STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) 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 4 of 4 sets of double smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (100, 200, 300 and 400 halls). The facility failed to repair the main dining room door with broken and splintered laminate and wood on the lower edges of the door on the 200 hall on 1 of 3 residents' hallways, failed to repair a door leading out to the courtyard smoking area with broken and splintered laminate and wood on the lower edges of the door and a large vinyl skin on the bottom of the door was chipped on the edges. The facility also failed to repair 2 resident's room doors with broken and splintered laminate and wood on the lower edges of the door with an area where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident rooms (Room #311 and #110), failed to repair resident room and bathroom doors with broken and splintered edges on the lower half of the door that were rough to touch in 6 of 35 occupied resident rooms (Room #200, #309, #310, #403, #405 and #412). Findings included: 1. a. Observations on 05/30/17 at 11:54 AM revealed a set of smoke prevention doors on the 100 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch.	F 253	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Genesis Healthcare Alleghany Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that form the basis for the deficiency. F253: 1. On 6/22/17 The set of smoke prevention doors for 100 Hall, 200 Hall, 300 Hall and 400 Hall were sanded by Maintenance Assistant to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. On 6/14/17 the 200 Hall main dining room doors were sanded to assure no rough to touch or splintered edges or broken laminate leaving sharp edges by Maintenance Director. On 6/14/17 the door leading out to the courtyard was sanded to assure no rough to touch or splintered edges by Maintenance Director. Vinyl covering for the courtyard door will be replaced by	6/30/17

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

Electronically Signed | 06/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 1 Observations on 05/31/17 at 8:50 AM revealed a set of smoke prevention doors on the 100 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 8:58 AM revealed a set of smoke prevention doors on the 100 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. b. Observations on 05/30/17 at 12:15 PM revealed a set of smoke prevention doors on the 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 05/31/17 at 8:55 AM revealed a set of smoke prevention doors on the 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 8:45 AM revealed a set of smoke prevention doors on the 200 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. c. Observations on 05/30/17 at 11:48 AM revealed a set of smoke prevention doors on the 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 05/31/17 at 3:35 PM revealed a set of smoke prevention doors on the 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 4:40 PM revealed a set of smoke prevention doors on the 300 hall	F 253	Maintenance Director on or before 6/30/17. On 6/26/17 the room doors for Rooms #200,#309,#310,#403,#405 and #412 were sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. On 6/26/17 The bathroom doors for Rooms #200,#309,#310,#403,#405 and #412 were sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. On 6/19/17 The room door for room #110 was sanded and painted by the Maintenance Assistant to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. Vinyl skin to be replaced by 6/30/17. On 6/26/17 the door for room #311 was sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. Vinyl skin to be replaced by 6/30/17. 2. By 6/30/17 all remaining room doors, bathroom doors, common area doors and smoke prevention doors will be audited by Maintenance Director to assure there are no rough to touch, splintered edges, broken laminate and/or vinyl coverings leaving sharp edges. By 6/30/17 the Maintenance Director will list all remaining room doors, bathroom doors, common area doors and smoke prevention doors in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 2 with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. d. Observations on 05/30/17 at 11:59 AM revealed a set of smoke prevention doors on the 400 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 05/31/17 at 9:10 AM revealed a set of smoke prevention doors on the 400 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 10:30 AM revealed a set of smoke prevention doors on the 400 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. 2. Observations on 05/30/17 at 12:20 PM revealed the main dining room door on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 05/31/17 at 9:02 AM revealed the main dining room door on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 8:51 AM revealed the main dining room door on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. 3. Observations on 05/30/17 at 12:25 PM revealed a door leading to the courtyard smoking area on the 200 hall had broken and splintered	F 253	need of repairs. These repairs will be placed on schedule for completion. 3. On 6/26/17 The Maintenance Director was reeducated by the Center Executive Director on the importance of assuring door edges are not rough to touch with splintered edges, broken laminate and/or vinyl coverings leaving sharp edges. Department Heads were reeducated by the Center Executive Director on 6/22/17 on the importance of observing doors during routine zone checks for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges and report findings to Center Executive Director. The Center Executive Director will assure reported findings/repairs are completed or scheduled for completion by Maintenance Director. Staff will be educated on 6/28/17 and 6/29/17 to monitor doors during daily duties for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges, reporting findings to Maintenance Director to be repaired or scheduled for repairs. 4.Department Heads will perform rounds one x weekly x 1 month then two x monthly x 1 month then one x monthly x 1 month. Any issues noted as a result of monitoring will be reported to Center Executive Director and Maintenance Director to be repaired or scheduled for repairs. Findings will be reviewed and addressed by Performance Improvement Committee q month x 3 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 3 laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/01/17 at 10:55 AM revealed a door leading to the courtyard smoking area on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. Observations on 06/02/17 at 11:30 AM revealed a door leading to the courtyard smoking area on the 200 hall had broken and splintered laminate and wood on the lower edges of the doors that were rough to touch. 4. a. Observations on 05/30/17 at 3:38 PM revealed resident room door #311 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. Observations on 05/31/17 at 3:10 PM revealed resident room door #311 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. Observations on 06/01/17 at 4:30 PM revealed resident room door #311 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. b. Observations on 05/31/17 at 8:45 AM revealed resident room door #110 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. Observations on 06/01/17 at 8:55 AM revealed	F 253	ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 4	F 253		

resident room door #110 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge.
Observations on 06/02/17 at 11:45 AM revealed resident room door #110 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge.

5. a. Observations on 05/31/17 at 8:49 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 8:40 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/02/17 at 11:34 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

b. Observations on 05/30/17 at 4:16 PM revealed resident room door #309 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 05/31/17 at 3:20 PM revealed resident room door #309 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 11:51 AM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 5	F 253		

resident room door #309 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

c. Observations on 05/31/17 at 11:11 AM revealed resident room door #310 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 8:37 AM revealed resident room door #310 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/02/17 at 12:06 PM revealed resident room door #310 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

d. Observations on 05/30/17 at 2:36 PM revealed resident room door #403 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 05/31/17 at 8:41 AM revealed resident room door #403 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 10:15 AM revealed resident room door #403 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

e. Observations on 05/30/17 at 2:45 PM revealed resident room door #405 and the bathroom door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 6	F 253		

had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 05/31/17 at 8:46 AM revealed resident room door #405 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 10:12 AM revealed resident room door #405 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

f. Observations on 05/30/17 at 12:35 PM revealed resident room door #412 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 05/31/17 at 11:22 AM revealed resident room door #412 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.
Observations on 06/01/17 at 10:05 AM revealed resident room door #412 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch.

During an interview on 06/02/17 at 3:40 PM with the Director of Maintenance he stated he had no assistant but they had hired a helper who worked 1 day every 2 weeks to help out. He explained they used a paper work order system and anyone could fill out a work order for repairs that needed to be made. He stated the forms were kept at the nurse's stations, in the therapy department and in break rooms. He explained when a work order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 7	F 253		

was filled out he got a copy and the Administrator got a copy and they discussed them in the morning meetings and he documented what he had fixed on the work order form. He stated he prioritized the work orders and he completed repairs that were safety concerns first. He explained he went over the work order process with new employees in orientation and it was his expectation for all staff to fill out a work order for anything that needed repair. He further explained and he wanted them to document the type of repair that needed to be done and the room number so he would know what needed to be repaired. He stated he was on call 24 hours a day/7 days a week and if there was an emergency he expected for staff to call him.

An environmental tour was conducted on 06/02/17 at 3:50 PM with the Director of Maintenance, the Director of Housekeeping and the Administrator. The Maintenance Director acknowledged the smoke prevention doors on 100, 200, 300 and 400 halls were damaged with splintered wood and laminate. He also acknowledged the main dining room door on the 200 hall and the door leading out to drink machine and smoking area were damaged with splintered laminate and wood on the lower edges of the doors. He confirmed the vinyl skin on the bottom of resident room #311 and #110 had pulled back from the door and protruded outward to create a rough edge. He stated no one had reported the damage to these doors but they needed repair. He also confirmed resident room and bathroom doors in room #200, #309, #310, #403. #405 and #412 had splintered and broken laminate and wood on the lower edges of the doors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 253	Continued From page 8 During an interview on 06/02/17 at 4:08 PM with the Administrator she stated it was her expectation for staff to report needed repairs on the work orders. She stated damage to doors was a constant problem and it was a work in progress to keep them sanded and repaired. She further stated the damage to doors occurred when wheelchairs hit them when staff transported residents or when residents transported themselves in and out of rooms. She confirmed she was not aware of any injuries or skin tears caused by splinters or rough edges of doors.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit.	F 272		6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 272	Continued From page 9 (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for psychotropic drug use and incontinence for 3 of 21 sampled residents (Resident #46, #22 and #104). The findings included: 1. Resident #46 was admitted to the facility on 07/04/15 with diagnoses of thyroid disorder and anxiety. Review of the significant change Minimum Data Set (MDS) dated 02/09/17 revealed Resident #46	F 272	1. Resident #46 CAAs for ARD 2/9/17 states that "when resident's wife leaves he calls out for her frequently". This is the underlying cause of the resident's anxiety and order for Anti-anxiety medication PRN. However in this look back period staff interventions also noted in the CAAs (cueing, redirecting, reorienting and encouraging diversional activity of choice) were successful as evidenced by the fact resident received no PRN or scheduled anti-anxiety medications during this look period and the order has since been discontinued for non-use. On 6/28/17 the CAAs were updated to state that in fact	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 272	Continued From page 10	F 272		

was severely cognitively impaired and received antianxiety medication daily during the assessment period.

Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 02/15/17 revealed Resident #46 had a diagnoses of anxiety that required the use of an antianxiety medication and was at risk for adverse psychotropic medication side effects. The CAA summary did not analyze how the psychotropic medications actually affected Resident #46's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or if the resident was receiving psychiatric services.

An interview conducted on 06/02/17 at 4:48 PM with the MDS Nurse revealed she has been an MDS Nurse for fifteen years and has attended MDS Training in Raleigh. She stated the CAA should address everything that triggered on the MDS, why it triggered, and how the triggers would be addressed. She stated she was not aware she should be more specific as to what triggered the resident's anxiety, how the medication affected it and if they were receiving therapy was it helpful.

2. Resident #22 was admitted to the facility on 07/31/14 with current diagnoses of non-Alzheimer's dementia, anxiety and schizophrenia.

Review of the significant change Minimum Data Set (MDS) dated 03/30/17 revealed Resident #22 was moderately cognitively impaired and received antipsychotic, antidepressant, and antianxiety medications daily during the assessment period.

resident received no anti-anxiety medications and staff's non-pharmacological interventions were successful.

Resident #22 CAAs for ARD 3/30/17 under the trigger for psychotropic meds analysis of findings states "requires varying assist with ADLs r/t to delusions and hallucinations, staff to assist with ADLs as needed and report any changes with resident's functional ability". "She has had a history of multiple falls and resident demented with little safety awareness". "She has a history of hallucinations and delusions that add to her fall risk." "Noted to run at times when having hallucinations, encouraged to walk and not run". "antipsychotics was attempted to be reduced without success, resident did have an increase in hallucinations and delusions upon attempt", "at risk for side effects and reactions to these medications, some may be permanent" "she will be observed for side effects and/or reactions and referred to MD and psych as needed."

Resident #104 CAA for ARD 11/9/16 under the trigger for Urinary Incontinence does not include strengths and weaknesses r/t incontinence because section 4 of the RAI manual does not list this as a requirement. However the CAA did address the causes and contributing factors for incontinence and how these affected his day-to-day function. As stated in the CAA "severe impairment in his ability to care for himself d/t a decline in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 272	Continued From page 11 Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated 03/31/17 revealed Resident #22 had a diagnoses of anxiety, schizophrenia and insomnia that required the use of an antianxiety, antipsychotic, and antidepressant medications and was at risk for adverse psychotropic medication side effects. The CAA summary did not analyze how the psychotropic medications actually affected Resident #22's day to day function and activities. The CAA summary also did not indicate if there had been any adverse drug reactions or if the resident was receiving psychiatric services. An interview conducted on 06/02/17 at 4:48 PM with the MDS Nurse revealed she has been an MDS Nurse for fifteen years and has attended MDS Training in Raleigh. She stated the CAA should address everything that triggered on the MDS, why it triggered, and how the triggers would be addressed. She stated she was not aware she should be more specific as to what triggered the resident's anxiety, how the medication affected it and if they were receiving therapy was it helpful. 3. Resident #104 was admitted to the facility on 04/14/16. His diagnoses included dementia, Alzheimer's Disease, behaviors, Parkinson's Disease and benign prostatic hyperplasia. A significant change Minimum Data Set (MDS) dated 11/09/16 coded him as rarely or never understood, having no behaviors, requiring total assistance with bed mobility, extensive assistance with transfers, being independent with ambulation and totally dependent for toileting needs. He was coded as being totally incontinent of bowel and bladder. Review of the Care Area Assessment (CAA)	F 272	mentation", "relies on staff to assist with daily decision making regarding clothing nutrition and hygiene." "Staff to redirect, orient and cue as needed. Staff to assist with adls rt impaired cognition, dementia, copd, parkinsons". By 6/30/17 the Clinical Reimbursement Specialist will update the CAA to state resident was incontinent upon admission to facility. He was under emergency guardianship of APS. His mother could no longer care for him d/t a decline in mentation which lead to his hospitalization. Monitoring of his toileting habits show that he made no attempt to control urges and urinated as well as defecated in inappropriate places even with redirection, cueing and reorientation to the toilet. He was mentally incapable of distinguishing the toilet from any other room or common area. Per APS Guardian resident was allowed and taught at home by family that defecating and urinating throughout the home and outside the home on porches and such was acceptable behavior in attempts to keep him from soiling himself. 2. On 6/26/17 Center Executive Director rein-serviced the Clinical Reimbursement Specialist on the importance of Care Area Assessments addressing the underlying causes and contributing factors for psychotropic drug use and incontinence. Regional Clinical Reimbursement Manager reassigned Clinical Reimbursement Specialist to complete company training module focused on appropriate documentation of Care Area Assessments. Training was completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 272	Continued From page 12 dated 11/09/16 for urinary incontinence revealed he was admitted from the hospital with severe impairment and inability to care for himself. The CAA listed his diagnoses, stated that he had difficulty understanding and needed staff assist to make daily decisions. He was noted as being incontinent to bowel and bladder and was at risk for skin breakdown ad needed pericare after incontinence. The CAA stated he needed redirection when voiding in inappropriate place. The CAA did not assess Resident #104's strengths or weaknesses relating to incontinence or attempt to identify causative factors for incontinence. The CAA failed to analyze how the incontinence affected his day to day function. An interview with the MDS coordinator was conducted on 06/02/17 at 4:48 PM. MDS nurse stated she had been an MDS Nurse for fifteen years and has attended MDS Training in Raleigh. She stated the CAA should address everything that triggered on the MDS, why it triggered, and how the triggers would be addressed. She stated she was not aware she should be more specific as to what triggered the area and how the resident was affected day to day with his incontinence. She reviewed the incontinent CAA and pointed out that she stated he was incontinent and that they were going to provide incontinent care. She stated that he had behaviors of urinating in inappropriate places. She further stated she was unaware that she was to describe more of his individual issues related to incontinence or if he could improve or had any sense of urges. She stated that the staff kept incontinence records showing when he was continent or if he dribbled etc, but she was not aware she could incorporate this information in the CAA.	F 272	with post test taken at 100% accuracy on 6/26/17. 3. By 6/30/17, Center Nurse Executive and/or Center Executive Director will review all MDS Assessments containing CAAs since 6/2/17 triggering incontinence and psychotropic drug use to assure addressing the underlying causes and contributing factors. 4. The Center Executive Director will audit 10% of all MDS Assessments with Care Area Assessments that trigger incontinence and psychotropic drug use to assure addressing the underlying causes and contributing factors. These audits will be performed 1 x monthly x 3 months. Any issues noted as a result of auditing will be reported to and addressed by Performance Improvement Committee monthly x 3 months and ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the care plan for smoking safety for 1 of 6 sampled residents who smoked (Resident #52). The findings included: Resident #52 was admitted to the facility on 08/04/16. His diagnoses included paraplegia, central cord syndrome, chronic pain syndrome, contractures, altered mental status, generalized muscle weakness, and mood affective disorder. The significant change Minimum Data Set dated 05/29/17 coded him with moderately impaired cognition, having sleep issues, being tired and having concentration issues and moving so slowly that people may notice 2 to 6 days in the previous 7 days. He was also coded with delusions, having behaviors including physical, verbal, and rejection of care 1 to 3 days of the previous 7 days. Resident #52 was coded as needing total care for all activities of daily living skills including eating. He was noted as being nonambulatory, having paraplegia and using tobacco. A smoking assessment was completed on	F 282	1. On 6/22/17 Resident #52 had a skin check and no areas were found on clothes or skin related to smoking. 2. On 6/26/17, A Smoking Assessment was performed on all smokers by Nurse Practice Educator and care plan was updated accordingly. Based on the care plan a list of items needed for each individual resident while smoking was placed with smoking accessories for staff as a reference to assure care plans are being followed for all smokers. 3. In-services will be completed by 6/30/17 with Nurse Practice Educator, Center Nurse Executive, Center Executive Director and/or the Assistant Center Nurse Executive to re-educate nursing, dietary, laundry and housekeeping staff on the need to follow plan of care for all residents who are smokers. 4. Staff and residents that smoke will be observed to assure plan of care being followed one x weekly x 1 month then two x monthly x 1 month then one x monthly x	6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 282	Continued From page 14 05/30/17. This form stated the resident did not use oxygen, and under cognition he was noted that he did not have dementia, does not have poor memory, and knew the location of the designated smoking area. Under behaviors he was noted to have no history of arson, no history of unsafe smoking habits, and no history of sharing or selling cigarettes or smoking material. Under observations he was coded as being able to hold a cigarette safely, not able to light a cigarette, being able to dispose of ashes or butts properly and can not smoke safely without the use of a smoking apron. The smoking decision was noted "supervised smoking is required" and the reason stated "policy of facility resident has unsafe smoking." An unsuccessful attempt to reach Nurse #1 who completed the smoking assessment dated 05/30/17 for Resident #52 was made on 06/02/17 at 2:41 PM. Nurse #1 did not return the call and clarification of the assessment information could not be obtained. A care plan was developed for the problem that the resident may smoke with supervision and staff assistance per the smoking assessment. This was most recently noted as revised on 02/27/17. The goal was for the resident to smoke safely every shift for 90 days per facility smoking policy. Interventions included: *"Staff to hold cigarette"; *"Inform of and reinforce smoking restriction"; *"Provide smoking apron"; and *"Supervise patient with smoking in accordance with assessed needs and facility policy." Resident #52 was observed on 05/31/17 at 3:06 PM in the smoking area outside courtyard. Admissions Director placed an unlit cigarette in Resident #52's mouth at 3:06 PM. She lit his	F 282	1 month by Director of Social Services. Any issues noted as a result of monitoring will be reported to and addressed by Performance Improvement Committee monthly x 3 months and ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 282	Continued From page 15	F 282		

cigarette, then moved over and lit another resident's cigarette then placed a smoking apron on Resident #52 at 3:09 PM. During the smoking of this cigarette, Resident #52 kept the cigarette in his mouth and used only his mouth, by moving his lips, to flick the ashes off the end of his lit cigarette. The ashes proceeded to hit his smoking apron and roll down, at times rolling over his stocking feet. On 05/31/17 at 3:15 PM, the Admissions Director made her first contact with him since 3:09 PM by holding the ash tray under the cigarette where he proceeded to spit out the end of the cigarette. At 3:16 PM, the Admissions Director placed a cigarette in Resident #52's mouth and lit it. She walked away and had her back to him. At 3:17 PM, Resident #52 attempted to reach for the cigarette with his right hand with tape around his forefinger and middle finger. He did not touch the cigarette, placed his hand on his lap and continued smoking without staff intervention as she remained faced away from the resident. Resident #52 proceeded to smoke the cigarette without anyone holding it or readjusting it. He proceeded to use his mouth to flick the ashes off the cigarette down his smoke apron and over his stocking feet. No attempt was made for staff to hold his cigarette or help catch fallen ashes through both cigarettes. Once he was finished he used his electric wheelchair to wheel over to staff who placed an ashtray under his chin and proceeded to spit out his cigarette butt. The Admissions Director had her back to him the entire time after placing an apron on him and until he went to spit out the cigarette butt.

Resident #52 was interviewed on 05/31/17 at 3:24 PM. He stated that he always let the ashes roll down his smoking apron.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 282	Continued From page 16	F 282		

On 06/02/17 at 9:00 AM the Admissions Director (AD) was interviewed. AD stated that she assisted with smoking about twice a month. She stated at the morning meetings, smoking residents and their needs were discussed. Resident #52 was 1 of 2 residents in the facility who required the use of a smoking apron per AD. She stated Resident #52 required no additional help during smoking only that she hold ashtray for him when he was finished smoking. She stated normally Resident #52 could not hold his cigarette so she placed it in his mouth for him and he used his mouth to shake the ashes onto his smoking apron, or he shook his head to the side so the ashes fell to the side. She further stated she was not aware of the care plan for staff to hold his cigarette and stated anytime she went out with him she put the cigarette in his mouth because he can't hold it with his hands.

The Director of Nursing was interviewed on 06/02/17 at 3:56 PM. She stated she had never observed residents in the smoking area including Resident #52. She stated he had some ability to use his fingers and thinks he could hold a cigarette. Her understanding of the care plan for staff to hold the cigarette was if he needed staff to hold his cigarette. She further stated that she could not say if letting the ashes drop onto the smoking apron was safe as she had not watched him smoke.

An interview with the Director of Social Services (DSS) was conducted on 06/02/17 at 4:30 PM. DSS stated that the intervention to hold his cigarette meant that he will hold his cigarette in his mouth, not in his hand a lot of the time. If he does not want to hold it in his mouth, he will ask staff to hold it lit for him. She further stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 282	Continued From page 17 at times he had refused to wear the smoking apron, or he only allowed it to be across his lap. She stated she herself had allowed him to smoke without the apron, holding the lit cigarette in his mouth. during these times which was several months ago, he would shake his head to the side to allow the ashes to fall to the side. She stated it was his choice to wear the apron or not or to let staff hold his cigarette. Interview with the Administrator occurred on 06/02/17 at 5:36 PM. The Administrator stated that Resident #52 was safe to smoke his cigarette with an apron and allowing the ashes to fall onto the apron during smoking. She stated that was what the apron was for. Resident #52 had behaviors and his choices varied day to day and if he refused to wear a smoking apron it was his choice as long as staff were present to supervise. She also thought the holding of his cigarette was if needed.	F 282		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited	F 323		6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 323	Continued From page 18 to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interview and staff interviews, the facility failed to maintain the safety of 1 of 6 sampled residents who smoked by not holding his cigarette for him and assisting with the disposal of ashes as he smoked (Resident #52). The findings included: Review of the undated pamphlet removed from the smoking apron's package stated in part "Smoker's Apron is designed as an aid in the prevention of accidental ignition of a resident's or patient's clothing. It is not a substitute for proper supervision." Resident #52 was admitted to the facility on 08/04/16. His diagnoses included paraplegia, central cord syndrome, chronic pain syndrome, contractures, altered mental status, generalized muscle weakness, and mood affective disorder. A smoking assessment dated 03/02/17 noted he had poor memory, no dementia, was not able to hold a cigarette, was not able to light a cigarette, was able to dispose of he ashes and smoked	F 323	1. On 6/22/17 Resident #52 had a skin check and no areas were found on clothes or skin related to smoking. 2. On 6/26/17, A Smoking Assessment was performed on all smokers by Nurse Practice Educator. Based on the findings, on 6/26/17 a list of safety items needed for each individual resident while smoking was placed with smoking accessories for staff as a reference to assure safety items are being utilized for all smokers. 3. In-services will be completed by 6/30/17 with Nurse Practice Educator, Center Nurse Executive, Center Executive Director and/or the Assistant Center Nurse Executive to re-educate nursing, dietary, laundry and housekeeping staff on the need to utilize safety items as needed for all residents who are smokers. 4. Staff and residents that smoke will be observed to assure safety items being utilized one x weekly x 1 month then two x monthly x 1 month then one x monthly x 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 323	Continued From page 19 safely without a smoking apron. The significant change Minimum Data Set dated 05/29/17 coded him with moderately impaired cognition, having sleep issues, being tired and having concentration issues and moving so slowly that people may notice 2 to 6 days in the previous 7 days. He was also coded with delusions, having behaviors including physical, verbal, and rejection of care 1 to 3 days of the previous 7 days. Resident #52 was coded as needing total care for all activities of daily living skills including eating. He was noted as being nonambulatory, having paraplegia and using tobacco. A smoking assessment was completed on 05/30/17. This form stated the resident did not use oxygen, and under cognition he was noted that he did not have dementia, does not have poor memory, and knew the location of the designated smoking area. Under behaviors he was noted to have no history of arson, no history of unsafe smoking habits, and no history of sharing or selling cigarettes or smoking material. Under observations he was coded as being able to hold a cigarette safely, not able to light a cigarette, being able to dispose of ashes or butts properly and can not smoke safely without the use of a smoking apron. The smoking decision was noted "supervised smoking is required" and the reason stated "policy of facility resident has unsafe smoking." An unsuccessful attempt to reach Nurse #1 who completed the smoking assessment dated 05/30/17 for Resident #52 was made on 06/02/17 at 2:41 PM. Nurse #1 did not return the call and clarification of the assessment information could not be obtained. A care plan was developed for the problem that	F 323	month by Director of Social Services. Any issues noted as a result of monitoring will be reported to and addressed by Performance Improvement Committee monthly x 3 months and ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 323	Continued From page 20	F 323		

the resident may smoke with supervision and staff assistance per the smoking assessment. This was most recently noted as revised on 02/27/17. The goal was for the resident to smoke safely every shift for 90 days per facility smoking policy. Interventions included:
*"Staff to hold cigarette";
*"Inform of and reinforce smoking restriction";
*"Provide smoking apron"; and
*"Supervise patient with smoking in accordance with assessed needs and facility policy."

Resident #52 was observed on 05/31/17 at 3:06 PM in the smoking area outside courtyard. Admissions Director placed an unlit cigarette in Resident #52's mouth at 3:06 PM. She lit his cigarette, then moved over and lit another resident's cigarette then placed a smoking apron on Resident #52 at 3:09 PM. During the smoking of this cigarette, Resident #52 kept the cigarette in his mouth and used only his mouth, by moving his lips, to flick the ashes off the end of his lit cigarette. The ashes proceeded to hit his smoking apron and roll down, at times rolling over his stocking feet. On 05/31/17 at 3:15 PM, the Admissions Director made her first contact with him since 3:09 PM by holding the ash tray under the cigarette where he proceeded to spit out the end of the cigarette. At 3:16 PM, the Admissions Director placed a cigarette in Resident #52's mouth and lit it. She walked away and had her back to him. At 3:17 PM, Resident #52 attempted to reach for the cigarette with his right hand with tape around his forefinger and middle finger. He did not touch the cigarette, placed his hand on his lap and continued smoking without staff intervention as she remained faced away from the resident. Resident #52 proceeded to smoke the cigarette without anyone holding it or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 323	Continued From page 21	F 323		

readjusting it. He proceeded to use his mouth to flick the ashes off the cigarette down his smoke apron and over his stocking feet. No attempt was made for staff to hold his cigarette or help catch fallen ashes through both cigarettes. Once he was finished he used his electric wheelchair to wheel over to staff who placed an ashtray under his chin and proceeded to spit out his cigarette butt. The Admissions Director had her back to him the entire time after placing an apron on him and until he went to spit out the cigarette butt.

Resident #52 was interviewed on 05/31/17 at 3:24 PM. He stated that he always let the ashes roll down his smoking apron.

On 06/02/17 at 9:00 AM the Admissions Director (AD) was interviewed. AD stated that she assisted with smoking about twice a month. She stated at the morning meetings, smoking residents and their needs were discussed. Resident #52 was 1 of 2 residents in the facility who required the use of a smoking apron per AD. She stated Resident #52 required no additional help during smoking only that she hold ashtray for him when he was finished smoking. She stated normally Resident #52 could not hold his cigarette so she placed it in his mouth for him and he used his mouth to shake the ashes onto his smoking apron, or he shook his head to the side so the ashes fell to the side. She further stated she was not aware of the care plan for staff to hold his cigarette and stated anytime she went out with him she put the cigarette in his mouth because he can't hold it with his hands.

The Director of Nursing was interviewed on 06/02/17 at 3:56 PM. She stated she had never observed residents in the smoking area including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 323	Continued From page 22 Resident #52. She stated he had some ability to use his fingers and thinks he could hold a cigarette. Her understanding of the care plan for staff to hold the cigarette was if he needed staff to hold his cigarette. She further stated that she could not say if letting the ashes drop onto the smoking apron was safe as she had not watched him smoke. An interview with the Director of Social Services (DSS) was conducted on 06/02/17 at 4:30 PM. DSS stated that the intervention to hold his cigarette meant that he will hold his cigarette in his mouth, not in his hand a lot of the time. If he does not want to hold it in his mouth, he will ask staff to hold it lit for him. She further stated that at times he had refused to wear the smoking apron, or he only allowed it to be across his lap. She stated she herself had allowed him to smoke without the apron, holding the lit cigarette in his mouth. during these times which was several months ago, he would shake his head to the side to allow the ashes to fall to the side. She stated it was his choice to wear the apron or not or to let staff hold his cigarette. Interview with the Administrator occurred on 06/02/17 at 5:36 PM. The Administrator stated that Resident #52 was safe to smoke his cigarette with an apron and allowing the ashes to fall onto the apron during smoking. She stated that was what the apron was for. Resident #52 had behaviors and his choices varied day to day and if he refused to wear a smoking apron it was his choice as long as staff were present to supervise.	F 323		
F 367 SS=E	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 23 (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to prepare and serve dysphagia advanced and consistent carbohydrate diets. This affected 9 sampled residents observed to receive a meal out of 20 residents with orders for a dysphagia advanced diet and 1 sampled resident observed to receive a meal out of 6 residents with orders for a consistent carbohydrate diet (Residents , #12, #13, #29, #38, #43, #64, #65, #74, #77, and #102). The findings included: 1. On 05/30/17 at 10:47 AM during the initial kitchen walk through, the Director of Dining Services (DDS) stated the facility was on a 3 week cycle of menus and provided this week's copies of the planned menus. Per the dietary menus provided, the noon meal this date was to include chicken and waffles, powdered sugar garnish, fried okra, and seasonal mixed fruit with the alternate to be shrimp scampi, linguine, peas and mushrooms, garlic bread and seasonal mixed fruit. The diets listed on this spread sheet included a regular, a dysphagia	F 367	1. On 6/1/17 prior to evening meal service and then again on 6/2/17 the Director of Dining Services rein-serviced dietary staff on the correct diet ordered for residents #12, #13, #29, #38, #43, #64, #65, #74, and #102 and corrected diets were then served. On 6/5/17 the Director of Dining Services rein-serviced dietary staff on the correct diet ordered for resident #77 and corrected diet was then served. 2. On 6/1/17 the Health Information Manager audited diet orders for all residents to assure dietary staff had the correctly ordered diets. On 6/1/17, 6/2/17, and 6/5/17 dietary staff were rein-serviced by Director of Dining Services on correct diets and correct consistency of diets. 3. On 6/27/17 the Center Executive Director will rein-service Director of Dining Services on the importance of insuring that dietary staff follow prescribed diet orders on all residents. On 6/21/17 Nurse Practice Educator rein-serviced nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 24 advanced, a dysphagia puree, a regular with chopped meat and a regular with ground meat. There was no evidence that a consistent carbohydrate diet was planned per review of the spread sheets. In addition, the Dysphagia Advanced diet per the spread sheet was to have ground chicken moistened, a cut waffle, powered sugar garnish and chopped fried okra. The alternate for this diet was ground shrimp scampi, cut up linguine, peas with mashed mushroom, white bread and both were to get chopped mixed seasonal fruit. The meal preparation was observed on 06/01/16 beginning at 9:32 AM. Observations of the kitchen preparation revealed that neither the chicken or the shrimp were ever prepared at the ground consistency and the okra was not chopped and the mushrooms were not mashed. In addition syrup was the garnish not powdered sugar. The waffles had been cooked with oil on the stove top griddle. On 06/01/17 at 11:35 AM, the mobile steam table was taken to the 300 hall for service. This steam table contained pureed items, chunks of chicken which was the consistency of pulled pork with pieces at least an inch long, shrimp scampi mixed with linguine with whole shrimp, fried round pieces of okra not chopped, whole waffles, and syrup in place of powered sugar. On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been	F 367	staff on appropriate food consistency for advanced dysphagia diet orders. On 6/1/17, 6/2/17 & 6/5/17 Director of Dining Services rein-serviced dietary staff on the correct use of menus and food consistency for advanced dysphagia diet and consistent carbohydrate orders. Additional in-services for nursing & dietary staff will be held on or before 6/30/17. 4. The Health Information Manager will audit physician ordered diets and compare to dietary tray cards one x monthly x 3 months. The Director of Dining Services or the Registered Dietician will observe 10% of resident meals to assure correct diets are being served one x weekly x 1 month, two x monthly x 1 month and one x monthly x 1 month. Findings of the audit and observations will be reported to the Process Improvement Committee monthly x 3 months and ongoing as needed and addressed accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 25	F 367		

served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground meat and always had considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. She further stated that if the chicken had been strips, like the recipe called for, she would have chopped it up.

On 06/01/17 at 12:53 PM, the cook stated that there was no menu to follow for a consistent carbohydrate diet and to her knowledge, there had never been a menu for a consistent carbohydrate diet during her 15 years as a cook at this facility.

The Director of Dining Services (DDS) joined the conversation on 06/01/17 at 12:57 PM. She stated there was a form that she had access to for a consistent carbohydrate diet that staff were to refer to. The DDS provided several sheets which talked about the foods to avoid and the serving amounts for the protein, fruits, vegetables, grains and fats and sugars to follow in total for each day. She did not provide any type of menu or spread sheet for amounts or foods for each meal for the consistent carbohydrate diet for the cooks should follow.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed. DDS stated that she had spoken with the Registered Dietician (RD) this date and that there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 26	F 367		

was a menu plan for a consistent carbohydrate diet that she had not been aware of and had not instructed her staff to follow and therefore had not been using or following. She stated she had no spread sheets to give to her cooks to follow. This change occurred with the menu change of 05/07/17. DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. Consistent Carbohydrate diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits. RD stated that a Consistent Carbohydrate Diet (CCD) had less carbohydrates per day and was not as flexible as different vegetables and desserts affect the carbohydrate intake of each meal. She stated she did not see any negative outcomes from the facility not having a CCD diet but would expect physician ordered diets to be followed.

On 06/01/17 at 4:00 PM, DDS provided the menu/spread sheet for the Consistent Carbohydrate Diet that should have been followed for this noon meal. It stipulated "diet chicken and waffle", fried okra and the alternate of shrimp scampi and 1/3 cup of linguine and sliced zucchini, which was not prepared. Further investigation revealed that the "diet chicken and waffle" was to have diet syrup and oven baked waffles.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 27	F 367		

company that operated this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

2. Resident #65 was admitted to the facility on 05/20/15 with diagnoses of deep vein thrombosis, diabetes, hypertension, cerebral vascular accident and hemiplegia. The significant change Minimum Data set (MDS) dated 03/09/17 coded him as being independent with set up for eating and being on a mechanically altered therapeutic diet.

His diet order per the monthly computerized physician orders dated May 2017 was a Dysphagia Advanced diet.

On 06/01/17 at 11:38 AM, staff approached Resident #65 offering him his selection. He chose shrimp scampi and was served the whole shrimp mixed with the linguine.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground. DDS stated that the kitchen "just didn't follow the menu."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 28	F 367		

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of meat the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits as it was an equivalent to mechanical soft texture.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

3. Resident #12 was admitted to the facility on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 29	F 367		

04/25/14 and her diagnoses included hypertension. Her quarterly Minimum Data Set dated 03/16/17 coded her with severely impaired cognition, as being independent with eating after set up and receiving a mechanically altered diet.

The diet order per the May 2017 computerized physician orders included a Dysphagia Advanced diet.

On 06/01/17 at 11:42 PM staff offered Resident #12 her choice of selections. Resident #12 was provided a whole uncut waffle and the chicken chunks and the pea and mushroom mixture.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 30	F 367		

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits.

On 06/01/17, DSS provided the menu/spread sheet for the Dysphagia Advanced diet that was to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

4. Resident #29 was readmitted to the facility on 05/25/12. His diagnoses included anemia, hypertension, diabetes, and cerebral vascular accident. His quarterly Minimum Data Set coded him with severely impaired cognition, being independent with eating after tray set up, and receiving a mechanically altered diet.

The diet order per the computerized May 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 31	F 367		

physician orders was a Dysphagia Advanced diet.

On 06/01/17 at 11:47 AM, Resident #29 received the chicken chunks on a whole uncut waffle with the peas and mushrooms combination.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits.

On 06/01/17, DSS provided the menu/spread

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 32	F 367		

sheet for the Dysphagia Advanced diet that was to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

5. Resident #102 was admitted to the facility on 05/03/17 with diagnoses including hypertension, diabetes and cerebral vascular accident. Per admission Minimum data Set dated 05/10/17 coded her as being independent with eating after tray set up and receiving a mechanically altered diet.

Speech therapy notes dated 05/04/17 that she had a cerebral vascular accident with left sided weakness.. She had decreased mastication skills and moderate pocketing/residue following wallows of a dysphagia advanced diet. As of 05/31/17 speech therapy noted she was still receiving a dysphagia advanced diet.

Her diet orders for May 2017 consisted of a Dysphagia Advanced diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 33	F 367		

On 06/01/17 at 12:11 PM she was served an uncut whole waffle, chicken chunks and uncut fried okra.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits.

On 06/01/17, DSS provided the menu/spread sheet for the Dysphagia Advanced diet that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 34	F 367		

to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

6. Resident #13 was admitted to the facility on 06/19/12 with diagnoses including hypertension and Parkinson's disease.

Resident #13's diet was downgraded to the Dysphagia Advanced diet on 01/18/17 by speech therapy due to decreased intake and extended mastication with regular diet texture. Per the discharge summary of speech therapy dated 02/02/17, the resident consumed the dysphagia advanced diet at this time. with compensatory strategies followed she demonstrated increased intake and reduced the risk of aspiration/penetration.

The significant change Minimum data Set dated 04/22/17 coded her as having moderately impaired cognition, being independent with eating after tray set up and receiving a mechanically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 35	F 367		

altered diet.

Her May 2017 computerized physician orders included a Dysphasia advanced diet.

On 06/01/17 at 12:33 PM, she received the chicken chunks, an uncut whole waffle the peas and mushroom combination and the uncut fried okra.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up.

During an addition interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 36	F 367		

She stated that Dysphagia Advanced diets should be cut into peas size portions bits.

On 06/01/17, DSS provided the menu/spread sheet for the Dysphagia Advanced diet that was to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

7. Resident #43 was admitted to the facility on 11/17/16 with diagnoses including Alzheimer's Disease and dementia. His quarterly Minimum Data Set dated 05/03/17 coded him with moderately impaired cognition, being independent with eating after tray set up and receiving a mechanically altered diet.

The diet list from the kitchen noted he was on a Dysphagia Advanced diet.

On 06/01/17 at 12:51 PM he received a whole uncut waffle, chunked chicken, peas and mushroom combination and fried uncut okra.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 37 On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup. Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up. During an addition interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed. Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits. On 06/01/17, DSS provided the menu/spread sheet for the Dysphagia Advanced diet that was to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 38	F 367		

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

8. Resident #77 was admitted to the facility on 11/29/16 with diagnoses including diabetes, below the knee amputation, congestive heart failure and hypertension. The significant change Minimum Data Set dated 03/03/17 coded him as being independent with eating after set up and receiving a therapeutic diet.

His May 2017 computerized physician orders included a consistent carbohydrate diet with double proteins.

On 06/01/17 at 12:39 PM Resident #77 chose the alternate of shrimp linguine. He declined the okra and peas and mushrooms. There was no zucchini prepared and so that was not an option for him. He received two 4 ounce scoops of the combination shrimp and noodles.

On 06/01/17 at 12:53 PM, the cook stated that there was no menu to follow for a consistent carbohydrate diet and to her knowledge, there had never been a menu for a consistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 39	F 367		

carbohydrate diet during her 15 years as a cook at this facility.
The Director of Dining Services (DDS) joined the conversation on 06/01/17 at 12:57 PM. She stated there was a form that she had access to for a consistent carbohydrate diet that staff were to refer to. The DDS provided several sheets which talked about the foods to avoid and the serving amounts for the protein, fruits, vegetables, grains and fats and sugars to follow each day. She did not provide any type of menu for each meal for this diet the cooks should follow.

On 06/01/17 at 2:52 PM the DDS stated that she had spoken with the Registered Dietician (RD) this date and that there was a menu plan for a consistent carbohydrate diet that she had not been aware of and had not instructed her staff to follow and therefore had not been using or following. She stated she had no spread sheets to give to her cooks to follow. This change occurred with the menu change of 05/07/17. DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. Consistent Carbohydrate diets were not followed.

Interview with the RD on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. RD stated that a Consistent Carbohydrate Diet (CCD) had less carbohydrates per day and was not as flexible as different vegetables and desserts affect the carbohydrate intake of each meal. She stated she did not see any negative outcomes from the facility not having a CCD diet but would expect physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 40 ordered diets to be followed. On 06/01/17, DDS provided the menu/spread sheet for the Consistent Carbohydrate Diet that should have been followed for this noon meal. It stipulated "diet chicken and waffle", fried okra and the alternate of shrimp scampi and 1/3 cup of linguine and sliced zucchini, which was not prepared. Further investigation revealed that the "diet chicken and waffle" was to have diet syrup and oven baked waffles. 9. Resident #74 was admitted to the facility on 09/16/14 with current diagnoses of thyroid disorder and anxiety. Review of the annual Minimum Data Set (MDS) dated 04/29/17 revealed Resident #74 was severely cognitively impaired and was independent with eating after set up. The MDS further revealed Resident #74 received a mechanically altered diet. The diet order per the May 2017 computerized physician orders included a Dysphagia Advanced diet. On 06/01/17 at 12:06 PM staff offered Resident #74 her choice of selections. Resident #74 was provided a whole uncut waffle, the chicken chunks, and the pea and mushroom mixture. On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been	F 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 41	F 367		

served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up.

During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed.

Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into peas size portions bits.

On 06/01/17, DSS provided the menu/spread sheet for the Dysphagia Advanced diet that was to be followed this date. The menu still stipulated ground chicken, cut waffle, chopped fried okra, and ground shrimp scampi.

Interview with the Speech Therapist on 06/02/17 at 3:30 PM revealed she was told that the company that operates this facility did not offer mechanical soft diets so they tried to ensure the physician ordered the dysphagia advanced diet for those normally on a mechanical soft diet. She stated the dietary staff had been educated on the meats and other items to be about pea size or a soft consistency. She further stated that if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 42	F 367		

residents had a choking hazard, they would be recommended for a pureed diet.

Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus.

10. Resident #38 was admitted to the facility on 04/01/2011. Resident #38 had diagnosis which included: dementia, Alzheimer's disease, Parkinson's disease, adult failure to thrive and anxiety.

The Minimum Data Set annual assessment indicated that Resident #38 was cognitive impaired and required extensive assistance for eating a mechanically altered diet.

A record review conducted on 06/01/2017 revealed MD ordered diet type of Dysphagia Advanced diet.

Resident #38 served in the 400 hall dining room on 06/01/17 at 12:29 PM a bowl containing a whole uncut waffle with chunked chicken on top, peas and mushrooms and the fried uncut okra.

On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup.

Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 367	Continued From page 43 the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. If the chicken had been strips, like the recipe called for, she would have chopped it up. During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed. Interview with the Registered Dietician (RD) on 06/01/17 at 3:09 PM revealed that this date was her first date back into this facility since December as another RD was visiting this facility. She stated that Dysphagia Advanced diets should be cut into pea's size portions bits.	F 367		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 44 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews and manual review, the facility failed to maintain a sanitary kitchen by sanitizing dishes, wash hands and change gloves to prevent food contamination, keep the food protected from contamination during service, keep the ice scoop from contaminating the ice, and clean the kitchen floors. The findings included:. 1. On 05/30/17 at 10:47 AM during the initial kitchen walk through, the Director of Dining Services (DDS) stated that the facility had a new mobile steam table which they utilized on the halls during meal times to serve those residents who ate in their rooms. The mobile steam table was electric with palates that were heated and it used no steam. Review of the Mobile Steam Table Training Manual included an example of the flow of service. Instructions included that the cook followed the mobile steam table down the hall careful not to contaminate their hands by only touching serving utensils and properly handling plates. The nurse aide was to push the steam table down the hall and plug in the steam table each time the table reached its destination.	F 371	1. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food, appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 staff members were provided with a container for storing ice scoops during meal service to prevent handle from touching ice by the Director of Dining Services. On 6/5/17 Center Executive Director observed dry storage to assure clean and free of debris as floors had been swept and mopped by dietary staff. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for checking sanitizer levels in dish machine. 2. On 6/27/17 the Director of Dining Services will be rein-serviced by Center Executive Director on the importance of monitoring staff regularly to assure using appropriate infection control procedures and cleanliness of kitchen floors. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 45 On 05/30/17 at 11:57 AM the mobile steam table was observed in use on the 300 hall. Options available to the residents included roast beef sandwiches potato salad, tater tots and a breakfast casserole. Dietary Aide #2, wearing gloves, would plate the food after Dietary #1 went to the resident rooms, informed the resident the food options and then told Dietary Aide #2 what each resident chose to eat. Dietary Aide #1 was observed carrying a resident's roast beef sandwich in a bowl that was pressed up against her shirt with the food touching her shirt. Dietary Aide #2 was observed to unplug the mobile steam table, push it down the hall, plug the unit into another outlet. Dietary Aide #2 then proceeded to plate the food including handling the roast beef sandwiches and lettuce and tomato with the same gloves that were on when she plugged and unplugged the mobile unit. Dietary Aide #2 also was observed to use the portable walkie talkie to alert the kitchen of needed items, with the same gloved hands she handled the sandwiches, lettuce and tomato. She put the walkie talkie back in the drawer and continued to serve the food, directly touching some food items without sanitizing her hands or changing her gloves. During this service, residents were observed rolling and walking by the mobile unit while the food lids were off the food items. Observations on 05/30/2017 at 12:09 PM were made of the mobile steam table on the 100 hall. Dietary Aide #1 would go to the rooms and offer the selections and then tell Dietary Aide #2 what the selection was to be prepared. At this time Dietary Aide #1 was observed holding a small bowl of potato salad between her wrist and the bowl was pressed against against her shirt.	F 371	appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 nursing and dietary staff members were rein-serviced on appropriate storage of ice scoop during meal service to prevent contamination. On or before 6/30/17 dietary staff will be rein-serviced on keeping kitchen floors clean and free of debris by Director of Dining Services. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for checking sanitizer levels in dish machine. 3.On 6/27/17 the Director of Dining Services will be rein-serviced by Center Executive Director on the importance of monitoring staff regularly to assure using appropriate infection control procedures and cleanliness of kitchen floors. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food, appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 nursing and dietary staff members were rein-serviced on appropriate storage of ice scoop during meal service to prevent contamination. On or before 6/30/17 dietary staff will be rein-serviced on keeping kitchen floors clean and free of debris by Director of Dining Services. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 46 On 05/30/17 at 12:14 PM, Dietary Aide #2 removed her gloves, unplugged the mobile steam table and pushed it to the 200 hall. She proceeded to plug the unit in and without any hand washing, put new gloves on and proceeded to handle the roast beef sandwiches, lettuce and tomatoes. While on this hall, Resident #63 came up to the mobile steam table looking at the food and standing over the food. Staff had to redirect away from the open food items. At 12:19 PM, Dietary Aide #2 used the walkie talkie with gloves on and with the same gloves, she proceeded to grab the inside of the bowls and serve up the food without hand washing or glove changing. Dietary Aide #2 continued to handle the sandwiches, lettuce and tomato with the same gloves she wore as she unplugged the mobile unit, pushed it further down the hall and replugged it into the electric socket. On 05/30/17 at 12:25 PM, Dietary Aide #2 removed her gloves and moved the mobile unit to the 400 hall. Without hand washing or hand sanitizing, she put on gloves and proceeded to handle the sandwiches, lettuce and tomato directly with gloved hands. At 12:31 PM, Dietary Aide #2 unplugged the unit, moved it up the hall, replugged it in and with the same gloves proceeded to directly handle the sandwiches, lettuce and tomato. On 05/30/17 at 12:37 PM Dietary Aide #2 used the walkie talkie and then with the same gloves handled the food. Then at 12:39 PM, Dietary Aide #2 dropped the walkie talkie on the ground, removed her glove and picked it up and placed it in the drawer. She regloved and never cleaned the walkie talkie. She then proceeded to handle the sandwiches and lettuce and tomato. She then used the	F 371	checking sanitizer levels in dish machine. On 6/21/17 Nurse Practice Educator and Regional Nurse Practice Educator provided on-time education for dietary staff infection control practices during meal service at lunch. 4. Dining Services Director and/or Regional Dietician will monitor meal service to assure appropriate infection control procedures, hand washing techniques and sanitation during dish washing 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month. Dining Services Director and/or Regional Dietician will observe kitchen to assure clean and cleaning schedules are being followed 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month. Center Nurse Executive and/or Assistant Center Nurse Executive will monitor ice service one x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month to assure ice scoops stored properly. Any issues as a result of monitoring and observation will be reported to and addressed by Process Improvement Committee q month x 3 months and ongoing as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 47	F 371		

walkie talkie with the gloves she had on, and once finished the request on the walkie talkie, continued to touch the sandwiches, tomato and lettuce with the contaminated gloves.

The Director of Dining Services (DDS) stated on 05/30/17 at 12:40 PM the facility had been using the mobile steam table for about 8 months.

On 06/01/17 at 11:00 AM, the DDS stated she trained her staff on the mobile steam table service and she periodically would observe the meal service to ensure compliance with the service.

On 06/01/17 at 11:38 AM, the mobile steam table was set up and beginning to be used on the 300 hall. The meal included waffles which were handled directly with gloved hands by the cook plating the meal. Dietary Aide #1 took the resident orders and the cook plated the food. During the service, the cook coughed onto the back of her gloved left hand on 06/01/17 at 11:44 AM. She proceeded to serve the food items without any hand washing or hand sanitizing or changing of the gloves.

On 06/01/17 at 11:45 AM the cook, wearing the gloves she had during service, unplugged the mobile steam table, moved it down the hall, replugged it and proceeded to directly handle the waffles with the same contaminated gloves. This was observed again on 06/01/17 at 11:53 AM.

On 06/01/17 at 12:02 PM, the cook left the mobile steam table on the hall, unattended to get more gloves from the kitchen.

On 06/01/17 at 12:12 PM, wearing the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 48	F 371		

gloves she had handled the waffles directly with, the cook unplugged the unit, moved it to the 200 hall, replugged it in the electric outlet and proceeded to handle the waffles with the same gloves.

On 06/01/17 at 12:17 PM the cook was interviewed. She stated she was taught to change her gloves when she moved from one hall to the next. She stated that as long as she stayed with the mobile steam table, she did not have to change gloves unless they got dirty. When asked about plugging and unplugging the unit on the hall, she stated she "guesses" she should change gloves but gave no reason she did not change gloves.

The DDS was interviewed on 06/01/17 at 12:19 PM. She stated she expected staff to change gloves when the staff moved the mobile steam table to a different hall. She further stated that the instructions that came with the mobile steam table did not address hand washing. She then stated that staff should change gloves when plugging and unplugging the mobile steam table. DDS then stated that staff should not have the walkie talkie in the mobile steam table and should have gotten a clean one from the kitchen once it fell to the floor.

On 06/01/17 at 3:09 PM the registered dietician stated she has observed the mobile steam table in use and had some issues which she verbally discussed but gave no written action plan to address. She stated she expected staff to remove gloves and wash their hands after they unplug the table, move it and replug it in. She also stated the food should never touch the body of the server.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 49 On 06/02/17 at 10:30 am, the cook and DDS stated during interview that they have a lot of trouble with residents coming up to the mobile steam table trying to get into the food. In addition, visitors are always passing the steam table during service as well as other staff. During an interview with the Administrator on 06/02/17 at 5:36 PM, she stated she expected hand washing and changing gloves when the dietary staff's gloves are contaminated. 2. Observations were made of the dishmachine on 05/31/17 at 8:49 AM. Dietary Aide #1 was observed in the dish room running dirty plates through the dish washer. She stated this was a low temperature dish washing machine and the water goes to 120 degrees Fahrenheit. At 8:57 AM the sanitation of the dish washer was checked with strips and with the Director of Dining Services (DDS). The test strip showed no change of color indicating there was sanitation chemicals being distributed. Dietary Aide #1 stated at this time that she had not checked the sanitation of the machine yet this date. she stated she normally runs several loads through then checks for sanitation levels. On 05/31/17 at 8:58 AM, DDS obtained a new box of test strips and again the strip showed no change of color. Then again with new strips at 9:00 AM, the dishmachine again and noted no evidence of sanitation chemicals being distributed into the dishmachine. Throughout this time, Dietary Aide #1 continued to run dishes through the machine and put the unsanitized items, including bowls and plate lids away ready for use. By 9:04 AM, Dietary Aide had put away 4	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 50	F 371		

dishwasher loads of plates and other items ready for use even though the sanitation was not working.

On 05/31/17 at 9:09 AM, Dietary Aide #1 continued to put items from the dishmachine away ready for use. Dietary Aide #1 stated during interview at this time that she "probably" would not use the dishes she was putting away for the next meal. Dietary Aide #2 joined the conversation and stated that they needed the bowls and such for the meal. Dietary Aide #1 stated she would run them all through the dishmachine once it was fixed. She further stated the temperature was correct and the dishes looked clean. On 05/31/17 at 9:17 AM Dietary Aide #1 continued to use the dishmachine and run dishes through and put them away despite the machine's sanitizer not working.

On 05/31/17 at 9:18 AM, DDS was interviewed about the dishes being put away. She then went and instructed staff to gather all the dishes and rerun them through the machine once the sanitation was fixed. This included the pitchers which had just been placed with the others in the kitchen. DDS then emptied the lorator of the plates she put away this morning.

On 05/31/17 at 9:38 AM DDS stated that she had fixed the problem as the dish machine needed to be primed. She was unaware of this feature on the dishmachine. On 05/31/17 at 9:44 AM, the sanitation was checked again on the dishmachine. Again the strips showed no sanitation being added to the rinse cycle. DDS stated at this time that she expected staff to check sanitation every shift. DDS tried to prime again and at 9:47 AM the sanitation was still not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 51	F 371		

evident by the test strips. On 05/31/17 at 10:21 AM, DDS stated there were holes in the tubing that pumped the sanitizer into the dishmachine. She stated she was going to buy paper products and use the 3 compartment sink for the larger items i.e. pitchers.

On 06/01/17 at 10:39 AM the dishmachine representative was interviewed. She stated he came monthly for routine maintenance. He stated that he needed to replace the tubing. He further stated that the sanitation should be checked after the dishmachine was run through several cycles before the dishes were cleaned. This should be done at each meal cycle.

3. On 05/31/17 at 9:08 AM, observations of the dry storage area revealed the floor had debris including cereal, a yellow plastic ring, and onion peels.

On 06/01/17 at 9:37 AM the dry storage area was again observed with the cereal and plastic ring on the floor. There were less onion peels on the floor.

The Director of Dining Services was shown the dry storage area with the cereal and yellow plastic ring on the floor on 06/02/17 at 10:21 AM. She stated that staff were expected to sweep and mop the floor every evening and it obviously was not being done.

During interview with the Administrator on 06/02/17 at 5:36 PM, she stated she expected the floor to the dry storage area be clean.

4. On 05/30/17 at 11:47 AM, in the main dining room, staff were observed scooping ice from a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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	Continued From page 52 small cooler. As they scooped the ice, staff left the ice scoop in the ice with the handle touching the ice. This continued and observed again on 05/30/17 at 12:02 PM. On 05/30/17 at 12:06 PM, the Director of Dining Services asked about the ice and scoop. She stated that the handle touching the ice was a source of cross contamination.	F 371		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of	F 520		6/30/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 53 action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May 2016. This was for 3 recited deficiencies which were originally cited in April 2016 on a Rectification survey and subsequently recited on the current recertification survey. The deficiencies were in the areas of environment, care plans and kitchen sanitation. The continued failure of the facility during three federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1. a. Based on observations and staff interviews the facility failed to repair 4 of 4 sets of double smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (100, 200, 300 and 400 halls). The	F 520	1. On 6/22/17 The set of smoke prevention doors for 100 Hall, 200 Hall, 300 Hall and 400 Hall were sanded by Maintenance Assistant to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. On 6/14/17 the 200 Hall main dining room doors were sanded to assure no rough to touch or splintered edges or broken laminate leaving sharp edges by Maintenance Director. On 6/14/17 the door leading out to the courtyard was sanded to assure no rough to touch or splintered edges by Maintenance Director. Vinyl covering for the courtyard door will be replaced by Maintenance Director on or before 6/30/17. On 6/26/17 the room doors for Rooms #200,#309,#310,#403,#405 and #412 were sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. On 6/26/17 The bathroom doors for Rooms #200,#309,#310,#403,#405 and #412	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 54 facility failed to repair the main dining room door with broken and splintered laminate and wood on the lower edges of the door on the 200 hall on 1 of 3 residents' hallways, failed to repair a door leading out to the courtyard smoking area with broken and splintered laminate and wood on the lower edges of the door and a large vinyl skin on the bottom of the door was chipped on the edges. The facility also failed to repair 2 resident's room doors with broken and splintered laminate and wood on the lower edges of the door with an area where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident rooms (Room #311 and #110), failed to repair resident room and bathroom doors with broken and splintered edges on the lower half of the door that were rough to touch in 6 of 35 occupied resident rooms (Room #200, #309, #310, #403, #405 and #412). The facility was recited for F 253 for failing to repair smoke prevention doors, a dining room door, a door leading to a courtyard for smoking and resident room and bathroom doors with broken and splintered laminate and wood on the lower edges of the doors. F 253 Environment was originally cited during the April 14, 2016 recertification survey for failing to maintain ceilings, walls, 1 AC/Heating unit, fixtures including light covers and toilet paper holders in bedrooms and bathrooms for 6 of 30 rooms (Rooms 200, 207, 303, 305, 308 and 406) reviewed for environmental issues. b. Based on observations, record review and staff interviews, the facility failed to follow the care plan for smoking safety for 1 of 6 sampled residents who smoked (Resident #52).	F 520	were sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges.On 6/19/17 The room door for room #110 was sanded and painted by the Maintenance Assistant to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. Vinyl skin to be replaced by 6/30/17.On 6/26/17 the door for room #311 was sanded by the Maintenance Director to assure no rough to touch or splintered edges or broken laminate leaving sharp edges. Vinyl skin to be replaced by 6/30/17. On 6/22/17 Resident #52 had a skin check and no areas were found on clothes or skin related to smoking. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food, appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 staff members were provided with a container for storing ice scoops during meal service to prevent handle from touching ice by the Director of Dining Services. On 6/5/17 Center Executive Director observed dry storage to assure clean and free of debris as floors had been swept and mopped by dietary staff. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for checking sanitizer levels in dish machine.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 55 During the recertification survey of April 14, 2016, the facility was cited for failure to follow the care plan for 1 of 4 residents dependent on staff for activities of daily living (Resident #42). On the current recertification survey F 282 was again recited for failing to follow the care plan for smoking safety for 1 of 6 sampled residents who smoked (Resident #52) c. Based on observations and staff interviews and manual review, the facility failed to maintain a sanitary kitchen by sanitizing dishes, wash hands and change gloves to prevent food contamination, keep the food protected from contamination during service, keep the ice scoop from contaminating the ice, and clean the kitchen floors. During the recertification survey of April 14, 2016 the facility was cited for failure to label and date stored food in the kitchen refrigerator and freezer, failed to label and date food in the nourishment refrigerator/freezer across from the 400 hall nurse's station, failed to cover food in dry storage, failed to ensure only resident beverages and food were kept in the nourishment refrigerator, and failed to replace insulated dome lids with degrading interior plastic in 1 of 1 kitchen refrigerator/freezers, 1 of 1 dry storage rooms, 1 of 1 nourishment refrigerator/freezers and 26 of 26 insulated dome lids. On the current recertification survey the facility was again recited for failing to maintain a sanitary kitchen by sanitizing dishes, wash hands and change gloves to prevent food contamination, keep the food protected from contamination during service, keep the ice scoop from contaminating the ice and clean the kitchen floors.	F 520	2. By 6/30/17 all remaining room doors, bathroom doors, common area doors and smoke prevention doors will be audited by Maintenance Director to assure there are no rough to touch, splintered edges, broken laminate and/or vinyl coverings leaving sharp edges. By 6/30/17 the Maintenance Director will list all remaining room doors, bathroom doors, common area doors and smoke prevention doors in need of repairs. These repairs will be placed on schedule for completion. On 6/26/17, A Smoking Assessment was performed on all smokers by Nurse Practice Educator and care plan was updated accordingly. Based on the care plan a list of items needed for each individual resident while smoking was placed with smoking accessories for staff as a reference to assure care plans are being followed for all smokers. On 6/27/17 the Director of Dining Services will be rein-serviced by Center Executive Director on the importance of monitoring staff regularly to assure using appropriate infection control procedures and cleanliness of kitchen floors. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food, appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 nursing and dietary staff members were rein-serviced on appropriate storage of ice scoop during meal service to prevent contamination. On or before 6/30/17 dietary staff will be rein-serviced on keeping kitchen floors	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 56 During an interview on 06/02/17 at 6:23 PM with the Administrator she explained the Quality Assessment and Assurance Committee met monthly and they had audited plans of correction for deficiencies cited in the Recertification Survey in April 2016. She stated some of the regulations were very broad and she could not fix every problem that happened every day. She further stated they had audited work orders since the last survey and they were aware of damage to doors but there wasn't enough manpower to keep up with the work that need to be done. She explained the kitchen issues that were cited last year had to do with dating and labeling but this year the areas of concern were different. She stated she felt the process was in place but there was not resources to get it all done.	F 520	clean and free of debris by Director of Dining Services. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for checking sanitizer levels in dish machine. 3. On 6/26/17 The Maintenance Director was reeducated by the Center Executive Director on the importance of assuring door edges are not rough to touch with splintered edges, broken laminate and/or vinyl coverings leaving sharp edges. Department Heads were reeducated by the Center Executive Director on 6/22/17 on the importance of observing doors during routine zone checks for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges and report findings to Center Executive Director. The Center Executive Director will assure reported findings/repairs are completed or scheduled for completion by Maintenance Director. Staff will be educated on 6/28/17 and 6/29/17 to monitor doors during daily duties for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges, reporting findings to Maintenance Director to be repaired or scheduled for repairs. In-services will be completed by 6/30/17 with Nurse Practice Educator, Center Nurse Executive, Center Executive Director and/or the Assistant Center Nurse Executive to re-educate nursing, dietary, laundry and housekeeping staff on the need to follow plan of care for all residents who are smokers.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 57	F 520	On 6/27/17 the Director of Dining Services will be rein-serviced by Center Executive Director on the importance of monitoring staff regularly to assure using appropriate infection control procedures and cleanliness of kitchen floors. On 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infection control procedures when handling food, appropriate changing of contaminated gloves and hand washing techniques with changing gloves during meal service by the Director of Dining Services. On 5/30/17 nursing and dietary staff members were rein-serviced on appropriate storage of ice scoop during meal service to prevent contamination. On or before 6/30/17 dietary staff will be rein-serviced on keeping kitchen floors clean and free of debris by Director of Dining Services. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer hose and the proper procedure for checking sanitizer levels in dish machine. On 6/21/17 Nurse Practice Educator and Regional Nurse Practice Educator provided on-time education for dietary staff infection control practices during meal service at lunch. 4.Department Heads will perform rounds one x weekly x 1 month then two x monthly x 1 month then one x monthly x 1 month then quarterly through June 2018. Any issues noted as a result of monitoring will be reported to Center Executive Director and Maintenance Director to be repaired or scheduled for repairs. Findings will be reviewed and addressed by Performance Improvement Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 58	F 520	q month x 3 months and quarterly ongoing. Residents that smoke will be observed by Nurse Practice Educator and/or Director of Social Services to assure plan of care being followed one x weekly x 1 month then two x monthly x 1 month then one x monthly x 1 month then 1 x quarterly through June 2018. Any issues noted as a result of monitoring will be reported to and addressed by Performance Improvement Committee monthly x 3 months and quarterly through ongoing. Dining Services Director and/or Regional Dietician will monitor meal service to assure appropriate infection control procedures, hand washing techniques and sanitation during dish washing 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month then 1 x quarterly through June 2018. Dining Services Director and/or Regional Dietician will observe kitchen to assure clean and cleaning schedules are being followed 1 x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month then 1 x quarterly through June 2018 . Center Nurse Executive and/or Assistant Center Nurse Executive will monitor ice service one x weekly x 1 month then 2 x monthly x 1 month then 1 x monthly x 1 month then 1 x quarterly through June 2018 to assure ice scoops stored properly. Any issues as a result of monitoring and observation will be reported to and addressed by Process Improvement Committee q month x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 520	Continued From page 59	F 520	months and 1 x quarterly through ongoing.	