STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/03/2015

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	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Care Area Assessment that addressed the underlying causes, contributing factors and risk factors for wandering behaviors for 1 of 6 residents with behaviors. The findings included: Resident #102 was admitted to the facility on 06/22/15 with diagnoses that included Alzheimer's disease and others. Review of Resident #102's medical record revealed an entry dated 06/22/15 that Resident #102 had a "wander guard" (a device to monitor residents and alert staff to prevent residents from exiting the building) in place. On 06/29/15 a nurse's entry read in part the resident was attempting to open and exit doors. On 06/29/15 the Social Worker documented in the progress notes that Resident #102 had episodes of increased confusion and exit seeking. The Minimum Data Set (MDS) dated 06/29/15 specified the resident had severely impaired cognition, wandering behaviors 1 to 3 days and was at risk for wandering into a dangerous place. Review of the Care Area Assessment (CAA) dated 07/01/15 specified that behavioral symptoms triggered and that the location and date of the CAA information was in the nurses' notes. Review of the nurses' notes for Resident #102 revealed that there was no documentation to analyze Resident #102's wandering behaviors and plan for addressing behaviors.	F 272	F -272 Comprehensive Assessments Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. The 07/01/15 CAA for Resident #102 was updated on August 13, 2015 to include the Social Progress note dated 6/29/15 within the body of the CAA as opposed to reading, ¿See Nurses Notes¿ where Social Progress Notes are electronically found. Comprehensive assessments, completed within the past year, of active residents, were reviewed to identify who triggered for wandering behaviors, therefore requiring a Behavioral Symptoms CAA. Any CAA¿s found to be insufficient based upon 483.20(b) (1) were corrected and placed within the resident¿s clinical chart as a CAA modification on September 2, 2015. The Social Worker was in-serviced on August 13, 2015 regarding CAA purpose and documentation according to the RAI Manual. To ensure quality assurance, Behavioral	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 272	Continued From page 2 The Care Area Trigger (CAT) worksheet dated 07/30/15 for Resident #102's behavioral symptoms' analysis of findings read, "Diagnoses included Alzheimer's, and medications include Klonopin, Seroquel, Namenda (antipsychotic medications). Resident is currently receiving an antibiotic." On 08/13/15 at 10:10 AM the Social Worker (SW) was interviewed and reported that she completed a "brief" summary on the CAT Worksheet. She explained that she relied on the nurses' notes to summarize the resident's behaviors. On 08/13/15 at 9:07 AM the MDS Coordinator was interviewed and explained that she did not review the analysis of findings written by the Social Worker but expected the analysis to reflect the resident.	F 272	CAA¿s will be reviewed during the Quality Assurance Meeting for at least three consecutive meetings and every six months afterward. All corrective action will be completed on or before September 9, 2015.	
F 371 SS=D	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, staff interviews and facility record review the facility failed to date an	F 371	F -371 Food Procure, Store/Prepare/Serve - Sanitary	9/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 3 opened container of a nutritional supplement and sandwiches stored ready for use in 1 of 1 nourishment refrigerator. The findings included: An initial tour of the kitchen was made on 08/10/15 at 9:00 AM with the Dietary Manager (DM). The tour included observations of the facility's nourishment room that revealed the following items not labeled or dated stored ready for use: - Three ½ ham and mayonnaise sandwiches wrapped in plastic wrap not dated - A container of Medpass (a fortified nutritional supplement) opened and partially consumed not dated On 08/10/15 at 9:15 AM the DM was interviewed and reported that all items were to be stored labeled and dated. She explained that a dietary staff member was assigned to check the nourishment refrigerator daily after the breakfast meal service to remove outdated items and items not dated. She also added that the nourishment refrigerator was stocked daily and all items including sandwiches should be labeled with the date it was made; adding that the sandwiches were good for 3 days. The DM was unaware of the date the 3 ½ sandwiches stored for use had been made or how long they had been in the refrigerator. The DM stated that nurses were responsible for dating containers of Medpass when they were opened and stored in the refrigerator. On 08/13/15 at 9:55 AM the Director of Nursing	F 371	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. The three ham and mayonnaise sandwiches and container of Medpass were disposed of on 8/10/15. All other coolers and storage locations were also checked on 8/10/15 without evidence of any improper storage. The snack delivery system was changed on August 13, 2015. All sandwiches are labeled and dated prior to leaving the kitchen as opposed to after distribution. All Dietary Staff and Nursing staff was in-serviced between September 2, 2015 and September 5, 2015. In-service materials included F-371, 483.35(i) Food Procure, Store/Prepare/Serve ¿ Sanitary. To ensure quality assurance, the Dietary Manager or designee, when the Manager is unavailable, will complete a daily food storage inspection by 9:00am. The results of these findings will be presented to the Administrator daily. A nurse designee on second shift (3-11) and third shift (11p ¿ 7a) will complete a daily inspection of the nourishment room to ensure food storage	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 4 (DON) was interviewed and reported that nurses stored containers of Medpass in the nourishment refrigerator for use. She explained that nurses were expected to date the containers when they opened them because they were to be used within 72 hours.	F 371	meets the standards of F371. Findings will be reviewed in the QAA Committee Meeting for the next 12 consecutive meetings and at least quarterly going forward. All corrective action will be completed on or before September 9, 2015.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to correctly transcribe physician orders to the electronic record resulting in medication errors and no specific oxygen administration flow rates for 2 of 6 residents reviewed for accurate physician orders. (Residents #133 and #138). The findings included:	F 514	F -514 Resident Records-Complete/Accurate/Accessible Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because	9/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 514	Continued From page 5 1. Resident #133 was admitted to the facility 01/14/15 with diagnoses which included edema of lower extremity, cerebral vascular accident (stroke) with right sided paraplegia, and history of diabetes mellitus. A review of Resident #133's medical record revealed a physician's order on the August 2015 electronic medication administration record (eMAR). The order was dated 06/09/15 and specified Lasix (a diuretic) 20 milligrams (mg) was to be administered daily. The area of the eMAR that contained initials of the nurse that administered the medication was noted to have every other day with a star in the signature block. An interview was conducted with the Nurse Supervisor (NS) on 08/12/15 at 4:19 PM. The NS confirmed the Lasix was ordered to be administered every day. The NS explained the star in the nurse initial block indicated the medication was to be administered every other day. The NS further explained the facility went on a new computer system in June of 2015. All of the physician orders were manually transposed from the former system to the present system. The NS stated this process began 06/09/15. The facility began using the new eMAR system on 06/15/15. He stated when the Lasix order was carried into the new system, a person from another facility assisted with the input. That person keyed the written order correctly which was for Lasix to be administered daily. But when that person keyed frequency, every other day was put in. The NS stated when the medication nurse brought up medicine to be administered on each day, the Lasix order appeared on an every other day basis. Therefore, the Lasix order was not seen by the administering nurse on a daily basis.	F 514	it is required by the provisions of the State and Federal law. The Lasix order for resident #133 was reviewed by the Medical Director on 8/12/15 and a new order was given to administer the Lasix on an every other day frequency. The Oxygen Administration Order for Resident #138 was corrected on 8/12/15 to reflect a flow rate for oxygen administration. All active orders were audited between August 14, 2015 to September 7, 2015 by comparing written physician orders and electronically transcribed orders. Any orders found to be incomplete or inaccurate were corrected by the nursing staff. To ensure quality assurance, the Director of Nursing or members of the Nurse Administration Team review all written orders and compare to the electronic Medication Administration Record to ensure completion and accuracy of physician orders. This process will continue for a minimum of six months. Findings of these daily reviews will be reported in the QAA Committee Meeting for a minimum of three consecutive meetings. All corrective action will be completed on or before September 9, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 514	Continued From page 6	F 514		

The NS reviewed eMARs back to 06/15/15 and confirmed 29 doses of Lasix had been missed since 06/15/15. The NS added the facility did review all the transposed orders to ensure they were correct. He stated this Lasix order for Resident #133 was overlooked resulting in the missed doses of Lasix.

An interview with the Director of Nursing (DON) on 08/13/15 at 9:39 AM revealed she expected medications to be administered as ordered. The DON stated the facility had begun reviewing physician orders at morning meeting to ensure the orders were transcribed into the computer correctly.

An interview was conducted via phone with the Medical Director (MD) on 08/13/15 at 11:30 AM. The MD stated the missed doses of Lasix were not harmful to the resident. He stated since the resident remained stable he has ordered the Lasix of 20 mg to remain at the frequency of every other day.

2. Resident #138 was admitted to the facility 07/20/15 with diagnoses which included anxiety and hypoxia (low oxygen saturations

A review of Resident #138's electronic medical record revealed a physician's order dated 07/20/15 for oxygen to be administered via nasal cannula continuously and oxygen saturation checks to be done every shift. No rate for the oxygen administration was noted. No oxygen saturation reading was recorded below 90%.

An interview was conducted with the Nurse Supervisor (NS) on 08/12/15 at 3:54 PM. The NS reviewed the hand written physician's order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 514	Continued From page 7 07/20/15 and found the oxygen was ordered to be administered at 2 liters per minute. The NS stated he transposed the orders to the electronic record and failed to include the flow rate of 2 liters per minute. The NS explained the facility had a system for another nurse to do a second check to ensure all physician orders were transposed correctly. He stated Nurse #1 signed the electronic record noting she was the nurse that checked this order. An interview was conducted with Nurse #1 on 08/12/15 at 4:49 PM. Nurse #1 stated she did review the physician orders for Resident #138 in the electronic record to be sure they were written correctly on 07/20/15. She stated she missed the oxygen administrator order did not have a flow rate. An interview with the Director of Nursing (DON) on 08/13/15 at 9:39 AM revealed she expected medications/treatments to be administered as ordered. The DON stated the facility had begun reviewing physician orders at morning meeting to ensure the order was transcribed into the computer correctly.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		9/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 520	Continued From page 8 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff and resident interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February of 2015. This was for one cited deficiency that was originally cited in February 2015 on a recertification and complaint survey and recited in August 2015 on the current recertification survey. The deficiency was in the area of food storage. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F371: Food storage: Based on observations, staff interviews and facility record review the facility failed to date an opened container of a nutritional supplement and sandwiches stored ready for use	F 520	F -520 ¿ QAA Committee-Members/Meet Quarterly/Plans Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. The facility has a Quality Assurance Committee consisting of the Medical Director, Director of Nursing, Administrator, and at least two other members. The QAA Committee meets monthly to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMELOT MANOR NURSING CARE FAC	100 SUNSET STREET GRANITE FALLS, NC 28630

(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 520	Continued From page 9 in 1 of 1 nourishment refrigerator. The facility was recited for F371 for failing to assure an opened container of a nutritional supplement and sandwiches stored ready for use were dated. F371 was originally cited during the February 2015 recertification and complaint survey for failing to discard an open container of cocoa with mold spores on the container top and on the outside of the container; keep kitchen equipment clean and free of food splatters and grease accumulation; keep food preparation and service equipment clean and dry; failed to keep cups stored with ice in the freezer covered and dated when placed in the freezer; failed to keep dinner plate bottoms, pans, bowls and cups ready for use free from moisture. During an interview on 08/13/15 at 2:10 PM the Administrator stated the Quality Assessment and Assurance Committee met monthly and their action plans had been driven by the plan of correction they developed as a result of the previous complaint and recertification surveys. She stated the facility had weekly risk meetings where they discussed monitoring tools for F371. She stated it was a work in progress and acknowledged they still had areas to work on.	F 520	review existing and newly identified quality deficiencies. A new QAA program was implemented for F371 on August 14, 2015 and findings are reviewed daily as well as monthly in the QAA Committee Meeting. All previous QAA identified quality deficiencies continue to be reviewed in the monthly QAA Committee Meeting as indicated based upon previous written plan of corrections. All corrective action will be completed on or before September 9, 2015.	