STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	05/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, service technician interview, and staff interview the facility failed to sanitize kitchenware during its dish machine process and failed to remove dust and dirt from a wall fan blowing into the food preparation area and onto drying kitchenware that had been run through the dish machine. Findings included: 1. During observation of the facility's low temperature dish machine process, beginning at 1:35 PM on 05/28/20, eight racks of kitchenware were run through the dish machine with four strips, used to check the strength of the sanitizing solution, registering between 0 - 10 parts per million (PPM) of hypochlorite. The final rinse temperature gauge on the dish machine did not register temperature during the process. Observation of the sanitizing solution revealed that the sanitizer was not feeding into the tubing correctly to be dispensed into the dish machine. Dietary Aide #1 had initialed off that a strip used to check the strength of the sanitizing solution registered 100 PPM at breakfast and lunch on 05/28/20 and 05/29/20. During an interview with Dietary Aide #1 on 05/28/20 at 2:00 PM she stated she thought the strips used to check the strength of the sanitizer feeding into the dish machine were supposed to register at least 160 PPM hypochlorite. She reported she had gotten mixed up about the day's date, and that was reason there were already readings documented on the dish machine log for tomorrow. She commented the last time she used a strip at the dish machine on 05/28/20 was around 10:00 AM. According to Dietary Aide #1, the strips she used at the dish machine remained almost all white and the rinse gauge did not move for at least the last couple of days she had worked. She stated the Dietary Manager (DM) had been told last week that the dish machine needed to be serviced because the kitchenware was not drying well. The aide reported the strips were supposed to turn purple when placed in or on the sanitizing solution that fed into the dish machine. She commented that residents were in danger of getting sick because the chemical solution was not strong enough to kill germs on the kitchenware. She also remarked the temperature gauges were important because they indicated whether the dish machine was working properly or not. During an interview with the DM on 05/28/20 at 2:08 PM he stated that no dietary employees had informed him last week that the dish machine was not working properly. He reported he expected the strips used to check the strength of the sanitizing solution feeding into the dish machine to turn purple and register at least 100 PPM of hypochlorite. He commented the facility's dish machine depended on a chemical solution to sanitize kitchenware, and he expected a strip to be used after each meal as the dish machine process started up. According to the DM, it was very important that both gauges on the dish machine registered temperatures of at least 140 degrees Fahrenheit in order that the chemical sanitizer functioned at its maximum capacity. The DM stated the last time the dish machine had been serviced was on 02/03/20 (review of the service report revealed assistance was requested because the wash temperature was too high, but an adjustment corrected the problem). He reported when the sanitizer feeding into the dish machine was not strong enough residents could get sick because bacteria, germs, [MEDICAL CONDITION] were not being killed. During an interview with the DM on 05/28/20 at 3:05 PM he stated the service technician informed him the final rinse gauge on the dish machine was non-functional because the probe which activated it was eaten away by the chemical sanitizer. During an interview with the service technician on 05/28/20 at 4:03 PM he stated the primer in the pump system which transported the chemical sanitizer into the dish machine was compromised due to corrosion. He explained that the facility's dish machine was not designed to be permanently converted over to chemical sanitization. He commented that he was under the impression that the facility was only used chemicals to sanitize its kitchenware temporarily until a booster system could be purchased to return the dish machine to heat sanitization. During an interview with the facility's Director of Nursing on 05/28/20 at 4:23 PM he stated no facility residents had been diagnosed with [REDACTED]. 2. During an observation of the kitchen on 05/28/20 at 1:35 PM a wall fan was blowing into the food preparation area and onto drying kitchenware that had been run through the dish machine. The face, back, and blades of the fan were coated in dirt and dust, and there were strands of dust blowing off the face of the fan. During an interview with Dietary Aide #1 on 05/28/20 at 2:00 PM she stated maintenance was responsible for cleaning the wall fan in the kitchen. She reported she could not remember the last time it was cleaned. However, she commented that in its present state it could blow dust and dirt onto clean kitchenware and into food that was being prepared for upcoming meals. According to the aide, the dust and dirt had the potential of making residents sick. During an interview with the Dietary Manager (DM) on 05/28/20 at 2:08 PM he stated maintenance was responsible for cleaning the kitchen fan, but he was unsure of the frequency of this cleaning on the Maintenance Manager's (MM's) cleaning schedule. He reported the dusty, dirty wall fan could cross-contaminate food being prepared and kitchenware that was drying after exiting the dish machine. During an interview with the MM on 05/28/20 at 2:24 PM he stated dietary employees were not supposed to be up on ladders cleaning wall fans. He explained that cleaning of fans in the kitchen was supposed to be done monthly by a member of the maintenance team. He reported he was not totally certain, but thought it might have been a couple of months since the kitchen wall fan was cleaned. The MM was unable to explain why there was a delay in cleaning the fan, and was unable to explain the dangers of dirty, dusty fans in the kitchen. According to the MM, he removed the face of the fan, and then used a bleach solution to clean the front, back, and blades of the fan.

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.