ALLEGHARY CENTER The COMBS STREET SPARTA, NC 28675 (24) ID THECK SUMMARY STATEMENT OF DEFICIENCIES (24) COMPARED EXAMPLE AND DEFICIENCY MIST BE PRECEDED BY FULL (24) COMPARED REGULATORY OR LSC IDENTIFYING INFORMATION) PRESX (24) COMPARED (24)		DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
ALLEGHARY CENTER TP COMBS STREET SPARTA, NC 28675 (M) ID (PREEK) TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION SIGULATE PERCEPTOR BY FULL (EACH CORRECTION SIGULATE PERCEPTOR ACTION SIGULATE (EACH CORRECTION SIGULATE PERCEPTOR ACTION SIGULATE (CACH CORRECTION SIGULATE (CACH CORREC			345261	B. WING		06/02/2017
ALLEGRANY CENTER SPARTA, NC 28675 (M) ID (PAC) TAG ISUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ALLEACTORY MUST & PROCEEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH ORRECTIVE ALLEACTORY OR LSC IDENTIFYING INFORMATION) ID (EACH ORRECTIVE ALLEACTION INFORMATION) ID	NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
DATE SPARTA, NC 2867 Image: Comparison of the component of the com					179 COMBS STREET	
Preferst Txg (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Txg CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) COMMENTION DATE F 253 483.10(1)(2) HOUSEKEEPING & MAINTENANCE SERVICES F 253 6/30/17 (1)(2) HOUSEKEEPING & MAINTENANCE SERVICES F 253 F 253 6/30/17 Image: Services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by; This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Genesis Healthcare Alleghany Center does not admit that the deficiency. The center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. 6/30/17 F253: 1. On 6/22/17 The set of smoke prevention doors with broken and spintered edges on the lower half of the door that were rough to touch in 6 35 occupied resident roor					SPARTA, NC 28675	
SS=ESERVICES(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair 4 of 4 sets of double smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (100, 200, 300 and 400 halls). The facility failed to repair the main dining room door with broken and splintered laminate and wood on the lower edges of the door on the 200 hall on 1 of 3 residents' hallways, failed to repair a door leading out to the courtyard smoking area with broken and splintered laminate and wood on the lower edges of the door and a large vinyl skin on the bottom of the door was chipped on the edges. The facility also failed to repair 2 resident's room doors with broken and splintered laminate and caused a sharp edge in 2 of 22 occupied resident room and bathroom doors with broken and splintered edges on the lower half of the door rithat were rough to toch in 6 of 35 occupied resident rooms (Room #200, #300, #310, #403, #405 and #412).This plan of correction is prepared and submittid as required by law. By submitting this plan of correction Genesis Healthcare Alleghany Center does not admit that the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency. The set of smoke prevention doors for 100 Hall, 200 Hall, 300 Hall and 400 Hall were sanded by Maintenance Assistant to assure no rough to touch or splintered deges on broken laminate laminate leaving sharp edges. On 6/14/17 the 200 Hall main dining room doors were sanded to	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO
necessary to maintain a sanitary, orderly, and comfortable interior;This REQUIREMENT is not met as evidenced by:Based on observations and staff interviews the facility failed to repair 4 of 4 sets of double smoke prevention doors with broken and splintered laminate and wood on the lower edges of the doors (100, 200, 300 and 400 halls). The facility failed to repair at down odor with broken and splintered laminate and wood on the lower edges of the door on the 200 hall on 1 of 3 resident's haltways, failed to repair a door leading out to the courtyard smoking area with broken and splintered laminate and wood on the lower edges of the door and a large vinyl skin on the bottom of the door as chipped on the edges. The facility also failed to repair 2 resident's room doors with broken and splintered laminate and wood on the lower edges of the door with an area where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident room and bathroom doors with broken and splintered edges on the lower half of the door that were rough to touch in 6 of 35 occupied resident rooms (Room #200, #309, #310, #403, #405 and #412).This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Genesis Healthcare Alleghany Center does not admit that the deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the edficiency. The set of smoke prevention doors with broken and splintered edges of the door with an area where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident rooms (Room #200, #309, #310, #403, #405 and #412).This plan deficiency. The set of smoke prevention doors for 100 Hall, 200 Hall, 300 Hall and 400 Hall were sanded by Maintenance Assistan			EKEEPING & MAINTENANCE	F 25	3	6/30/17
Image: Second		necessary to maint comfortable interior This REQUIREMEN by: Based on observat facility failed to repar prevention doors w laminate and wood doors (100, 200, 30 failed to repair the residents' hallways out to the courtyard and splintered lami edges of the door a bottom of the door a	Ain a sanitary, orderly, and ", NT is not met as evidenced tions and staff interviews the air 4 of 4 sets of double smoke ith broken and splintered on the lower edges of the 00 and 400 halls). The facility main dining room door with red laminate and wood on the door on the 200 hall on 1 of 3 , failed to repair a door leading d smoking area with broken nate and wood on the lower and a large vinyl skin on the was chipped on the edges. ed to repair 2 resident's room and splintered laminate and edges of the door with an area in had peeled back and caused of 22 occupied resident rooms 110), failed to repair resident in 6 of 35 occupied resident b, #309, #310, #403, #405 and on 05/30/17 at 11:54 AM moke prevention doors on the n and splintered laminate and edges of the doors that were		 submitted as required by law. By submitting this plan of correction Genes Healthcare Alleghany Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceeding the deficiency statements, facts, and conclusions that form the basis for the deficiency. F253: 1. On 6/22/17 The set of smoke prevention doors for 100 Hall, 200 Hall, 300 Hall and 400 Hall were sanded by Maintenance Assistant to assure no rout to touch or splintered edges or broken laminate leaving sharp edges. On 6/14/ the 200 Hall main dining room doors were sanded to assure no rough to touch or splintered edges or broken laminate leaving sharp edges by Maintenance Director. On 6/14/17 the door leading of to the courtyard was sanded to assure rough to touch or splintered edges by Maintenance Director. Vinyl covering for the courtyard door will be replaced by 	sis s s ugh 17 ere ut no ur

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.

06/26/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 253 Continued From page 1 F 253 Observations on 05/31/17 at 8:50 AM revealed a Maintenance Director on or before 6/30/17. set of smoke prevention doors on the 100 hall with broken and splintered laminate and wood on the lower edges of the doors that were rough to On 6/26/17 the room doors for Rooms #200,#309,#310,#403,#405 and #412 touch. Observations on 06/01/17 at 8:58 AM revealed a were sanded by the Maintenance Director set of smoke prevention doors on the 100 hall to assure no rough to touch or splintered with broken and splintered laminate and wood on edges or broken laminate leaving sharp the lower edges of the doors that were rough to edges. On 6/26/17 The bathroom doors touch. for Rooms #200,#309,#310,#403,#405 and #412 were sanded by the b. Observations on 05/30/17 at 12:15 PM Maintenance Director to assure no rough revealed a set of smoke prevention doors on the to touch or splintered edges or broken 200 hall with broken and splintered laminate and laminate leaving sharp edges. wood on the lower edges of the doors that were rough to touch. On 6/19/17 The room door for room #110 Observations on 05/31/17 at 8:55 AM revealed a was sanded and painted by the set of smoke prevention doors on the 200 hall Maintenance Assistant to assure no rough with broken and splintered laminate and wood on to touch or splintered edges or broken the lower edges of the doors that were rough to laminate leaving sharp edges. Vinyl skin to be replaced by 6/30/17. touch. Observations on 06/01/17 at 8:45 AM revealed a On 6/26/17 the door for room #311 was set of smoke prevention doors on the 200 hall with broken and splintered laminate and wood on sanded by the Maintenance Director to the lower edges of the doors that were rough to assure no rough to touch or splintered touch. edges or broken laminate leaving sharp edges. Vinyl skin to be replaced by c. Observations on 05/30/17 at 11:48 AM 6/30/17. revealed a set of smoke prevention doors on the 2. By 6/30/17 all remaining room doors, 300 hall with broken and splintered laminate and wood on the lower edges of the doors that were bathroom doors, common area doors and rough to touch. smoke prevention doors will be audited by Observations on 05/31/17 at 3:35 PM revealed a Maintenance Director to assure there are set of smoke prevention doors on the 300 hall no rough to touch, splintered edges, with broken and splintered laminate and wood on broken laminate and/or vinyl coverings the lower edges of the doors that were rough to leaving sharp edges. By 6/30/17 the touch. Maintenance Director will list all remaining Observations on 06/01/17 at 4:40 PM revealed a room doors, bathroom doors, common set of smoke prevention doors on the 300 hall area doors and smoke prevention doors in

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

If continuation sheet Page 2 of 60

PRINTED: 06/30/2017 FORM APPROVED

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 253 Continued From page 2 F 253 with broken and splintered laminate and wood on need of repairs. These repairs will be the lower edges of the doors that were rough to placed on schedule for completion. touch. d. Observations on 05/30/17 at 11:59 AM 3. On 6/26/17 The Maintenance Director revealed a set of smoke prevention doors on the was reeducated by the Center Executive 400 hall with broken and splintered laminate and Director on the importance of assuring wood on the lower edges of the doors that were door edges are not rough to touch with rough to touch. splintered edges, broken laminate and/or Observations on 05/31/17 at 9:10 AM revealed a vinyl coverings leaving sharp edges. set of smoke prevention doors on the 400 hall Department Heads were reeducated by with broken and splintered laminate and wood on the Center Executive Director on 6/22/17 the lower edges of the doors that were rough to on the importance of observing doors touch. during routine zone checks for rough to Observations on 06/01/17 at 10:30 AM revealed a touch splintered edges, broken laminate set of smoke prevention doors on the 400 hall and/or vinyl coverings leaving sharp with broken and splintered laminate and wood on edges and report findings to Center the lower edges of the doors that were rough to Executive Director. The Center Executive touch. Director will assure reported findings/repairs are completed or 2. Observations on 05/30/17 at 12:20 PM scheduled for completion by Maintenance revealed the main dining room door on the 200 Director. Staff will be educated on 6/28/17 and 6/29/17 to monitor doors during daily hall had broken and splintered laminate and wood on the lower edges of the doors that were rough duties for rough to touch splintered edges, to touch. broken laminate and/or vinyl coverings Observations on 05/31/17 at 9:02 AM revealed leaving sharp edges, reporting findings to the main dining room door on the 200 hall had Maintenance Director to be repaired or broken and splintered laminate and wood on the scheduled for repairs. lower edges of the doors that were rough to touch. 4.Department Heads will perform rounds Observations on 06/01/17 at 8:51 AM revealed one x weekly x 1 month then two x the main dining room door on the 200 hall had monthly x 1 month then one x monthly x 1 broken and splintered laminate and wood on the month. Any issues noted as a result of lower edges of the doors that were rough to monitoring will be reported to Center touch. **Executive Director and Maintenance** Director to be repaired or scheduled for 3. Observations on 05/30/17 at 12:25 PM repairs. Findings will be reviewed and revealed a door leading to the courtyard smoking addressed by Performance Improvement area on the 200 hall had broken and splintered Committee q month x 3 months and

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STA	ATE, ZIP CODE		
ALLEGHA	NY CENTER				OCOMBS STREET ARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	doors that were rough Observations on 06/0 door leading to the co 200 hall had broken a wood on the lower ed rough to touch. Observations on 06/0 door leading to the co 200 hall had broken a wood on the lower ed rough to touch. 4. a. Observations on revealed resident roon and splintered lamina edges of the door and the vinyl protective sk caused a sharp edge. Observations on 05/3 resident room door #3 splintered laminate ar of the door and also h protective skin had pe sharp edge. Observations on 06/0 resident room door #3 splintered laminate ar of the door and also h protective skin had pe sharp edge. b. Observations on 06/0 resident room door #3 splintered laminate ar	n the lower edges of the n to touch. 1/17 at 10:55 AM revealed a purtyard smoking area on the and splintered laminate and ges of the doors that were 2/17 at 11:30 AM revealed a purtyard smoking area on the and splintered laminate and ges of the doors that were 05/30/17 at 3:38 PM m door #311 had broken te and wood on the lower d also had an area where in had peeled back and 1/17 at 3:10 PM revealed 311 had broken and nd wood on the lower edges had an area where the vinyl eeled back and caused a 1/17 at 4:30 PM revealed 311 had broken and nd wood on the lower edges had an area where the vinyl eeled back and caused a	F 25		ongoing as needed			
	sharp edge.	eeled back and caused a 1/17 at 8:55 AM revealed						

Facility ID: 923249

If continuation sheet Page 4 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 253 Continued From page 4 F 253 resident room door #110 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. Observations on 06/02/17 at 11:45 AM revealed resident room door #110 had broken and splintered laminate and wood on the lower edges of the door and also had an area where the vinyl protective skin had peeled back and caused a sharp edge. 5. a. Observations on 05/31/17 at 8:49 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observations on 06/01/17 at 8:40 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observations on 06/02/17 at 11:34 AM revealed resident room door #200 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch. b. Observations on 05/30/17 at 4:16 PM revealed resident room door #309 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observations on 05/31/17 at 3:20 PM revealed resident room door #309 and the bathroom door had broken and splintered laminate and wood on the lower edges of the door that were rough to touch. Observations on 06/01/17 at 11:51 AM revealed

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

If continuation sheet Page 5 of 60

	-	D HUMAN SERVICES				FORM	: 06/30/2017 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	-	(X3) DATE COMP	
		345261	B. WING		_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
			1'	79 COMBS STREET			
ALLEGHA	NY CENTER		s	PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	resident room door #3 had broken and splint the lower edges of the touch. c. Observations on 05 revealed resident room bathroom door had br laminate and wood or door that were rough Observations on 06/0 resident room door #3 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #3 had broken and splint the lower edges of the touch. d. Observations on 06 resident room door #4 had broken and splint the lower edges of the touch. Observations on 05/3 resident room door #4 had broken and splint the lower edges of the touch. Observations on 05/3 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch.	309 and the bathroom door ered laminate and wood on e door that were rough to 5/31/17 at 11:11 AM m door #310 and the roken and splintered n the lower edges of the	F 253				

Facility ID: 923249

If continuation sheet Page 6 of 60

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALLEGHA	NY CENTER				79 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	the lower edges of the touch. Observations on 05/3 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch. f. Observations on 05 resident room door #4 had broken and splint the lower edges of the touch. Observations on 05/3 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch. Observations on 06/0 resident room door #4 had broken and splint the lower edges of the touch. During an interview of the Director of Mainter assistant but they had 1 day every 2 weeks they used a paper wo could fill out a work of to be made. He state	ered laminate and wood on a door that were rough to 1/17 at 8:46 AM revealed 405 and the bathroom door be reed laminate and wood on a door that were rough to 1/17 at 10:12 AM revealed 405 and the bathroom door be reed laminate and wood on a door that were rough to 1/30/17 at 12:35 PM revealed 412 and the bathroom door be reed laminate and wood on a door that were rough to 1/17 at 11:22 AM revealed 412 and the bathroom door be reed laminate and wood on a door that were rough to 1/17 at 11:22 AM revealed 412 and the bathroom door be reed laminate and wood on a door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be reed laminate and wood on a door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at 10:05 AM revealed 412 and the bathroom door be door that were rough to 1/17 at	F	253				
	they used a paper wo could fill out a work of to be made. He state nurse's stations, in the	rk order system and anyone der for repairs that needed						

If continuation sheet Page 7 of 60

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALLEGHA	NY CENTER				79 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	got a copy and they d morning meetings and had fixed on the work or repairs that were safe explained he went over with new employees i expectation for all star anything that needed and he wanted them the repair that needed to number so he would be repaired. He stated he day/7 days a week an emergency he expect An environmental tou 06/02/17 at 3:50 PM v Maintenance, the Direct the Administrator. The acknowledged the small 100, 200, 300 and 400 splintered wood and be acknowledged the mall 200 hall and the door machine and smoking splintered laminate ar of the doors. He confib bottom of resident root pulled back from the of to create a rough edg reported the damage needed repair. He als and bathroom doors i #403. #405 and #412	a copy and the Administrator iscussed them in the d he documented what he order form. He stated he ders and he completed ty concerns first. He er the work order process in orientation and it was his ff to fill out a work order for repair. He further explained to document the type of be done and the room know what needed to be e was on call 24 hours a d if there was an ed for staff to call him. If was conducted on with the Director of ector of Housekeeping and e Maintenance Director toke prevention doors on to halls were damaged with aminate. He also in dining room door on the	F	253				

If continuation sheet Page 8 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALLEGHA	NY CENTER				79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253 F 272 SS=D	the Administrator she expectation for staff to the work orders. She was a constant proble progress to keep then further stated the dam when wheelchairs hit residents or when res themselves in and our she was not aware of caused by splinters or 483.20(b)(1) COMPR ASSESSMENTS (b) Comprehensive As (1) Resident Assessm must make a compref resident's needs, stre preferences, using the instrument (RAI) spec assessment must incl (i) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behavit (vii) Psychological we (viii) Physical func- problems. (ix) Continence.	n 06/02/17 at 4:08 PM with stated it was her o report needed repairs on stated damage to doors em and it was a work in n sanded and repaired. She hage to doors occurred them when staff transported idents transported to f rooms. She confirmed any injuries or skin tears r rough edges of doors. EHENSIVE ssessments ment Instrument. A facility hensive assessment of a ngths, goals, life history and e resident assessment cified by CMS. The lude at least the following: demographic information ne. is.		253				6/30/17

Facility ID: 923249

If continuation sheet Page 9 of 60

				PLE CONSTRUCTION		MB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	(X	3) DATE SURVEY COMPLETED
		345261	B. WING			06/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 272	Continued From page	2 Q	F 2	72		
	· · · · · · · · · · · · · · · · ·		1 2	2		
	(xiv) Medications (xv) Special treatment					
	(xvi) Discharge p					
		tion of summary information				
		nal assessment performed				
	on the	·				
	care areas	triggered by the completion				
	of the Minimum Data	Set (MDS).				
	(xviii) Documentat	tion of participation in				
	assessment. The ass	sessment process must				
	include direct					
		n and communication with				
		as communication with				
	licensed and					
	non-license on all shifts.	ed direct care staff members				
	The assessment proc	cess must include direct				
		munication with the resident,				
	as well as communica	ation with licensed and				
	non-licensed direct ca shifts.	are staff members on all				
		is not met as evidenced				
	by:	iowo and atoff interviews the		1 Desident #4	6 CAAs for ARD 2/9/17	
		iews and staff interviews the			6 CAAs for ARD 2/9/17 en resident's wife leaves h	<u> </u>
	that addressed the ur	lete Care Area Assessments			en resident's wife leaves n r frequently". This is the	C
		or psychotropic drug use and			se of the resident's anxiety	,
	incontinence for 3 of 2				nti-anxiety medication	
	(Resident #46, #22 a)				in this look back period	
		- /			ons also noted in the CAAs	;
	The findings included	:			cting, reorienting and versional activity of choice	`
	1. Resident #46 was	admitted to the facility on			al as evidenced by the fact	
		ses of thyroid disorder and			ed no PRN or scheduled	
	anxiety.				edications during this look	
					order has since been	
	Review of the signific	ant change Minimum Data			or non-use. On 6/28/17 the	
	Set (MDS) dated 02/0	09/17 revealed Resident #46		0.0.0	dated to state that in fact	1

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 10 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 272 Continued From page 10 F 272 was severely cognitively impaired and received resident received no anti-anxiety antianxiety medication daily during the medications and staff's assessment period. non-pharmacological interventions were successful. Review of the Care Area Assessment (CAA) summary for Psychotropic Drug Use dated Resident #22 CAAs for ARD 3/30/17 02/15/17 revealed Resident #46 had a diagnoses under the trigger for psychotropic meds analysis of findings states "requires of anxiety that required the use of an antianxiety varying assist with ADLs r/t to delusions medication and was at risk for adverse psychotropic medication side effects. The CAA and hallucinations, staff to assist with summary did not analyze how the psychotropic ADLs as needed and report any changes with resident's functional ability". "She has medications actually affected Resident #46's day to day function and activities. The CAA summary had a history of multiple falls and resident also did not indicate if there had been any demented with little safety awareness". adverse drug reactions or if the resident was "She has a history of hallucinations and delusions that add to her fall risk." "Noted receiving psychiatric services. to run at times when having An interview conducted on 06/02/17 at 4:48 PM hallucinations, encouraged to walk and with the MDS Nurse revealed she has been an not run". "antipsychotics was attempted to MDS Nurse for fifteen years and has attended be reduced without success, resident did MDS Training in Raleigh. She stated the CAA have an increase in hallucinations and should address everything that triggered on the delusions upon attempt", "at risk for side MDS, why it triggered, and how the triggers would effects and reactions to these be addressed. She stated she was not aware she medications, some may be permanent" should be more specific as to what triggered the "she will be observed for side effects resident's anxiety, how the medication affected it and/or reactions and referred to MD and and if they were receiving therapy was it helpful. psych as needed." 2. Resident #22 was admitted to the facility on Resident #104 CAA for ARD 11/9/16 under the trigger for Urinary Incontinence 07/31/14 with current diagnoses of non-Alzheimer's dementia, anxiety and does not include strengths and schizophrenia. weaknesses r/t incontinence because section 4 of the RAI manual does not list Review of the significant change Minimum Data this as a requirement. However the CAA Set (MDS) dated 03/30/17 revealed Resident #22 did address the causes and contributing was moderately cognitively impaired and received factors for incontinence and how these antipsychotic, antidepressant, and antianxiety affected his day-to-day function. As stated medications daily during the assessment period. in the CAA "severe impairment in his ability to care for himself d/t a decline in

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 11 of 60

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MI II TI	IPLE CONSTRUCTION	OMB NO. 09 (X3) DATE SURV	
	CORRECTION	IDENTIFICATION NUMBER:	· /	NG	COMPLETE	
		345261	B. WING		06/02/20	017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
ALLEGHA				179 COMBS STREET SPARTA, NC 28675		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		CTION SHOULD BE COM THE APPROPRIATE	MPLETIO DATE
F 272	Continued From page	e 11	F 2	272		
		rea Assessment (CAA)		mentation", "relies on sta	ff to assist with	
		tropic Drug Use dated		daily decision making reg		
		esident #22 had a diagnoses		nutrition and hygiene." "S		
		enia and insomnia that		orient and cue as needed		
	required the use of a	n antianxiety, antipsychotic,		with adls rt impaired cogr	nition, dementia,	
		nedications and was at risk		copd, parkinsons". By 6/3		
		opic medication side effects.		Reimbursement Specialis	•	
		id not analyze how the		CAA to state resident was		
		tions actually affected		upon admission to facility		
	-	b day function and activities.		emergency guardianship		
		Iso did not indicate if there the drug reactions or if the		mother could no longer c decline in mentation whic		
	-	ig psychiatric services.		hospitalization. Monitorin		
		ig psychiatric services.		habits show that he made		
	An interview conduct	ed on 06/02/17 at 4:48 PM		control urges and urinate	-	
		revealed she has been an		defecated in inappropriat		
		n years and has attended		with redirection, cueing a		
		eigh. She stated the CAA		to the toilet. He was men		
	should address every	thing that triggered on the		distinguishing the toilet fr	om any other	
	MDS, why it triggered	d, and how the triggers would		room or common area. P	er APS Guardian	
	be addressed. She st	tated she was not aware she		resident was allowed and	taught at home	
		ific as to what triggered the		by family that defecating		
		w the medication affected it		throughout the home and		
	-	iving therapy was it helpful.		home on porches and su		
		s admitted to the facility on		acceptable behavior in at	tempts to keep	
		oses included dementia, , behaviors, Parkinson's		him from soiling himself.		
		prostatic hyperplasia.		2. On 6/26/17 Center Exe	outivo Director	
		פיסטמווט וויידר ואסומ.		rein-serviced the Clinical		
	A significant change	Minimum Data Set (MDS)		Specialist on the importa		
		d him as rarely or never		Assessments addressing		
		o behaviors, requiring total		causes and contributing f		
	assistance with bed r	· •		psychotropic drug use an		
	assistance with trans	fers, being independent with		Regional Clinical Reimbu	rsement	
		y dependent for toileting		Manager reassigned Clin		
		ed as being totally incontinent		Reimbursement Specialis	-	
	of bowel and bladder			company training module		
				appropriate documentation		
	Review of the Care A	rea Assessment (CAA)		Assessments. Training w	as completed	

Facility ID: 923249

If continuation sheet Page 12 of 60

		MEDICAID SERVICES			OMB NO. 0938-0
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345261	B. WING		06/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675	
				<i>,</i>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 272	Continued From page	e 12	F 27	72	
	dated 11/09/16 for uri he was admitted from	inary incontinence revealed the hospital with severe lity to care for himself. The		with post test taken at 100 6/26/17.)% accuracy on
	CAA listed his diagno difficulty understandir make daily decisions incontinent to bowel a for skin breakdown at incontinence. The C	ases, stated that he had ng and needed staff assist to . He was noted as being and bladder and was at risk d needed pericare after AA stated he needed ling in inappropriate place.		3. By 6/30/17, Center Nur and/or Center Executive I review all MDS Assessme CAAs since 6/2/17 trigger and psychotropic drug use addressing the underlying contributing factors.	Director will ents containing ing incontinence e to assure
	strengths or weakness or attempt to identify incontinence. The C _i incontinence affected	eses relating to incontinence causative factors for AA failed to analyze how the I his day to day function.		4. The Center Executive I 10% of all MDS Assessme Area Assessments that tri incontinence and psychot assure addressing the un	ents with Care gger ropic drug use to derlying causes
conducted on 06/02/17 at 4:48 PM. ME stated she had been an MDS Nurse for years and has attended MDS Training in She stated the CAA should address eve that triggered on the MDS, why it trigger how the triggers would be addressed. S she was not aware she should be more as to what triggered the area and how th resident was affected day to day with hi incontinence. She reviewed the inconti and pointed out that she stated he was incontinent and that they were going to incontinent care. She stated that he ha behaviors of urinating in inappropriate p She further stated she was unaware that to describe more of his individual issues to incontinence or if he could improve o sense of urges. She stated that the states		an MDS Nurse for fifteen ed MDS Training in Raleigh. should address everything MDS, why it triggered, and id be addressed. She stated he should be more specific he area and how the day to day with his eviewed the incontinent CAA she stated he was hey were going to provide e stated that he had g in inappropriate places. e was unaware that she was is individual issues related he could improve or had any		and contributing factors. T be performed 1 x monthly Any issues noted as a res will be reported to and ad Performance Improvemer monthly x 3 months and c needed.	x 3 months. sult of auditing dressed by ht Committee
	incontinence records continent or if he drib	showing when he was bled etc, but she was not rporate this information in			

Facility ID: 923249

If continuation sheet Page 13 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 282 483.21(b)(3)(ii) SERVICES BY QUALIFIED F 282 6/30/17 PERSONS/PER CARE PLAN SS=D (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-(ii) Be provided by qualified persons in accordance with each resident's written plan of care This REQUIREMENT is not met as evidenced bv: 1. On 6/22/17 Resident #52 had a skin Based on observations, record review and staff interviews, the facility failed to follow the care plan check and no areas were found on for smoking safety for 1 of 6 sampled residents clothes or skin related to smoking. who smoked (Resident #52). 2. On 6/26/17, A Smoking Assessment The findings included: was performed on all smokers by Nurse Practice Educator and care plan was updated accordingly. Based on the care Resident #52 was admitted to the facility on 08/04/16. His diagnoses included paraplegia, plan a list of items needed for each central cord syndrome, chronic pain syndrome, individual resident while smoking was contractures, altered mental status, generalized placed with smoking accessories for staff muscle weakness, and mood affective disorder. as a reference to assure care plans are being followed for all smokers. The significant change Minimum Data Set dated 05/29/17 coded him with moderately impaired 3. In-services will be completed by cognition, having sleep issues, being tired and 6/30/17 with Nurse Practice Educator. having concentration issues and moving so slowly Center Nurse Executive. Center Executive that people may notice 2 to 6 days in the previous Director and/or the Assistant Center 7 days. He was also coded with delusions, Nurse Executive to re-educate nursing, having behaviors including physical, verbal, and dietary, laundry and housekeeping staff rejection of care 1 to 3 days of the previous 7 on the need to follow plan of care for all days. Resident #52 was coded as needing total residents who are smokers. care for all activities of daily living skills including 4. Staff and residents that smoke will be eating. He was noted as being nonambulatory, having paraplegia and using tobacco. observed to assure plan of care being followed one x weekly x 1 month then two A smoking assessment was completed on x monthly x 1 month then one x monthly x

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

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 14 of 60

		MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION		D. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	l` í			PLETED
		345261	B. WING _		06/	/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIC DATE
F 282	Continued From page	e 14	F 2	82		
	05/30/17. This form use oxygen, and und that he did not have of poor memory, and kr designated smoking was noted to have no of unsafe smoking has sharing or selling cig Under observations h to hold a cigarette sa cigarette, being able properly and can not use of a smoking apr was noted "supervise the reason stated "po unsafe smoking." Ar reach Nurse #1 who assessment dated 05 made on 06/02/17 at return the call and cla information could not	stated the resident did not ler cognition he was noted dementia, does not have new the location of the area. Under behaviors he o history of arson, no history abits, and no history of arettes or smoking material. ne was coded as being able ifely, not able to light a to dispose of ashes or butts smoke safely without the ron. The smoking decision ed smoking is required" and olicy of facility resident has n unsuccessful attempt to completed the smoking 5/30/17 for Resident #52 was 2:41 PM. Nurse #1 did not arification of the assessment t be obtained.		1 month by Director Any issues noted as will be reported to an Performance Improv monthly x 3 months a needed.	a result of monitoring nd addressed by rement Committee	
	This was most recent 02/27/17. The goal was safely every shift for policy. Interventions *"Staff to hold cigared *"Inform of and reinfor *"Provide smoking ap	tte"; orce smoking restriction"; oron"; and vith smoking in accordance				
	PM in the smoking an Admissions Director	oserved on 05/31/17 at 3:06 rea outside courtyard. placed an unlit cigarette in h at 3:06 PM. She lit his				

Facility ID: 923249

If continuation sheet Page 15 of 60

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 06/30/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	SURVEY
		345261	B. WING		_	06/0	02/2017
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHA	NY CENTER			79 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	cigarette, then moved resident's cigarette th on Resident #52 at 3: of this cigarette, Resid in his mouth and used his lips, to flick the as cigarette. The ashes smoking apron and ro his stocking feet. On 0 Admissions Director r him since 3:09 PM by the cigarette where he end of the cigarette. A Director placed a cigar mouth and lit it. She back to him. At 3:17 F to reach for the cigaret tape around his forefin did not touch the cigar lap and continued sm intervention as she re the resident. Resider the cigarette without a readjusting it. He pro flick the ashes off the apron and over his sto made for staff to hold fallen ashes through t was finished he used wheel over to staff wh his chin and proceede butt. The Admissions him the entire time aff and until he went to s	over and lit another en placed a smoking apron 09 PM. During the smoking dent #52 kept the cigarette d only his mouth, by moving hes off the end of his lit proceeded to hit his oll down, at times rolling over 05/31/17 at 3:15 PM, the nade her first contact with holding the ash tray under e proceeded to spit out the At 3:16 PM, the Admissions arette in Resident #52's walked away and had her PM, Resident #52 attempted ette with his right hand with nger and middle finger. He rette, placed his hand on his oking without staff mained faced away from at #52 proceeded to smoke anyone holding it or ceeded to use his mouth to cigarette down his smoke bocking feet. No attempt was his cigarettes. Once he his electric wheelchair to to placed an ashtray under ed to spit out his cigarette Director had her back to the placing an apron on him pit out the cigarette butt.	F 282				

If continuation sheet Page 16 of 60

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA				IO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>			E SURVEY IPLETED	
		345261	B. WING		06/02/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 282	On 06/02/17 at 9:00 / (AD) was interviewed assisted with smoking stated at the morning residents and their ne Resident #52 was 1 c who required the use She stated Resident is help during smoking of him when he was finis normally Resident #5 so she placed it in his his mouth to shake th apron, or he shook hi ashes fell to the side. not aware of the care cigarette and stated a him she put the cigar he can't hold it with hi The Director of Nursin 06/02/17 at 3:56 PM. observed residents in Resident #52. She st use his fingers and th cigarette. Her unders staff to hold the cigar hold his cigarette. Sh could not say if letting smoking apron was s him smoke. An interview with the (DSS) was conducted DSS stated that the ir cigarette meant that h	AM the Admissions Director AD stated that she g about twice a month. She meetings, smoking eeds were discussed. of 2 residents in the facility of a smoking apron per AD. #52 required no additional only that she hold ashtray for shed smoking. She stated 2 could not hold his cigarette a mouth for him and he used the ashes onto his smoking s head to the side so the She further stated she was plan for staff to hold his anytime she went out with ette in his mouth because is hands. mg was interviewed on She stated she had never the smoking area including tated he had some ability to	F 28	2			

Facility ID: 923249

If continuation sheet Page 17 of 60

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MELLTIPI	E CONSTRUCTION	(X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPL	
		345261	B. WING		06/0	2/2017
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 282	Continued From page	e 17	F 282	2		
	at times he had refus	ed to wear the smoking				
	apron, or he only allo	wed it to be across his lap.				
		If had allowed him to smoke				
	-	Iding the lit cigarette in his				
	-	imes which was several d shake his head to the side				
		fall to the side. She stated it				
		ar the apron or not or to let				
	staff hold his cigarette					
	Interview with the Adu	ministrator occurred on				
		The Administrator stated				
	that Resident #52 wa					
	cigarette with an apro	on and allowing the ashes to				
	-	ring smoking. She stated				
		ron was for. Resident #52				
		s choices varied day to day vear a smoking apron it was				
	his choice as long as	0				
		hought the holding of his				
	cigarette was if need					
F 323 SS=D	483.25(d)(1)(2)(n)(1) HAZARDS/SUPERVI	-(3) FREE OF ACCIDENT SION/DEVICES	F 323	3	e	6/30/17
	(d) Accidents.					
	The facility must ensu	ure that -				
	(1) The resident envir	ronment remains as free				
	from accident hazard					
		eives adequate supervision es to prevent accidents.				
		facility must attempt to use es prior to installing a side or				
		ide rail is used, the facility				
	must ensure correct i					
	maintenance of bed r					

Facility ID: 923249

If continuation sheet Page 18 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES				06/30/2017 APPROVED 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		345261	B. WING		06/02	2/2017
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.01	
			1	79 COMBS STREET		
ALLEGHA	NY CENTER		s	PARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page to the following eleme		F 323			
	(1) Assess the resider from bed rails prior to	nt for risk of entrapment installation.				
	. ,	nd benefits of bed rails with nt representative and obtain r to installation.				
	This REQUIREMENT	ed's dimensions are sident's size and weight. is not met as evidenced				
	interview and staff inter maintain the safety of who smoked by not he	ns, record review, resident erviews, the facility failed to 1 of 6 sampled residents olding his cigarette for him		1. On 6/22/17 Resident #52 had a s check and no areas were found on clothes or skin related to smoking.		
	smoked (Resident #5			2. On 6/26/17, A Smoking Assessme was performed on all smokers by Nu Practice Educator. Based on the find	rse ings,	
	The findings included	:		on 6/26/17 a list of safety items need for each individual resident while sm		
	the smoking apron's p "Smoker's Apron is de	d pamphlet removed from backage stated in part esigned as an aid in the tal ignition of a resident's or		was placed with smoking accessorie staff as a reference to assure safety are being utilized for all smokers.	s for	
		not a substitute for proper		3. In-services will be completed by 6/30/17 with Nurse Practice Educate Center Nurse Executive, Center Exe		
	08/04/16. His diagnos central cord syndrome contractures, altered i	nitted to the facility on ses included paraplegia, e, chronic pain syndrome, mental status, generalized d mood affective disorder.		Director and/or the Assistant Center Nurse Executive to re-educate nursin dietary, laundry and housekeeping s on the need to utilize safety items as needed for all residents who are smo	taff S	
	had poor memory, no hold a cigarette, was	nt dated 03/02/17 noted he dementia, was not able to not able to light a cigarette, f he ashes and smoked		4. Staff and residents that smoke wil observed to assure safety items beir utilized one x weekly x 1 month then monthly x 1 month then one x month	g two x	

Facility ID: 923249

TATEMENT C	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE (CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	<u> </u>		COMF	PLETED	
		345261	B. WING			06/02/2017		
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ALLEGHA	NY CENTER				9 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE	
F 323	Continued From page	e 19	F 32	3				
	safely without a smok				month by Director of Social Services.	Any		
					issues noted as a result of monitoring	will		
		e Minimum Data Set dated with moderately impaired			be reported to and addressed by Performance Improvement Committee			
		ep issues, being tired and			monthly x 3 months and ongoing as	5		
		issues and moving so slowly			needed.			
		ce 2 to 6 days in the previous						
		coded with delusions,						
r d c		uding physical, verbal, and 3 days of the previous 7						
		was coded as needing total						
		of daily living skills including						
		d as being nonambulatory,						
	having paraplegia and	d using tobacco.						
	A smoking assessme	nt was completed on						
	05/30/17. This form s	stated the resident did not						
		er cognition he was noted						
		dementia, does not have						
	•	ew the location of the area. Under behaviors he						
		history of arson, no history						
		bits, and no history of						
		arettes or smoking material.						
		he was coded as being able						
		fely, not able to light a to dispose of ashes or butts						
		smoke safely without the						
		on. The smoking decision						
		ed smoking is required" and						
	•	licy of facility resident has						
	-	unsuccessful attempt to completed the smoking						
		5/30/17 for Resident #52 was						
		2:41 PM. Nurse #1 did not						
	return the call and cla	arification of the assessment						
	information could not	be obtained.						
							1	

Facility ID: 923249

If continuation sheet Page 20 of 60

						O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	E SURVEY PLETED
		345261	B. WING		06	6/02/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 20	F 32	3		
		ke with supervision and				
		he smoking assessment.				
		ly noted as revised on				
	02/27/17. The goal w	as for the resident to smoke				
		90 days per facility smoking				
	policy. Interventions					
	*"Staff to hold cigaret					
		rce smoking restriction";				
	*"Provide smoking ap					
	with assessed needs	ith smoking in accordance and facility policy."				
		served on 05/31/17 at 3:06				
	PM in the smoking an	-				
	-	placed an unlit cigarette in n at 3:06 PM. She lit his				
	cigarette, then moved					
		en placed a smoking apron				
		09 PM. During the smoking				
	of this cigarette, Resi	dent #52 kept the cigarette				
		d only his mouth, by moving				
		hes off the end of his lit				
	cigarette. The ashes					
		oll down, at times rolling over				
		05/31/17 at 3:15 PM, the made her first contact with				
		holding the ash tray under				
		e proceeded to spit out the				
		At 3:16 PM, the Admissions				
		arette in Resident #52's				
	mouth and lit it. She	walked away and had her				
		PM, Resident #52 attempted				
		ette with his right hand with				
		nger and middle finger. He				
		rette, placed his hand on his				
	lap and continued sm					
		emained faced away from nt #52 proceeded to smoke				
		THE THE SHORE				1 · · · · · · · · · · · · · · · · · · ·

Facility ID: 923249

If continuation sheet Page 21 of 60

		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PROVIDER	OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
	TED			1	79 COMBS STREET			
ALLEGHANY CEN	IER			s	SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
readjus flick th apron made fallen a was fir wheel his chi butt. T him the and ur Reside 3:24 P roll dow On 06/ (AD) w assiste stated reside Reside She st help du him wh norma so she his mo apron, ashes not aw cigaret him sh he can	e ashes off the and over his sta for staff to hold ashes through th hished he used over to staff wh n and proceede The Admissions e entire time aff the Admission e entire time aff th	ceeded to use his mouth to cigarette down his smoke ocking feet. No attempt was his cigarette or help catch ooth cigarettes. Once he his electric wheelchair to o placed an ashtray under ed to spit out his cigarette Director had her back to er placing an apron on him pit out the cigarette butt. erviewed on 05/31/17 at hat he always let the ashes apron. AM the Admissions Director . AD stated that she g about twice a month. She meetings, smoking eds were discussed. f 2 residents in the facility of a smoking apron per AD. #52 required no additional only that she hold ashtray for shed smoking. She stated 2 could not hold his cigarette mouth for him and he used e ashes onto his smoking s head to the side so the She further stated she was plan for staff to hold his nytime she went out with ette in his mouth because	F	323				

Facility ID: 923249

If continuation sheet Page 22 of 60

	S FOR MEDICARE &				OMB NO.	0000 000
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SI COMPLE	
		345261	B. WING		06/02/201	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	E	
ALLEGHA	NY CENTER			9 COMBS STREET PARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From pag	e 22	F 323			
	Resident #52. She s	stated he had some ability to				
	use his fingers and the					
		standing of the care plan for				
		rette was if he needed staff to he further stated that she				
	•	g the ashes drop onto the				
		safe as she had not watched				
	him smoke.					
		Director of Social Services				
		d on 06/02/17 at 4:30 PM. ntervention to hold his				
		he will hold his cigarette in				
	-	hand a lot of the time. If he				
		d it in his mouth, he will ask				
		im. She further stated that				
		sed to wear the smoking wed it to be across his lap.				
		elf had allowed him to smoke				
		olding the lit cigarette in his				
	-	times which was several				
	-	Id shake his head to the side				
		fall to the side. She stated it ar the apron or not or to let				
	staff hold his cigarett					
		ministrator occurred on				
		. The Administrator stated				
	that Resident #52 wa	on and allowing the ashes to				
		uring smoking. She stated				
	that was what the ap	ron was for. Resident #52				
		is choices varied day to day				
		vear a smoking apron it was				
	supervise.	s staff were present to				
F 367		RAPEUTIC DIET	F 367		6	/30/17
	PRESCRIBED BY P				U	

Facility ID: 923249

If continuation sheet Page 23 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 367 Continued From page 23 F 367 (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced bv: Based on observations, record review and staff 1. On 6/1/17 prior to evening meal interviews, the facility failed to prepare and serve service and then again on 6/2/17 the dysphagia advanced and consistent carbohydrate Director of Dining Services rein-serviced diets. This affected 9 sampled residents dietary staff on the correct diet ordered for observed to receive a meal out of 20 residents residents #12, #13, #29, #38, #43, #64, with orders for a dysphagia advanced diet and 1 #65, #74, and #102 and corrected diets sampled resident observed to receive a meal out were then served. On 6/5/17 the Director of 6 residents with orders for a consistent of Dining Services rein-serviced dietary carbohvdrate diet (Residents . #12. #13. #29. staff on the correct diet ordered for resident #77 and corrected diet was then #38, #43, #64, #65, #74, #77, and #102). served The findings included: 2. On 6/1/17 the Health Information 1. On 05/30/17 at 10:47 AM during the initial Manager audited diet orders for all kitchen walk through, the Director of Dining residents to assure dietary staff had the Services (DDS) stated the facility was on a 3 correctly ordered diets. On 6/1/17, 6/2/17, week cycle of menus and provided this week's and 6/5/17 dietary staff were rein-serviced copies of the planned menus. by Director of Dining Services on correct diets and correct consistency of diets. Per the dietary menus provided, the noon meal 3. On 6/27/17 the Center Executive this date was to include chicken and waffles, powdered sugar garnish, fried okra, and seasonal Director will rein-service Director of Dining mixed fruit with the alternate to be shrimp scampi, Services on the importance of insuring linguine, peas and mushrooms, garlic bread and that dietary staff follow prescribed diet seasonal mixed fruit. The diets listed on this orders on all residents. On 6/21/17 Nurse spread sheet included a regular, a dysphagia Practice Educator rein-serviced nursing

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

Facility ID: 923249

If continuation sheet Page 24 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 367 Continued From page 24 F 367 advanced, a dysphagia puree, a regular with staff on appropriate food consistency for chopped meat and a regular with ground meat. advanced dysphagia diet orders. On 6/1/17, 6/2/17 & 6/5/17 Director of Dining There was no evidence that a consistent Services rein-serviced dietary staff on the carbohydrate diet was planned per review of the correct use of menus and food spread sheets. In addition, the Dysphagia consistency for advanced dysphagia diet Advanced diet per the spread sheet was to have and consistent carbohydrate orders. ground chicken moistened, a cut waffle, powered Additional in-services for nursing & dietary sugar garnish and chopped fried okra. The staff will be held on or before 6/30/17. alternate for this diet was ground shrimp scampi, cut up linguine, peas with mashed mushroom, 4. The Health Information Manager will white bread and both were to get chopped mixed audit physician ordered diets and seasonal fruit. The meal preparation was compare to dietary tray cards one x observed on 06/01/16 beginning at 9:32 AM. monthly x 3 months. The Director of Observations of the kitchen preparation revealed Dining Services or the Registered that neither the chicken or the shrimp were ever Dietician will observe 10% of resident prepared at the ground consistency and the okra meals to assure correct diets are being was not chopped and the mushrooms were not served one x weekly x 1 month, two x mashed. In addition syrup was the garnish not monthly x 1 month and one x monthly x 1 powdered sugar. The waffles had been cooked month. Findings of the audit and with oil on the stove top griddle. observations will be reported to the Process Improvement Committee monthly x 3 months and ongoing as needed and On 06/01/17 at 11:35 AM, the mobile steam table was taken to the 300 hall for service. This steam addressed accordingly. table contained pureed items, chunks of chicken which was the consistency of pulled pork with pieces at least an inch long, shrimp scampi mixed with linguine with whole shrimp, fried round pieces of okra not chopped, whole waffles, and syrup in place of powered sugar. On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles being served whole and not cut up. DDS stated that the kitchen "just didn't follow the menu" and that the powdered sugar should have been

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 25 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 367 Continued From page 25 F 367 served not syrup. Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground meat and always had considered it the same and so she had not been grinding up the meat per the menu for Dysphagia Advanced diets. She further stated that if the chicken had been strips, like the recipe called for, she would have chopped it up. On 06/01/17 at 12:53 PM, the cook stated that there was no menu to follow for a consistent carbohydrate diet and to her knowledge, there had never been a menu for a consistent carbohydrate diet during her 15 years as a cook at this facility. The Director of Dining Services (DDS) joined the conversation on 06/01/17 at 12:57 PM. She stated there was a form that she had access to for a consistent carbohydrate diet that staff were to refer to. The DDS provided several sheets which talked about the foods to avoid and the serving amounts for the protein, fruits, vegetables, grains and fats and sugars to follow in total for each day. She did not provide any type of menu or spread sheet for amounts or foods for each meal for the consistent carbohydrate diet for the cooks should follow. During an additional interview on 06/01/17 at 2:52 PM, DDS further stated that she looked over the meal plans and observed the meal preparation randomly to ensure meals are prepared correctly and as planned. She stated the meals for the Dysphagia Advanced diets were not followed. DDS stated that she had spoken with the Registered Dietician (RD) this date and that there

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

If continuation sheet Page 26 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 06/30/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPL	SURVEY
		345261	B. WING		_	06/0	02/2017
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALLEGHA	NY CENTER			79 COMBS STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	diet that she had not f instructed her staff to been using or followin spread sheets to give change occurred with 05/07/17. DDS further over the meal plans a preparation randomly prepared correctly and Carbohydrate diets with Interview with the Reg 06/01/17 at 3:09 PM r her first date back into December as another She stated that Dyspf be cut into peas size f a Consistent Carbohy carbohydrates per dat different vegetables a carbohydrate intake of she did not see any n facility not having a C physician ordered die On 06/01/17 at 4:00 F menu/spread sheet for Carbohydrate Diet that followed for this noon chicken and waffle", f of shrimp scampi and sliced zucchini, which investigation revealed waffles.	a consistent carbohydrate been aware of and had not follow and therefore had not of the cooks to follow. This the menu change of er stated that she looked and observed the meal to ensure meals are d as planned. Consistent ere not followed. gistered Dietician (RD) on revealed that this date was to this facility since RD was visiting this facility. hagia Advanced diets should portions bits. RD stated that rdrate Diet (CCD) had less y and was not as flexible as and desserts affect the of each meal. She stated egative outcomes from the CD diet but would expect ts to be followed. PM, DDS provided the or the Consistent at should have been meal. It stipulated "diet ried okra and the alternate 1/3 cup of linguine and was not prepared. Further a that the "diet chicken and iet syrup and oven baked	F 367				

Facility ID: 923249

If continuation sheet Page 27 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/30/2017 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY
		345261	B. WING		_	06/0	02/2017
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHA	NY CENTER			79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	company that operate mechanical soft diets physician ordered the for those normally on stated the dietary staf meats and other items soft consistency. She residents had a chokin recommended for a p Interview with the Adm 5:36 PM revealed she to prepare foods per t 2. Resident #65 was 05/20/15 with diagnos diabetes, hypertensio accident and hemiples Minimum Data set (M him as being indepen and being on a mecha diet. His diet order per the physician orders date Dysphagia Advanced On 06/01/17 at 11:38 Resident #65 offering chose shrimp scampi shrimp mixed with the On 06/01/17 at 12:19 interviewed about the per the menu and the served specifically rel	ed this facility did not offer so they tried to ensure the e dysphagia advanced diet a mechanical soft diet. She ff had been educated on the s to be about pea size or a e further stated that if ng hazard, they would be oureed diet. ministrator on 06/02/17 at e expected the kitchen staff the menus. admitted to the facility on ses of deep vein thrombosis, n, cerebral vascular gia. The significant change IDS) dated 03/09/17 coded ident with set up for eating anically altered therapeutic monthly computerized ad May 2017 was a diet. AM, staff approached him his selection. He and was served the whole e linguine.	F 367				

If continuation sheet Page 28 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
ALLEGHA	NY CENTER				79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRE CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	revealed she consider same as ground and a same and so she had meat per the menu for diets. During an additional in PM, DDS further state meal plans and obser randomly to ensure m and as planned. She Dysphagia Advanced Interview with the Reg 06/01/17 at 3:09 PM r her first date back into December as another She stated that Dysph be cut into peas size equivalent to mechan Interview with the Spe at 3:30 PM revealed s company that operate mechanical soft diets physician ordered the for those normally on stated the dietary staf meats and other items soft consistency. She residents had a choki recommended for a p	k on 06/01/17 at 12:24 PM red the chunks of meat the always has considered it the not been grinding up the r Dysphagia Advanced herview on 06/01/17 at 2:52 ed that she looked over the ved the meal preparation neals are prepared correctly stated the meals for the diets were not followed. gistered Dietician (RD) on revealed that this date was o this facility since r RD was visiting this facility. hagia Advanced diets should portions bits as it was an ical soft texture. eech Therapist on 06/02/17 she was told that the st his facility did not offer so they tried to ensure the dysphagia advanced diet a mechanical soft diet. She f had been educated on the s to be about pea size or a e further stated that if ng hazard, they would be ureed diet. ministrator on 06/02/17 at e expected the kitchen staff	F 3	67				

Facility ID: 923249

If continuation sheet Page 29 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/30/2017 1 APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345261	B. WING				06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALLEGHA	ANY CENTER				179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 367	04/25/14 and her diag hypertension. Her qu dated 03/16/17 coded cognition, as being in set up and receiving a The diet order per the physician orders inclu diet. On 06/01/17 at 11:42 #12 her choice of sele provided a whole unc chunks and the pea a On 06/01/17 at 12:19 interviewed about the per the menu and the served specifically rel ground, the okra not the being served whole a that the kitchen "just of that the powdered sug served not syrup. Interview with the coor revealed she conside the same and so she the meat per the men diets. If the chicken has recipe called for, she During an additional in PM, DDS further state meal plans and obser randomly to ensure m and as planned. She	gnoses included aarterly Minimum Data Set d her with severely impaired dependent with eating after a mechanically altered diet. May 2017 computerized uded a Dysphagia Advanced PM staff offered Resident ections. Resident #12 was but waffle and the chicken and mushroom mixture. PM the DDS was e Dysphagia Advanced diet boysphagia Advanced diet boysphagia Advanced diet lated to the meats not being being cut up or the waffles and not cut up. DDS stated didn't follow the menu" and	F	367				

Facility ID: 923249

If continuation sheet Page 30 of 60

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALLEGHA	NY CENTER				179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page	30	F	367				
	06/01/17 at 3:09 PM in her first date back into December as another She stated that Dysph be cut into peas size in On 06/01/17, DSS pro- sheet for the Dysphag to be followed this dat ground chicken, cut we and ground shrimp so Interview with the Spe at 3:30 PM revealed so company that operates mechanical soft diets physician ordered the for those normally on stated the dietary staff meats and other items soft consistency. She residents had a choki recommended for a p Interview with the Adm 5:36 PM revealed she to prepare foods per to 4. Resident #29 was no 05/25/12. His diagnon hypertension, diabete accident. His quarter him with severely imp	RD was visiting this facility. hagia Advanced diets should portions bits. ovided the menu/spread gia Advanced diet that was te. The menu still stipulated vaffle, chopped fried okra, tampi. eech Therapist on 06/02/17 she was told that the tes this facility did not offer so they tried to ensure the dysphagia advanced diet a mechanical soft diet. She f had been educated on the s to be about pea size or a e further stated that if ng hazard, they would be ureed diet. ninistrator on 06/02/17 at e expected the kitchen staff he menus. readmitted to the facility on ses included anemia, s, and cerebral vascular ly Minimum Data Set coded aired cognition, being ng after tray set up, and						
	The diet order per the	computerized May 2017						

Facility ID: 923249

If continuation sheet Page 31 of 60

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FORM	2: 06/30/2017 APPROVED 0: 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE	
	345261	B. WING		_	06/0	02/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALLEGHANY CENTER			179 COMBS STREET SPARTA, NC 28675			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
On 06/01/17 at 11:47 A the chicken chunks on the peas and mushrood On 06/01/17 at 12:19 F interviewed about the D per the menu and the D served specifically rela ground, the okra not be being served whole and that the kitchen "just di that the powdered suga served not syrup. Interview with the cook revealed she considered the same as ground an the same and so she h the meat per the menu diets. If the chicken has recipe called for, she w During an additional inf PM, DDS further stated meal plans and observ randomly to ensure me and as planned. She s Dysphagia Advanced d Interview with the Regi 06/01/17 at 3:09 PM re her first date back into December as another f	 Dysphagia Advanced diet. M, Resident #29 received a whole uncut waffle with ms combination. PM the DDS was Dysphagia Advanced diet Dysphagia Advanced diet Dysphagia Advanced diet ted to the meats not being eing cut up or the waffles d not cut up. DDS stated dn't follow the menu" and ar should have been on 06/01/17 at 12:24 PM ed the chunks of chicken id always has considered it ad not been grinding up for Dysphagia Advanced ad been strips, like the yould have chopped it up. terview on 06/01/17 at 2:52 that she looked over the ed the meal preparation eas are prepared correctly stated the meals for the liets were not followed. stered Dietician (RD) on evealed that this date was this facility since RD was visiting this facility. agia Advanced diets should ortions bits.	F 367				

Facility ID: 923249

If continuation sheet Page 32 of 60

	-	D HUMAN SERVICES				FORM	: 06/30/2017 APPROVED	
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP		
345261		345261	B. WING		_	06/02/2017		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-		
ALLEGHA	NY CENTER			79 COMBS STREET SPARTA, NC 28675				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 367	to be followed this dat ground chicken, cut w and ground shrimp so Interview with the Spe at 3:30 PM revealed s company that operate mechanical soft diets physician ordered the for those normally on stated the dietary staf meats and other items soft consistency. She residents had a chokin recommended for a p Interview with the Adm 5:36 PM revealed she to prepare foods per t 5. Resident #102 was 05/03/17 with diagnos diabetes and cerebral admission Minimum d coded her as being in tray set up and receiv diet. Speech therapy notes had a cerebral vascul weakness She had o and moderate pocketi wallows of a dysphag 05/31/17 speech thera	gia Advanced diet that was te. The menu still stipulated vaffle, chopped fried okra, ampi. eech Therapist on 06/02/17 she was told that the es this facility did not offer so they tried to ensure the dysphagia advanced diet a mechanical soft diet. She f had been educated on the s to be about pea size or a e further stated that if ng hazard, they would be ureed diet. ninistrator on 06/02/17 at e expected the kitchen staff he menus. admitted to the facility on ses including hypertension, vascular accident. Per lata Set dated 05/10/17 dependent with eating after ing a mechanically altered s dated 05/04/17 that she ar accident with left sided decreased mastication skills ing/residue following ia advanced diet. As of apy noted she was still a datanced diet.	F 367					

Facility ID: 923249

If continuation sheet Page 33 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
345261		345261	B. WING			_	06/02/2017	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALLEGHANY CENTER					179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page 33		F	367				
	On 06/01/17 at 12:11 PM she was served an uncut whole waffle, chicken chunks and uncut fried okra.							
	per the menu and the served specifically rel ground, the okra not to being served whole a that the kitchen "just of that the powdered sug served not syrup. Interview with the coor revealed she conside the same as ground a the same and so she	Dysphagia Advanced diet Dysphagia Advanced diet lated to the meats not being being cut up or the waffles nd not cut up. DDS stated didn't follow the menu" and						
	diets. If the chicken harecipe called for, she During an additional in PM, DDS further state meal plans and obser randomly to ensure m and as planned. She Dysphagia Advanced Interview with the Reg 06/01/17 at 3:09 PM m her first date back into December as another She stated that Dyspl be cut into peas size On 06/01/17, DSS pro	ad been strips, like the would have chopped it up. Interview on 06/01/17 at 2:52 ed that she looked over the rved the meal preparation heals are prepared correctly stated the meals for the diets were not followed. gistered Dietician (RD) on revealed that this date was to this facility since r RD was visiting this facility. hagia Advanced diets should						

If continuation sheet Page 34 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 MAPPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345261		345261	B. WING			_	06/02/2017		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ALLEGHANY CENTER					79 COMBS STREET PARTA, NC 28675				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 367	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	367					

Facility ID: 923249

If continuation sheet Page 35 of 60

		ID HUMAN SERVICES				FORM	2: 06/30/2017 1 APPROVED 2: 0938-0391
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345261	B. WING		_	06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHANY CENTER				179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page altered diet.	: 35	F 367	7			
	Her May 2017 compu included a Dysphasia	terized physician orders advanced diet.					
		PM, she received the ncut whole waffle the peas ination and the uncut fried					
	per the menu and the served specifically rel ground, the okra not b being served whole a	Dysphagia Advanced diet Dysphagia Advanced diet ated to the meats not being being cut up or the waffles nd not cut up. DDS stated didn't follow the menu" and					
	revealed she consider the same as ground a the same and so she the meat per the men diets. If the chicken h	ok on 06/01/17 at 12:24 PM red the chunks of chicken and always has considered it had not been grinding up u for Dysphagia Advanced nad been strips, like the would have chopped it up.					
	PM, DDS further state meal plans and obser randomly to ensure m and as planned. She	erview on 06/01/17 at 2:52 ed that she looked over the rved the meal preparation heals are prepared correctly stated the meals for the diets were not followed.					
	06/01/17 at 3:09 PM r her first date back into	gistered Dietician (RD) on revealed that this date was o this facility since r RD was visiting this facility.					

Facility ID: 923249

If continuation sheet Page 36 of 60
	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHA	NY CENTER				179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	be cut into peas size p On 06/01/17, DSS pro- sheet for the Dysphag to be followed this dat ground chicken, cut w and ground shrimp sc Interview with the Spe at 3:30 PM revealed s company that operate mechanical soft diets physician ordered the for those normally on stated the dietary staf meats and other items soft consistency. She residents had a chokin recommended for a p Interview with the Adm 5:36 PM revealed she to prepare foods per t 7. Resident #43 was a 11/17/16 with diagnos Disease and dementia Data Set dated 05/03, moderately impaired of with eating after tray s mechanically altered of The diet list from the H Dysphagia Advanced On 06/01/17 at 12:51 uncut waffle, chunked	hagia Advanced diets should portions bits. ovided the menu/spread gia Advanced diet that was te. The menu still stipulated vaffle, chopped fried okra, campi. eech Therapist on 06/02/17 she was told that the es this facility did not offer so they tried to ensure the e dysphagia advanced diet a mechanical soft diet. She ff had been educated on the s to be about pea size or a e further stated that if ng hazard, they would be ureed diet. ministrator on 06/02/17 at e expected the kitchen staff the menus. admitted to the facility on ses including Alzheimer's a. His quarterly Minimum /17 coded him with cognition, being independent set up and receiving a diet. NM he received a whole d chicken, peas and	F	367				
		on and fried uncut okra.						

Facility ID: 923249

If continuation sheet Page 37 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/30/2017 APPROVED 0: 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY
		345261	B. WING			06/0	02/2017
NAME OF PR	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page		F 367				
	per the menu and the served specifically rel	PM the DDS was Dysphagia Advanced diet Dysphagia Advanced diet ated to the meats not being being cut up or the waffles					
	being served whole a	nd not cut up. DDS stated didn't follow the menu" and					
	revealed she conside the same as ground a the same and so she the meat per the men diets. If the chicken h	k on 06/01/17 at 12:24 PM red the chunks of chicken and always has considered it had not been grinding up u for Dysphagia Advanced had been strips, like the would have chopped it up.					
	PM, DDS further state meal plans and obser randomly to ensure m and as planned. She	erview on 06/01/17 at 2:52 ed that she looked over the ved the meal preparation heals are prepared correctly stated the meals for the diets were not followed.					
	06/01/17 at 3:09 PM r her first date back into December as another	RD was visiting this facility. Nagia Advanced diets should					
	sheet for the Dysphag to be followed this dat	ovided the menu/spread gia Advanced diet that was te. The menu still stipulated vaffle, chopped fried okra, campi.					

Facility ID: 923249

If continuation sheet Page 38 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345261	B. WING			_	06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ALLEGHA	ANY CENTER				179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Interview with the Spe at 3:30 PM revealed s company that operate mechanical soft diets physician ordered the for those normally on stated the dietary staf meats and other items soft consistency. She residents had a choki recommended for a p Interview with the Adr 5:36 PM revealed she to prepare foods per t 8. Resident #77 was a 11/29/16 with diagnos below the knee ampu failure and hypertensi Minimum Data Set da being independent wi receiving a therapeuti His May 2017 comput included a consistent double proteins. On 06/01/17 at 12:39 alternate of shrimp lin and peas and mushro zucchini prepared and for him. He received combination shrimp a On 06/01/17 at 12:53 there was no menu to	eech Therapist on 06/02/17 she was told that the est his facility did not offer so they tried to ensure the e dysphagia advanced diet a mechanical soft diet. She ff had been educated on the s to be about pea size or a e further stated that if ing hazard, they would be oureed diet. ministrator on 06/02/17 at e expected the kitchen staff the menus. admitted to the facility on ses including diabetes, itation, congestive heart ion. The significant change ated 03/03/17 coded him as th eating after set up and ic diet. terized physician orders carbohydrate diet with PM Resident #77 chose the figuine. He declined the okra poms. There was no d so that was not an option I two 4 ounce scoops of the and noodles. PM, the cook stated that o follow for a consistent d to her knowledge, there	F	367				

Facility ID: 923249

If continuation sheet Page 39 of 60

		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 06/30/201 DRM APPROVEI NO. 0938-039
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ì í		DNSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345261	B. WING				06/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
ALLEGHA	NY CENTER						
				SPA	ARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 367	Continued From pag	e 39	F 3	67			
		ring her 15 years as a cook					
	The Director of Dinin conversation on 06/0	g Services (DDS) joined the 01/17 at 12:57 PM. She orm that she had access to					
	for a consistent carbo to refer to. The DDS						
	which talked about th						
	serving amounts for	the protein, fruits, nd fats and sugars to follow					
		ot provide any type of menu					
	for each meal for this follow.	s diet the cooks should					
		PM the DDS stated that she Registered Dietician (RD)					
	this date and that the	ere was a menu plan for a					
		ate diet that she had not ad not instructed her staff to					
		had not been using or					
		d she had no spread sheets					
		to follow. This change enu change of 05/07/17.					
	DDS further stated th	nat she looked over the meal					
	plans and observed t	the meal preparation neals are prepared correctly					
		nsistent Carbohydrate diets					
	were not followed.						
	Interview with the RD	0 on 06/01/17 at 3:09 PM					
		te was her first date back into					
	-	cember as another RD was RD stated that a Consistent					
	Carbohydrate Diet (C	CCD) had less carbohydrates					
		as flexible as different					
	-	erts affect the carbohydrate She stated she did not see					
	any negative outcom	es from the facility not					
	having a CCD diet bu	ut would expect physician					

Facility ID: 923249

If continuation sheet Page 40 of 60

PRINTED: 06/30/2017 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/30/2017 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		345261	B. WING		_	06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	NY CENTER			179 COMBS STREET			
ALLEGHA			:	SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page ordered diets to be fo On 06/01/17, DDS pro- sheet for the Consiste should have been foll stipulated "diet chicket the alternate of shrim linguine and sliced zu prepared. Further inv "diet chicken and waff and oven baked waffl 9. Resident #74 was a 09/16/14 with current disorder and anxiety. Review of the annual dated 04/29/17 revea severely cognitively ir independent with eati further revealed Resid mechanically altered The diet order per the physician orders inclu- diet. On 06/01/17 at 12:06 #74 her choice of sele provided a whole unc chunks, and the pea a On 06/01/17 at 12:19	e 40 llowed. ovided the menu/spread ent Carbohydrate Diet that owed for this noon meal. It en and waffle", fried okra and p scampi and 1/3 cup of locchini, which was not vestigation revealed that the fle" was to have diet syrup es. admitted to the facility on diagnoses of thyroid Minimum Data Set (MDS) led Resident #74 was ng after set up. The MDS dent #74 received a diet. e May 2017 computerized ided a Dysphagia Advanced PM staff offered Resident ections. Resident #74 was ut waffle, the chicken and mushroom mixture. PM the DDS was	F 367				
	per the menu and the served specifically rel ground, the okra not to being served whole a	Dysphagia Advanced diet Dysphagia Advanced diet ated to the meats not being being cut up or the waffles nd not cut up. DDS stated didn't follow the menu" and gar should have been					

Facility ID: 923249

If continuation sheet Page 41 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 06/30/2017 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	
		345261	B. WING		_	06/	02/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367	Continued From page served not syrup.	e 41 ok on 06/01/17 at 12:24 PM	F 367				
	revealed she conside the same as ground a the same and so she	red the chunks of chicken and always has considered it had not been grinding up u for Dysphagia Advanced					
		ad been strips, like the would have chopped it up.					
	PM, DDS further state meal plans and obser	nterview on 06/01/17 at 2:52 ed that she looked over the ved the meal preparation					
	and as planned. She	neals are prepared correctly stated the meals for the diets were not followed.					
	06/01/17 at 3:09 PM in her first date back into December as another	RD was visiting this facility.					
	She stated that Dyspl be cut into peas size	nagia Advanced diets should portions bits.					
	sheet for the Dysphag to be followed this da	ovided the menu/spread gia Advanced diet that was te. The menu still stipulated vaffle, chopped fried okra, campi.					
	at 3:30 PM revealed s company that operate mechanical soft diets physician ordered the for those normally on stated the dietary stat	eech Therapist on 06/02/17 she was told that the es this facility did not offer so they tried to ensure the e dysphagia advanced diet a mechanical soft diet. She ff had been educated on the s to be about pea size or a					
	soft consistency. She						

Facility ID: 923249

If continuation sheet Page 42 of 60

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-00 STATEMENT OF DEFICIENCIES (01) PROVIDER SUPPLIER (02) MULTIPLE CONSTRUCTION (03) MULTIPLE CONSTRUCTION		-	ID HUMAN SERVICES				FOR	D: 06/30/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE ALLEGHANY CENTER STREET ADDRESS, CITY, STATE, 2P CODE (M) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY NOR LSS IDEMTFYING INFORMATION) ID PREFIX F 367 Continued From page 42 residents had a choking hazard, they would be recommended for a pureed diet. F 367 Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus. F 367 No. Resident #38 was admitted to the facility on 04/01/2011. Resident #38 was cognitive impaired and required extensive assistance for eating a mechanically altered diet. F 367 The Minimum Data Set annual assessment indicated that Resident #38 was cognitive impaired and required extensive assistance for eating a mechanically altered diet. F second review conducted on 06/01/2017 revealed MD ordered diet type of Dysphagia Advanced diet. Resident #38 served in the 400 hall dining room on 06/01/17 at 12:39 PM the DDS was interviewed dib the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per viewed on the Duy of the waffles	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	i í			(X3) DATE	SURVEY
ALLEGHANY CENTER 179 COMBS STREET SPARTA, NC 28675 Image: Comparison of the			345261	B. WING			06/	/02/2017
ALLEGHANY CENTER SPARTA, NC 28675 (%1)D PREER/ TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BERERCIBED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) D PREER/ PREER/ COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (%9) (EACH ORRECTIVE AUGUED REPRECIBED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (%9) (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 367 Continued From page 42 resident \$30 as a dmitted to the facility on 04/01/2011. Resident #38 had diagnosis which included: dementia, Alzheimer's disease, Parkinson's disease, adult failure to thrive and anxiety. F 367 The Minimum Data Set annual assessment indicated that Resident #38 was cognitive impaired and required extensions do for eating a mechanically altered diet. A record review conducted on 06/01/2017 revealed MD ordered diet type of Dysphagia Advanced diet. Resident #38 served in the 400 hall dining room on 06/01/17 at 12:29 PM a bowl containing a whole uncut waffle with chunked chicken on top, peas and mushrooms and the fried uncut okra. On 06/01/17 at 12:29 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per the menu and the Dysphagia Advanced di	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Predirix TxG (EACH ORFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTFYING INFORMATION) PRE/TX TxG CEACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMUNT DEFICIENCY F 367 Continued From page 42 residents had a choking hazard, they would be recommended for a pureed diet. F 367 Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus. F 367 10. Resident #38 was admitted to the facility on 04/01/2011. Resident #38 had diagnosis which included: dementa, Alzheimer's disease, Parkinson's disease, adult failure to thrive and anxiety. F The Minimum Data Set annual assessment indicated that Resident #38 was cognitive impaired and required extensive assistance for eating a mechanically altered diet. A record review conducted on 06/01/2017 revealed MD ordered diet type of Dysphagia Advanced diet. Resident #38 served in the 400 hall dining room on 06/01/17 at 12:29 PM a bowl containing a whole uncut waffle with chunked chicknen on top, peas and mushrooms and the fried uncut okra. On 06/01/17 at 12:19 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet served specifically related to the meats not being ground, the okra not being cut up or the waffles	ALLEGHA							
residents had a choking hazard, they would be recommended for a purced diet. Interview with the Administrator on 06/02/17 at 5:36 PM revealed she expected the kitchen staff to prepare foods per the menus. 10. Resident #38 was admitted to the facility on 04/01/2011. Resident #38 had diagnosis which included: dementia, Alzheimer's disease, Parkinson's disease, adult failure to thrive and anxiety. The Minimum Data Set annual assessment indicated that Resident #38 was cognitive impaired and required extensive assistance for eating a mechanically altered diet. A record review conducted on 06/01/2017 revealed MD ordered diet type of Dysphagia Advanced diet. Resident #38 served in the 400 hall dining room on 06/01/17 at 12:29 PM a bow containing a whole uncut waffle with chunked chicken on top, peas and mushrooms and the fried uncut okra. On 06/01/17 at 12:29 PM the DDS was interviewed about the Dysphagia Advanced diet per the menu and the Dysphagia Advanced diet per ved specifically related to the meats not being ground, the okra not being cut up or the waffles	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	ЗE	COMPLETION
that the kitchen "just didn't follow the menu" and that the powdered sugar should have been served not syrup. Interview with the cook on 06/01/17 at 12:24 PM revealed she considered the chunks of chicken the same as ground and always has considered it	F 367	residents had a choki recommended for a p Interview with the Adr 5:36 PM revealed she to prepare foods per t 10. Resident #38 was 04/01/2011. Resident included: dementia, A Parkinson's disease, a anxiety. The Minimum Data So indicated that Resider impaired and required eating a mechanically A record review condu- revealed MD ordered Advanced diet. Resident #38 served on 06/01/17 at 12:29 whole uncut waffle wi peas and mushrooms On 06/01/17 at 12:19 interviewed about the per the menu and the served specifically rel ground, the okra not the being served whole a that the kitchen "just of that the powdered sug- served not syrup.	ing hazard, they would be bureed diet. ministrator on 06/02/17 at e expected the kitchen staff the menus. s admitted to the facility on #38 had diagnosis which Alzheimer's disease, adult failure to thrive and et annual assessment nt #38 was cognitive d extensive assistance for y altered diet. ucted on 06/01/2017 diet type of Dysphagia in the 400 hall dining room PM a bowl containing a th chunked chicken on top, s and the fried uncut okra. PM the DDS was e Dysphagia Advanced diet ated to the meats not being being cut up or the waffles ind not cut up. DDS stated didn't follow the menu" and gar should have been	F	367	7		

If continuation sheet Page 43 of 60

	-	D HUMAN SERVICES				FORM): 06/30/2017 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345261	B. WING		_	06/	02/2017
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
ALLEGHA	NY CENTER			79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
				[DEFICIENCY)		
F 367	the meat per the men diets. If the chicken have recipe called for, she During an additional in PM, DDS further state meal plans and obser randomly to ensure m and as planned. She Dysphagia Advanced Interview with the Reg 06/01/17 at 3:09 PM m her first date back inter	had not been grinding up u for Dysphagia Advanced ad been strips, like the would have chopped it up. Interview on 06/01/17 at 2:52 ed that she looked over the ved the meal preparation leals are prepared correctly stated the meals for the diets were not followed. gistered Dietician (RD) on revealed that this date was o this facility since	F 367				
F 371 SS=E	She stated that Dysph be cut into pea's size 483.60(i)(1)-(3) FOOD STORE/PREPARE/SI (i)(1) - Procure food fr considered satisfactor authorities. (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	D PROCURE, ERVE - SANITARY rom sources approved or ry by federal, state or local ood items obtained directly subject to applicable State llations. s not prohibit or prevent roduce grown in facility ompliance with applicable	F 371				6/30/17
	(i)(2) - Store, prepare	, distribute and serve food in					

Facility ID: 923249

If continuation sheet Page 44 of 60

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:				PLETED
		345261	B. WING		06	/02/2017
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALLEGHA	NY CENTER			179 COMBS STREET SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 371	Continued From page accordance with professory	e 44 essional standards for food	F 371			
	foods brought to resid visitors to ensure safe handling, and consum This REQUIREMENT by: Based on observatio manual review, the fa sanitary kitchen by sa and change gloves to contamination, keep to contamination during from contaminating the floors. The findings included 1. On 05/30/17 at 10: kitchen walk through, Services (DDS) state mobile steam table w halls during meal time who ate in their room was electric with pala used no steam.	is not met as evidenced ns and staff interviews and acility failed to maintain a anitizing dishes, wash hands prevent food the food protected from service, keep the ice scoop ne ice, and clean the kitchen		1. On 6/1/17 & 6/3/17 dietary staff rein-serviced on appropriate infect control procedures when handling appropriate changing of contamina gloves and hand washing techniqu changing gloves during meal servi the Director of Dining Services. Or 5/30/17 staff members were provid a container for storing ice scoops of meal service to prevent handle fro touching ice by the Director of Dini Services. On 6/5/17 Center Execu Director observed dry storage to a clean and free of debris as floors h been swept and mopped by dietar On 6/1/17 & 6/3/17 dietary staff we rein-serviced on how to prime sani hose and the proper procedure for checking sanitizer levels in dish material	ion food, ated les with ce by led with during m ng tive ssure lad y staff. ere tizer	
	Manual included an e service. Instructions followed the mobile s careful not to contam touching serving uten plates. The nurse aid table down the hall ar	-		2. On 6/27/17 the Director of Dinin Services will be rein-serviced by C Executive Director on the importar monitoring staff regularly to assure appropriate infection control proce and cleanliness of kitchen floors. C 6/1/17 & 6/3/17 dietary staff was rein-serviced on appropriate infect	enter ace of ausing dures Dn	

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 45 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 45 F 371 On 05/30/17 at 11:57 AM the mobile steam table appropriate changing of contaminated was observed in use on the 300 hall. Options gloves and hand washing techniques with available to the residents included roast beef changing gloves during meal service by sandwiches potato salad, tater tots and a the Director of Dining Services. On breakfast casserole. Dietary Aide #2, wearing 5/30/17 nursing and dietary staff members gloves, would plate the food after Dietary #1 went were rein-serviced on appropriate storage to the resident rooms, informed the resident the of ice scoop during meal service to food options and then told Dietary Aide #2 what prevent contamination. On or before each resident chose to eat. Dietary Aide #1 was 6/30/17 dietary staff will be rein-serviced observed carrying a resident's roast beef on keeping kitchen floors clean and free sandwich in a bowl that was pressed up against of debris by Director of Dining Services. her shirt with the food touching her shirt. On 6/1/17 & 6/3/17 dietary staff were rein-serviced on how to prime sanitizer Dietary Aide #2 was observed to unplug the hose and the proper procedure for mobile steam table, push it down the hall, plug checking sanitizer levels in dish machine. the unit into another outlet. Dietary Aide #2 then proceeded to plate the food including handling the 3.On 6/27/17 the Director of Dining roast beef sandwiches and lettuce and tomato Services will be rein-serviced by Center Executive Director on the importance of with the same gloves that were on when she plugged and unplugged the mobile unit. Dietary monitoring staff regularly to assure using appropriate infection control procedures Aide #2 also was observed to use the portable walkie talkie to alert the kitchen of needed items, and cleanliness of kitchen floors. On with the same gloved hands she handled the 6/1/17 & 6/3/17 dietary staff was sandwiches, lettuce and tomato. She put the rein-serviced on appropriate infection walkie talkie back in the drawer and continued to control procedures when handling food, serve the food, directly touching some food items appropriate changing of contaminated without sanitizing her hands or changing her gloves and hand washing techniques with gloves. During this service, residents were changing gloves during meal service by observed rolling and walking by the mobile unit the Director of Dining Services. On while the food lids were off the food items. 5/30/17 nursing and dietary staff members were rein-serviced on appropriate storage Observations on 05/30/2017 at 12:09 PM were of ice scoop during meal service to made of the mobile steam table on the 100 hall. prevent contamination. On or before Dietary Aide #1 would go to the rooms and offer 6/30/17 dietary staff will be rein-serviced the selections and then tell Dietary Aide #2 what on keeping kitchen floors clean and free the selection was to be prepared. At this time of debris by Director of Dining Services. Dietary Aide #1 was observed holding a small On 6/1/17 & 6/3/17 dietary staff were bowl of potato salad between her wrist and the rein-serviced on how to prime sanitizer bowl was pressed against against her shirt. hose and the proper procedure for

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

If continuation sheet Page 46 of 60

STATEMENT	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345261	B. WING		06/02/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·
				179 COMBS STREET	
ALLEGHA	NY CENTER		:	SPARTA, NC 28675	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIO
F 371	Continued From page	e 46	F 371		
	table and pushed it to proceeded to plug the hand washing, put ne to handle the roast be tomatoes. While on th up to the mobile stea and standing over the away from the open f Dietary Aide #2 used on and with the same grab the inside of the food without hand wa Dietary Aide #2 contine sandwiches, lettuce a gloves she wore as s unit, pushed it further replugged it into the e On 05/30/17 at 12:25 removed her gloves a the 400 hall. Without sanitizing, she put on handle the sandwiched directly with gloved h Aide #2 unplugged th replugged it in and wi proceeded to directly lettuce and tomato. O Dietary Aide #2 used with the same gloves 12:39 PM, Dietary Aide	unplugged the mobile steam of the 200 hall. She e unit in and without any ew gloves on and proceeded eef sandwiches, lettuce and his hall, Resident #63 came im table looking at the food e food. Staff had to redirect food items. At 12:19 PM, the walkie talkie with gloves e gloves, she proceeded to e bowls and serve up the ashing or glove changing. nued to handle the and tomato with the same she unplugged the mobile r down the hall and electric socket. 5 PM, Dietary Aide #2 and moved the mobile unit to t hand washing or hand o gloves and proceeded to es, lettuce and tomato ands. At 12:31 PM, Dietary he unit, moved it up the hall, ith the same gloves handle the sandwiches, On 05/30/17 at 12:37 PM the walkie talkie and then a handled the food. Then at de #2 dropped the walkie removed her glove and		 checking sanitizer levels in dish r On 6/21/17 Nurse Practice Educate provided on-time education for di staff infection control practices du meal service at lunch. 4. Dining Services Director and/or Regional Dietician will monitor m service to assure appropriate infe control procedures, hand washin techniques and sanitation during washing 1 x weekly x 1 month the monthly x 1 month then 1 x month month. Dining Services Director Regional Dietician will observe ki assure clean and cleaning sched being followed 1 x weekly x 1 mont 2 x monthly x 1 month then 1 x m 1 month. Center Nurse Executive Assistant Center Nurse Executive monitor ice service one x weekly month then 2 x monthly x 1 mont x monthly x 1 month to assure ice stored properly. Any issues as a monitoring and observation will b reported to and addressed by Pre- Improvement Committee q month months and ongoing as needed. 	ator and pr ietary uring pr leal ection g dish en 2 x thly x 1 and/or itchen to dules are ponth then nonthly x e and/or e will x 1 th then 1 e scoops result of pe ocess h x 3

Facility ID: 923249

If continuation sheet Page 47 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE	
		345261	B. WING			_	06/	02/2017
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
ALLEGHA					79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	walkie talkie with the e once finished the required to touch the lettuce with the contain The Director of Dining 05/30/17 at 12:40 PM the mobile steam table On 06/01/17 at 12:40 PM the mobile steam table On 06/01/17 at 11:00 trained her staff on th service and she perior meal service to ensur- service. On 06/01/17 at 11:38 was set up and begin hall. The meal include handled directly with g plating the meal. Die resident orders and th During the service, th back of her gloved lef AM. She proceeded without any hand was changing of the glove On 06/01/17 at 11:45 gloves she had during mobile steam table, n replugged it and proc waffles with the same was observed again of On 06/01/17 at 12:02 steam table on the hat gloves from the kitche	gloves she had on, and uest on the walkie talkie, e sandwiches, tomato and minated gloves. g Services (DDS) stated on the facility had been using e for about 8 months. AM, the DDS stated she e mobile steam table dically would observe the e compliance with the AM, the mobile steam table ning to be used on the 300 ed waffles which were gloved hands by the cook tary Aide #1 took the ne cook plated the food. e cook coughed onto the t hand on 06/01/17 at 11:44 to serve the food items shing or hand sanitizing or s. AM the cook, wearing the g service, unplugged the noved it down the hall, eeded to directly handle the o contaminated gloves. This on 06/01/17 at 11:53 AM. PM, the cook left the mobile ill, unattended to get more	F	371				

Facility ID: 923249

If continuation sheet Page 48 of 60

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ____ 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 48 F 371 gloves she had handled the waffles directly with, the cook unplugged the unit, moved it to the 200 hall, replugged it in the electric outlet and proceeded to handle the waffles with the same gloves. On 06/01/17 at 12:17 PM the cook was interviewed. She stated she was taught to change her gloves when she moved from one hall to the next. She stated that as long as she stayed with the mobile steam table, she did not have to change gloves unless they got dirty. When asked about plugging and unplugging the unit on the hall, she stated she "guesses" she should change gloves but gave no reason she did not change gloves. The DDS was interviewed on 06/01/17 at 12:19 PM. She stated she expected staff to change gloves when the staff moved the mobile steam table to a different hall. She further stated that the instructions that came with the mobile steam table did not address hand washing. She then stated that staff should change gloves when plugging and unplugging the mobile steam table. DDS then stated that staff should not have the walkie talkie in the mobile steam table and should have gotten a clean one from the kitchen once it fell to the floor. On 06/01/17 at 3:09 PM the registered dietician stated she has observed the mobile steam table in use and had some issues which she verbally discussed but gave no written action plan to address. She stated she expected staff to remove gloves and wash their hands after they unplug the table, move it and replug it in. She also stated the food should never touch the body of the server.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923249

If continuation sheet Page 49 of 60

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/30/2017 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		E CONSTRUCTION		(X3) DATE	
		345261	B. WING				06/	02/2017
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STA	TE, ZIP CODE		
ALLEGHA	NY CENTER				179 COMBS STREET			
					SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page) 49	F	371				
	stated during interview trouble with residents steam table trying to g addition, visitors are a table during service a During an interview w 06/02/17 at 5:36 PM, hand washing and ch dietary staff's gloves a 2. Observations were on 05/31/17 at 8:49 A observed in the dish r through the dish wash low temperature dish water goes to 120 deg AM the sanitation of the checked with strips an Dining Services (DDS change of color indica chemicals being distri- stated at this time tha sanitation of the mach stated she normally ru then checks for sanitation of to 05/31/17 at 8:58 A box of test strips and change of color. The 9:00 AM, the dishmach evidence of sanitation into the dishmachine. Dietary Aide #1 contin the machine and put for	always passing the steam is well as other staff. with the Administrator on she stated she expected anging gloves when the are contaminated. Is made of the dishmachine M. Dietary Aide #1 was room running dirty plates her. She stated this was a washing machine and the grees Fahrenheit. At 8:57 he dish washer was nd with the Director of S). The test strip showed no ating there was sanitation ibuted. Dietary Aide #1 it she had not checked the hine yet this date. she uns several loads through ation levels. AM, DDS obtained a new again the strip showed no n again with new strips at chine again and noted no n chemicals being distributed Throughout this time, hued to run dishes through the unsanitized items,						
		late lids away ready for use.						

Facility ID: 923249

If continuation sheet Page 50 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 50 F 371 dishwasher loads of plates and other items ready for use even though the sanitation was not working. On 05/31/17 at 9:09 AM, Dietary Aide #1 continued to put items from the dishmachine away ready for use. Dietary Aide #1 stated during interview at this time that she "probably" would not use the dishes she was putting away for the next meal. Dietary Aide #2 joined the conversation and stated that they needed the bowls and such for the meal. Dietary Aide #1 stated she would run them all through the dishmachine once it was fixed. She further stated the temperature was correct and the dishes looked clean. On 05/31/17 at 9:17 AM Dietary Aide #1 continued to use the dishmachine and run dishes through and put them away despite the machine's sanitizer not working. On 05/31/17 at 9:18 AM, DDS was interviewed about the dishes being put away. She then went and instructed staff to gather all the dishes and rerun them through the machine once the sanitation was fixed. This included the pitchers which had just been placed with the others in the kitchen. DDS then emptied the lorator of the plates she put away this morning. On 05/31/17 at 9:38 AM DDS stated that she had fixed the problem as the dish machine needed to be primed. She was unaware of this feature on the dishmachine. On 05/31/17 at 9:44 AM, the sanitation was checked again on the dishmachine. Again the strips showed no sanitation being added to the rinse cycle. DDS stated at this time that she expected staff to check sanitation every shift. DDS tried to prime again and at 9:47 AM the sanitation was still not

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

Facility ID: 923249

If continuation sheet Page 51 of 60

	-	ID HUMAN SERVICES				FORM	: 06/30/2017 1APPROVED
STATEMENT (S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		345261	B. WING		_	06/0	02/2017
NAME OF P	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
ALLEGHANY CENTER				79 COMBS STREET PARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 371	evident by the test str AM, DDS stated there that pumped the sanit She stated she was g and use the 3 compar- items i.e. pitchers. On 06/01/17 at 10:39 representative was in came monthly for rour stated that he needed further stated that the checked after the dish several cycles before This should be done a 3. On 05/31/17 at 9:00 dry storage area reve including cereal, a yel peels. On 06/01/17 at 9:37 <i>A</i> again observed with t the floor. There were floor. The Director of Dining dry storage area with ring on the floor on 06 stated that staff were the floor every evenin being done. During interview with 06/02/17 at 5:36 PM, floor to the dry storag 4. On 05/30/17 at 11:4	 ips. On 05/31/17 at 10:21 a were holes in the tubing tizer into the dishmachine. ioing to buy paper products rtment sink for the larger AM the dishmachine terviewed. She stated he tine maintenance. He does not be the tubing. He is anitation should be not be not be the dishes were cleaned. at each meal cycle. 8 AM, observations of the aled the floor had debris flow plastic ring, and onion AM the dry storage area was he cereal and plastic ring on the cereal and plastic ring on the sonic not be sonic peels on the the cereal and yellow plastic 5/02/17 at 10:21 AM. She expected to sweep and mop and it obviously was not 	F 371				

Facility ID: 923249

If continuation sheet Page 52 of 60

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	TE SURVEY		
AND PLAN OF CORRECTION IDENTIFICAT		IDENTIFICATION NUMBER:	A. BUILDING	UILDING		MPLETED	
	345261		B. WING		0	06/02/2017	
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER			STE)E			
			179 COMBS STREET SPARTA, NC 28675				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 371	the ice scoop in the ice the ice. This continue 05/30/17 at 12:02 PM	v scooped the ice, staff left ce with the handle touching ed and observed again on	F 371				
F 520 SS=E	stated that the handle source of cross conta 483.75(g)(1)(i)-(iii)(2)	(i)(ii)(h)(i) QAA ERS/MEET	F 520			6/30/17	
	(g) Quality assessme(1) A facility must ma and assurance comm minimum of:	intain a quality assessment					
	(i) The director of nur	sing services;					
	(ii) The Medical Direc	tor or his/her designee;					
	staff, at least one of v	a board member or other					
	(g)(2) The quality ass committee must :	essment and assurance					
	coordinate and evalu	n respect to which quality					

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 53 of 60

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345261		IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		B. WING		0	6/02/2017	
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP COD	E	
	NY CENTER			179 COMBS STREET		
				SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 520	Continued From page	e 53	F 520	o		
		tified quality deficiencies;		-		
		rmation. A State or the				
		quire disclosure of the nittee except in so far as				
		ated to the compliance of				
	such committee with	the requirements of this				
	section.					
	(i) Sanctions. Good fa	aith attempts by the				
	committee to identify	· ·				
	deficiencies will not b	e used as a basis for				
	sanctions.	F is set set as a side set of				
	by:	Γ is not met as evidenced				
	-	ons, record reviews and staff		1. On 6/22/17 The set of smo	oke	
		es Quality Assessment and		prevention doors for 100 Hall,	, 200 Hall,	
	Assurance Committe			300 Hall and 400 Hall were sa	•	
		ures and monitor these		Maintenance Assistant to ass	0	
		committee put into place in for 3 recited deficiencies		to touch or splintered edges of laminate leaving sharp edges		
		cited in April 2016 on a		the 200 Hall main dining room		
		and subsequently recited on		sanded to assure no rough to		
	the current recertifica	-		splintered edges or broken la		
		the areas of environment, an sanitation. The continued		leaving sharp edges by Maint Director. On 6/14/17 the door		
		luring three federal surveys		to the courtyard was sanded t	0	
	-	tern of the facilities inability to		rough to touch or splintered e		
		Quality Assurance Program.		Maintenance Director. Vinyl c	overing for	
	Findings installed			the courtyard door will be rep	•	
	Findings included:			Maintenance Director on or b 6/30/17. On 6/26/17 the room		
	This tag is cross refe	rred to:		Rooms #200,#309,#310,#403		
	0			#412 were sanded by the Ma		
		vations and staff interviews		Director to assure no rough to		
	-	epair 4 of 4 sets of double		splintered edges or broken la		
	smoke prevention do	ors with broken and nd wood on the lower edges		leaving sharp edges. On 6/26 bathroom doors for Rooms	wir ine	
	spinnereu ianimale a	0, 300 and 400 halls). The		#200,#309,#310,#403,#405 a		

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 54 of 60

PRINTED: 06/30/2017 FORM APPROVED

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
345261			B. WING			0	6/02/2017
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
					79 COMBS STREET PARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 520	Continued From page	2 54	F 5	520			
		the main dining room door			were sanded by the Maintenance Dire	ctor	
		tered laminate and wood on			to assure no rough to touch or splinter		
		e door on the 200 hall on 1			edges or broken laminate leaving shar		
	of 3 residents' hallway			edges.On 6/19/17 The room door for			
	leading out to the cou			room #110 was sanded and painted by	/		
	broken and splintered			the Maintenance Assistant to assure n	0		
	lower edges of the do			rough to touch or splintered edges or			
	the bottom of the doo			broken laminate leaving sharp edges.			
	The facility also failed			Vinyl skin to be replaced by 6/30/17.0	n		
	doors with broken and splintered laminate and				6/26/17 the door for room #311 was		
	wood on the lower edges of the door with an area				sanded by the Maintenance Director to		
	where the vinyl skin had peeled back and caused a sharp edge in 2 of 22 occupied resident rooms				assure no rough to touch or splintered edges or broken laminate leaving shar		
	(Room #311 and #110			edges. Vinyl skin to be replaced by	ρ		
	room and bathroom d				6/30/17.		
		ne lower half of the door that			On 6/22/17 Resident #52 had a skin		
		n 6 of 35 occupied resident			check and no areas were found on		
	•	4309, #310, #403, #405 and			clothes or skin related to smoking.		
	#412).				On 6/1/17 & 6/3/17 dietary staff was		
					rein-serviced on appropriate infection		
	The facility was recite	d for F 253 for failing to			control procedures when handling food	d,	
		ion doors, a dining room			appropriate changing of contaminated		
		o a courtyard for smoking			gloves and hand washing techniques v		
	and resident room and bathroom doors with				changing gloves during meal service b	у	
		l laminate and wood on the			the Director of Dining Services. On		
	•	ors. F 253 Environment uring the April 14, 2016			5/30/17 staff members were provided a container for storing ice scoops durir		
	recertification survey				meal service to prevent handle from	iy	
	ceilings, walls, 1 AC/F				touching ice by the Director of Dining		
		and toilet paper holders in			Services. On 6/5/17 Center Executive		
		oms for 6 of 30 rooms			Director observed dry storage to assur	е	
	(Rooms 200, 207, 303				clean and free of debris as floors had		
	reviewed for environm				been swept and mopped by dietary sta	aff.	
					On 6/1/17 & 6/3/17 dietary staff were		
		vations, record review and			rein-serviced on how to prime sanitizer	r	
		acility failed to follow the care			hose and the proper procedure for		
	plan for smoking safe residents who smoke	-			checking sanitizer levels in dish machi	ne.	

Facility ID: 923249

If continuation sheet Page 55 of 60

		()(0)		OMB NO. 0938-03
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345261		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		B. WING		06/02/2017
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER			STREET ADDRESS, CITY, STATE, ZIP COE	DE
			179 COMBS STREET SPARTA, NC 28675	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
ntinued From page	2 55	F 520		
ing the recertificat facility was cited f in for 1 of 4 resider vities of daily living rent recertification ited for failing to for oked (Resident #5 based on observat nual review, the fa- itary kitchen by sa change gloves to tamination, keep to tamination during n contaminating the res. ing the recertificat facility was cited f red food in the kitch ed to label and dat igerator/freezer ac se's station, failed ed to ensure only re kept in the nour ed to replace insul grading interior pla igerator/freezers, nourishment refri insulated dome lid ertification survey failing to maintain itizing dishes, was prevent food conta	tion survey of April 14, 2016, for failure to follow the care ints dependent on staff for g (Resident #42). On the survey F 282 was again ollow the care plan for of 6 sampled residents who (2) ions and staff interviews and acility failed to maintain a anitizing dishes, wash hands o prevent food the food protected from service, keep the ice scoop he ice, and clean the kitchen tion survey of April 14, 2016 for failure to label and date then refrigerator and freezer, the food in the nourishment cross from the 400 hall to cover food in dry storage, resident beverages and food ishment refrigerator, and ated dome lids with stic in 1 of 1 kitchen 1 of 1 dry storage rooms, 1 igerator/freezers and 26 of is. On the current the facility was again recited a sanitary kitchen by sh hands and change gloves mination, keep the food	F 520	2. By 6/30/17 all remaining repetition doors, common are smoke prevention doors will a Maintenance Director to assure no rough to touch, splintered broken laminate and/or vinyl leaving sharp edges. By 6/30 Maintenance Director will list room doors, bathroom doors, area doors and smoke prever need of repairs. These repair placed on schedule for comp On 6/26/17, A Smoking Asser performed on all smokers by Practice Educator and care pupdated accordingly. Based of plan a list of items needed for individual resident while smot placed with smoking accessor as a reference to assure care being followed for all smokers on 6/27/17 the Director of Di will be rein-serviced by Center Director on the importance of staff regularly to assure using infection control procedures a cleanliness of kitchen floors. 6/3/17 dietary staff was rein-sappropriate infection control procedures as a reference by the Director of Di with andling food, approprior of contaminated gloves and h techniques with changing glo meal service by the Director of Services. On 5/30/17 nursing staff members were rein-serviced	ea doors and be audited by ure there are edges, coverings //17 the all remaining , common ntion doors in s will be letion. ssment was Nurse blan was on the care r each king was or the care r each king was ories for staff e plans are s. ning Services er Executive f monitoring g appropriate and On 6/1/17 & serviced on procedures iate changing nand washing oves during g and dietary viced on
	RECTION DER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Intinued From page ing the recertificat facility was cited fan for 1 of 4 resider vities of daily living rent recertification ited for failing to for bked (Resident #5 Based on observat mual review, the fan itary kitchen by sa I change gloves to tamination during n contaminating the res. ing the recertificat facility was cited fan to a failing to recertificat facility was cited fan to a failing to recertificat facility was cited fan to a failing the recertificat facility was cited fan red food in the kito ed to label and dat igerator/freezer ac se's station, failed ed to ensure only in the kept in the nour ed to replace insul prading interior plan igerator/freezers, nourishment refri- insulated dome lidd ertification survey failing to maintain itizing dishes, was revent food conta tected from contantantantantantantantantantantantantan	RECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345261 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Antinued From page 55 ing the recertification survey of April 14, 2016, facility was cited for failure to follow the care n for 1 of 4 residents dependent on staff for vities of daily living (Resident #42). On the rent recertification survey F 282 was again ted for failing to follow the care plan for obked (Resident #52) Based on observations and staff interviews and nual review, the facility failed to maintain a itary kitchen by sanitizing dishes, wash hands change gloves to prevent food tamination during service, keep the ice scoop n contaminating the ice, and clean the kitchen	IDENTIFICATION NUMBER: A. BUILDING 345261 B. WING	RECTION IDENTIFICATION NUMBER: A. BUILDING 345261 B. WING ER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL DENTER STREET ADDRESS, CITY, STATE, ZIP COL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D Trag CROSS-REFERENCED TO THE (EACH OBERCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D trinued From page 55 TAG CROSS-REFERENCED TO TH DEFICIENCY) tritinued From page 55 F 520 2. By 6/30/17 all remaining re bathroom doors, common and smoke prevention doors will Maintenance Director to assis no rough to touch, splintered borken laminate and/or vinyl leaving sharp edges. By 6/33. king safety for 1 of 6 sampled residents who oked (Resident #52) F 520 kased on observations and staff interviews and nual review, the facility failed to maintain a itary kitchen by sanitizing dishes, wash hands change gloves to prevent food tarination during service, keep the ice scoop na contaminating the ice, and clean the kitchen res. F 620 ing the recertification survey of April 14, 2016 facility was cited for failure to label and date red food in the Nitchen refrigerator; and red to replace insulated dome lids with rading interior plastic in 1 of 1 kitchen regerator/freezers, 1 of 1 dry storage, red to ensulate insulated broken lids with radig interior plastic in 1 of 1 kitchen regerator/freezers, 1 of 1 dry storage roms, 1

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 56 of 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345261 B. WING 06/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **179 COMBS STREET** ALLEGHANY CENTER **SPARTA, NC 28675** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 520 Continued From page 56 F 520 During an interview on 06/02/17 at 6:23 PM with clean and free of debris by Director of the Administrator she explained the Quality Dining Services. On 6/1/17 & 6/3/17 Assessment and Assurance Committee met dietary staff were rein-serviced on how to monthly and they had audited plans of correction prime sanitizer hose and the proper for deficiencies cited in the Recertification Survey procedure for checking sanitizer levels in in April 2016. She stated some of the regulations dish machine. were very broad and she could not fix every problem that happened every day. She further 3. On 6/26/17 The Maintenance Director stated they had audited work orders since the last was reeducated by the Center Executive survey and they were aware of damage to doors Director on the importance of assuring but there wasn't enough manpower to keep up door edges are not rough to touch with with the work that need to be done. She splintered edges, broken laminate and/or explained the kitchen issues that were cited last vinyl coverings leaving sharp edges. year had to do with dating and labeling but this Department Heads were reeducated by year the areas of concern were different. She the Center Executive Director on 6/22/17 stated she felt the process was in place but there on the importance of observing doors was not resources to get it all done. during routine zone checks for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges and report findings to Center Executive Director. The Center Executive Director will assure reported findings/repairs are completed or scheduled for completion by Maintenance Director. Staff will be educated on 6/28/17 and 6/29/17 to monitor doors during daily duties for rough to touch splintered edges, broken laminate and/or vinyl coverings leaving sharp edges, reporting findings to Maintenance Director to be repaired or scheduled for repairs. In-services will be completed by 6/30/17 with Nurse Practice Educator, Center Nurse Executive, Center Executive Director and/or the Assistant Center Nurse Executive to re-educate nursing, dietary, laundry and housekeeping staff on the need to follow plan of care for all residents who are smokers.

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

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 57 of 60

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	OMB NO. 0938-03 (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
345261			B. WING		06/02/2017
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
ALLEGH	ANY CENTER			179 COMBS STREET SPARTA, NC 28675	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 520	Continued From page	je 57	F 524	 On 6/27/17 the Director of Dinit will be rein-serviced by Center Director on the importance of m staff regularly to assure using a infection control procedures an cleanliness of kitchen floors. O 6/3/17 dietary staff was rein-se appropriate infection control prowhen handling food, appropriat of contaminated gloves and ha techniques with changing glove meal service by the Director of Services. On 5/30/17 nursing a staff members were rein-servic appropriate storage of ice scoor meal service to prevent contam or before 6/30/17 dietary staff vere rein-serviced on keeping kitcher clean and free of debris by Director and free of debris by Director and Free of checking sanitizer hose and the priprocedure for checking sanitized dish machine. On 6/21/17 Nurse Educator provided on-time edu dietary staff infection control priduring meal service at lunch. 4.Department Heads will perfor one x weekly x 1 month then the number of will be reported to Center Exect Director and Maintenance Direr repaired or scheduled for repair Findings will be reviewed and a by Performance Improvement of the service of th	Executive nonitoring appropriate d n 6/1/17 & rviced on ocedures te changing nd washing es during Dining and dietary sed on op during nination. On will be en floors ector of 3/3/17 d on how to roper er levels in se Practice Practice for actices rm rounds vo x monthly x 1 une 2018. i monitoring cutive ctor to be rs. addressed

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 58 of 60

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 06/30/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	B. WING _		06/02/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE
ALLEGHANY CENTER			179 COMBS STREET	
ALLEGHANT CENTER			SPARTA, NC 28675	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	A OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE IENCY)
F 520 Continued From p	age 58	F 5	 q month x 3 months and ongoing. Residents that smoke w Nurse Practice Educato of Social Services to as being followed one x we then two x monthly x 1 monthly x 1 monthly x 1 month then through June 2018. Any result of monitoring will addressed by Performa Committee monthly x 3 quarterly through ongoi Dining Services Directo Dietician will monitor ma assure appropriate infer procedures, hand wash and sanitation during di weekly x 1 month then 1 month then 1 x monthly x quarterly through June Services Director and/o Dietician will observe ki clean and cleaning sche followed 1 x weekly x 1 monthly x 1 month then month then 1 x quarterl 2018 . Center Nurse Ex Assistant Center Nurse monitor ice service one month then 2 x monthly x monthly x 1 month the through June 2018 to a stored properly. Any iss monitoring and observa reported to and address Improvement Committe 	vill be observed by or and/or Director soure plan of care eekly x 1 month month then one x 1 x quarterly y issues noted as a be reported to and ince Improvement months and ng. or and/or Regional eal service to ction control ing techniques sh washing 1 x 2 x monthly x 1 x 1 month then 1 e 2018. Dining or Regional tchen to assure edules are being month then 2 x 1 x monthly x 1 y through June tecutive and/or Executive will x weekly x 1 x 1 month then 1 en 1 x quarterly ssure ice scoops uses as a result of ttion will be sed by Process

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 59 of 60

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		IDENTIFICATION NUMBER.	A. BUILDING		COMPLETED
		345261	B. WING		06/02/2017
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER				CODE	
				179 COMBS STREET SPARTA, NC 28675	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 520 Continued From page 59		e 59	F 52	0 months and 1 x quarterly th	nrough ongoing.

Event ID: YHOV11

Facility ID: 923249

If continuation sheet Page 60 of 60