PRINTED: 12/22/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		0.45400	D MINO			R-C
NAME ∩E PI	ROVIDER OR SUPPLIER	345163	B. WING _	STREET ADDRESS, CITY, STATE, ZIP (	CODE	12/13/2023
	DGE HEALTH AND REHA	ABILTATION		211 MILTON BROWN HEIRS ROAD BOONE, NC 28607	SOBE	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
F 000	INITIAL COMMENTS	3	FO	000		
{F 804} SS=D	additional information the exit date is 12/13, 761 and F 801 were received and F 801 were received at the time still out of compliance Nutritive Value/Appea CFR(s): 483.60(d)(1) \$483.60(d) Food and Each resident received \$483.60(d)(1) Food processor of conserve nutritive value (shallow) at the still out of compliance (shallow) and Each resident received (shallow) at the shallow in the sh	on survey that was a of the revisit. The facility is a c. Event ID# CECQ12.  ar, Palatable/Prefer Temp (2)  drink as and the facility provides- orepared by methods that due, flavor, and appearance; and drink that is palatable, afe and appetizing  is not met as evidenced ons, record review, test trays, erviews, the facility failed to be a palatable and appetizing propearance for 2 meals ents (Resident #1). The ontial to affect other residents the kitchen.  it:  initted to the facility 01/02/23.  Im Data Set assessment	{F 8	04}		
	dated 12/04/23 indica moderately intact cog					
ARODATORY.	NIPECTOR'S OR PROVINER/	SUPPLIER REPRESENTATIVE'S SIGNATUE	)E	TITI F		(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C	
		345163	B. WING _			12/13/2023	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION				STREET ADDRESS, CITY, STATE, ZIF 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI D THE APPROPRIA	DATE	
{F 804}	Continued From page	e 1	{F 8	04}			
	with Resident #1 on Resident explained the but some days it was meat, especially chick tough and the pastary broccoli was always at that she informed the broccoli anymore with The lunch meal served chicken thigh, mashed beans and pears.  The meal cart was broapproximately 11:45 tray was removed from When the lid was removed from the food. The Dithe food and agreed chicken was dry. The	ed on 12/12/23 was roasted d sweet potatoes, lima					
	Manager on 12/12/23 the reason the food whe fact that they had the food on. One was hold the heat long an which held the heat of The test tray had a pregardless, the food states.	ducted with the Dietary 3 at 12:03 PM who offered was cold could be related to two types of plates to serve a hard plastic which did not d the other was ceramic onger than the plastic plates. lastic plate. The DM stated should be hot. ducted with Resident #1 on					
		1 as she was eating her I chicken thigh, mashed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245462	B. WING			R-C		
		345163	B. WING_			12/	13/2023	
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
GLENBRIDGE HEALTH AND REHABILTATION					MILTON BROWN HEIRS ROAD DNE, NC 28607			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
{F 804}	and about ¼ of the m #1 explained that the she could not cut it w pick it up with her fing chicken was on the d she did not get butter potatoes and the lima added her vinaigrette Resident expressed usual but barely room b. An observation of was conducted on 12 tray was requested.  The menu consisted a dinner roll.  The test tray was pla 5:33 PM on 12/12/23  The meal cart arrived 12/12/23 and Reside tray at 5:47 PM.  A test tray was condu Director at 6:02 PM d Director lifted the pla there was no steam t temperature was war the baked ziti was "g cauliflower was over cold as well. The bot	ima beans. She had chicken, all the lima beans nashed potatoes. Resident e chicken was so tough that with a knife, so she had to gers to bite it. She stated the dry side. She remarked that it for her mashed sweet a beans were good when she e dressing to them. The the food was not cold as in temperature at best.  Ithe evening meal tray line 2/12/23 at 4:20 PM. A test  of baked ziti, cauliflower and ted on a ceramic plate at 3.  If on the unit at 5:35 PM on and #1 received her supper cucted with the Dietary on 12/12/23. The Dietary te cover from the meal and	{F 8	04}	DEFICIENCY)			
	not eat that.  An interview conduct	ed with the Dietary Director						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345163	B. WING			1	-C	
NAME OF D		345163	D. WING			12/	13/2023	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GLENBRII	DGE HEALTH AND REH	IABILTATION			211 MILTON BROWN HEIRS ROAD			
					BOONE, NC 28607			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE	
{F 804}	Continued From pag	ge 3	{F 8	304	}			
	on 12/12/23 at 6:04	PM revealed, the Director						
		r meal was prepared too						
		ne reason why the cauliflower						
		ould not cook that long. She						
	,	the baked ziti will start to get						
		ld, and it was visibly greasy.						
		ed that it was unacceptable						
	for the residents to b	pe served cold meals.						
	On 12/12/23 at 6:18	PM during an observation						
		esident #1, she explained						
		as greasy, and the cauliflower						
		and cooked to death. She						
		was cooked cabbage until						
		cket that identified it as						
		t didn't look like cauliflower to						
		emarked the roll was doughy						
		ie only ate the top. The						
	i i	food was warmer than what						
	she usually received	I but not by much.						
		ted with the Dietary Manager						
		on 12/12/23 at 6:45 PM						
		r explained that the food was						
	-	use it was cooked and in the						
		rived at the facility in the						
	_	s. She stated the cauliflower						
		should be cooked last and						
		reason it was cooked to						
	_	stated he had counseled the						
		e food so early and let it sit in						
		nager repeated the reason						
	_	re cold could be the fact that						
	ceramic.	ard plastic, and some were						
	At 7:15 PM on 12/12	2/23 during an interview with						
		e explained that she did not						
		herefore, she could not speak						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED:		IPLE CONSTRUCTION  NG	ľ	(X3) DATE SURVEY COMPLETED	
		345163	B. WING _			R-C <b>12/13/2023</b>	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION				STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		12/10/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	D.4TE	
{F 804}		nperature of the food but	{F 8	04}			
	food.	she would start testing the					
F 812 SS=E		Store/Prepare/Serve-Sanitary (2)	F 8	312			
	§483.60(i) Food safe The facility must -	ety requirements.					
	approved or conside state or local authori (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using pardens, subject to c safe growing and foc (iii) This provision do from consuming food §483.60(i)(2) - Store	food items obtained directly , subject to applicable State qulations. es not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. es not preclude residents ds not procured by the facility. , prepare, distribute and					
	standards for food set This REQUIREMEN' by: Based on observation facility failed to ensu stored for use after the	T is not met as evidenced ons and staff interviews the re bread was dated and not he use by date in the dry eficient practice had the					
		d: on of the dry storage area on along with the Dietary					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	(X3) DATE SURVEY COMPLETED	
		345163	B. WING		I	R-C 2/13/2023	
NAME OF PROVIDER OR SUPPLIER  GLENBRIDGE HEALTH AND REHABILTATION				STREET ADDRESS, CITY, STATE, ZIP COD 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607		2/13/2023	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	hotdog buns with a co of 12 hamburger bur the packages.  An interview was condition of 12 hamburger burs the hotdog buns shouther shelves on the epackages and there clarification date for hamburger buns. The best used unless there date.  During an interview of 12/12/23 at 4:15 PM he tried to check the breads about every because he was not his process when check the breads the day because he felt the condition of the breads and help because he was not have an expiration of did not remember chon 12/11/23. He stattwice a week and help bread delivery many dates on the breads  An interview was conditionally and interview was conditionally and the breads especially should have been chon the breads especially should have be	tion yielded 3 packs of 12 date of 12/10/23 and 3 packs as that had no date printed on inducted with the Dietary on 12/12/23 who explained and have been pulled from expiration date printed on the should have been a the expiration date for the end hamburger buns should not end as a known expiration.  With the Dietary Manager on the Manager explained that expiration dates on the day and he missed the dates checking them good enough. The date on the breads would not manager also explained that the hamburger buns did not ate on them. He stated he necking the expiration dates ed the bread delivery was a needed to make sure the was checking the expiration as well.	F8	12			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 211 MILTON BROWN HEIRS ROAD BOONE, NC 28607				
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F 812	Continued From pag available for use pas	te 6 st the expiration dates.	F 812					