STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to get the resident out of bed at their preferred time for 1 of 2 sampled Residents (Resident #65) who was reviewed for preferences in their daily routine. Findings included: Resident #65 was admitted on 12/26/13. The most current diagnoses list included a muscular disorder, generalized muscle weakness and diabetes. The 12/10/14 Annual Minimum Data Set (MDS) identified Resident #65 as alert and oriented with no behaviors or rejection of care. Review of the resident's preferences for Customary Routine and Activities indicated it was very important to choose his own daily routines. Resident #65 was identified as requiring extensive assistance for bed mobility, transfer, bathing, dressing and personal hygiene. The 8/25/15 Quarterly MDS also identified the resident as alert and oriented with no behaviors or rejection of care. The resident was coded as requiring extensive assistance with bed mobility, transfer, bathing, dressing and personal hygiene. On 9/23/15, the resident filed a grievance	F 242	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. Preparation and submission of the Plan is in response to CMS-2567 and is not a admission by Autumn Care of Nash that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by federal and state law. RESIDENT AFFECTED; All nursing staff in-serviced by Staff Development Coordinator or RN designee on Resident's Rights to Make Choices regarding aspects of his life in the facility and the significance of same. Social Worker or designee will inform resident of his rights to make choices about aspects of his life in the facility which are significant to him. Director of Nursing and Administrator will be informed of the resident's choices and choices will be documented in Resident Care Guide and on resident's Care Plan. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All nursing staff will be in-serviced on Resident's Rights to Make	11/24/15

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

Electronically Signed | 11/27/2015

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F 242	Continued From page 1 indicating that he was not gotten up until 11:00 AM. It was signed by the Administrator and the action taken was to tell the nursing assistant (NA) to get the resident up prior to getting dependent residents up if possible. The named NA involved was NA #1. Review of Resident #65's care plan and the care guide, used by the NAs, not dated, failed to identify the resident's desire to arise prior to breakfast. On 10/27/15 at 9:50 AM, Resident #65 was interviewed. He stated he preferred to get up before breakfast, but that did not always happen. The resident stated staff were aware. Resident #65 gave as an example 10/26/15. He stated he was not gotten up until 10:30 AM; stating the NA told him they were short staffed. An interview was held with Resident #65 on 10/28/15 at 8:50 AM. He identified the NA that worked with him on Monday, and stated again short staffing was given as the reason he was not gotten up prior to breakfast, as was his preference. On 10/29/15 at 9:00 AM, the resident was in the bed. He stated today was his shower day, so therefore, he had been unable to get up before breakfast as he preferred. The Director of Nursing (DON) was interviewed on 10/29/15 at 9:22 AM. She stated any preferences for arising verbalized by a resident was posted at the nurse's station so all staff would be aware. Nurse #1 who cared for Resident #65 was interviewed on 10/29/15 at 10:55 AM. She stated resident preferences were relayed to NAs verbally and not written on the care guide used by the NAs. Nurse #1 added showers were not given before breakfast because giving residents showers was time consuming. She added the	F 242	Choices about aspects of his/her life in the facility and the significance of same. In the next Monthly Resident Council Meeting, the Activity Director, Social Worker or designee, by invitation of the Council, will review Tag F242 and the resident's right to make choices about aspects of his/her life in the facility, and what action to take should they feel their choices are not honored. SYSTEMIC CHANGES: Monthly, for 3 months, the Social Worker or designee will interview Resident #65 and allow resident to participate in his preferences in his daily routines including meal time preferences, shower times and whether the resident wants to be out of bed for meals or in bed for meals. Monthly, for 3 months, Social Worker or designee will interview 10% of the residents concerning their preferences in their routines, including meal time preferences, shower times and whether the resident wants to be out of bed for meals or in bed for meals. Monthly for 3 months, MSD or RN designee will review 10% of the residents' care guides to ascertain that each individual care guide is up-to-date and identifying the individual resident's preferences. MONITORING OF CHANGES: Results of the above noted audits will be reported monthly to the special meeting of the Quality Assessment and Assurance (QAA)Committee for a period of 3 months After 3 months, the QAA Committee will determine if ongoing monitoring is necessary or if the audits can be	

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F 242	Continued From page 2 11:00 PM to 7:00 AM NAs could not give a shower to Resident #65 so he could get up early because there was not enough staff working on that shift. She added Resident #65 was aware if he's scheduled for a shower he would not be getting up before breakfast and added he did not mind. Nurse #1 added on his shower days, the staff tried to accommodate Resident #65 by making sure he's the first one showered so he could attend activities. Nurse #1 stated Resident #65 was alert and oriented. The nurse pointed out another resident whose preference to be up early had been posted at the nurse's station. She acknowledged there was not a note posted alerting staff to Resident #65's preference to arise early. Resident #65 reported during an interview on 10/29/15 at 1:05 PM that he had gotten up at 9:30 AM that morning. He acknowledged this had been his shower day. NA #1 was interviewed on 10/29/15 at 1:10 PM. She stated she worked with Resident #65 most days and stated she knew he liked to be out of bed by 8:00 AM. The NA stated when she was assigned Resident #65 she arrived at work early to try to accommodate his preference to be up by 8:00 AM. On 10/29/15 at 1:41 PM, NA #2 was interviewed. The NA stated she had been assigned to care for Resident #65 on 10/26/15 and had helped another NA with his shower on 10/29/15. The NA stated she was aware the resident preferred to be up by 8:00 AM, but on 10/26/15, she had not gotten him out of bed until 10:00 to 10:30 AM. NA #1 stated prior to getting Resident #65 up, she had to get those residents that attended Restorative dining up and dressed. NA #1 stated she had told Nurse #1 that she was unable to get the resident up by his preferred time, but	F 242	discontinued for the purpose of this Plan of Correction(PoC).	

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F 242	Continued From page 3 she had received no help. The NA added this morning, 10/29/15, Resident #65 had gotten up between 9:30 AM and 10:00 AM. She stated she had assisted the NA with Resident #65's shower, because that NA was not used to working with Resident #65. NA #2 added the NA she had helped was aware Resident #65 liked to be up by 8:00 AM and she had gotten him up as quickly as she could. The NA added they had not showered Resident #65 prior to breakfast because the NAs had been told showers could not be given before breakfast since that would not leave enough time to get those residents that needed assistance with eating up before breakfast. The DON was interviewed on 10/29/15 at 2:11 PM. She stated if a resident had a preferred time for being out of bed it was posted at the nurse's station. The DON stated the nursing staff all knew Resident #65 preferred to be out of bed before breakfast. The DON added there was no valid reason the resident had been so late on Monday and Thursday getting out of bed; adding staff had not been told not to shower people before breakfast. Resident #65 was interviewed on 10/29/15 at 2:42 PM. He stated he was happy the issue was to be resolved because he really enjoyed being in the dining room with his friends for breakfast.	F 242		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		11/24/15

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F 329	Continued From page 4 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop a care plan identifying target behaviors, goals and interventions for the use of a psychotropic medication for 1 of 5 sampled residents (Resident #9) whose meds were reviewed. Findings included: Resident #9 was readmitted on 3/9/15 with diagnoses that included hypertension, kidney disease, anxiety and depression. The Psychiatric follow up evaluation, dated 9/28/15, was reviewed. The chief complaint was documented as increased irritability, noncompliance and recent hypomania. The note	F 329	RESIDENT AFFECTED: Psychiatric provider, MD or PA/NP to provide a comprehensive assessment of the resident and to review resident's medication to ensure that the antipsychotic drug therapy is necessary to treat the resident's specific condition. Psychiatric provider, MD, or PA/NP to assess the resident to determine if a gradual dose reduction and behavioral interventions are appropriate, in an effort to discontinue the antipsychotics. Activity Director or Social Worker to interview the resident to determine what activities may be of interest to the resident for use as non-pharmacological intervention if targeted behaviors are	

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F 329	Continued From page 5 indicated Resident #9 felt sad, but her affect was incongruent with stated mood noting the resident smiled and laughed appropriately. The evaluation indicated the resident's insight was poor, judgement fair with no suicidal ideation. Review of the October 2015 physician's orders included Wellbutrin 150 milligram (mg) daily, Trazadone 125 mg at bedtime, Lorazepam 0.5 mg twice daily for anxiety and Geodon 80 mg twice daily. Review of the care plan,with a start date of 8/11/14 and no review date, indicated the resident received an antipsychotic medication. The target behaviors were not listed and there were no non-pharmacological interventions listed in the care plan for the antipsychotic or the as needed medications. The Director of Nursing (DON) was interviewed on 10/29/15 at 9:22 AM. She stated if a resident had a mental illness and received psychoactive medications, their moods and behaviors should be monitored. The DON stated she had not heard the term target behaviors and was unaware target behaviors should be care planned. The DON added she was not aware non-pharmacological interventions should be attempted prior to giving as needed psychoactive medications. The DON stated there was no process in place to alert nurses and nursing assistants (NA) about target behaviors and non-pharmacological interventions. The Minimum Data Set (MDS) nurse was interviewed on 10/29/15 at 10:17 AM. The MDS nurse stated residents that received psychoactive medications were usually care planned for staff to	F 329	identified. Pharmacist Consultant/Director of Nursing to in-service licensed nurses in identifying targeted behaviors and emphasizing non-pharmacological alternatives to the drugs to reduce unnecessary drug use. RESIDENTS WITH THE POTENTIAL TO BE AFFECTED: Pharmacy Consultant/Director of Nursing to in-service licensed nurses in identifying targeted behaviors and emphasizing non-pharmacological alternatives to the drugs to reduce unnecessary drug use. SYSTEMIC CHANGES: Patients at Risk Committee will review residents on antipsychotic therapy weekly x 4 weeks to determine if non-pharmacological alternatives were used prior to medicating. MDS or designee will review care plans of residents taking antipsychotic medications to be assured that it includes a behavior care plan. For 5 days per week for 4 weeks, orders written for antipsychotic medications will be reviewed by the Director of Nursing or RN designee to determine the reason for the medication and if the order contains a diagnosis and targeted behaviors. For 5 days per week for 4 weeks, nurses notes will be reviewed by the Director of Nursing or RN designee to determine if the note includes the reason for giving a PRN antipsychotic medication, includes targeted behaviors, and includes what non-pharmacological alternatives were used prior to medication use. MONITORING OF CHANGES: Results of the above noted audits will be reported	

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F 329	Continued From page 6 monitor their moods and behaviors, to refer to psychiatric services if needed and for staff to monitor the resident for side effects of the medications. The nurse stated she had not been instructed to care plan target behaviors or non-pharmacological interventions to be used by staff prior to the administration of an as needed medication. The MDS nurse stated general terms such as anxiety/agitation were used on the care plan and not resident specific behaviors. During and interview with Nurse #1 on 10/29/15 at 11:04 AM, she stated she had not been instructed on what specific behaviors to look for that may be exhibited by Resident #9. The nurse added she was taught in nursing school to attempt non-pharmacological interventions prior to as needed medication administration; but had not received that instruction from the facility. The nurse added she had not seen non-pharmacological interventions listed on the care plan for Resident #9.	F 329	weekly to the special meeting of the Quality Assessment and Assurance (QAA) Committee for one month. After that one month, the QAA Committee with determine if ongoing monitoring is necessary or if the audits can be discontinued for the purpose of the Plan of Correction(PoC).	
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:	F 371		11/25/15

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F 371	Continued From page 7 Based on observations and staff interview the facility failed to properly thaw beef, label opened food items stored in the freezer and discard raw carrots by the discard date on the label. The findings included: 1. On 10/26/15 at 1:18PM four sealed bags of beef were observed sitting on the stainless steel single compartment sink next to the convections oven. The packages of beef were observed to have coagulated blood around the edges. During an observation on 10/26/15 at 1:45 PM the meat was still sitting on the counter. Food Service Worker #1 was then interviewed and he stated he had removed the beef from the cooler, felt it was not thawed sufficiently so he placed the beef under hot running water prior to attending the 1:15 PM facility staff meeting. He stated he had not gotten back to the beef since returning from the meeting and he planned to wash the meat in order to get all the blood off of the meat. During an interview with the Director of Nutritional Services on 10/26/15 at 1:48 PM she stated the meat should have been thawed only with cold running water, not hot water. 2. During a tour of the kitchen on 10/26/15 at 1:30 PM a zip lock plastic bag of frozen chicken and an open bag of French Fries were observed to have no label present and a zip lock plastic bag of raw carrots had a label which indicated the carrots were packaged on 8/28/15 and were to be discarded in 7 days. The Director of Nutritional Services stated the opened food items should have had a label on them and the bag of raw carrots should have been discarded. She stated she was taught that all opened foods should be discarded in 7 days so that was the reason the bag of carrots was labeled with a discard date of 7 days on the label.	F 371	RESIDENTS THAT HAVE THE POTENTIAL TO BE AFFECTED: Regional dietician or designee will in-service all dietary staff members on storing, preparing, distributing and serving food under sanitary conditions, including proper food handling and preparation, cross contamination, food labeling and dating. SYSTEMIC CHANGES: Weekly for 4 weeks the dietary manager, regional dietician or administrator will conduct a full audit of the kitchen, including storing, preparing, distributing and serving food under sanitary conditions, including proper food handling and preparation, cross contamination and food labeling and dating. AM and PM cook together, will daily audit the freezer, refrigerators and dry storage areas for proper storage of food. Dietary Manager will accompany when working. MONITORING OF CHANGES: Results of the above noted audits will be reported weekly to the special meeting of the Quality Assessment and Assurance (QAA) Committee for one month. After one month, the QAA Committee will determine of ongoing monitoring is necessary or if the audits can be discontinued for the purpose of this Plan of Correction(PoC).	

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F 441	Continued From page 8	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		11/24/15

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F 441	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to wash hands between touching residents and prior to touching the end of the straw residents used for consumption of fluids and while passing meal trays during 1 of 2 meal observations for Residents #131, #105, #36 and #38). Findings included: On 10/26/15 at 5:45 PM a continuous observation started of Nursing Assistant (NA) #3 passing dinner trays on the 600 hall. The NA was observed exiting a room and beginning the delivery of trays. The NA passed the dinner tray to Resident #131 and was not observed washing her hands before or after setting up the meal tray; although she had touched the resident's over bed table where multiple personal items were stored. During the meal tray set up, the NA touched the end of the straw the resident would be drinking from. The NA then entered the room of Resident #105. NA #3 assisted Resident #105 to slide up in bed by pulling the pad on the bed that Resident #105 had been lying on. After positioning the resident, NA #3 failed to wash her hands before unwrapping the straw; touching the end of the straw the resident was putting into his mouth. The NA entered Resident #36's room. She failed to wash her hands before setting up the resident' s meal tray. NA #3 touched the end of the straw the resident was using to drink her fluids. NA #3 then entered Resident #131's room again and placed oxygen tubing on a resident's face, touching his ear and his face. She failed to wash her hands before the task and after completion of the task. The NA then continued passing dinner	F 441	RESIDENT AFFECTED: C.N.A.'s involved in passing trays on 600 Hall will be in-serviced by the Staff Development RN or designated RN on proper hand hygiene when providing personal care to residents, preparing residents to receive meals, handling foods and feeding residents. RESIDENTS WITH THE POTENTIAL TO BE AFFECTED: All C.N.A. staff will be in-serviced by Staff Development RN or RN designee on proper hand hygiene when providing personal care to residents, preparing residents for meals, handling foods, and feeding residents. All nursing staff will be in-serviced by Staff Development RN or RN designee on infection control. SYSTEMIC CHANGES: Staff Development RN or licensed nurse designee will observe 2 C.N.A.'s during meal time, passing trays and assisting residents with meals three times weekly for four weeks. MONITORING OF CHANGES: Results of above noted audits will be reported to the special meeting of the Quality Assessment and Assurance (QAA) Committee weekly for one month. After one month, the QAA Committee will determine if ongoing monitoring is necessary or if the audits can be discontinued for the purpose of this Plan of Correction(PoC).	

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F 441	Continued From page 10	F 441		

trays and entered Resident #38's room. She set up the resident's tray touching the end of the straw the resident would use to consume her fluids. The NA had not washed her hands.
At 5:58 PM on 10/26/15, NA #3 was interviewed. The NA stated she had been taught to wash her hands after providing care to a resident and before going to another resident. She stated when she assisted the resident to position, she had only touched the pad on which Resident #105 was lying. The NA stated she had not provided a bath or incontinent care and washing her hands after touching the resident's bed linens was news to her. She stated when she applied the oxygen, she had touched the resident's face and ear, and acknowledged she had not washed her hand. The NA again said she had not provided care and washing her hands after applying oxygen and touching the resident's ear was something new to her. She acknowledged that any germs on her hands from touching the pad on Resident #105's bed and the Resident 103's ear had been transferred to the other resident's and their straws as she prepared their meal trays.
The Director of Nursing (DON) was interviewed on 10/28/15 at 1:46 PM. The DON stated NAs were expected to wash hands when they enter the room, before and after care and in between residents as meal trays are passed. If the NA touched the resident's arm, bedding, ear or face, her hands would need to be washed prior to going to another resident to pass a meal tray or provide care. The DON added hand washing was an ongoing focus of the Quality Assurance (QA) program, that she had started 2 to 3 months ago with no end date. The DON stated she had not started the hand washing QA in response to any identified issues. The NA was last trained on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345514	A. BUILDING _____ B. WING _____	10/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NASH	1210 EASTERN AVENUE NASHVILLE, NC 27856

(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 441	Continued From page 11 hand washing on 12/9/14. The DON stated the NA had presented the knowledge and knew she needed to wash her hands. She added there was no excuse for the NA not washing her hands. She stated the potential hazard of the NA of going from room to room without washing her hands was contamination and passing infection from one resident to another. The Infection Control (IC) nurse was interviewed on 10/29/15 at 3:26 PM. The IC nurse stated staff were expected to wash their hands before and after provision of care and between residents during meals. She added staff were expected to wash their hands after touching any items in a resident's room including linens and oxygen tubing. Without hand washing, the IC nurse stated there was a high likelihood of staff spreading infection	F 441		
F 520 SS=E	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	F 520		11/24/15

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 12 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 staff interview and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed to correct deficiencies in the areas of infection control (F441) and kitchen sanitation (F371) cited during the recertification survey of 11/21/14. As a result, a deficiency in the area of infection control and kitchen sanitation were again cited on the current recertification survey. Findings included: This tag is cross referenced to: F441: Based on observations and staff interviews the facility failed to wash hands between touching residents and prior to touching the end of the straw resident ' s used for consumption of fluids and while passing meal trays during 1 of 2 meal observations. During the recertification survey of 11/21/14 the facility was cited for failing to clean and disinfect a pair of scissors before and after use during pressure ulcer treatment, and for placing soiled care items on top of the resident ' s bed while providing wound and incontinent care. F371: Based on observation and staff interviews, the facility failed to properly thaw beef, label opened food items stored in the freezer and discard raw carrots by the discard date on the	F 520	RESIDENTS AFFECTED AND HAVE THE POTENTIAL TO BE AFFECTED: The facility will develop a QAPI Steering Committee to maintain a culture of continuous quality improvements. The Committee will meet monthly to discuss data and look for trends and patterns and to set priorities on which areas need a Performance Improvement Project (PIP). The Committee members will be an interdisciplinary team including the Administrator, Director of Nursing, key department managers, and the medical director when available. SYSTEMIC CHANGES: A PIP will be developed for infection control and it will be monitored monthly and revised as needed to correct deficiencies in the areas of infection control. The PIP will continue for a period of 3 months. A PIP will be developed for kitchen sanitation and it will be monitored monthly and revised as needed to correct deficiencies in the areas of issues related to the kitchen. The PIP will continue for a period of 3 months. MONITORING OF CHANGES:	

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F 520	Continued From page 13 label. During the recertification survey of 11/21/14, the facility was cited for failing to maintain sanitizing solutions at an effective strength, failed to air dry kitchenware before stacking in storage, failed to sanitize meal carts which were previously in resident care areas and common areas, failed to discard damaged kitchenware, failed to rewash kitchenware contaminated by dried food particles and failed to monitor storage areas for labeling/use-by dates/contamination. An interview with the director of nursing (DON) was held on 10/29/15 at 4:05 PM. She stated issues that required QA involvement were identified through random observations, monthly reports and interviews with staff, residents and families. The DON stated she had recently become responsible for the QA program and was not aware of previous citations for kitchen sanitation and infection control. The DON added she was unaware of previous plans of corrections and actions used to correct the previously cited deficiencies.	F 520	Results of the above noted PIPS will be reported at the Quarterly Quality Assessment and Assurance (QAA) Committee for one quarter. After the quarter, the QAA Committee will determine if ongoing monitoring is necessary of if the PIP's can be discontinued for the purpose of this Plan of Correction(PoC).	