STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted 7/25/2023 through 7/27/2023. Event ID # MZH711. The following intakes were investigated NC00204984, NC00204915, NC00204593, NC00203779, NC00203136, NC00201153 and NC00201182. 13 of 13 complaint allegations did not result in a deficiency.	F 000		
F 812 SS=F	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 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure the internal temperature of cooked food for the lunch meal was monitored prior to service. This was for 1 of 2 meal observations. This practice had the potential to serve residents food not within safe temperature	F 812	1. The facility failed to ensure the internal temperature of cooked food for the lunch meal was monitored prior to service. This was for 1 of 2 meal observations. This practice had the potential to serve residents food not within	8/1/23

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

Electronically Signed | 08/11/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 812	Continued From page 1 ranges to minimize bacterial growth. The finding included: On 07/26/23 at 12:15 PM observation of the lunch meal tray line was already in process with Cook #1 plating the food. Further observation revealed meal trays had already been assembled, loaded onto the meal carts and waiting for delivery. The meal included: sliced pork lion, puree pork, fish patty, roasted potatoes, mashed potatoes, green peas, broccoli, and puree broccoli. The Dietary Manager (DM) was present for the tray line observations and was asked about the system for monitoring food temperatures. The DM explained that the food temperatures should be taken prior to meal service by the Cook and recorded on a log. Review of the temperature log for 07/26/23 revealed no temperatures recorded for the lunch meal. The DM revealed Cook #1 had not taken the temperatures for the lunch meal. At 12:20 PM on 07/26/23 the DM was asked to stop plating and distributing the lunch meal process and obtain temperatures for the food items on the steam table. The Dietary Manager obtained the following food temperatures with a digital thermometer that registered the degrees in Fahrenheit. Food items left to serve were recorded at temperatures of sliced pork lion 181, puree pork 187, fish patty 165, roasted potatoes 209, puree mashed potatoes 166, green peas 167, broccoli 167, puree broccoli 162 degrees (no puree diets left to be served). An interview was conducted with Cook #1 on 07/26/23 at 12:25 PM. The Cook explained that she knew she had to obtain the temperature the food before she started the plating process, but	F 812	safe temperature ranges to minimize bacterial growth. Upon notification of deficient practice, the tray line was stopped, and temperatures were obtained prior to finishing the tray line. No adverse outcomes resulted from deficient practice. 2. All current facility residents are at risk of being affected by this deficient practice. 3. The facility has put the following in place to ensure the deficient practice does not reoccur. The cook will be responsible for obtaining and recording food temperature prior to serving food. The Administrator educated all current dietary staff on 8.1.23 on requirements of obtaining food temperatures prior to serving to ensure food is at safe temperature ranges. Any new dietary employee or employee not educated by 8.1.23 will be educated prior to working their first shift. 4. The Administrator will audit the tray line and temperature logs 5 times a week for 4 weeks, then 3 times a week for 4 weeks, and then weekly for 4 weeks to ensure the food is being temperature checked prior to serving to ensure food is being served within a safe temperature range. The certified dietary manager will bring data from audits to the Quality Assurance Performance Improvement meeting weekly for 3 months to review for compliance. 5. Compliance Date: 8.1.23	

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F 812	Continued From page 2 she decided to start the tray line process without measuring the temperatures of the food. The Cook indicated she understood that it was important to obtain the temperatures of the food before plating began to ensure the food was served in the acceptable temperature range. An interview conducted on 07/26/23 at 5:40 PM with the Administrator revealed he expected the food temperatures to be taken and recorded before the meals were plated to ensure the temperatures were within a safe range for consumption.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		8/1/23

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F 867	Continued From page 3	F 867		

will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 4 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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F 867	Continued From page 5 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification surveys of 1/28/2022 and 12/16/2022. The repeat deficiency was cited on the current complaint investigation of 7/27/23 in the area of Food and Nutrition (F812). The facility's continued failure during three Federal surveys showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to: F-812: Based on observations and staff interviews the facility failed to ensure the internal temperature of cooked food for the lunch meal was monitored prior to service. This was for 1 of 2 meal observations. This practice had the potential to service residents' food not within safe temperature ranges to minimize bacterial growth. During the recertification and complaint survey of 1/28/2022 the facility was cited for failing to discard food with visible signs of spoilage and to	F 867	1) The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification surveys of 1/28/2022 and12/16/2022. The repeat deficiency was cited on the current complaint investigation of 7/27/23 in the area of Food and Nutrition (F812). The facility's continued failure during three Federal surveys showed a pattern of the facility's inability to sustain an effective QAA program. 2) On 8.1.23, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility Interdisciplinary Team (IDT) including the Medical Director, VP of Clinical & QAPI and VP of Operations to review F812 and the Food Temperature Policy and the facilities previous F812 citations and failure to prevent repeat citation. Root cause analysis determined to be the dietary manager s lack of fully understanding facility Quality Assurance (QA) process and a lack of quality oversight.	

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F 867	Continued From page 6 ensure that dietary staff had all hair covered during meal service. During the recertification and complaint survey of 12/16/2022 the facility was cited for failing to date, remove, or discard potentially hazardous foods stored for use with signs of spoilage, store foods in sealed containers, and store nonperishable foods off the floor. A telephone interview was conducted with the Administrator on 7/27/2023 at 9:07 AM. He indicated he was the head of the QAA committee. The Administrator revealed the facility had provided on-going education to dietary staff on monitoring and documenting food temperatures prior to service for safety. He stated he believed that the new Dietary Manager did not fully understand the QAA process of what issues to report, when an issue is identified to report to the Administrator, and to follow-up with the results of the audits to the Administrator and QAA committee. The Administrator stated he was responsible for ensuring the Dietary Manager understood the QAA process of what identified issue to report, when to report the identified issue, and the follow-up of conducting audits and reporting the results of the audits to himself and QAA committee.	F 867	3) On 8/1/23, the Regional Director of Clinical Services provided education to the IDT including the Medical Director, the Administrator, Director of Nursing, Food Service Director, the Unit Managers, the Activity Director, the Business Office, the Receptionist, the facility Scheduler, the Social Worker, the Rehab Manager, and the Medical Record Clerck, on maintaining an effective QAPI program to prevent repeat citations. The administrator did one on one education with dietary manager on the facilities QA process. Any new IDT staff or IDT staff not educated by 8/1/23 will be educated. Effective 8/1/23, the facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained per corrective plan. 4) The Regional Director of Clinical Services will attend QAPI meetings monthly for three (3) months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAPI improvement activities. Completion Date: 8.1.23	