did they clean the ice machine. During an interview, on 03/04/2020 at 11:06 AM, Dietary Worker #2 confirmed she picked up the paper sleeve containing the piece of sandwich bread, from the floor and placed it back on top of the cart with the other sleeves of bread. Dietary Worker #2 stated she was not supposed to do that. Dietary Worker #2 stated she should have thrown it away. Dietary Worker #2 revealed she threw the sleeve of bread away, but it was after she had sat it on the other sleeves of bread, on the cart. Dietary Worker #2 stated they still served the other sleeves of bread to the residents for lunch, and they should have thrown it away. On 03/04/2020 at 11:29 AM, during an interview, the Dietary Manager (DM) stated that she saw Dietary Worker #2 drop the sleeve, with the piece of bread in it, pick it up, and put it on top of the cart with the other sleeves containing the bread. The DM confirmed she saw Dietary Worker #2 throw away the sleeve of bread that had fallen on the floor, but it was after she had placed the contaminated bread back on the cart. The DM stated she told Dietary Worker #2 not to put it back on the cart, but she did it anyway. The DM stated what Dietary Worker #2 had done was contamination. She stated that Dietary Worker #2 should have discarded the whole cart of bread, after she laid the contaminated bread back onto the cart. During an interview, on 03/04/2020 at 1:25 PM, the DM stated that it was ultimately her responsibility to make sure the equipment was cleaned as scheduled. The DM stated that it was also her responsibility to make sure that the contaminated food was not served. On 03/06/2020 at 9:14 AM, during an interview, with the DM, revealed she saw Dietary Worker #2 go back to the serving line, without washing her hands and changing gloves, after picking the bread up off of the floor. During an interview, on 03/06/2020 at 11:47 AM, the Administrator stated that she considered it an infection control issue, with the staff not following the cleaning schedule for cleaning the oven and back splash on the oven. The Administrator stated the Dietary Manager getting the ice from the ice machine without gloves on, and without using the scoop, was an infection control issue. She stated that the Dietary Manager not washing her hands and changing gloves, after picking the bread up off the floor, and before returning to the serving line, was an infection control issue. The Administrator stated Dietary Worker #2 should not have placed the bread back on the cart. She stated the tray of bread, on the cart, should have been discarded since it was contaminated, and fresh bread should have been brought out to be served. The Administrator stated Dietary Worker #2 contaminated the other bread on the serving cart, when she placed the bread that was picked up off of the floor, back onto the serving cart. A review of the facility's training record, dated 02/26/2020, revealed the Dietary Manager and Dietary Worker #2 were in-serviced on Food Safety and Dietary Procedures.

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

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.