STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #LUO411.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide 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 maintain cleanliness in 2 of 3 common shower rooms (C-Hall common shower room and B-Hall common shower room). The findings are: 1. Initial observation of C-Hall common shower room on 12/03/12 at 9:40 AM revealed a functioning heater/fan on wall of shower room with the air flow directed towards the resident shower stalls. The vent of the heater/fan had a coating of gray dust covering the majority of the surface area. Large clumps of dust were noted clinging on the bottom of the vent slats of the heater/fan. An observation of C-Hall common shower room on 12/05/12 at 10:50 AM revealed the vent of the heater/fan on wall of shower room had a coating of gray dust covering the majority of the surface area. Large clumps of dust were noted clinging to the bottom of the vent slats of the heater/fan. A final observation of C-Hall common shower	F 253	*THIS PLAN OF CORRECTIONS IS THE FACILITIES CREDIBLE ALLEGATION OF COMPLIANCE* *PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTH OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STAEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.* F 253 1- HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENT AFFECTED: -THE C- HALL SHOWER ROOM FAN WAS CLEANED BY HOUSEKEEPING ON 12-06-2012 -THE B-HALL SHOWER MATS WERE DISPOSED OF BY HOUSEKEEPING ON 12-06-2012. 2- HOW CORRECTIVE ACTION WILL ACCOMPLISHED FOR THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Verna McEntire — TITLE: Administrator — (X6) DATE: 12-26-2012

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.

DHSR NC Received Black Mountain Regional Office JAN 1 2013 by: PAM

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F 253	Continued From page 1 room on 12/06/12 at 9:26 AM revealed a functioning heater/fan on wall of shower room with the air flow directed towards the resident shower stalls. The vent of the heater/fan had a coating of gray dust covering the majority of the surface area. Large clumps of dust were noted clinging on the bottom of the vent slats of the heater/fan. During an interview on 12/06/12 at 10:10 AM, Nurse Aide (NA) #1 observed the heater/fan on the wall of C-Hall common shower room and confirmed it was dirty and stated it was not the job of NAs to clean the common shower room heater/fan vents. During an interview on 12/06/12 at 10:20 AM, Unit Manager (UM) #1 observed the heater/fan on the wall of C-Hall common shower room and confirmed it was dirty and stated it was not the job of nurses or unit managers to clean the common shower room heater/fan vents. During an interview on 12/06/12 at 2:23 PM with Laundry Asslstant (LA) #1, who stated she was filling in for the housekeeping supervisor during the week of the survey. LA #1 explained it was ordinarily the responsibility of the floor cleaner to clean the vents of the common shower room heater/fans. LA #1 stated the floor cleaner had been moved temporarily to the position of maintenance while maintenance projects were being done. LA #1 observed the heater/fan on the wall of C-Hall common shower room and confirmed it was dirty and she would arrange to have it cleaned immediately. 2. Initial observation of B-Hall common shower	F 253	-MAINTENANCE AND HOUSEKEEPING SUPERVISOR WERE IN-SERVICED ON 12-07-2012 BY ADMINISTRATOR ON THE FOLLOWING: -MAINTAINING A CLEAN AND PRESENTABLE FACILITY -PROPER ENVIROMENTAL ROUNDS -THE FACILITY CLEANING SCHEDULE 3-WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE CORRECTION: -EACH DEPERTMENT HEAD IS ASSIGNED AN AREA OF THE FACILITY. THEY WILL COMPLETE ENVIROMENTAL AUDIT ROUNDS DAILY WHILE IN THE FACILITY TO ENSURE THE FACILITY IS IN GOOD REPAIR AND CLEAN. 4-HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: -THE QA TOOLS WILL BE REVIEWED AT THE DAILY QA COMMITTEE MEETING TO OBSERVE FOR DEFICIENCIES/TRENDS, IF ANY DEFICIENCIES ARE IDENTIFIED THE QA PLAN WILL BE MODIFIED AT THE TIME OF THE MEETING -THE ADMINISTRATOR OR DESIGNEE IS RESPONSIBLE FOR OVER ALL COMPLIANCE.	

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F 253	Continued From page 2 room on 12/03/12 at 10:00 AM revealed 2 of 3 bath floor mats hanging on rods in shower stall with black flaky debris coating the backs of the mats. Observation of B-Hall common shower room on 12/05/12 at 12:50 PM revealed 2 of 3 bath floor mats hanging on two separate hangers in shower stalls with black flaky debris coating the backs of the mats. During this observation, both shower stall floors, walls, and bath floor mats were wet. Observation of B-Hall common shower room on 12/06/12 at 2:15 PM revealed 2 of 3 bath floor mats hanging on hangers in shower stalls with black flaky debris coating the backs of the mats. Large clumps of debris were observed sticking to the center of the back of each of the two mats. The clumps of debris chipped off when rubbed with a paper towel. During an interview on 12/06/12 at 2:23 PM with Laundry Assistant (LA) #1, who stated she was filling in for the housekeeping supervisor during the week of the survey. LA #1 stated it was her expectation the B-hall housekeeper would monitor the cleanliness of the bath floor mats daily. LA #1 stated housekeepers were to take the mats outside and scrub them, clean them with bleach, and replace them with new mats which are stored downstairs if the black debris could not be removed from the backs of any bath floor mat. LA #1 observed the bath floor mats in the B-Hall common shower room on 12/06/12 at 2:35 PM and confirmed they were covered with debris and would be removed and replaced by housekeeping staff immediately.	F 253		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 3 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to apply palmar rolls to promote hand hygiene as recommended by Occupational Therapy (OT) for 1 of 1 resident reviewed for range of motion (Resident #51). The findings are: Resident #51 was admitted to the facility with diagnoses including dementia, diabetes mellitus, chronic renal failure, osteoporosis, and coronary artery disease. A significant change Minimum Data Set (MDS) completed on 09/30/12 revealed Resident #51 totally dependent on staff for activities of daily living and her functional range of motion (ROM) was impaired on both sides of her upper body. Review of care plans revealed none which addressed Resident #51's bilateral hand contractures. Further review of the medical record revealed Resident #51 received OT services for treatment of bilateral hand flexion contractures from 04/24/12 through 06/11/12. The initial assessment dated 04/24/12 noted Resident #51's	F 309	F 309 1-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENT AFFECTED: -R-51 HAND PALM GUARDS APPLIED 12-06-2012 BY NURSING 2-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: -THE NURSING DEPARTMENT HEADS COMPLETED AUDITS OF ALL RESIDENTS WHO HAVE CONTRACTURES AND/OR SPLINTS/GUARDS TO ENSURE THAT ALL CARE WAS BEING PROVIDED AS ORDERED AND/OR REQUIRED. NO FURTHER DISCREPANCIES WERE NOTED. THIS WAS COMPLETED ON 12-06-2012 3-WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE CORRECTION: -THE NURSING STAFF WERE IN-SERVICED BY THE STAFF DEVELOPMENT COORDINATOR, 12-26-2012 ON THE FOLLOWING : • THE RESIDENTS WHO REQUIRE CONTRACTURE EQUIPMENT AND THE REASONS WHY THEY ARE REQUIRED.	12-30-12

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F 309	Continued From page 4 bilateral hand contractures were greater on the left hand than the right and the middle digits pressed into her palms. Short term goals included increasing bilateral hand extension using palm guards as tolerated, increased hand extension, and improved hygiene in hands. The OT discharge summary dated 06/25/12 stated Resident #51 had reached maximum rehabilitation potential and demonstrated improved bilateral hand hygiene using palmar rolls. During a staff interview on 12/04/12 at 9:05 AM Nurse #2 stated Resident #51's elbows were contracted bilaterally and her fingers on both hands could be fully extended with passive ROM. The interview with Nurse #2 further revealed she was not aware of Resident #51 wearing palmar rolls in either hand. An observation of Resident #51 on 12/04/12 at 10:30 AM revealed her sitting up in a chair with her arms folded across her chest and both hands were in a fisted position. A subsequent observation on 12/05/12 at 2:25 PM revealed Resident #51 was resting in bed with her arms folded across her chest and both hands in a fisted position. Her fingers touched the palms of her hands. The palms of her hands were intact and were only slightly pink. An interview with Nurse Aide (NA) #3 on 12/05/12 at 2:26 PM revealed Resident #51 could not extend the fingers of either hand. NA #3 stated she provided passive ROM while providing care and filed the resident's finger nails as needed. NA #3 could not recall Resident #51 having splints or palmar rolls for her hands.	F 309	• LOCATION OF THE FACILITY MASTER EQUIPMENT LIST AND KARDEX. • ENSURING THAT EACH RESIDENTS PLAN OF CARE IS BEING CARRIED OUT. -THE MASTER EQUIPMENT/SUPPORTIVE DEVICE LIST HAS BEEN DERIVED FOR EACH WING. COMPLETED ON 12-07-2012 -EACH DEPARTMENT HEAD HAS BEEN ASSIGNED A WING IN THE FACILITY AND WILL COMPLETE RANDOM DAILY ROUNDS WHILE IN THE FACILITY TO ENSURE THAT THE RESIDENTS PLAN OF CARE ARE BEING FOLLOWED -THERAPY DEPARTMENT WILL CONTINUE TO ASSESS EACH RESIDENT QUARTERLY FOR CONTRACTURES AND POSSIBLE EQUIPMENT NEEDS. 4-HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT CORRECTIONS ARE ACHIEVED AND SUSTAINED -ALL QA MONITORING TOOLS WILL BE REVIEWED AT THE DAILY QA COMMITTEE MEETING FOR COMPLIANCE /EFFECTIVNESS	

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F 309	Continued From page 5 An observation on 12/06/12 at 2:20 PM revealed Resident #51 was awake in her chair with her arms folded across her chest and both hands were in a fisted position. Her fingers touched the palms of her hands. The palms of her hands were intact and were only slightly pink. There was a faint sour odor noted. NA #4 was interviewed during the observation and stated she cleaned Resident #51's hands at least once during the shift when she cared for her. NA #4 could not recall Resident #51 having splints or palmar rolls for her hands. During an interview on 12/06/12 at 2:55 PM the Rehabilitation Director assessed the ROM of Resident #51's bilateral hands/fingers. The Rehabilitation Director stated Resident #51 could extend the fingers of her left hand approximately 25% and the fingers of her right hand approximately 50%. The Rehabilitation Director further stated Resident #51 needed "at least a wash cloth" in the palm of her left hand. The Director of Nursing was present during the interview and located a palm guard in Resident #51's drawer but was not certain what the current interventions were for Resident #51. An interview was conducted with the Director of Nursing (DON) on 12/06/12 at 4:00 PM. The DON stated she reviewed Resident #51's medical record and did not locate an order to discontinue the palm guard or palmar roll.	F 309	-ANY DISCREPANCIES/INEFFECTIVNESS OR TRENDS WILL BE DISCUSSED AND REVIEWED AT THE DAILY QA COMMITTEE MEETING. FURTHUR EDUCATION AND INTERVENTIONS WILL OCCUR AS NEEDED -THE DEPARTMENT HEAD QA ROUNDS WILL CONTINUE UNTIL SUBSTANTIAL COMPLIANCE IS OBTAINED. AT THAT TIME THE QA COMMITTEE WILL MEET AND REVIEW THIS PROCESS AND DECREASE THE ROUNDS TO WEEKLY -DIRECTOR OF NURSING/DESIGNEE IS RESPONSIBLE FOR COMPLIANCE.	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them.	F 369		

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F 369	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide food in bowls as ordered by the Speech Therapist for 1 of 1 sampled resident (Resident #173). The findings are: An initial observation of Resident #173 having a meal on 12/04/12 at 12:00 noon revealed she was sitting on her bed, being served food by a private caregiver from a regular-sized plate. An observation of Resident #173 having a meal on 12/05/12 at 12:20 PM revealed she was sitting in the dining room at a table with 3 other residents, eating her food from a regular-size plate with a small bowl of jello next to the plate and drinks. The diet card on the tray was identified as being for Resident #173 and it read "Special Instructions: no straws, all food in bowls". A final observation of Resident #173 on 12/05/12 at 5:19 PM revealed she sitting on her bed, being served food by an NA from a regular-sized plate. When resident #173 was finished eating, the tray was brought out into the hall where it was observed with a regular-size plate with food on it, fruit in a small bowl next to the plate, and drinks. The diet card on the tray was identified as being for Resident #173 and it read "Special Instructions: no straws, all food in bowls". Review of order for Resident #173's dietary tray	F 369	F369 12.30.12 1-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHEDFOR THE RESIDENT AFFECTED: -R # 173 WAS PROVIDED HER MEALS AS ORDERED BY SPEECH THERAPIST ON 12-07-2012. 2-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED: -ONCE NOTIFIED OF THIS ALLEGED DEFICIENCY FACILITY DEPARTMENT HEADS COMPLETED ROUNDS TO ENSURE THAT ALL OTHER RESIDENTS HAD ORDERED ADAPTIVE EATING EQUIPMENT IN PLACE. NO FURTHER DISCREPANCIES WERE NOTED. 3-WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE CORRECTION: -THE DIETARY DEPARTMENT WAS IN-SERVICED BY THE DIETARY MANAGER ON 12-07-2012:	

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F 369	Continued From page 7 card revealed change was made on 11/20/12 at 1:45 PM to "Special Instructions: all food in bowls". Interview with NA #2 on 12/06/12 at 1:45 PM revealed she was aware Resident #173's meal trays came with food in small bowls and staff were to serve all food to Resident #173 in small bowls. NA #2 reported she had not served a meal to Resident #173 on 12/04/12 or 12/05/12. Interview with Unit Manager (UM) #1 on 12/06/12 at 2:20 PM revealed she was not aware of the recommendation for Resident #173 to receive all food served in bowls. A follow up interview with UM #1 on 12/06/12 at 2:45 PM revealed the Dietitian had just informed UM #1 the Speech Therapist had ordered that all Resident #173's food be served in small bowls a few weeks earlier. The Speech Therapist recommended the intervention in hopes it would increase Resident #173's intake at meals. UM #1 reported she had not been made aware of the order change until now. Interview with Dietary Manager (DM) on 12/06/12 at 3:15 PM revealed that although 3 dietary aides review the diet tray card while preparing trays in the kitchen, only the 3rd dietary aide was responsible for requesting that Resident #173's food be put in bowls. The DM stated she cannot explain why Resident #173's tray had food on a regular plate on 12/04/12 and 12/05/12. The DM stated her expectation was that the dietary aides will check the food, equipment, and utensils on each tray against the orders on the diet tray card before loading the trays on the cart to go to the units.	F 369	*PROVIDING ORDERED ADAPTIVE EATING EQUIPMENT TO ALL RESIDENTS. * OBSERVING AND PROVIDING ORDERED ADAPTIVE EQUIPMENT AS LISTED ON THE DIETARY TRAY CARDS. -EACH DEPARTMENT HEAD HAS BEEN ASSIGNED A DINING ROOM WHILE IN THE FACILITY AND WILL COMPLETE RANDOM QA DAILY ROUNDS WHILE IN THE FACILITY TO ENSURE THAT THE RESIDENTS PLAN OF CARE IS BEING FOLLOWED 4-HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE ACHIEVED AND MAINTAINED: -ALL QA MONITORING TOOLS WILL BE REVIEWED AT THE DAILY QA COMMITTEE MEETING FOR COMPLIANCE -ANY DISCREPANCIES OR TRENDS WILL BE DISCUSSED AND REVIEWED AT THE DAILY QA COMMITTEE MEETING . FURTHUR EDUCATION AND INTERVENTIONS WILL OCCUR AS NEEDED.	

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F 369	Continued From page 8 Interview with Interim Director of Nursing (DON) on 12/06/12 at 4:12 PM revealed her expectation was any staff person who takes a food tray from the tray cart to a resident would review the resident's diet tray card for accuracy of the food form, equipment, and utensils before serving the food tray to the resident.	F 369	-THE DEPARTMENT HEAD QA ROUNDS WILL CONTINUE UNTIL SUBSTANTIAL COMPLIANCE IS OBTAINED. AT THAT TIME THE QA COMMITTEE WILL MEET AND REVIEW THIS PROCESS AND DECREASE TO WEEKLY THEREAFTER.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store foods in the refrigerator in sealed containers and with a date of storage or an expiration date. The findings are: 1. An observation on 12/03/12 at 9:24 AM revealed two 5 pound bags of shredded mozzarella cheese and two 48 ounce bricks of cream cheese without visible expiration dates. The cheeses were observed stored in a reach in refrigerator.	F 371	-DIETARY MANAGER/.DESIGNEE IS RESPONSIBLE FOR COMPLIANCE. F371 1-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE ~~RESIDENT AFFECTED~~: -THE BAGS OF SHREDDED CHEESE WERE DISPOSED OF ONCE NOTIFIED OF THE ALLEGED DEFICIENCY -THE OPEN SAUSAGE PATTIES WERE DISPOSED OF ONCE NOTIFIED OF THIS ALLEGED DEFICIENCY. 2-HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:	123012

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F 371	Continued From page 9 An interview with the Dietary Manager (DM) on 12/03/12 at 9:55 AM revealed she was also unable to find visible expiration dates on the cheeses. The DM acknowledged if the expiration date was unknown, the dietary staff could not ensure the cheeses were used or discarded by the expiration dates. An interview with the Registered Dietician on 12/05/12 at 10:49 AM revealed foods received from outside the facility should contain expiration dates for monitoring purposes. Further interview with the DM on 12/06/12 at 4:19 PM revealed she placed a phone call to the facility food supplier representative. The DM stated she was informed the expiration dates were on the packaging container in which the cheeses were delivered. She added expiration dates should be visible on all foods for monitoring purposes. 2. A review of an undated facility Food Storage policy revealed all leftover food that was to be reused should be wrapped or covered with plastic wrap or placed in a suitable plastic container and refrigerated. The leftover food should be dated by using a felt tip pen and writing the name of the food and date on the wrap or a label. An observation on 12/03/12 at 9:41 AM revealed an open 12 pound box of sausage patties stored in a reach in refrigerator. The box was observed with the unsealed cardboard lid folded over the top and was approximately half full of the raw, unthawed patties. One patty was uncovered and exposed to air. A thin piece of paper was observed between each layer of patties that were	F 371	-VISUAL ROUNDS WERE CONDUCTED BY THE DIETARY MANAGER DURING THE SURVEY TO ENSURE THAT ALL FOOD WAS PROPERLY LABELED AND STORED. NO FUTHER DISCREPANCIES WERE NOTED. 3-WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE CORRECTION : -THE DIETARY STAFF WAS IN-SERVICED ON 12-07-2012 BY THE DIETARY MANAGER. * PROPERLY LABELING ALL FOOD WITH THE EXPIRATION AND OPEN DATES AS APPILICABLE. * PROPER STORAGE OF OPEN FOOD. -THE DIETARY MANAGER/DESIGNEE WILL COMPLETE THE QA TOOL DAILY WHILE IN THE FACILITY TO ENSURE THAT ALL FOOD IS PROPERLY LABELED AND STORED.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC LLC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 10 also exposed to air. The Dietary Manager (DM) was present during this observation. She stated the sausage should have been placed in a sealed container and dated when it was removed from the freezer. An interview was conducted with a Dietary Cook (DC) on 12/03/12 at 9:45 AM. The DC stated she removed the box of sausage from the freezer on 11/29/12 or 11/30/12. The DC added she should have placed the unused sausage in a sealed container with the date opened and use by date written on the container. The DC was unable to state the date the unused sausage should have been used by. Further interview with the DM on 12/06/12 at 4:19 PM revealed the sausage was removed from the freezer on 11/30/12. She stated the unused portion of sausage should have been placed in a sealed container. The container should contain the date the sausage was opened and removed from the freezer and an expiration date that was 7 days later. The DM stated the unused portion of sausage was used within that time frame.	F 371	4- HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT CORRECTION IS ACHIEVED AND SUSTAINED: -ALL QA MONITORING TOOLS WILL BE REVIEWED AT THE DAILY QA COMMITTEE MEETING FOR COMPLIANCE. -ANY DISCREPANCIES OR TRENDS WILL BE DISCUSSED ANDS REVIEWED AT THE DAILY QA COMMITTEE MEETING. FURTHER EDUCATION/ INTERVENTION WILL BE DISCUSSED AT THAT TIME. -THE DEPARTMENT HEAD QA ROUNDS WILL CONTINUE UNTIL SUBSTANTIAL COMPLIANCE IS OBTAINED. AT THAT TIME THE QA COMMITTEE WILL MEET AND REVIEW THIS PROCESS AND DECREASE TO WEEKLY THEREAFTER. -THE DIETARY MANAGER/DESIGNEE IS RESPONSIBLE FOR COMPLIANCE.	