STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 10/23/2015

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CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

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F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: The facility failed to determine the cause and attempt interventions for a behavior which caused issuance of a 30 day discharge notice for 1 of 1 sampled residents who received a 30 day discharge notice (Resident #112).	F 201	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain	11/18/15

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

Electronically Signed | 11/16/2015

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F 201	Continued From page 1 The findings included: Resident #112 was admitted to the facility on 02/04/11 with diagnoses which included unspecified psychosis. Review of Resident #112's face sheet revealed a family member listed as legal guardian. Review of Resident #112's quarterly Minimum Data Set dated 09/09/15 revealed an assessment of intact cognition with no behavior problems. Review of a nursing note, written by Nurse #1 dated 10/04/15 revealed Resident #112 urinated in the facility's lobby and received redirection. Nurse #1 documented Resident #112 continued to urinate publicly and did not want to use the toilet. Review of a discharge notice dated 10/05/15 revealed Resident #112 was to be discharged by 11/04/15. The notice did not contain a reason for the discharge. The notice contained a hand written note which indicated Resident #112 received verbal notification of the discharge and an attempt was made to contact Resident #112's guardian. Review of Resident #112's mental health nurse practitioner (MHNP) note dated 10/05/15 revealed Resident #112 received a routine visit that day (10/05/15). The MHNP documented "no worsening of psychosis. Staff has not reported new symptoms or worsening of behavioral symptoms." Review of a nursing note dated 10/13/15 revealed documentation of Resident #112's discharge to a	F 201	in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F201 Reasons for transfer/discharge of resident 1. Resident # 112 was transferred to a skilled nursing facility and he is stable at this time. 2. All other residents with behaviors have the potential to be affected by this same deficient practice. An audit of residents with a history of behaviors will be completed by the Discharge Planner (Social Worker) as of 11/18/15.Residents behaviors will be reported to the attending physician as indicated. 3. All Nursing staff will be re-educated by the Staff Development Coordinator regarding the importance of reporting behaviors and documentation regarding behaviors as of 11/18/15. All Nursing staff will be re-educated by the SDC regarding the importance of notification of resident□s physician regarding behaviors as of 11/18/15. Newly hired nursing staff will be oriented on the importance of reporting behaviors and notification of physician related to behaviors at the time of hire. 4. The Unit Managers will audit 24 hour reports for behaviors daily to ensure that the physician has been notified of new or	

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F 201	Continued From page 2 skilled nursing facility. Telephone interview on 10/22/15 at 10:24 AM with Resident #112 ' s guardian revealed she did not receive the discharge notice until after Resident #112's 10/13/15's discharge to another facility because she was out of town. Resident #112 ' s guardian reported the facility's administrator informed her the reason for discharge was public urination. Interview on 10/22/15 at 11:19 AM with Nurse Aide #1 revealed Resident #112 did not exhibit behavior problems on the nursing unit. Interview on 10/22/15 at 11:23 AM with Nurse #2 revealed Resident #112 did not exhibit behavior problems on the nursing unit. Interview on 10/22/15 at 11:30 AM with Nurse #3 revealed Resident #112 did not exhibit behavior problems on the nursing unit. Interview with the facility's social worker on 10/22/15 at 3:30 PM revealed Resident #112 received a discharge notice due to public urination. The social worker explained she met with Resident #112 to explain his behavior was inappropriate and a discharge notice would be given if he continued to urinate in the lobby and outside. The social worker reported she informed Resident #112 a bed was available at another facility. The social worker reported Resident #112 agreed to be discharged. The social worker reported she was not aware of any interdisciplinary team discussion regarding Resident #112's behavior to prevent a discharge notice.	F 201	worsening behaviors as indicated and report to the Interdisciplinary team daily during morning meeting. The Weekend Supervisor will audit 24 hour reports for behaviors and ensure that the physician has been notified of new or worsening behaviors. The weekend supervisor will report to the DON the results of her findings weekly. The DON will report results of audits to the QA&A committee monthly x one year effective 12/16/15 The QA&A committee will evaluate the results of these audits to determine the effectiveness of the plan and make changes as needed.	

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F 201	Continued From page 3 Interview on 10/22/15 at 3:50 PM with the Administrator revealed Resident #112 s urination in the lobby and outside of the facility caused the discharge notice. The administrator reported an attempt was made to notify Resident #112' s guardian by phone. The discharge notice was mailed to Resident #112's guardian. Interview with the Director of Nursing (DON) on 10/22/15 at 4:10 PM revealed Resident #112 received a discharge notice due to the public urination. The DON reported she was not aware of any interventions to alter the behavior. Interview with Nurse #1 on 10/22/15 at 4:39 PM revealed she spoke with Resident #112 on 10/04/15 when urination occurred in the facility's lobby. Nurse #1 explained she was not aware of any interventions to prevent the behavior other than to redirect Resident #112 to a bathroom. Telephone interview with Resident #112 s MHNP on 10/22/15 at 5:05 PM revealed he was not aware of Resident #112's public urination, receipt of a discharge notice and discharge. The MHNP explained he would have addressed and met with staff regarding Resident #112's behavior on 10/05/15.	F 201		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250		11/18/15

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F 250	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility failed to provide medically related social services regarding assessment and interventions for resident behavior for 1 of 1 sampled residents who exhibited inappropriate behavior (Resident #112). The findings included: Resident #112 was admitted to the facility on 02/04/11 with diagnoses which included unspecified psychosis. Review of Resident #112's quarterly Minimum Data Set dated 09/09/15 revealed an assessment of intact cognition with no behavior problems. Review of a nursing note, written by Nurse #1 dated 10/04/15 revealed Resident #112 urinated in a public place and received redirection. Nurse #1 documented Resident #112 continued to urinate in a public place. Review of Resident #112's mental health nurse practitioner (MHNP) note dated 10/05/15 revealed Resident #112 received a routine visit that day (10/05/15). The MHNP documented "no worsening of psychosis. Staff has not reported new symptoms or worsening of behavioral symptoms." Interview with the facility's social worker on 10/22/15 at 3:30 PM revealed Resident #112 received a discharge notice due to public urination. The social worker explained she met with Resident #112 to explain his behavior was inappropriate and a discharge notice would be given. The social worker reported she was not	F 250	F250 Provision of Medically Related Social Services DOC 11/18/15 1 Resident 112 was admitted to a skilled nursing facility and he is stable at this time. All residents have the potential to be affected by this same deficient practice. 2 An audit of residents with a history of behaviors will be completed by the Discharge Planner (Social Worker) as of 11/18/15. Residents behaviors will be reported to the attending physician as indicated. 3 All Nursing staff will be re-educated by the SDC regarding the importance of reporting behaviors and documentation regarding behaviors as of 11/18/15. All Nursing staff will be re-educated by the SDC regarding the importance of notification of resident□s physician regarding behaviors as of 11/18/15. The Discharge Planner (Social Worker) was reeducated by the NHA on 10/22/15 regarding the responsibility to provide medically necessary social services to the residents. All newly hired Discharge Planners (Social Workers) will be educated during orientation regarding the responsibility to provide medically necessary social services to the residents. 4 The Unit Managers will audit 24 hour reports for behaviors to ensure that the physician has been notified of new or	

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F 250	Continued From page 5 aware of any interdisciplinary team discussion regarding Resident #112's behavior to prevent a discharge notice. The social worker explained she did not interact with Resident #112's MHNP or the nursing staff regarding interventions for behavior problems due to other job responsibilities. Interview with the Director of Nursing (DON) on 10/22/15 at 4:10 PM revealed Resident #112 received a discharge notice due to the public urination. The DON explained the social worker met with Resident #112 to request public urination cease. The DON reported she was not aware of any interventions to alter the behavior but the social worker and nursing staff were responsible to coordinate behavioral interventions. The DON could not provide a reason Resident #112's MHNP and the social worker were not involved in behavioral interventions. Interview with Nurse #1 on 10/22/15 at 4:39 PM revealed she spoke with Resident #112 on 10/04/15 when urination occurred in the facility's lobby. Nurse #1 explained she was not aware of any interventions to prevent the behavior other than to redirect the Resident to a bathroom. Telephone interview with Resident #112's MHNP on 10/22/15 at 5:05 PM revealed he was not aware of Resident #112's public urination, receipt of a discharge notice and discharge. The MHNP explained he would have addressed and met with staff regarding Resident #112's behavior on 10/05/15.	F 250	worsening behaviors as indicated and report to the Interdisciplinary team daily during morning meeting. The Weekend Supervisor will audit 24 hour reports for behaviors and ensure that the physician has been notified of new or worsening behaviors. The weekend supervisor will report to the DON the results of her findings weekly. The Discharge Planner will develop behavior management plans for residents with new or worsening behaviors along with the Interdisciplinary Team which includes: DON, NHA, DP (SW), MDSC, Activity Director. The IDT will evaluate the effectiveness of the individual residents plan to determine the effectiveness of the individual Behavior Management Plan. The Discharge Planner (Social Worker) will audit the effectiveness of behavior management plans weekly and report the results of audits to the QA&A committee monthly as of x one year. The QA&A committee will evaluate the results of these audits to determine the effectiveness of the plan and make changes as needed.	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		11/18/15

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F 272	Continued From page 6 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		

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F 272	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to conduct a comprehensive assessment to identify and analyze how condition affected function and quality of life related to the risk for falls, psychoactive medication, and activities of daily living for 2 of 23 sampled residents (Residents #3 and #73). The findings included: 1. Resident #10 was admitted to the facility on 11/22/14 with diagnoses which included dementia and chronic obstructive pulmonary disease. Review of Resident #10's annual Minimum Data Set (MDS) dated 09/03/15 revealed an assessment of short and long term memory problems with verbal behavioral problems directed toward others. The MDS indicated Resident #10 received anti-depressant medication. The MDS indicated Resident #10 had two falls without injury since the prior assessment. Review of Resident #10's Fall Care Area Assessment (CAA) dated 09/07/15 revealed no documentation of findings with a description of the problem, description of fall history, causes, contributing factors and risk factors related to a fall risk. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Review of Resident #10's Psychotropic Drug Use Care Area Assessment (CAA) dated 09/07/15 revealed no documentation of findings with a description of the problem, name and dose of	F 272	F272 Comprehensive Assessments DOC 11/18/15 1 Resident #10 and Resident # 73 Resident #10s Fall CAA from his 9/03/15 MDS was revised to include a description of the problem, a description of his fall history, causes and contributing factors related to fall risk and risk factors. An analysis was documented of the reason to proceed to care plan as of 11/16/15. Resident #10s Psychotropic Drug Use CAA dated 9/03/15 was revised to include documentation of findings and a description of the problem. The CAA now reflects the name and dosage of the medication. Contributing factors and risk factors related to psychotropic drug use have been added to the CAA. An analysis was documented of the reason to proceed to care plan as of 11/16/15. Resident #73s ADL/Rehabilitation CAA from his 5/28/15 MDS was revised to include a description of the physical limitations, the impact of his mood, causes and contributing factors related to ADLs and risk factors as of 11/16/15. Resident was interviewed to garner his input on 11/16/15. An analysis was documented of the reason to proceed to care plan as of 11/16/15. As of 11/18/15 all comprehensive MDS with an ARD of 10/24/15 or after were audited by the MDSCs and the MDS Consultant to determine if the Fall CAA included documentation of findings with a description of the problem, description of	

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F 272	Continued From page 8 medications, contributing factors and risk factors related to psychotropic drug use. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #10's fall and psychotropic drug use CAAs did not contain documentation of an analysis of findings. 2. Resident #73 was admitted to the facility on 06/28/14 with diagnoses which included cerebral vascular disease. Review of Resident #73's annual Minimum Data Set (MDS) dated 05/28/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #73 required the extensive assistance of one person with dressing and hygiene. Review of Resident #73's Activities of Daily Living Functional/Rehabilitation Care Area Assessment (CAA) dated 05/29/15 revealed no documentation of findings with a description of Resident #73's physical limitations, impact of mood, input from Resident #73, causes, contributing factors and risk factors related to. There was no documentation of an analysis of the findings supporting the decision to proceed or not to proceed to the care plan. Interview with MDS Coordinator #1 on 10/23/15 at 12:31 PM revealed Resident #73's Activities of Daily Living Functional/Rehabilitation CAA did not contain documentation of an analysis of findings.	F 272	fall history, causes, and contributing factors and risk factors as well as an analysis of the reason to proceed or not proceed to care plan is documented. As of 11/18/15 all comprehensive MDS with an ARD of 10/24/15 or after were audited by the MDSCs and the MDS Consultant to determine if the Psychotropic Drug Use CAAs include the medication and the dosage, the contributing factors and risk factors related to psychotropic drug use and an analysis was documented of the reason to proceed to care plan. As of 11/18/15 all comprehensive MDS with an ARD of 10/24/15 or after were audited by the MDSCs and the MDS consultant to determine if the ADL/Rehabilitation CAA includes a description of the physical limitations, the impact of mood as applicable, causes and contributing factors related to ADLs and risk factors as well as an analysis of the reason to proceed to care plan. MDSC Consultant provided education to the MDSC on 11/16/15 to include documentation of findings with a description of the problem, causes, contributing factors and risk factors related to Fall CAAs, Psychotropic Drug Use CAAs and ADL Function/Rehabilitation CAAs as well as the need to analyze the decision to proceed to care plan. The MDS Consultant will audit 5 residents comprehensive MDS per week for one month, then twice monthly for one month and then monthly x 10 months to ensure the Fall CAA, Psychotropic Drug Use CAA	

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F 272	Continued From page 9	F 272	and ADL Function/Rehabilitation CAAs as applicable include documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to the risk associated with the problem as well as an analysis of the need to proceed to care plan. MDS Consultant will also audit those CAAs to ensure that an interview is documented as indicated. The MDSC will report findings of audits to the QA&A committee monthly x one year. The QA&A committee will evaluate the findings from those audits to determine the effectiveness of the plan and make changes as necessary.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to administer seizure medication to 1of 6 sampled residents (Resident #185) on 6 days for a total of 8 missed doses of medications. Findings included: Resident #185 had diagnoses that included unspecified convulsions. A review of the resident's record indicated that the medication order 6/10/2015 was for Lacosamide 200 mg twice a day by mouth for seizures and was scheduled for 9:00 AM and 5:00 PM. As a controlled substance, the Lacosamide had to be	F 333	F333 Residents Free of Significant Med Errors 1 Resident # 185s physician was notified on 10/24/15 with no new orders given. Resident # 185 has received his medication per physician□s order. 2 All other residents have the potential to be affected by this same deficient practice. An audit of Medication Administration Records (MARs) will be completed as of 11/18/15 to ensure that medications are given per physicians orders.	11/18/15

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F 333	Continued From page 10 signed out on a controlled substance logbook each time it was given. Review of the controlled substance logbook regarding Resident #185's Lacosamide 200 mg revealed there were eight occasions (9/26, 10/5, 10/11, 10/12, 10/16, and 10/18/2015) when the medication had not been signed out and given. The eight occasions involved three nurses who should have signed out and given the Lacosamide 200 mg to Resident #185. An interview with the unit manager (UM) occurred at 9:30 AM on 10/22/2015.She verified that based on the documentation in the controlled substance logbook, the medication was not given and she would follow up with the nurse. At 10:39 AM on 10/23/2015 the nurse practitioner (NP) stated her expectation was that all medications were to be given and the NP added, "Especially seizure medications." She stated she was called last night about this. The NP was going to see Resident #185 and had not been informed of any seizure activity. At 2:29 PM on 10/24/2015 the Director of Nursing (DON) was interviewed about Resident #185. The DON identified the nurses who had not signed for the medication which included Nurse #4, Nurse# 6, and Nurse #8. During an interview at 2:37 PM on 10/24/2015 nurse #4 stated Resident #185 was up and "likes to go so I pulled meds fast and gave them." Nurse #4 indicated Resident #185 had been impatient on 10/16/15 so she had worked quickly to get his medication ready. Nurse #4 indicated she must have forgotten to give the Lacosamide.	F 333	3 All nurses were reeducated by the SDC regarding the importance of providing medications per physician□s orders as of 11/18/15. All newly hired nurses will be educated during orientation regarding the importance of providing medications per physician□s orders. 4 The Director of Nurses will audit MARs one time monthly to ensure that medications are being given per physician□s orders effective 11/18/15 The Director of Nurses will report findings of these audits to the QA&A committee monthly x one year effective 12/16/15 The QA&A committee will evaluate the effectiveness of the plan and make changes as needed.	

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F 333	Continued From page 11 She had not signed on the control substance logbook as having given it to Resident #185. Nurse #8 was not available for interview during the survey. At 3:23 PM on 10/23/2015 the DON stated she expected the nurses to administer medications as ordered by the physician. If a medication is omitted the DON's expectation was that it would be reported to the unit manager or DON. During an interview at 3:40 PM on 10/23/2015 nurse #6 stated she was not aware that the 10/12/2015 9:00 AM dose of Lacosamide was not signed off. After reviewing the log for the controlled substance, Nurse #6 concluded that she must not have given Resident #185 the morning dose of Lacosamide 200 mg on 10/12/15.	F 333		
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 and staff interviews the facility failed to maintain sanitary conditions for 2	F 371	F371 Food Procure/Store/Prepare/Serve-Sanitary	11/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 12 of 2 nourishment rooms on the 100 and 200 hallway. The findings included: 1. An observation was made of the refrigerator in the nourishment room on the 100 hallway on 10/20/15 at 9:20 AM. The observation revealed inside the refrigerator on the top and bottom shelf there was dark brown and red sticky substance on the shelves. Interview with housekeeper #1 on 10/20/15 at 9:38 AM stated she was responsible for cleaning the nourishment room on 100 hallway. She stated the refrigerators was to be cleaned in the mornings and the evenings. During the interview, she acknowledge the refrigerator had a lot of dark brown and red sticky substance on the top and bottom shelf. 2. An observation was made of the refrigerator in the nourishment room on the 200 hall on 10/20/15 at 9:25 AM revealed on the top and bottom shelf there was dark brown and red sticky substance. Interview with housekeeper #2 on 10/20/15 at 9:35 AM accompanied to the nourishment room revealed she was responsible for cleaning common areas and the nourishment room on the 200 hallway. During the interview, she acknowledge the nourishment room had not been cleaned and had a lot of dark brown and red sticky substance on the top and bottom shelf. Interview conducted with the Director of Housekeeping on 10/20/15 at 9:42 AM stated staff is trained to clean nourishment rooms. The Director of housekeeping was accompanied to the nourishment room and revealed it had a lot of dark brown and red sticky substance on the top and bottom shelf. During the interview, he stated	F 371	Nourishment room refrigerators were cleaned as of 10/19/15. An audit of all nourishment room refrigerators was completed as of 10/19/15 All staff were reeducated by the SDC regarding the importance of keeping refrigerators clean as of 11/18/15. All newly hired staff will be educated during orientation regarding the importance of maintaining cleanliness of refrigerators The Director of Environmental Services will audit the cleanliness of refrigerators daily Monday through Friday x one month then 3 x weekly x 2 month, then monthly x 9 months with report to the NHA. The Director of Environmental Services will report the results of audits to the QA&A committee monthly x one year beginning on 12/16/15. The QA&A committee will evaluate the results of the findings and make changes to the plan as needed.	

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F 371	Continued From page 13 housekeepers were responsible for cleaning the nourishment rooms in the mornings and the evenings. He further stated his expectation was for staff to round before the end of the shift and to make sure the nourishment rooms were cleaned daily.	F 371		
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 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 observations and staff interviews and	F 520	F520	11/18/15

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F 520	Continued From page 14 record review, the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions the committee put into place in December 2104. This was for a 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 food sanitation. The continued failure of the facility during two federal survey of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: F371: Based on observations and staff interviews, the facility failed to maintain sanitary conditions for 2 of 2 nourishment rooms. The facility was recited for F371 regarding the cleanliness of 2 of 2 nourishment kitchen refrigerators. F371 was originally cited in December 2014 for failure to utilize beard restraints during food preparation. Interview with the Administrator on 10/23/15 at 3:40 PM revealed she began employment at the facility in September 2015 and did not know if the nourishment rooms were included in the dietary monitoring after the 2014 survey. The Administrator explained housekeeping staff cleaned the refrigerators. A second interview with the Administrator on 10/23/15 at 4:28 PM revealed the facility's monitoring did not include cleanliness of the nourishment kitchen refrigerators.	F 520	QAA Committee-Members/Meet Quarterly/Plans See F371 for corrective action for the associated deficiency. Reeducation was given to all Department managers by the NHA on 11/13/15 regarding the policy and intent of QA&A program. All newly hired Department Managers will be educated at the time of hire regarding QA&A processes. Administrator will ensure completion of audits for F371 monthly x one year. The Dietary Manager will report on the findings of these audits monthly to the QA&A committee x one year. The QA&A committee will evaluate the findings from these audits in order to ensure that the plan is effective and make changes as necessary.	