STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING ______ B. WING ______	C 09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 #D9TC11.	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 label bathing basins and bedpans in 4 of 7 sampled semi-private resident bathrooms. (Bathrooms 107, 201, 203, and 206) The findings included: An observation occurred on 09/11/15 at 11:00 AM of pink plastic bathing basins and pink plastic bedpans stored in semi-private resident bathrooms without a system to indicate which resident the bathing basin and bedpan belonged to. The observation occurred in the following resident bathrooms: · Room 107 (semi-private room with two residents) the bathing basin and bedpan were not labeled with a resident name. · Room 201 (semi private room with two residents) the bathing basin was not labeled with a resident name · Room 203 (semi-private room with 2 residents) the bathing basin was not labeled with a resident name · Room 206 (semi-private room with 2 residents) three bathing basins were not labeled with a resident name. An interview occurred on 09/11/15 at 10:00 AM	F 253	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 this statement 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 completion date 10/9/15 The facility will assure to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Residents in rooms 107, 201, 203, and 206, received new bathing basins and bedpans which were properly labeled. Facility-wide, all residents received new bathing basins and bedpans which were properly labeled. For new admissions, clinical staff will be responsible to assure	10/9/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/02/2015

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.

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F 253	Continued From page 1 with a nurse aide and revealed that each resident's basin were labeled with the resident's name. An interview occurred on 9/11/2015 at 12:15 PM with nurse#1 and revealed bathing basins and bedpans were to be labeled with a resident name using a marker and if the resident name faded, staff were expected to rewrite the resident name on the bathing basin or bedpan as needed.	F 253	bathing basins and bedpans are properly labeled. Director of Nursing/designee provided education to direct care staff, maintenance service and housekeeping staff regarding proper labeling of bathing basins and bedpans. Ongoing, this education will be provided during new employee orientation. EVS Manager or designee will conduct weekly audits of 10% of resident¿s rooms. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		10/9/15

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F 279	Continued From page 2 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan to include measurable goals and individualized interventions for 1 of 15 sampled residents. (Resident #215). The findings included: Resident #215 was admitted to the facility 08/06/15 with diagnoses which included depression and anxiety state. A review of an admission Minimum Data Set (MDS) dated 08/13/15 indicated the resident's cognition was intact. The MDS specified the resident demonstrated no behaviors and took antipsychotic and antidepressant medications for the past 7 days and antianxiety medications for the past 6 days. The resident was assessed with mild depression. A Care Area Assessment associated with the admission MDS indicated nursing would proceed with a care plan related to psychotropic medications. A review of Resident #215's care plans revealed there was no care plan provided related to psychotropic medications and monitoring for behaviors and drug effectiveness and side	F 279	F 279 completion date 10/9/15 The facility will assure to use the results of the assessment to develop, review and revise resident¿s comprehensive plan of care. Resident #215 Care Plan in the area of Psychotropic Medications was reviewed and analyzed by the MDS Coordinator to assure it was comprehensive and addressed monitoring for behaviors, drug effectiveness, and side effects. The MDS Coordinators conducted an audit of all residents that have Care Area Assessments (CAAs) completed since September 2015 and confirmed care plans were developed and in place to address all triggered areas. All staff that develop care plans will be provided education by the Director of Clinical Operations and Outcomes, regarding Federal and State regulation on completing a comprehensive Care Plan. In addition, MDS Coordinators will utilize a new MDS Worksheet to document each	

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F 279	Continued From page 3 effects. A review of Resident # 215's medical record revealed a Preadmission Screening and Resident Review form that expired 09/03/15 related to previously received treatment related to severe depression. The review was renewed for continued long term care rehabilitation until 11/09/15. An interview was conducted with the MDS Nurse on 09/11/15 at 11:01 AM. The MDS Nurse confirmed no care plan related to psychotropic medications had been provided for Resident #215. The MDS nurse explained when the psychotropic assessment was completed she should have initiated a care plan as stated in the psychotropic drug CAA. An interview was conducted with the Director of Nursing (DON) on 09/11/15 at 2:37 PM. The DON stated she expected care plans to be completed as indicated by individualized resident CAA assessments.	F 279	resident's CAA Triggered Areas and date of comprehensive Care Plan completion. Director of Nursing or designee, will conduct weekly audits of 100% of residents that have Care Area Assessments (CAAs) completed since September 2015 to confirm care plans were developed and addressed all triggered areas. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 363	F 363 completion date 10/9/15	10/9/15

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F 363	Continued From page 4 review of the menu, the facility failed to serve a 4 ounce portion of rice according to the facility's preplanned menu to 3 of 3 residents. (Residents #150, #112, and #223). The findings included: Review of the facility's preplanned lunch menu for 09/10/15 revealed rice was to be served in a 4 ounce portion. On 09/10/15 from 12:01 PM to 12:45 PM, the lunch meal tray line was observed. Rice was on the tray line with a 3 ounce serving utensil available for use. During this observation, dietary staff #1 plated a 3 ounce portion of rice for Residents #150, #112 and #223. During an interview on 09/10/15 at 1:06 PM the certified dietary manager (CDM) stated that she routinely worked Monday - Friday and monitored the tray line about once per week from 5 minutes to 1 hour which included checking for correct portions. The CDM further stated that she missed checking serving utensils on the tray line that day. The CDM stated she expected staff to follow the menu for portion sizes. During an interview on 09/10/15 at 1:15 PM dietary staff #1 stated that she did not know what happened with the serving utensil for the rice, but that she must have picked up the wrong size utensil to serve for the rice. Dietary staff #1 confirmed that she was trained to use the preplanned menu as a guide for providing the correct portions of food. A telephone interview on 09/11/15 at 5:36 PM with the consultant registered dietitian (RD) revealed	F 363	The facility will assure menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Academy of Science. Registered Dietician re-assessed the nutritional needs for Resident #150, #112, #223, and determined each resident's nutritional needs were being met. Following observation on 9/10/15, serving utensil was corrected. In addition, Certified Dietary Manager re-educated Dietary staff on using correct serving utensils. Ongoing, this education will be provided during new employee orientation. Certified Dietary Manager or designee, will conduct weekly audits of correct portion size to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 363	Continued From page 5 that she worked part-time for the facility. The RD stated that she consulted with the CDM when requested and she was not aware of a concern related to portion sizes. The RD stated she expected the facility to follow the preplanned menu regarding food portions.	F 363		
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, staff interviews and review of facility records, the facility failed to 1) maintain and serve pureed beef at least 135 degrees Fahrenheit (F) from the tray line for 2 of 2 residents (Residents #116 and #141), 2) maintain milk 41 degrees F or below on the tray line, 3) remove soiled gloves and complete hand hygiene prior to plating sliced turkey, stuffing and/or pasta for 8 of 8 residents (Resident #217, #204, #60, #32, #125, #62, #160 and #131) and 4) sanitize a soiled thermometer in between use. Pureed beef was on the tray line at 91.2 degrees F and served at 119 degrees F and 113.9 degrees; milk was on the tray line at 47.8 degrees F, 42.4 degrees F, and 41.5 degrees F; sliced turkey, stuffing and/or pasta was plated for	F 371	F 371 completion date 10/9/15 The facility will assure to procure food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute, and serve food under sanitary conditions. Registered Dietician re-assessed the nutritional needs for Resident #116, #141, #217, #204, #60, #32, #125, #62, #160, and #131, and determined each resident's nutritional needs were being met. Following observation on 9/10/15, these	10/9/15

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residents with the use of soiled gloves and a soiled thermometer was not sanitized prior to use for temperature monitoring.

The findings included:

1. Review of the facility policy Service and Delivery, 2015, recorded in part, At What Temperatures Should Food be Maintained, cold time/temperature control for safety (TCS) foods/condiments: 41 degrees F or below, hot TCS foods/condiments 140 degrees F or above.

A. A lunch meal tray line observation occurred on 09/10/15. The steam table temperature was observed set to its highest setting (10). During the observation, from 12:04 PM to 12:25 PM, dietary staff #1 conducted temperature monitoring of hot foods on the tray line with the facility's thermometer. The certified dietary manager (CDM) was present and stated prior to temperature monitoring that the thermometer was routinely calibrated on Wednesdays and had been calibrated the previous day (Wednesday).

Twelve individually wrapped packages of pureed beef were observed on the tray line in a 6 inch pan. Temperature monitoring was conducted by dietary staff #1 and revealed the following temperature which was less than 135 degrees F:
· Pureed beef - 91.2 degrees F

On 09/10/15 at 1:06 PM, the CDM was interviewed and revealed that dietary staff was instructed to serve hot foods at least 135 degrees F. The CDM further stated that there were too many individual packages of pureed beef on the tray line at one time and placing smaller quantities of foods on the tray line would help to

food items were pulled from the service line and replaced. In addition, Certified Dietary Manager re-educated Dietary staff on ensuring proper food temperatures prior to serving, sanitizing thermometer in between use, hand hygiene and proper use of gloves. Ongoing, this education will be provided during new employee orientation.

Dietary staff #1 received disciplinary action regarding proper food temperatures prior to serving, sanitizing thermometer in between use, hand hygiene and proper use of gloves.

Certified Dietary Manager or designee, will conduct weekly audits of proper food temperatures prior to serving, sanitizing thermometer in between use, hand hygiene and proper use of gloves, to ensure compliance. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.

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keep foods at the correct temperature. The CDM also stated that it was a routine practice for dietary staff to conduct temperature monitoring prior to the start of the tray line, but dietary staff had not been trained to conduct temperature monitoring during the tray line to identify foods that were not at the correct temperature.

On 09/20/25 at 1:15 PM, dietary staff #1 stated in interview that she was aware that the pureed beef was not hot enough, but felt that the addition of hot gravy while plating would help to heat the pureed beef. She further stated "that was wrong, and I know it."

B. A lunch meal tray line observation occurred on 09/10/15. The steam table temperature was observed set to its highest setting (10). During this observation on 09/10/15 from 12:50 PM to 12:58 PM, dietary staff #1 was observed to plate 2 of 12 individually wrapped packages of pureed beef for Residents #116 and #141, which were stored on the tray line in a 6 inch pan. The certified dietary manager (CDM) was present and stated that the facility's thermometer was routinely calibrated on Wednesdays and had been calibrated the previous day (Wednesday). At the request of the surveyor, dietary staff #1 used the facility's thermometer and conducted temperature monitoring of the plated pureed beef for Residents #116 and #141 with the following results:

· Resident #116 - A temperature of 119 degrees F was obtained. Resident #116's lunch meal was then covered, to include the pureed beef, with a temperature of 119 degrees F and placed on the cart for delivery to the Resident.
· Resident #141 - A temperature of 113.9

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degrees F was obtained. Resident #141's lunch meal was then covered, to include the pureed beef, with a temperature of 113.9 degrees F and placed on the cart for delivery to the Resident.

On 09/10/15 at 1:06 PM, the CDM was interviewed and revealed that dietary staff was instructed to serve hot foods at least 135 degrees F. The CDM further stated that there were too many individual packages of pureed beef on the tray line at one time and placing smaller quantities of foods on the tray line would help to keep foods at the correct temperature. The CDM also stated that it was a routine practice for dietary staff to conduct temperature monitoring prior to the start of the tray line, but dietary staff had not been trained to conduct temperature monitoring during the tray line to identify foods that were not at the correct temperature.

On 09/20/25 at 1:15 PM, dietary staff #1 stated in interview that she was aware that the pureed beef was not hot enough, but felt that the addition of hot gravy would help to heat the pureed beef. She further stated "that was wrong, and I know it."

C. During a lunch meal tray line observation on 09/10/15 from 11:38 AM - 1:00 PM an insulated cooler was observed with 4 milk crates which contained individual cartons of milk, 8 ounces each. The certified dietary manager (CDM) was present and stated that the facility's thermometer was routinely calibrated on Wednesdays and had been calibrated the previous day (Wednesday). The CDM used the facility's thermometer and obtained the following temperatures which were above 41 degrees F for milk available for use:

· Whole milk, 40 cartons - 1 carton had a

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temperature of 47.8 degrees and a second carton had a temperature of 48 degrees F
· Chocolate milk, 20 cartons - 1 carton had a temperature of 42.4 degrees F
· Skim milk, 20 cartons - 1 carton had a temperature of 41.5 degrees F

An interview with dietary staff #2 occurred on 09/10/145 at 12:15 PM and revealed that staff routinely placed the insulated cooler in the freezer overnight to get cold and used it for storage of milk (whole, skim and chocolate) and juice for the duration of the tray line.

On 09/10/15 at 1:06 PM, the CDM was interviewed and revealed that dietary staff were instructed to serve cold foods 41 degrees F or below. The CDM further stated that there were too many cartons of milk on the tray line at one time and placing smaller quantities of milk on the tray line would help to keep foods at the correct temperature. The CDM also stated that it was a routine practice for dietary staff to conduct temperature monitoring prior to the start of the tray line, but dietary staff had not been trained to conduct temperature monitoring during the tray line to identify foods that were not at the correct temperature.

2. Review of the facility policy, Disposable Gloves, 2015, recorded in part, Disposable gloves, do not replace hand washing. Change disposable gloves in between tasks and/or food items, when they become dirty, or torn and wash hands in between glove changes.

Review of the facility policy, Service and Delivery, 2015, recorded in part, Food Monitoring and Temperatures - use a clean, sanitized, and

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calibrated digital thermometer to take food temperatures.

On 09/10/15 a lunch meal tray line observation occurred from 11:38 AM to 1:00 PM with the certified dietary manager (CDM) present during the observation. During the observation, dietary staff #1 plated turkey, stuffing and pasta with soiled gloves that were not removed, hand hygiene was not completed and a soiled thermometer was not sanitized prior to use.

At 11:38 AM dietary staff #1 picked up and plated stuffing and sliced turkey with soiled gloved hands that came in direct contact with the food after the same gloves were wiped on a soiled towel on the tray line and came in direct contact with a heating element used to heat insulated plates. The soiled gloves were not removed and hand hygiene was not completed.
At 11:50 AM dietary staff #1 picked up and plated stuffing for Resident #217 with the same soiled gloves that came in direct contact with the food. These gloves were wiped again on a soiled cloth. The soiled gloves were not removed and hand hygiene was not completed.
At 11:51 AM, dietary staff #1 picked up and plated sliced turkey and stuffing for Resident #204 with the same soiled gloves that came in direct contact with the food. The soiled gloves were not removed and hand hygiene was not completed.
At 11:52 AM and at 11:55 AM, dietary staff #1 used the same soiled gloves to pick up a soiled cloth, wiped up a food spill on the steam table, made contact with a heating element used to heat insulated plates and at 11:56 AM, dietary staff rested her right gloved hand on a soiled cloth on the steam table. The soiled gloves were not removed and hand hygiene was not completed.

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F 371	Continued From page 11 At 12:04 PM, dietary staff #1 used the same soiled gloves and conducted temperature monitoring by removing a thermometer from her pocket and used it to obtain a temperature of 129 degrees F (less than 135 degrees F) for stuffing. The thermometer was not sanitized prior to being used to obtain a temperature for mixed vegetables. Additionally, the same soiled gloves and thermometer were used to obtain a temperature of 91.2 degrees F (less than 135 degrees F) for pureed beef. The thermometer was not sanitized prior to being used to obtain a temperature for pureed rice. The same soiled gloves were not removed and hand hygiene was not completed. At 12:33 PM, dietary staff #1 picked up and plated stuffing for Resident #60 with the same soiled gloves that came in direct contact with the food and then wiped the steam table with a soiled cloth. The soiled gloves were not removed and hand hygiene was not completed. At 12:35 PM, dietary staff #1 picked up and plated stuffing for Resident #32 with the same soiled gloves that came in direct contact with the food. At 12:36 PM, dietary staff #1 picked up a soiled cloth and handed it to another staff member and at 12:37 PM took a clean towel and wiped up a food spill on the steam table with the same soiled gloves. The soiled gloves were not removed and hand hygiene was not completed. At 12:38 PM, dietary staff #1 picked and plated stuffing for Residents #125 and #62 with the same soiled gloves that came in direct contact with the food. Dietary staff #1 then used the same soiled gloves and wiped the steam table with a soiled cloth. The soiled gloves were not removed and hand hygiene was not completed. At 12:48 PM, dietary staff #1 picked up and plated stuffing for Resident #160 with the same soiled	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING ______ B. WING ______	C 09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

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F 371	Continued From page 12 gloves that came in direct contact with the food. The soiled gloves were not removed and hand hygiene was not completed. At 12:57 PM, dietary staff #1 picked up and plated pasta for Residents #131 and #141 with the same soiled gloves that came in direct contact with the food. The soiled gloves were not removed and hand hygiene was not completed. On 09/10/15 at 1:15 PM, dietary staff #1 was interviewed and stated that she knew to use utensils when plating foods and to sanitize the thermometer when it became soiled. Dietary staff #1 stated she had no explanation as to why she plated foods with soiled gloves instead of using utensils, did not complete hand hygiene or sanitize the thermometer as needed. On 09/11/2015 at 4:24 PM the CDM stated in interview that she instructed dietary staff to use utensils when plating foods, and if the gloves became soiled, dietary staff was expected to change gloves and complete hand hygiene. The CDM further stated that she monitored the tray line routinely Monday - Friday for 5 minutes up to 1 hour, but that she had not noticed a problem or habit of staff using soiled gloves to plate foods. The CDM also stated that a sufficient supply of alcohol wipes was available for use and she expected dietary staff to sanitize the thermometer when it was used to obtain a temperature between 42 degrees F - 134 degrees F.	F 371		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		10/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520 Continued From page 13

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 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 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 January of 2015. This was for one recited deficiency which was originally cited in December of 2014 on a recertification survey and on the current recertification survey. The deficiency was in the area of development of comprehensive care plans. 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.

F 520

F 520 completion date 10/9/15

The facility will assure to maintain a quality assessment and assurance committee consisting of the director of nursing services; physician designated by the facility; and at least three other members of the facility. Will meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies.

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F 520	Continued From page 14 Findings included: This tag is cross referred to: F 279: Development of a Comprehensive Care Plan: Based on record review and staff interview, the facility failed to develop a care plan to include measurable goals and individualized interventions for 1 of 15 sampled residents. (Resident #215). The facility was recited for F279 when they failed to develop a care plan after completing a Care Area Assessment (CAA) and indicating they would proceed to care plan. F 279 was originally cited during the December 2014 recertification survey for failing to develop care plans as indicated by CAA's. An interview was conducted with the Administrator on 09/11/15 at 4:57 PM. The Administrator stated the facility had some staff turnover in the Minimum Data Set (MDS) department since July 2015. She explained the new staff was in the progress of getting trained on completing MDS assessments and writing care plans. The facility had hired a consulting firm to do a 2 day MDS training that was already scheduled in the near future. The facility had also sent staff to MDS training conducted by the State.	F 520	Resident #215 Care Plan in the area of Psychotropic Medications was reviewed and analyzed by the MDS Coordinator to assure it was comprehensive and addressed monitoring for behaviors, drug effectiveness, and side effects. The MDS Coordinators conducted an audit of all residents that have Care Area Assessments (CAAs) completed since September 2015 and confirmed care plans were developed and in place to address all triggered areas. All staff that develop care plans will be provided education by the Director of Clinical Operations and Outcomes, regarding Federal and State regulation on completing a comprehensive Care Plan. In addition, MDS Coordinators will utilize a new MDS Worksheet to document each resident's CAA Triggered Areas and date of comprehensive Care Plan completion. QAPI meeting was held on 9/25/15 with a plan of action to initiate a Performance Improvement Project (PIP) team, with the aim to achieve compliance utilizing the Plan Do Study Act (PDSA) Cycle. As the PIP team makes progress with tests of change to meet the aim, the PIP team's progress will be reported to QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	