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 _____	C 01/18/2022

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 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 01/13/22 with an exit from the facility on 01/13/22. Additional information was obtained through 01/18/22 therefore the exit date was changed to 01/18/22. There were twenty three (23) allegations investigated and three (3) allegations were substantiated. Event ID #NNW011.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		2/17/22

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

Electronically Signed | 02/04/2022

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F 732	Continued From page 1 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to retain the daily posted nurse staffing information from 06/26/21 through 01/12/22. The finding included: On 01/13/22 at 9:30 AM during the entrance conference meeting with the Administrator and the Director of Nursing a request was made for the daily posted nurse staffing sheets since 04/01/21. A review of the daily posted nurse staffing information sheets provided revealed the sheets were only retained from 04/01/21 through 06/25/21. During an interview with the Director of Nursing (DON) on 01/13/22 at 4:55 PM the DON explained that she had only been employed by the facility for about a week and was informed that the facility did not retain the staffing sheets. An interview was conducted with the Clinical Scheduler on 01/13/22 at 6:00 PM. The Clinical Scheduler explained that she printed the nurse	F 732	1. The posted census/staffing sheets have been corrected to reflect actual census and hours per position per shift and archived within a binder for review. 2. Accurate reporting of staffing has the potential to affect all residents within the facility if the facility should be staffed lower than the state minimums. The staffing information is currently readily accessible and visible to residents within the facility and maintained in a binder in Director of Nursing office to meet requirement of maintaining for 18 months. 3. The DON/designee to educate nursing scheduler on requirement to post Daily Nursing Staffing Information, including daily census, total number and actual hours worked by licensed nursing staff who are directly responsible to resident care per shift. Education provided by the Administrator to the Director of Nursing, Human Resources and Scheduler on regulation of maintaining the staffing sheets for 18 months and readily available upon request.	

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F 732	Continued From page 2 posted staffing sheets and gave them to the Screener who documented the daily resident census on the sheets and posted the sheets in the entrance hallway. The Clinical Scheduler continued to explain that up until 06/25/21 she would retain the daily nurse posted sheets in a binder but since 06/26/21 she had not been given the sheets to maintain. During an interview with the Screener on 01/14/22 at 1:15 PM she explained that she was hired in November 2021 and was directed by the Administrator in December 2021 to post the daily nurse staffing information every day and to throw the old sheets away. An interview was conducted with the Administrator on 01/18/22 at 3:15 PM. The Administrator explained that the nurse posted staffing sheets were posted every day in the main entrance hall by the Clinical Scheduler and should be retained for 18 months. The Administrator continued to explain that he thought the staffing sheets were being maintained in a binder by the Clinical Scheduler which was his expectation.	F 732	4. The Administrator will audit the staffing sheet binder weekly x 4 weeks, and then monthly thereafter to ensure that records are maintained according to regulation. Audit results and findings will be included within the in the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 5. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 802		2/17/22

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F 802	Continued From page 3 §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure dietary staff had the necessary competencies and skills for food production and meal service. This resulted in dietary staff not following the recipe for pureed egg salad and serving egg salad above 41 degrees Fahrenheit. This affected 2 of 12 residents on 1 of 4 hallways (100 hall). The findings included: Review of a facility recipe for Egg Salad with no date noted read, Puree: prepare per recipe. Remove needed portions. Transfer to food processor, blend until smooth. If too thick, add small amount of milk, if too thin, add small amount of nonnutritive food thickener. Process until soft whipped cream consistency. Transfer to a 2-inch-deep hotel pan. Cover and chill to 41 degree or below for service. A continuous observation was made on 01/13/22 from 12:06 PM to 12:56 PM. Cook #1 and Cook #2 were observed on the lunch tray line plating meals and were observed to run out of puree egg salad at approximately 12:30 PM. Cook #1 left the tray line to go make more puree egg salad to	F 802	1. Affected residents were served a substitute meal of similar nutritive value. Administrator educated dietary staff about appropriate food temperature on 01/14/2022. Appropriate food temperature education was provided to dietary staff 1/20/2022, by the District Manager. 1. All Residents that are on a puree diet within the facility have the potential to be affected by this deficient practice. Staff instructed to monitor residents for any abnormal GI signs and symptoms (Fever, nausea diarrhea etc.) on 01/13/2022 as a result of residents potentially receiving hazardous food items, no residents observed to experience any complications. 2. All dietary staff will be trained/educated reviewing the fundamental concepts and competencies for food service and safe handling by the District Manager. The dietary manger will educate the dietary staff on the proper	

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F 802	Continued From page 4 finish the lunch meal service. Cook #2 remained on the tray line and continued to plate meals. Cook #1 was observed to go to the refrigerator and remove a Styrofoam plate that contained premade egg salad. Cook #1 placed the premade egg salad in the food processor and was observed to throw 4 slices of bread into the food processor, place the lid on the processor and turn it on. Once the egg salad and bread had made a thick puree mixture, Cook #1 placed the mixture back into the serving dish and placed a thermometer in the mixture and stated that the temperature of the pureed egg salad was 64-degree Fahrenheit (F). The container of the pureed egg salad was then placed on the steam table which was turned on and had visible steam coming off the table. Cook #1 and Cook #2 continued to plate the remaining plates on the 100 hall that required pureed egg salad. Once the trays had been plated the cart was then taken from the dietary kitchen to the 100 hall for service to the residents. Cook #1 was interviewed on 01/13/22 at 1:23 PM. Cook #1 stated that he had only worked at the facility for a week and had been showed how to do things in the kitchen by the Assistant Dietary Manager (ADM). He stated that when they ran out of pureed egg salad on the lunch service line, he offered to go make more so that they could finish the meal service. Cook #1 confirmed that he had used the left-over egg salad that was in the refrigerator and 4 slices of bread to puree the egg salad. Once the mixture was pureed, he stated that he placed the pureed egg salad mixture back into the serving dish and obtained the temperature which was 64 F and then placed the egg salad back on the steam table and continued to plate the lunch meals until all had	F 802	temperatures to serve hot and cold food items along with the importance of following the standard recipes to prepare meals the correct way. New staff member education will be incorporated in the orientation process upon hire. 3. The Dietary Manager will audit temperatures for hot and cold food five times a week for three weeks and twice a week for two months thereafter The Dietary Manager will audit recipes to ensure meals are prepared and served according to documented recipe books three times a week for three weeks and weekly for two months thereafter. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 4. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	

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F 802	Continued From page 5	F 802		

been plated. Cook #1 stated that he had not seen a menu on the correct way to puree the egg salad and was not familiar with the appropriate temperatures that food should be served and was going by what he had been told by the ADM during his training. Cook #1 stated that there was a chart for food temperatures in the kitchen that he could refer to if he needed too but had not done so for the puree egg salad.

Cook #2 was interviewed on 01/13/22 at 1:51 PM. Cook #2 stated that she had worked at the facility for 3 days and indicated she had received some training by the ADM. Cook #2 stated that she had prepared the egg salad yesterday (01/12/22) along with the ADM and placed it in the refrigerator and while preparing for the lunch meal service on 01/13/22 she had made the egg salad sandwiches and placed the rest back into the refrigerator to be used for the pureed meals. Cook #2 stated that it was a miss communication between herself and Cook #1 that the pureed egg salad got put on the steam table. Cook #2 stated that the pureed egg salad should be served cold but could not recall the appropriate temperature to serve. She stated that the temperature guide was new to her, and she was not familiar with it.

The Dietary Manager (DM) was interviewed on 01/13/22 at 2:05 PM. The DM stated that the ADM was tasked with training new employees and showing them around the kitchen. She stated that all cooks and dietary aides needed to be trained to know the appropriate temperatures to serve food. The DM stated that she expected the ADM to provide oversight to the Cooks and Aides during the meal service but stated during that meal service the ADM had remained in the dietary office located in the kitchen. The DM

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F 802	Continued From page 6	F 802		

stated that she expected Cook #1 and Cook #2 to recognize that the temperature of 64 F was not a safe temperature to serve to the residents and added that Cook #1 and Cook #2 should have spoken up and removed the pureed egg salad from the service line and placed it in the refrigerator to cool down or thrown it away and started over.

The ADM was interviewed on 01/13/22 at 4:15 PM. The ADM confirmed that he had provided the hands-on training to Cook #1 and Cook #2. The ADM stated that the temperature guide was located on the refrigerator for reference and all cold foods should be served below 41-degree Fahrenheit. He confirmed that he and Cook #2 had prepared the egg salad the day before and placed it in the refrigerator. The ADM stated that he was unaware that the puree egg salad had been placed on the steam table for service on 01/13/22 and stated, "it should have never happened." The ADM stated that the DM should have been providing the oversight in the kitchen for the lunch meal service because he had gone out to obtain preference for a new admission. The ADM stated that the egg salad could have been on the steam table in an ice bath and if the temperature of the egg salad was higher than 41 degrees it should have been thrown out and new prepared because it could not be served to the residents.

The Administrator was interviewed on 01/13/22 at 4:31 PM. The Administrator stated that the DM was responsible for training the new dietary staff and was responsible for the operation of the kitchen and should have been providing the oversight to Cook #1 and Cook #2 when preparing and serving the lunch meal.

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F 802	Continued From page 7	F 802		

An additional interview with the DM was conducted on 01/14/22 at 2:07 PM. The DM stated that the ADM was tasked with training new employees and showing them around the kitchen. She stated that she had been provided with education and competency sheets on 01/14/22 to go over with her employees. The education included food preparation, service line checklist, meal distribution, food quality and palatability, dining/food preferences, professional staffing, therapeutic diets, and infection control considerations. The competency worksheets were for the DM, Cooks, and Dietary Aides. The DM confirmed that Cook #1 and Cook #2 did not have the education and competencies completed upon hire and did not have the education to safely perform the lunch meal service line due to their lack of training and education.

The District Dietary Manager (DDM) of the dietary department was interviewed on 01/14/22 at 2:40 PM who confirmed that the DM or lead cook was supposed to take new employees under their wing for at least 3 shifts and start at the top with the recipes and work their way through the entire process. If the new employee needed additional training, then the DM would be responsible for ensuring that the employee had the training needed to safely carry out the functions of the kitchen. The DDM stated that once the employees were trained, they should remain under the close observation and supervision of the DM. He further stated that he had provided education and competency worksheets to the DM on 01/14/22 to go over with all the dietary employees and complete their competency worksheet. He stated that the education and competency worksheet should have been

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F 802	Continued From page 8 completed upon hire and then annually, he could not state why the competencies for Cook #1 and Cook #2 were completed upon hire.	F 802		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to honor a resident's preference of salad dressing for 1 of 3 residents reviewed for preferences (Resident #4). The findings included: Resident #4 was readmitted to the facility on 08/19/21. Review of the quarterly Minimum Data Set (MDS) dated 11/24/21 indicated that Resident #4 was cognitively intact and required set up assistance only with eating. Review of Resident #4's physician orders dated 01/01/22 through 01/31/22 contained the following order: Regular Diet/Regular texture. Review of Resident #4's medical record revealed	F 806	1. Thousand Island dressing was purchased for resident #4 per their preference on 01/20/2022. Resident is currently receiving preferred dressing on salad. 2. All Residents within the facility have the potential to be affected by this deficient practice. All current resident interviews will be conducted by the Dietary Manager to gather dietary preferences by 2/17/2022. Newly admitted residents will have their preferences documented upon admission and as needed thereafter to ensure that their preferences are being honored. Resident preferences will be entered into the system. 3. All dietary staff will be trained/educated by the District Manager	2/17/22

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F 806	Continued From page 9 no dietary preferences. Review of a facility document dated 01/13/22 revealed that Resident #4 required a regular diet, and no additional dietary likes or dislikes were listed for Resident #4. A continuous observation was made on 01/13/22 from 12:06 PM to 12:56 PM of the lunch meal tray service line in the facility's kitchen. At 12:26 PM Cook #2 stated to Cook #1 that they were starting to plate the 200 hall where Resident #4 resided. Cook #2 stated that Resident #4 had requested a salad and asked Cook #1 to step away from the steam table and make the salad with thousand island dressing for Resident #4. Cook #1 was observed to step away from the steam table to prepare Resident #4's salad and put it on a plate and cover the plate with a lid. Cook #1 returned to the steam table with the salad. Cook #2 again stated to Cook #1 that Resident #4 wanted thousand island dressing with her salad. Cook #1 was observed to grab 2 packs of ranch dressing and handed the tray with the ranch dressing to the Dietary Aide (DA) to put on the cart to be served to Resident #4. Cook #1 was interviewed on 01/13/22 at 12:30 PM. Cook #1 confirmed that he had prepared the salad for Resident #4 and stated that he knew she wanted thousand island dressing for her salad but all he could find in the kitchen was ranch, so he gave her ranch dressing. Resident #4 was interviewed on 01/13/22 at 3:36 PM. Resident #4 confirmed that she had ordered a salad with thousand island dressing for lunch that day. She stated she ordered a salad a lot and always requested thousand island dressing and	F 806	and Social Worker regarding resident rights and preferences regarding meals and alternatives, to include steps/actions to take if resident preference items are not readily available. New staff member education will be incorporated in the orientation process upon hire. 4. The Dietary Manager will audit 5 trays for matching resident preferences four times a week for three weeks and 10 trays weekly for 2 months thereafter. The Dietary Manager will perform a condiment audit three times a week for three weeks and weekly for three weeks thereafter ensuring that inventory par levels are adequate to meet resident needs and prefrences. Social Services will interview 5 alert and oriented residents weekly regarding food preferences being honored for three weeks. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 5. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	

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F 806	Continued From page 10	F 806		

they always served me ranch and "I don't like ranch." She stated that she did not eat her salad today at lunch because she did not like the ranch dressing that was served with her salad.

The Dietary Manager (DM) was interviewed on 01/13/22 at 4:04 PM. The DM stated she was not sure who obtained preferences at the facility, she stated she had not obtained any preferences since she started at the facility about a month ago. The DM stated if a resident requested something different for a meal, she would write it down and hand the request to the cook and if it was something that needed to be changed on the tray ticket, she would update that at that time. For example, if a resident did not like grits, she would let the cook know and then update that residents tray ticket to reflect the dislike. The DM stated that she was aware that Resident #4 did not like tomatoes but was not aware that she did not like ranch dressing. She stated she had placed an order on 01/13/22 that included thousand island dressing because the facility was out. She also confirmed that she had not ordered thousand island dressing since she had been at the facility. The DM stated that thousand island dressing was not an unreasonable request and if Cook #1 or Cook #2 would have said something to her she could have gone to the local grocery store to get the dressing for Resident #4.

The Assistant Dietary Manager (ADM) was interviewed on 01/13/22 at 4:15 PM. The ADM stated that he obtained preferences routinely from new admissions and then as needed for other residents. He confirmed that Resident #4 ordered a lot of salads from the kitchen and stated that she preferred French, or thousand island dressing and added "ranch is not her favorite."

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F 806	Continued From page 11 The ADM stated that if the kitchen was out of something that a resident requested, he would go the local grocery store and get enough to get by until the item could be ordered and delivered to the facility. The ADM stated that if Cook #1 or Cook #2 had said something about being out of thousand island dressing, he could have ran to the grocery store and got the dressing for Resident #4. The Administrator was interviewed on 01/13/22 at 4:31 PM. The Administrator stated that the DM was responsible for obtaining preferences and ensuring that the kitchen had the residents preferred items. He stated that the DM could have gone to the grocery store and picked up the salad dressing if the kitchen was out of it.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/17/22

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F 812	Continued From page 12 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to follow their recipe for pureed egg salad and failed to serve pureed egg salad, a potentially hazardous food, at 41 degree or below per the recipe on the lunch tray line for 1 of 1 observed meal. This had the potential to affect 2 of 12 residents on the 100 hall. The facility also failed to remove expired food items and unlabeled food items from 1 of 1 refrigerator, 1 of 1 freezer, 1 of 1 dry storage areas, and 1 of 2 nourishment rooms (200 hall) reviewed. The findings included: 1a. Review of a facility recipe for Egg Salad with no date noted read, Puree: prepare per recipe. Remove needed portions. Transfer to food processor, blend until smooth. If too thick, add small amount of milk, if too thin, add small amount of nonnutritive food thickener. Process until soft whipped cream consistency. Transfer to a 2-inch-deep hotel pan. Cover and chill to 41 degree or below for service. A continuous observation was made on 01/13/22 from 12:06 PM to 12:56 PM. Cook #1 and Cook #2 were observed on the lunch tray line plating meals and were observed to run out of puree egg salad at approximately 12:30 PM. Cook #1 left the tray line to go make more puree egg salad to finish the lunch meal service. Cook #2 remained on the tray line and continued to plate meals. Cook #1 was observed to go to the refrigerator and remove a Styrofoam plate that contained premade egg salad. Cook #1 placed the premade egg salad in the food processor and was	F 812	1. All outdated/expired food items were thrown out and discarded immediately on 1/13/2022. Lids were fastened to food containers that required them on 1/13/2022. Affected residents were served a substitute meal of similar nutritive value. Administrator educated dietary staff about appropriate food temperature on 01/14/2022. Appropriate food temperature education was provided to dietary staff 1/20/2022, by the District Manager. 2. All Residents within the facility have the potential to be affected by this deficient practice. Staff instructed to monitor residents for any abnormal GI signs and symptoms (Fever, nausea diarrhea etc.) on 01/13/2022 as a result of residents potentially receiving hazardous food items, no residents observed to experience any complications. 3. All dietary staff will be trained/educated on marking and dating foods properly along with proper storage by the District Manager. New staff member education will be incorporated in the orientation process upon hire. District Manger will implement new labeling system for food items to be utilized in the nourishment room, refrigerated food areas and dry storage food areas. The dietary manger will educate the dietary staff on the proper temperatures to serve hot and cold food items along with the	

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F 812	Continued From page 13 observed to throw 4 slices of bread into the food processor, place the lid on the processor and turn it on. Once the egg salad and bread had made a thick puree mixture, Cook #1 placed the mixture back into the serving dish and placed the egg salad back on the steam table and Cook #1 and Cook #2 finished plating the remaining plates on the 100 hall that required pureed egg salad. Cook #1 was interviewed on 01/13/22 at 1:23 PM. Cook #1 stated that he had only worked at the facility for a week and had been showed how to do things in the kitchen by the Assistant Dietary Manager (ADM). He stated that when they ran out of pureed egg salad on the lunch service line, he offered to go make more so that they could finish the meal service. Cook #1 confirmed that he had used the left-over egg salad that was in the refrigerator and 4 slices of bread to puree the egg salad. Once the mixture was pureed, he stated that he placed the pureed egg salad mixture back into the serving dish and back on the steam table. Then continued to plate the lunch meals until all had been plated. Cook #1 stated that he had not seen a menu on the correct way to puree the egg salad and was going by what he had told by the ADM during his training. The Dietary Manager (DM) was interviewed on 01/13/22 at 2:05 PM. The DM stated that the lunch meal service was a result of lack of communication and a lack of training. The DM stated she was unaware that Cook #1 had pureed the egg salad incorrectly. She continued to say that when she arrived at work that day most of the preparation for the lunch meal had already been done so was doing other things. The DM stated that she expected the ADM to provide	F 812	importance of following the standard recipes to prepare meals the correct way. 4. The Dietary Manager /and weekend manager on duty will audit the nourishment room, refrigerated food areas and dry storage food areas for expired/outdated items daily for three weeks and twice a week for two months thereafter. The Dietary Manager will audit 5 trays for temperatures for hot and cold food items 5 X□s per week for three weeks and twice a week for two months thereafter The Dietary Manager will audit recipes to ensure meals are prepared and served according to documented recipe books three times a week for three weeks and weekly for two months thereafter. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 5. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	

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oversight to the Cooks and Aides during the meal service but stated during that meal service the ADM had remained in the dietary office located in the kitchen.

The ADM was interviewed on 01/13/22 at 4:15 PM. The ADM confirmed that he had provided the hands-on training to Cook #1 and Cook #2. He confirmed that he and Cook #2 had prepared the egg salad the day before and placed it in the refrigerator. The ADM confirmed that he did not use the recipe when preparing the egg salad, the day before because "he just knew how to make the egg salad." The ADM stated that he was unaware that the puree egg salad had been pureed incorrectly on 01/13/22 and stated, "it should have never happened." The ADM stated that the DM should have been providing the oversight in the kitchen for the lunch meal service because he had gone out to obtain preference for a new admission.

The Administrator was interviewed on 01/13/22 at 4:31 PM. The Administrator stated that the DM was responsible for training the new dietary staff and was responsible for the operation of the kitchen and should have been providing the oversight to Cook #1 and Cook #2 when preparing and serving the lunch meal.

1b. A continuous observation was made on 01/13/22 from 12:06 PM to 12:56 PM. Cook #1 and Cook #2 were observed on the lunch tray line plating meals and were observed to run out of puree egg salad at approximately 12:30 PM. Cook #1 left the tray line to go make more puree egg salad to finish the lunch meal service. Cook #2 remained on the tray line and continued to plate meals. Cook #1 was observed to puree

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additional egg salad and place the mixture back into the serving dish and placed a thermometer in the mixture and stated that the temperature of the pureed egg salad was 64-degree Fahrenheit (F). The container of the pureed egg salad was then placed on the steam table which was turned on and had visible steam coming off the table. Cook #1 and Cook #2 continued to plate the remaining plates on the 100 hall that required pureed egg salad. Once the trays had been plated the cart was then taken from the dietary kitchen to the 100 hall for service to the residents. During the continuous observation of the lunch meal the Dietary Manager (DM) and Assistant Dietary Manager (ADM) remained in the office located in the kitchen. Once the meals trays were taken to the 100 hall the meal service was stopped by the surveyor and the DM was notified that puree egg salad, a potential hazardous food had a temperature 64 F. The DM immediately proceeded to the kitchen to begin preparing something for the residents to eat.

Cook #1 was interviewed on 01/13/22 at 1:23 PM. Cook #1 stated that he had only worked at the facility for a week and had been showed how to do things in the kitchen by the ADM. He stated that when they ran out of puree egg salad on the lunch service line, he offered to go make more so that they could finish the meal service. Once the mixture was pureed, he stated that he placed the pureed egg salad mixture back into the serving dish and obtained the temperature which was 64 F, and he placed the puree egg salad mixture back on the steam table that was turned on. Then continued to plate the lunch meals until all had been plated. Cook #1 could not explain why he placed the puree egg salad mixture on the steam table and stated that he was not familiar

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with the appropriate temperatures that food should be served. Cook #1 stated that there was a chart for food temperatures in the kitchen that he could refer to if he needed too but had not done so for the puree egg salad. He continued to say he was just going by what the ADM had showed him during his hands on training.

Cook #2 was interviewed on 01/13/22 at 1:51 PM. Cook #2 stated that she had worked at the facility for 3 days and indicated she had received some training by the ADM. Cook #2 stated that she had prepared the egg salad yesterday (01/12/22) along with the ADM and placed it in the refrigerator and while preparing for the lunch meal service on 01/13/22 she had made the egg salad sandwiches and placed the rest back into the refrigerator to be used for the pureed meals. Cook #2 stated that it was a miss communication between herself and Cook #1 that the pureed egg salad got put on the steam table. Cook #2 stated that the pureed egg salad should be served cold but could not recall the appropriate temperature to serve. She stated that the temperature guide was new to her and she was not familiar with it.

The DM was interviewed on 01/13/22 at 2:05 PM. The DM stated that the lunch meal service was a result of lack of communication and a lack of training. She stated that all cooks and dietary aides needed to be trained to know the appropriate temperatures to serve food. The DM stated she was unaware that the egg salad was on the steam table for service. She continued to say that when she arrived at work that day most of the preparation for the lunch meal had already been done so was doing other things. The DM stated that she expected the ADM to provide oversight to the Cooks and Aides during the meal

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service but stated during that meal service the ADM had remained in the dietary office located in the kitchen. The DM stated that she expected Cook #1 and Cook #2 to recognize that the temperature of 64 F was not a safe temperature to serve to the residents. She added that Cook #1 and Cook #2 should have spoken up and removed the pureed egg salad from the service line and placed it in the refrigerator to cool down or thrown it away and started over. The DM stated that the staff was able to stop the service to the residents on the 100 hall and confirmed that no one had received the pureed egg salad.

The ADM was interviewed on 01/13/22 at 4:15 PM. The ADM confirmed that he had provided the hands-on training to Cook #1 and Cook #2. The ADM stated that the temperature guide was located on the refrigerator for reference and all cold foods should be served below 41-degree Fahrenheit. He confirmed that he and Cook #2 had prepared the egg salad the day before and placed it in the refrigerator. The ADM stated that he was unaware that the puree egg salad had been placed on the steam table for service on 01/13/22 and stated, "it should have never happened." The ADM stated that the DM should have been providing the oversight in the kitchen for the lunch meal service because he had gone out to obtain preference for a new admission. The ADM stated that the egg salad could have been on the steam table in an ice bath and if the temperature of the egg salad was higher than 41 degrees it should have been thrown out and new prepared because it could not be served to the residents.

The Administrator was interviewed on 01/13/22 at 4:31 PM. The Administrator stated that the DM

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was responsible for training the new dietary staff and was responsible for the operation of the kitchen and should have been providing the oversight to Cook #1 and Cook #2 when preparing and serving the lunch meal.

The Registered Dietician (RD) was interviewed on 01/14/22 at 8:33 AM. The RD stated that the way Cook #1 pureed the egg salad did not change the nutritional value of the food but added he should have followed the recipe. The RD stated that the DM was responsible for how the kitchen functioned and for training or delegating training of all new employees and ensuring that they knew the policies and procedures of the facility regarding serving safe food. She added that foods that were in the "danger zone" could not be used especially if you don ' t know how long it had been sitting out. The RD stated she expected the DM, ADM, and kitchen staff to following their policies and recipe to ensure safe food service delivery.

2a. During an initial tour of the facility's kitchen on 01/13/22 at 10:15 AM an observation of the facility's reach in refrigerator revealed one open and undated tub of butter that was ¼ used. An observation of the facility's dry storage area revealed 2 8-count packages of hotdog buns with a use by date of 12/08/21, 4 12-count packages of hotdog buns with a use by date of 12/22/21, and 4 individual hamburger buns outside of the bag sitting on the bread shelf that the Dietary Manager described as being "hard as a rock." There was a large flour container with a reported 50 pounds of loose flour that was missing it's lid and was open to the air.

During an interview with the Dietary Manager on

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01/13/22 at 10:37 AM, she reported she checks the kitchen daily for food that was not labeled or dated, out of date, or expired. She stated the facility's bread delivery company was responsible for swapping out bread when it reached the use by date and that she did not know how they missed the out-of-date bread since they "just came yesterday". The Dietary Manager reported all food items should be dated when opened before being stored and she did not know how the items were missed.

During an interview with Dietary Aide #1 and Dietary Aide #2 on 01/13/22 at 10:45 AM, they reported they were still in training and they were unaware that food items that were opened needed an opened date on them. They both reported they thought if there was a "use by" or expiration date on the food items, then that served as the date for discarding the food items.

During an interview with the Administrator on 01/13/22 at 4:38 PM, he reported there had recently been a major overhaul of the kitchen staff and that they were having to train new staff members. He indicated that he expected all food items to be properly dated and stored in the kitchen.

2b. During a tour of the facility's nourishment room on 01/13/22 at 10:24 AM the following items were observed in the nourishment room refrigerator and were opened and undated: one 8 ounce bag of sharp cheddar cheese, a 16 ounce soda, and a 12 ounce bottle of mayonnaise. Also observed in the nourishment room refrigerator was 7 cups of strawberry and harvest peach yogurt that expired on 11/23/21 and 1 cup of yogurt with an expiration date of 10/01/21.

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F 812	Continued From page 20 During an interview with the Dietary Manager on 01/13/22 at 10:39 AM she reported dietary staff were responsible for monitoring the food in the nourishment room. She stated she expected the nourishment room refrigerator to be checked daily and food that has expired is to be removed. She reported she checked the nourishment room refrigerator this morning and did not see the undated and opened items, nor did she see the expired yogurt.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place on 04/09/21. This was for one deficiency in the area of Food Procurement, Store/Prep/Serve-Sanitary that was originally cited on the 03/12/21 recertification survey. The deficiency was cited again on the current complaint investigation survey with an exit date of 01/18/22. The continued failure of the facility during the two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.	F 867	1. All outdated/expired food items were thrown out and discarded immediately on 1/13/2022. Lids were fastened to food containers that required them on 1/13/2022. Affected residents were served a substitute meal of similar nutritive value. Administrator educated dietary staff about appropriate food temperature on 01/14/2022. Appropriate food temperature education was provided to dietary staff 1/20/2022, by the District Manager. 2. All Residents within the facility have the potential to be affected by this deficient practice. Staff instructed to	2/17/22

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F 867	Continued From page 21 The finding included: This citation is cross referenced to: F-812: Based on observations, record review and staff interview the facility failed to follow their recipe for pureed egg salad and failed to serve pureed egg salad, a potentially hazardous food at 41 degrees or below per the recipe on the lunch tray line for 1 of 1 observed meal. The had to potential to affect 2 of 12 residents on the 100 hall. The facility also failed to remove expired food items and unlabeled food items from 1 of 1 refrigerator, 1 of 1 freezer, 1 of 1 dry storage areas and 1 of 2 (200 hall) nourishment rooms reviewed. During the recertification survey completed on 3/12/21 the facility was cited for failing to label and date opened food items in one of two kitchen refrigerators and one of one nourishment room refrigerators and failed to remove expired items from one of one nourishment room refrigerators. An interview was conducted with the Administrator on 01/18/22 at 3:15 PM. The Administrator explained that there had been a recent mass turnover in the Dietary department due to multiple issues such as employee termination, death, and the universal vaccine mandate. Regardless, the Administrator stated his expectation was for the food items to be properly labeled and expired food items be removed from storage per the facility policy.	F 867	monitor residents for any abnormal GI signs and symptoms (Fever, nausea diarrhea etc.) on 01/13/2022 as a result of residents potentially receiving hazardous food items, no residents observed to experience any complications. 3. All dietary staff will be trained/educated on marking and dating foods properly along with proper storage by the District Manager. District Manger will implement new labeling system for food items to be utilized in food storage areas. The dietary manger will educate the dietary staff on the proper temperatures to serve hot and cold food items along with the importance of following the standard recipes to prepare meals the correct way. The District Manager will participate in the facility QAPI meetings for three months. Administrator, Director of Nursing and Interdisciplinary Team all completed education regarding Quality Assurance and Performance Improvement to include process for maintaining systems, implementations of plans and monitoring of plans to ensure deficient practice is corrected. 4. The Dietary Manager will audit food storage areas for expired/outdated items four times a week for three weeks and twice a week for two months thereafter. The Dietary Manager will audit 5 trays for temperatures for hot and cold food items 5 X week for three weeks and twice a	

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F 867	Continued From page 22	F 867	week for two months thereafter The Dietary Manager will audit recipes to ensure meals are prepared and served according to documented recipe books three times a week for three weeks and weekly for two months thereafter. Regional Nurse will review center Quality Assurance and Performance Improvement Committee minutes monthly X 3 months to ensure adequate measures and practices are implemented and monitored to ensure compliance with regulation. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 5. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		2/17/22

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(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 880	Continued From page 23 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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	345261	A. BUILDING _____ B. WING _____	C 01/18/2022

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F 880	Continued From page 24 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow the facility hand washing policy when 1 of 3 staff members (Nurse Aide #2) failed to wash her hands and change her gloves between contact between 2 residents (Resident #2 and Resident #3) on 1 of 4 halls (300 hall) and also failed to follow Center for Disease Control and Prevention (CDC) guidelines regarding appropriate Personal Protective Equipment (PPE) for counties of high transmission rate when 1 of 1 Hospice Staff failed to wear eye protection when providing care to 1 of 1 resident (Resident #1). The failure occurred during a COVID-19 pandemic. The findings included: 1. Review of the facility hand washing policy dated 2/15/2021, revealed in part that staff was to	F 880	1. Proper Infection Control practices related to handwashing as well as CDC guidelines regarding appropriate use of PPE are currently being followed in the center. Education provided by the Director of Nursing to the Hospice staff member on appropriate PPE. 2. All Residents within the facility have the potential to be affected by this deficient practice. Center currently has no diagnosed Covid positive residents. 3. Director of Nursing or designee to provide staff education for all staff, on the facility handwashing policy and CDC guidelines regarding proper use of PPE, hand hygiene, use of eye protection in resident care areas for counties with high	

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F 880	Continued From page 25 use hand hygiene practices before patient care, before an aseptic procedure, after any contact with blood or other body fluids, even if gloves were worn, after patient care and after contact with patient environment. An observation was made Nurse Aide (NA) #2 on 1/13/22 at 10:10 AM. NA #2 leaving Resident #2's room with gloves on her hands and she proceeded down the hallway to Resident #3's room. Resident #3 was sitting in a wheelchair in the hallway, NA #2 was observed turning Resident #3 around in her wheelchair and pushed the wheelchair back to Resident #3's room and entered the room without washing her hands, removing, or changing gloves. NA #2 was interviewed on 1/13/2022 at 10:56AM, she stated that she had been trained on infection control and she knew she should have removed her gloves and washed her hands when she left Resident #2's room and before she assisted Resident #3. NA #2 confirmed that she had provided personal care to Resident #2 before she assisted Resident #3. NA #2 stated that she simply forgot to perform hand hygiene and change her gloves. The Director of Nursing (DON) was interviewed on 1/13/2022 at 5:25pm, she stated that all staff received infection control training that included handwashing, personal protective equipment, and isolation. She stated that NA #2 should have removed her gloves and washed her hands when she left Resident #2's room and prior to helping Resident #3 per the facility hand hygiene policy. 2. The Center for Disease Control and Prevention	F 880	transmission rates. Screener education to include hand hygiene and proper PPE for staff and visitors based on outbreak status and county transmission rates. Education to Hospice agencies providing care regarding proper use of PPE with current county transmission rates, outbreak status, and CDC guidance. Director of Nursing or designee to provide screeners education on ensuring visitors, vendors and outside providers are wearing appropriate PPE before entering resident care areas. 4. Infection control rounds will be performed by the clinical leadership with a focus on appropriate use of gloves and handwashing three times a week for three weeks then weekly for three weeks thereafter. Infection Control round sheets to be audited by CNE/ or designee three times a week for three weeks then weekly for three weeks thereafter. Visiting healthcare personnel PPE inspection audits to be completed daily by CNE/or designee for three weeks then twice a week for three weeks thereafter. Results and findings of the audits will be reported/presented to the Administrator for review. Audit results and findings will be included within the in the Quality Assurance Performance Improvement committee meeting monthly for 2 months to evaluate the effectiveness of the plan adjusting where necessary. 5. All corrective action for the deficient practice will be completed with a compliance date of 02/17/2022.	

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(CD) guidance titled "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic" updated on 09/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for Healthcare Personnel (HCP): If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), the HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.

The CDC Covid19 Tracker was reviewed on 01/14/22 and revealed that Alleghany County was in the red (high) for transmission of COVID19.

An observation and interview were conducted with Nurse Aide (NA) #1 on 01/13/22 at 10:09 AM. NA #1 was observed pushing Resident #1 up the hallway from her room to the day room on the unit. NA #1 had on a N95 mask but had no eye protection on. NA #1 stated that she worked with hospice and had just visited with Resident #1 and provided her a full bed bath, washed her hair, trimmed her nails, and transferred her to her wheelchair and then taken her to the day room on the unit. NA #1 stated that when she visited the facility she stopped at the front door and was screened by the facility Screener but was not informed that she needed to apply eye protection. She further explained that she had goggles and if the facility staff informed her that she needed to wear eye protection she would put them on.

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The Screener was interviewed on 01/14/22 at 3:46 PM. The Screener confirmed that she screened all employees/vendors/visitors upon entrance to the facility during her shift. She also confirmed that she had screened NA #1 on 01/13/22 and did not provide her with eye protection because she was not aware that she had to do so. The Screener stated that she was informed late yesterday (01/13/22) that everyone except visitors had to wear eye protection while in the facility and she had been instructed to ensure that they either had eye protection or provide them some after screening and before allowing them to enter the facility.

The Administrator was interviewed on 01/13/22 at 4:31 PM. The Administrator stated that the facility had a Screener at the front door who was responsible for screening all employees, visitors, and vendors at the facility. He added that eye protection should be worn in all resident care areas and NA #1 should have been provided eye protection when she was screened at the front door on 01/13/22 or informed that she needed to apply eye protection if she had her own.

The Director of Nursing (DON) was interviewed on 01/13/22 at 5:40 PM. The DON stated that the facility was in a county of high transmission and staff were expected to wear eye protection when in resident care areas and while performing resident care. The DON stated that NA #1 came in and was screened for COVID-19 at the front door by the Screener but was not provided eye protection and indicated that they would have to retrain the Screener to provide eye protection to all staff and vendors entering the facility.