STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

(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 onsite complaint investigation survey was conducted on 12/12/23, with additional information obtained on 12/13/23. Therefore, the exit date was changed to 12/13/23. See Event ID #DON311. Intakes #NC00208800 and NC00210561 were investigated. Two (2) of the 2 allegations resulted in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		1/4/24

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

Electronically Signed | 01/01/2024

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to treat residents in a dignified manner when they served the resident's supper meals in Styrofoam containers for 2 of 3 residents reviewed for dignity (Resident #2 and Resident #3). The findings included: 1. Resident #2 was admitted to the facility on 08/04/23. The quarterly Minimum Data Set assessment dated 11/07/23 indicated Resident #2's cognition was moderately impaired. On 12/12/23 at 5:30 PM during an observation of the supper meal tray line in process of plating the food, Cook #1 obtained 7 black Styrofoam containers to utilize for the residents' meals to complete the plating process. An interview conducted with Cook #1 on 12/12/23 at 5:30 PM who explained that they often had to use the containers because they did not have	F 550	Address how corrective action will be accomplished for those residents found to have been affected: Resident #2 and Resident #3 were identified as the Residents affected. Small wares were ordered and arrived to the facility on 12/18/2023 to ensure adequate supply is available so when the last hall is served all Residents will receive small wares and not Styrofoam containers. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Small wares were ordered and arrived to the facility on 12/18/2023 to ensure adequate supply is available for all residents. In-service was conducted with manager and staff on utilizing proper small wares for all residents with every meal. All new Dietary staff onboarded with Healthcare Services group will be in serviced on the areas already included in the onboarding process: Bloodborne Pathogens, Chemical Use, Dilution and	

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F 550	Continued From page 2	F 550		

enough plate covers to use for the meals. The Cook continued to explain that they normally had enough for breakfast but throughout the day they had to resort to the containers because for whatever reason the covers did not make it back to the kitchen in time to be washed for the next meals.

During an interview with the Dietary Manager (DM) on 12/12/23 at 5:57 PM the DM explained that he had known about having to utilize the black Styrofoam containers for the residents' meals for a few months because he notified the Administrator before the last recertification (10/05/23) and since the new company took over (11/01/23) that they did not have enough of the plate toppers. He stated they had to utilize the containers about twice a week.

An interview and observation were conducted with Resident #2 at 6:00 PM on 12/12/23. The Resident was sitting on the side of his bed eating his supper meal which was in a black Styrofoam container. The Resident was asked why he received his meal in the black container, and he replied he did not know but it comes that way about three fourths of the time. He remarked "I don't know why I have to have my food like this when everybody else gets theirs on a plate." When asked how it made him feel Resident #2 remarked "like I am not as good as everybody else."

On 12/12/23 at 6:02 PM during an interview with the Dietary Director, she indicated that it was unacceptable for the kitchen to serve meals in Styrofoam containers except if the resident had a specific care plan that indicated the need for the container. She stated it was the facility's

Hazards Hand Hygiene, Hazard Communication Program, Hepatitis B Vaccine Procedure, Personal Protective Equipment, Infection Control Policy, Workplace Injuries Injury/Illness, Incident Reporting, Safety Data Sheets (SDS), Lock Out Tag Out, TB Awareness, Dementia Overview, Employee Conduct and Work Rules Policy, Employee Handbook, Harassment, Sexual Harassment, Discrimination, HIPAA, Patient/Resident Rights Abuse/Neglect Elder Justice Act, Social Responsibilities in the Workplace, Workplace Violence, Cross Contamination, Glove Usage, Hand-Hygiene, Garbage and Trash Disposal, Food Code □ Health Reporting Responsibilities, Personal Protective Equipment, Common Causes of Foodborne Illness and Prevention, Cleaning and Sanitizing, Service Line Procedures in addition to these areas, all new dietary staff will be in serviced on utilizing proper small wares for all Residents for every meal. Dietary staff will utilize the Service Line Checklist at each meal and will be overseen by Healthcare Service Group management to ensure this form is filled out correctly and timely. The Service Line Checklist is a form that is to be completed with every meal 7 days a week. This form includes check offs of: Appropriate service ware available for all Residents, food temperatures, etc. Healthcare Services Group staff typically does a smallware inventory on a quarterly basis. A new inventory spreadsheet was created that Healthcare Services Group staff can

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F 550	Continued From page 3 responsibility to provide the plate covers and it should not have taken this long to obtain them. An interview was conducted with the Administrator on 12/12/23 at 7:15 PM. The Administrator stated that she was aware of and had been told of the shortage of plate covers and had to resort to using the Styrofoam containers. She explained that she was under the impression that the new company would purchase the covers and bill the facility for them. 2. Resident #3 was admitted to the facility on 07/06/23. The quarterly Minimum Data Set assessment dated 09/12/23 indicated Resident #3 was cognitively intact. On 12/12/23 at 5:30 PM during an observation of the supper meal tray line in process of plating the food, Cook #1 obtained 7 black Styrofoam containers to utilize for the residents' meals to complete the plating process. An interview conducted with Cook #1 on 12/12/23 at 5:30 PM who explained that they often had to use the containers because they did not have enough plate covers to use for the meals. The Cook continued to explain that they normally had enough for breakfast but throughout the day they had to resort to the containers because for whatever reason the covers did not make it back to the kitchen in time to be washed for the next meals. During an interview with the Dietary Manager (DM) on 12/12/23 at 5:57 PM the DM explained that he had known about having to utilize the	F 550	inventory the small wares weekly for 4 weeks, bi-weekly 4 weeks then monthly thereafter. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Manager or designee will present to QI committee will review the results of Audit Tools and checklists referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the quarterly QA meeting. Compliance Date 01/04/2024	

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F 550	Continued From page 4	F 550		

black Styrofoam containers for the residents' meals for a few months because he notified the Administrator before the last recertification (10/05/23) and since the new company took over (11/01/23) that they did not have enough of the plate toppers. He stated they had to utilize the containers about twice a week.

An interview and observation were conducted on 12/12/23 at 6:33 PM with Resident #3. The Resident was sitting in his straight back chair and had finished eating his meal. His supper tray was sitting on the over bed table and had the black Styrofoam container sitting on the tray. The Resident had finished eating and remarked the meal was okay. Resident #3 was asked why he received his meal in the black container, and he replied, "well I don't like it, they are cheap, I am paying a lot of money to eat cheap." He continued to explain that he received his meals in containers a lot and sometimes even plastic forks and knives as well. The Resident stated, "no one has told me why I get them."

On 12/12/23 at 6:02 PM during an interview with the Dietary Director, she indicated that it was unacceptable for the kitchen to serve meals in Styrofoam containers except if the resident had a specific care plan that indicated the need for the container. She stated it was the facility's responsibility to provide the plate covers and it should not have taken this long to obtain them.

An interview was conducted with the Administrator on 12/12/23 at 7:15 PM. The Administrator stated that she was aware of and had been told of the shortage of plate covers and had to resort to using the Styrofoam containers. She explained that she was under the impression

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F 550	Continued From page 5 that the new company would purchase the covers and bill the facility for them.	F 550		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, test trays, staff and resident interviews, the facility failed to provide meals that were palatable and appetizing in temperature and appearance for 2 meals served to 1 of 3 residents (Resident #1). The practice had the potential to affect other residents receiving meals from the kitchen. The findings included: Resident #1 was admitted to the facility 01/02/23. The quarterly Minimum Data Set assessment dated 12/04/23 indicated Resident #1 had moderately intact cognition. a. An observation and interview were conducted with Resident #1 on 12/12/23 at 11:00 AM. The Resident explained that the food was not good but some days it was better than others. The meat, especially chicken, was overcooked and tough and the pasta was not good. She stated the	F 804	Address how corrective action will be accomplished for those residents found to have been affected: It was found that Residents #1 was affected by the deficient practice. In-service was conducted on 12/18/2023 with Manager and staff by Healthcare Services Group on following menus, recipes, and proper food temps. Food temperatures will be taken prior to each meal service and recorded on the Service Line Checklist to ensure proper food temps. Appropriate small wares will be utilized to ensure proper food temps are maintained during delivery. Kitchen staff will be provided Production Sheets and Recipes each shift to assist in production and food palatability. Test Tray Assessment to be completed 3 times a week for 4 weeks then weekly for 4 weeks to ensure proper food temps and palatability. Healthcare Services Group	1/4/24

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F 804	Continued From page 6 broccoli was always so overcooked and mushy that she informed the kitchen not to bring her broccoli anymore with her meals. The lunch meal served on 12/12/23 was roasted chicken thigh, mashed sweet potatoes, lima beans and pears. The meal cart was brought to the hall approximately 11:45 AM on 12/12/23. The test tray was removed from the cart last at 12:00 PM. When the lid was removed from the plate at 12:01 PM there was no steam visible coming from the food. The Dietary Manager (DM) tasted the food and agreed the food was not hot and the chicken was dry. The DM stated the mashed sweet potatoes tasted watery and the lima beans were okay. An interview was conducted with the Dietary Manager on 12/12/23 at 12:03 PM who offered the reason the food was cold could be related to the fact that they had two types of plates to serve the food on. One was a hard plastic which did not hold the heat long and the other was ceramic which held the heat longer than the plastic plates. The test tray had a plastic plate. The DM stated regardless, the food should be hot. An interview was conducted with Resident #1 on 12/12/23 at 12:25 PM as she was eating her lunch meal of roasted chicken thigh, mashed sweet potatoes and lima beans. She had consumed ¼ of the chicken, all the lima beans and about ¼ of the mashed potatoes. Resident #1 explained that the chicken was so tough that she could not cut it with a knife, so she had to pick it up with her fingers to bite it. She stated the chicken was on the dry side. She remarked that	F 804	management will oversee that the processes are being followed and complete the test tray assessment while at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Healthcare Services Group management conducted in-service on 12/18/2023 with Manager and staff on following menus, recipes, and proper food temps. All new Dietary staff onboarded with Healthcare Services group will be in serviced on the areas already included in the onboarding process: Bloodborne Pathogens, Chemical Use, Dilution and Hazards Hand Hygiene, Hazard Communication Program, Hepatitis B Vaccine Procedure, Personal Protective Equipment, Infection Control Policy, Workplace Injuries Injury/Illness, Incident Reporting, Safety Data Sheets (SDS), Lock Out Tag Out, TB Awareness, Dementia Overview, Employee Conduct and Work Rules Policy, Employee Handbook, Harassment, Sexual Harassment, Discrimination, HIPAA, Patient/Resident Rights Abuse/Neglect Elder Justice Act, Social Responsibilities in the Workplace, Workplace Violence, Cross Contamination, Glove Usage,	

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F 804	Continued From page 7 she did not get butter for her mashed sweet potatoes and the lima beans were good when she added her vinaigrette dressing to them. The Resident expressed the food was not cold as usual but barely room temperature at best. b. An observation of the evening meal tray line was conducted on 12/12/23 at 4:20 PM. A test tray was requested. The menu consisted of baked ziti, cauliflower and a dinner roll. The test tray was plated on a ceramic plate at 5:33 PM on 12/12/23. The meal cart arrived on the unit at 5:35 PM on 12/12/23 and Resident #1 received her supper tray at 5:47 PM. A test tray was conducted with the Dietary Director at 6:02 PM on 12/12/23. The Dietary Director lifted the plate cover from the meal and there was no steam to indicate the food temperature was warm. The Director observed the baked ziti was "greasy" and cold and the cauliflower was overcooked and mushy and was cold as well. The bottom of the bread roll was doughy. The Dietary Director stated she would not eat that. An interview conducted with the Dietary Director on 12/12/23 at 6:04 PM revealed, the Director explained the supper meal was prepared too early and that was one reason why the cauliflower was so mushy, it should not cook that long. She continued to explain the baked ziti will start to get greasy when it is cold, and it was visibly greasy. The Director indicated that it was unacceptable	F 804	Hand-Hygiene, Garbage and Trash Disposal, Food Code Health Reporting Responsibilities, Personal Protective Equipment, Common Causes of Foodborne Illness and Prevention, Cleaning and Sanitizing, Service Line Procedures in addition to these areas, all new dietary staff will be in serviced on following menus, recipes, and proper food temperatures. Food temperatures will be taken prior to each meal service and recorded on the Service Line Checklist to ensure proper food temps. Appropriate small wares will be utilized to ensure proper food temps are maintained during delivery. Kitchen staff will be provided Production Sheets and Recipes each shift to assist in production and food palatability. Test Tray Assessment to be completed 3 times a week for 4 weeks then Bi-Weekly for 4 weeks to ensure proper food temps and palatability. Resident satisfaction surveys will be completed by Healthcare Services Group weekly at random with alert and oriented Residents. Weekly for 4 weeks 10 Residents will be interviewed, and the satisfaction survey will be completed. At the completion of the 4 weeks the Resident satisfaction survey will be completed biweekly for 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Dietary Leadership with Healthcare Services Group will perform Test Tray Assessment. This is to be completed 3 times a week for 4 weeks then weekly for 4 weeks to ensure proper food temps and	

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F 804	Continued From page 8 for the residents to be served cold meals. On 12/12/23 at 6:18 PM during an observation and interview with Resident #1, she explained that the baked ziti was greasy, and the cauliflower was slick and slimy and cooked to death. She stated she thought it was cooked cabbage until she read the meal ticket that identified it as cauliflower, stated "it didn't look like cauliflower to me". The Resident remarked the roll was doughy on the bottom, so she only ate the top. The Resident stated the food was warmer than what she usually received but not by much. An interview conducted with the Dietary Manager and Dietary Director on 12/12/23 at 6:45 PM revealed the Director explained that the food was made too early because it was cooked and in the warmer when she arrived at the facility in the early afternoon hours. She stated the cauliflower was overcooked and should be cooked last and stated that was the reason it was cooked to death. The Manager stated he had counseled the cook not to make the food so early and let it sit in the warmer. The Manager repeated the reason why some meals were cold could be the fact that some plates were hard plastic, and some were ceramic. At 7:15 PM on 12/12/23 during an interview with the Administrator she explained that she did not eat the facility food therefore, she could not speak to the quality and temperature of the food but stated it looked like she would start testing the food.	F 804	palatability. The Dietary Manager or designee will present to QI committee the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at QA meeting. Compliance Date 1/04/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		1/4/24

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F 812	Continued From page 9 §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 bread was dated and not stored for use after the use by date in the dry storage area. This deficient practice had the potential to affect the food served to the residents. The findings included: During an observation of the dry storage area on 12/12/23 at 3:30 PM along with the Dietary Director the observation yielded 3 packs of 12 hotdog buns with a date of 12/10/23 and 3 packs of 12 hamburger buns that had no date printed on the packages. An interview was conducted with the Dietary Director at 3:40 PM on 12/12/23 who explained	F 812	Address how corrective action will be accomplished for those residents found to have been affected: All 88 Residents were identified as being affected for all findings. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: In-service was conducted with Manager and staff on 12/18/2023 on properly dating	

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F 812	Continued From page 10 the hotdog buns should have been pulled from the shelves on the expiration date printed on the packages and there should have been a clarification date for the expiration date for the hamburger buns. The hamburger buns should not be used unless there was a known expiration date. During an interview with the Dietary Manager on 12/12/23 at 4:15 PM the Manager explained that he tried to check the expiration dates on the breads about every day and he missed the dates because he was not checking them good enough. His process when checking the dates was to pull the breads the day before the expiration date because he felt the date on the breads would not be good to use. The Manager also explained that he did not notice that the hamburger buns did not have an expiration date on them. He stated he did not remember checking the expiration dates on 12/11/23. He stated the bread delivery was twice a week and he needed to make sure the bread delivery man was checking the expiration dates on the breads as well. An interview was conducted with the Administrator on 12/12/23 at 7:15 PM. The Administrator explained that the dietary staff should have been checking for expiration dates on the breads especially since they were cited for it on the recertification. She stated the bread should not have been on the shelves and available for use past the expiration dates.	F 812	and labeling perishable items and discarding prior to expiration by Healthcare Services Group leadership. All new Dietary staff onboarded with Healthcare Services group will be in serviced on the areas already included in the onboarding process: Bloodborne Pathogens, Chemical Use, Dilution and Hazards Hand Hygiene, Hazard Communication Program, Hepatitis B Vaccine Procedure, Personal Protective Equipment, Infection Control Policy, Workplace Injuries Injury/Illness, Incident Reporting, Safety Data Sheets (SDS), Lock Out Tag Out, TB Awareness, Dementia Overview, Employee Conduct and Work Rules Policy, Employee Handbook, Harassment, Sexual Harassment, Discrimination, HIPAA, Patient/Resident Rights Abuse/Neglect Elder Justice Act, Social Responsibilities in the Workplace, Workplace Violence, Cross Contamination, Glove Usage, Hand-Hygiene, Garbage and Trash Disposal, Food Code Health Reporting Responsibilities, Personal Protective Equipment, Common Causes of Foodborne Illness and Prevention, Cleaning and Sanitizing, Service Line Procedures in addition to these areas, all new dietary staff will be in serviced on properly dating and labeling perishable items and discarding prior to expiration. The monitoring tool titled Glenbridge Audit Tool will be initiated 12/18/2023 and utilized by dietary employees and leadership to ensure all items within the kitchen are properly dated and labeled and all items have been discarded prior to	

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F 812	Continued From page 11	F 812	expiration. The monitoring tool titled Glenbridge Audit Tool will be utilized daily for 8 weeks and adjustments will be made as needed. Sanitation Audit will be completed Monthly by the Registered Dietitian. Management from Healthcare Services Group will oversee that the processes are being followed and that the audit tools are being completed correctly and timely. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary Manager or designee will present to QI committee will review the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at the quarterly QA meeting. Compliance Date 1/04/2024	
F 867 SS=E	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	F 867		1/4/24

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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 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

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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.

§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

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F 867	Continued From page 14 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 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 reviews and interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification and complaint survey dated 10/05/23. This was for two repeat deficiencies that were cited in the areas of F-804: Nutritive Value/Appearance/Palatable/Preferred Temp, and F-812: Food Procurement/Storage/Preparation/Serve/Sanitary that were originally cited during the recertification and complaint survey dated 10/05/23. The continued failure of the facility during 2 federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included:	F 867	On 12/29/2023 the facility Executive QI Committee held a meeting with 4 upper management from Healthcare Services Group. All key personnel and a representative from Healthcare Services Group will attend QI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. During this meeting one of the areas that was addressed was F804 and F812 and how these two deficiencies were cited on our annual survey in October 2023. The audit tools and checklists were reviewed and discussed during this meeting. On 12/29/2023 the facility consultant in serviced the facility QI Committee related to the appropriate functioning of the QI Committee and the purpose of the	

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F 867	Continued From page 15 This tag is crossed referenced to: F-804 Based on observations, record review, test trays, staff and resident interviews, the facility failed to provide meals that were palatable and appetizing in temperature and appearance for 2 meals served to 1 of 3 residents (Resident #1). The practice had the potential to affect other residents receiving meals from the kitchen. During the recertification and complaint survey dated 10/05/23 the facility failed to provide palatable food that was appetizing in appearance and temperature for 4 of 6 residents reviewed for food concerns. F- 812 Based on observations and staff interviews the facility failed to ensure bread was dated and not stored for use after the use by date in the dry storage area. This deficient practice had the potential to affect the food served to the residents. During the recertification and complaint survey dated 10/05/23 the facility failed to maintain the final rinse cycle of the high temperature dish machine according to manufacturer's recommendations, failed to remove expired food items from the dry goods storage area, failed to maintain a clean floor free from grease build-up and clean vent on the reach-in cooler and failed to keep the food preparation area free of chemicals and personal drinks. In addition, the facility failed to maintain the walk-in freezer free of ice build-up and failed to discard frozen food with signs of freezer burn. The facility also failed to ensure dietary staff wore hair coverings in the food preparation area. This deficient practice had	F 867	committee to include identify issues related to quality assessment and assurance activities as needed and developing and implementing appropriate plans of action for identified facility concerns. The Committee will continue to meet at a minimum of monthly. The Executive QI Committee, will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring Committee concerns are addressed through further training or other interventions. The administrator or her designee will report back to the Executive QI Committee at the next scheduled meeting. Compliance Date 1/04/2024	

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the potential to affect the food served to residents. The facility census was 88 residents.

An interview was conducted with the Administrator on 12/13/23 at 1:15 PM. The Administrator explained that there had only been one Quality Assurance (QA) meeting since the completion of their plan of correction and the new food service company had not been involved but the audit tools had been presented in the meetings and there were no concerns found with the audits. She indicated that the auditing would be revised, and closer guidance would be given to the Dietary Manager. The Administrator stated since the new company took over, there had been new systems to get use to. Going forward the Administrator stated she would conduct more walk-through rounds in the kitchen to ensure the plan of corrections was implemented correctly.