()		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 03/13/2014		
345080			B. WING					
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	CODE		
BRIAN CE	NTER HEALTH & REI	HAB HICKORY VIEWMONT	220 13TH AVE PLACE NW		20 13TH AVE PLACE NW			
	NTER HEALTH & REI			H	HICKORY, NC 28601			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE			
PREFIX TAG			PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE		
F 000 F 371	INITIAL COMMENTS		F	000				
	No deficiencies resulted from this complaint investigation (T2WD11).							
	483.35(i) FOOD PROCURE,		F	371			4/9/14	
SS=E		/SERVE - SANITARY						
	The facility must -							
	(1) Procure food from sources approved or							
		ctory by Federal, State or local						
	authorities; and	distribute and converteed						
	under sanitary con	distribute and serve food						
	This REQUIREME	NT is not met as evidenced						
	by:				F 074			
		tion, staff interview and			F 371			
		ections, the facility failed to portioned packets of carrots			The pureed carrot and chicken portions	s in		
		internal temperature of 165			question were reheated in the microwa			
		acing on the tray line and			to a minimum temperature of 165 F for			
		the food for service. Ten out of			minimum of 15 seconds per food safety	/		
	91 residents had of Findings included:	rders for pureed diets.			standards.			
					All residents on pureed diets received			
		0 AM food was observed being			foods from the kitchen at appropriate a	nd		
		m table and temperatures were A pan of pre-portioned			safe food temperatures.			
		chicken and pureed carrots			FSD/AFSD will re educate all dietary st	aff		
		the steamer and placed on			on proper food temperatures and			
		he staff pierced the packet of			temperature logs. Food temperatures	are		
		the temperature was 148			taken and recorded prior to each meal			
		it (F) and the pureed chicken			assure foods are served at appropriate			
		8. Without prompting, the			and safe food temperatures. Precooked	d		
	Dietary Manager ([DM) removed the pan from the			foods are reheated to a minimim			

Electronically Signed

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.

04/03/2014

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345080		. ,	, ,	LE CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C	
		B. WING		0	3/13/2014		
	ROVIDER OR SUPPLIER	AB HICKORY VIEWMONT		STREET ADDRESS, CITY, STATE, ZIP COE 220 13TH AVE PLACE NW HICKORY, NC 28601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH		OULD BE COMPLETIC	
F 371	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 37				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 923004

If continuation sheet Page 2 of 2