

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Eckerd Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Hospital Drive Highlands, NC 28741	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51383</p> <p>Based on observations and staff interviews, the facility failed to ensure dishware was air dried prior to stacking for use and free from dried debris. Additionally, the facility failed to ensure the double oven and stove were free of food and grease debris, the floors were free from built-up dark debris, and the high temperature dish-machine reached the manufacturer's recommended temperatures for dish sanitation. The facility failed to utilize the 3-compartment sink according to manufacturer's recommendations for the amount of time dishware was required to soak in the chemical solution for sanitizing dishware and the facility also failed to remove expired food stored for use, date leftover foods and ensure foods were sealed in 1 of 1 walk-in cooler and 1 of 1 walk-in freezer. These practices had the potential to affect food served to residents.</p> <p>Findings included:</p> <p>a. During the initial tour of the kitchen with Dietary Staff #2 on [DATE] at 10:12 AM the following areas of concern were observed. Five plastic food preparation containers located on a shelf ready for use were stacked wet, one of five observed dinner plates contained dried dark debris located on the tray line ready for use, five divided plates and one cold plate lid contained dark yellow debris located on the tray line ready for use, the double oven and stove had dark dried grease and food debris on the cooking surfaces, and the floors had built up dark debris under storage racks, around the edges of the floor and wall and in corners.</p> <p>On [DATE] at 10:32 AM an interview was conducted with Dietary Staff #1 that revealed the process for cleaning dishes was to check for cleanliness and return the dishes to the dirty area for reprocessing if found dirty. He reported the process for drying dishware was once dishes were cleaned, they were placed on the drying rack to air dry the dishes.</p> <p>b. An observation of the walk-in cooler on [DATE] at 10:38 AM revealed one 3-pound bag of opened broccoli with no date and one block of [NAME] cheese that expired on [DATE].</p> <p>An observation of the walk-in freezer on [DATE] at 10:42 AM revealed a package of opened fried chicken without a seal or date, seven premade puree country style chicken single serve packages. without dates, eight premade puree country style pork single serve packages without dates, nine premade puree sausage single serve packages without dates, and 22 premade puree macaroni and cheese single serve packages without dates.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 11:00AM with Dietary Staff #2 revealed he was not sure when premade puree products expired and that generally they went through the premade puree products quickly. He stated that Monday through Friday he was responsible for the cleanliness of the kitchen and ensuring opened food items were dated. On the weekends, the Sous Chef was responsible for kitchen cleanliness and ensured that open food items were dated.</p> <p>c. During a continued kitchen tour on [DATE] at 11:00 AM, the following concerns were identified: 6 plastic plate lids located on the tray line ready for use were stacked wet, the plate warmer had dark crumbly debris, and 3 dinner plates located on the tray line ready for use had dark brown debris and red staining.</p> <p>d. An observation was completed on [DATE] at 11:00 AM. Dietary Staff #2 tested the high temperature dish machine at the request of the surveyor and the wash temperature came to 159 degrees Fahrenheit (F) and the rinse cycle came to 141 F. There was a placard observed on the dish machine that indicated the wash temperature was to reach 160 degrees F and the rinse cycle was to reach 180 degrees F.</p> <p>An interview and observation with Dietary Staff #2 was conducted on [DATE] at 11:00 AM and revealed dietary staff had been working on repairing the dish machine with facility operations. Dietary staff were utilizing the 3 compartment sink to sanitize dishes or an added sodium hypochlorite chemical in the dish machine during the repair. Observation of the chemical container secured to the wall to the right of the dish machine revealed it was empty. Dietary Staff #2 stated they had gotten the chemical from their supervisor. He explained the chemical container had been empty for a while and were utilizing the 3 compartment sink to sanitize dishware until the chemical could be ordered. Observation of the 3 compartment sink process revealed Dietary Staff #2 allowed the dishes to dwell within the sanitizer for an estimated 5 seconds. Observation of a sign above the 3-compartment sink directed staff to dwell for a minimum of 60 seconds in the sanitizer. Dietary Staff #2 stated no one had ever told him how long the dishes needed to be in the sanitized water. Observation of Dietary Staff #2 revealed the tested parts per million (PPM) of the sanitizer were at 300. According to the manufacturer for the sanitizer, the required PPM range is ,d+[DATE].</p> <p>An interview was completed with Facility Operations Staff #1 and Facility Operations Staff #2 on [DATE] at 12:21 PM revealed that they were aware that the dish machine was not coming up to the required water temperatures. They replaced the booster heater on [DATE] and were not aware that there was a concern with dish machine water temperatures on [DATE]. Facility Operations Staff #1 stated they also had a regulator on order to correct the water temperature concern with the dish machine. They also stated they were unaware that the kitchen staff had run out of the sanitizing chemicals.</p> <p>An interview with the Administrator on [DATE] at 12:27 PM revealed that the Dietary Manager was responsible for kitchen sanitation, however she was out on leave. The Administrator was aware that Facility Operations was working on repairing the dish machine.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>51383</p> <p>Based on observation and staff interview the facility failed to contain trash when the dumpster doors were not closed and failed to keep the area around the trash compactor free from accumulated trash and debris for 2 of 2 dumpsters observed and 1 of 1 trash compactor observed.</p> <p>The findings included:</p> <p>An observation was completed on 2/17/25 at 11:45am. The observation revealed 2 dumpsters, the first dumpster door was completely open, and the second dumpster door was completely open with cardboard visible in both dumpsters. The area around the trash compactor had a soiled plastic bag, a tarp, and a box on the ground.</p> <p>An interview on 2/17/25 at 12:10 pm with Dietary Staff #2 revealed central supply staff use the dumpsters for cardboard and verified that the doors were left open. Dietary Staff #2 also explained that everyone used the trash compactor, and he was not sure who was responsible for keeping the area clean.</p>		