STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 survey of 12/10/15. Event ID 2K7811.	F 000		
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 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 interviews, the facility failed to initiate a care plan addressing nutrition for 1 of 4 residents (resident #89) reviewed for nutrition. Findings included: Resident #89 was admitted 7/9/15 and last readmitted 9/10/15. Resident #89 was admitted	F 279	Resident #89 was discharged from the center prior to this survey. On December 10, 2015 the Dietary Manager and the Staff Development Coordinator began an audit on nutritional care plans. 100% of care plans were	12/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/29/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(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 279	Continued From page 1 with cumulative diagnoses which included congestive heart failure and end stage renal disease. A review of the admission minimum data assessment (MDS) dated 7/31/15 revealed the resident was cognitively intact. The admission assessment also revealed that the resident was able to feed self with set up only, had no dental or swallowing issues, and was on dialysis. He was noted to be on a therapeutic, no added salt (NAS) regular texture diet. The Care Area Assessment was shown to trigger for nutritional status and the care plan decision was yes. An interview was conducted with the dietary manager (DM) on 12/09/15 at 3:15. The DM indicated she was responsible for initiating nutrition care plans and thought she had done one for resident #89. The DM then reviewed the resident's records and reported there was no care plan for nutrition. She contacted the medical records department and stated they did not have one and could not find one in the chart either. On 12/10/15 at 8:24 am, MDS nurse #3 and Nurse #4 came to the conference room to look through resident #89's closed record for a nutrition care plan and returned the chart stating, "no luck there". On 12/10/15 at 9:02 am Director of Nursing was interviewed. She stated that it is her expectation that a resident on dialysis would be care planned for nutrition.	F 279	completed in the audit for all current residents on December 18, 2015. Center was found to be in compliance with nutritional care plans. All active resident's Care Plans were entered into the Eletronic Medical Records (EMR) by the Dietary Manager and the Staff Development Coordinator. All new admission's care plans will be entered in the EMR. Care Plan Focus Summary Report will be pulled up weekly by the Staff Care Plan Coordinator to ensure compliance. The Interdisciplinary Team (Administrator, Director of Nursing, Mininum Data Set Nurse, Care Plan Coordinator, Dietary Manager, Activity Director, Mood and Behavior RN and Therapy) meeting weekly in Standards of Care will review all new admissions for 4 weeks to ensure care plan is current and entered into the EMR. The Care Plan Coordinator will run weekly the Care Plan Focus Summary Report to ensure compliance. Any areas of non-compliance will result in re-education of staff. A Process Improvement Performance (PIP)will be stared as part of the plan of correction. The results of the Care Plan Focus Summary Report will be reviewed by the PIP Committee (Committee members are Dietary Manager, Director of Nursing, Care Plan Coordinator and Staff Development Coordinator) monthly and those results will be presented by the Staff Development Coordinator to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 279	Continued From page 2	F 279	Assurance/Process Improvement monthly meeting for 3 months our until PIP goals are met. The Regional Nurse Consultant will provide additional oversight to ensure compliance with F tag 279.	
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 observation, record review and staff interviews the facility failed to keep one of two ice machines free from mold build up. The findings included: On 12/9/15 at 10:50 AM the ice machine located in the kitchen was observed to have a buildup of pink and black mold along the bottom edge of the white ice cube deflector door located inside the ice bin area. During an interview with the Dietary Manager (DM) on 12/9/15 at 10:55 AM she stated the ice machine needed to be cleaned. She added that the dietary staff were responsible for cleaning the ice machine and that it was on a cleaning schedule for the "Position A" person to complete. She stated she checked behind her staff to make sure the cleaning was completed as assigned but	F 371	On December 9. 2015 the ice machine located in the kitchen was cleaned by the dietary staff. The ice machine located in the kitchenette are at the nurse's station was inspected and no build up was noted. All dietary and housekeeping staff were in-serviced by the Dietary Manager on December 12, 2015 on proper cleaning of ice machine. The cleaning list for both ice machines was revised by the Dietary Manager and staff were inserviced on the new cleaning schedule. This was completed by	12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 3 she did not assign everything on a daily bases as indicated on the form. An review of the "RSHC Position 'A' - Cleaning Schedule" dated 12/2/15 revealed item 9 which stated, "Keep clean ice machine, scoop and holder at all times." The frequency was listed as daily and the Initials of Dietary Staff #1 were present but the time was not filled in. An interview was conducted with Dietary Staff #1 on 12/9/15 at 11:20 AM she stated that she wrote her initials on all the tasks but only put times next to the items she actually completed. She stated she did not clean the ice machine on 12/2/15. A review of the "RSHC Position 'A' - Cleaning Schedule dated 11/28/15 revealed item 9 was timed and had initials on it. The DM confirmed it indicated that was when the ice machine was cleaned.	F 371	December 24, 2015. The ice machines are monitor daily by the assigned dietary aide and cleaned weekly by the assigned dietary aide. The Housekeeping Supervisor will do weekly audits of the cleaning schedule and inspection of the ice machines. Any areas of non-compliance will result in re-education of staff. The results of this audit will be reviewed by the PIP Committee (Committee members are Housekeeping Supervisor, Dietary Manager, and Staff Development Coordinator) monthly and those result will be presented by the Housekeeping Supervisor to the Quality Assurance/Process Improvment (QAPI) monthly meeting for 3 months or until PIP goals are met. The Regional Nurse Consultant will provide additional oversignt to ensure compliance with F tag 371.	
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,	F 441		12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(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 4 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to disinfect non-disposable medical equipment removed from a contact isolation room for one of one sampled resident reviewed on contact isolation (Resident #21). The findings included: Resident #21 had been readmitted to the facility on 11/27/2015. Diagnoses included clostridium-difficile infection (C-Diff is an infectious diarrhea) and was placed on contact isolation precautions.	F 441	Resident #21 was the only resident in isolation. All current residents were reviewed for isolation. No additional residents were identified on isolation. On December 9, 2015 the Staff Development Coordinator in-serviced therapy staff on proper cleaning of equipment according to manufacturer's directions and according to SPICE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 5 On 12/09/2015 at 9:10 AM an observation of Resident #21 revealed an electrical stimulation (E-stim) machine had been placed on the over bed table and was attached to the resident. A contact isolation precautions sign had been posted on the Resident's door and indicated "clean and disinfect shared equipment between patients." On 12/09/2015 at 9:35 AM an observation of Resident #21's room revealed the E-stim machine was no longer on the over bed table and was not observed in the Resident's room. An interview with the Rehabilitation Director (RD) was conducted on 12/09/2015 at 10:18 AM. The RD indicated Resident #21 had been receiving E-stim therapy for pain control. The RD stated he had placed the equipment into a plastic bag while in the isolation room and had taken it to the therapy department for disinfection. The RD stated the E-stim which had been used on Resident #21 had already been disinfected by him and returned to its storage location. The RD gave a demonstration of the disinfection process. The RD placed a clean towel on a table top, placed an E-stim package on the towel, donned gloves and started wiping the surface of the box, wires and power cord. As the RD was wiping the E-stim box with Micro-Kill brand disinfectant wipes, the disinfectant was observed to dry within a few seconds. The RD placed the towel in a dirty linen hamper and indicated the table top would be wiped with a disinfectant wipe. An interview with the infection control nurse was conducted on 12/9/2015 at 2:52 PM. The nurse stated the facility followed the Statewide Program for Infection Control and Prevention (SPICE) protocol for infection control. The nurse stated for the Micro-Kill disinfectant to be effective, the surface being disinfected needed to remain wet	F 441	(Statewide Program for Infection Control and Epidemiology)guiedlines for contact isolation precautions for Special Enteric. On December 11, 2015 Staff Development Coordinator in-serviced therapy department related to contact isolation precaution for special enteric and viewed the DVD Module 4 environmental disinfection according to SPICE guidelines and post test with certification of completion. Education was provided by the Staff Development Coordinator on December 7, 2015 with each department related to proper isolation procedure. Education will be provided to in-house staff with each new case of isolation according to environmental protection agency for proper cleaning of durable medical equipment. Any areas of non-compliance will result in re-education of staff. A Process Improvement Performance (PIP) related to infection control and proper cleaning of equipment was stated on December 24, 2015 as part of the plan of correction. This committee will review any new isolation cases, any deficient practices and education related to this. The results will be reviewed by the PIP Committee (Committee Members are Director of Nursing, Staff Development Coordinator, Care Plan Coordinator) monthly and results presented by the Staff Development Coordinator to the Quality Assurance/Process Improvement monthly meeting for 3 months or until PIP goals are met. The Regional Nurse Consultant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(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 6 with disinfectant solution for two to five minutes. The nurse also indicated linen used for an isolation resident should bagged separately and marked with an isolation sticker for special handling by the laundry room staff. The nurse stated she monitors isolation residents for symptoms of infection and their need for continued isolation. The nurse indicated Resident #21's symptoms of C-Diff were improving and the resident would continue to be on isolation until the symptoms were resolved. An interview with the infection control nurse was conducted on 12/10/2015 at 10:50 AM. The nurse stated it was her expectation if any employee was unsure about isolation precautions or how to disinfect medical equipment removed from an isolation room they should ask the nurse or the infection control nurse. The nurse stated the E-stim equipment had not been properly disinfected prior to reuse. An interview with the administrator and the director of nursing (DON) was conducted on 12/10/2015 at 1:40 PM. The administrator stated it was her expectation that employees read the isolation signs, follow the directions and ask questions of the nurse as needed.	F 441	will provide additional oversight to ensure compliance with F tag 441.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		12/29/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 7 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 review, observation and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor and revise these interventions that the committee put into place in March 2015. This was for 2 recited deficiencies which were originally cited in February 2015 on a recertification survey and again on the current recertification survey. The deficiencies were in the areas of comprehensive plan of care and food procurement, storage, preparation and distributions. The continue failure of the facility during 2 surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F279 - Comprehensive Care Plans - Based on record review and staff interviews the facility failed to initiate a care plan addressing nutrition	F 520	The center has a Quality Assurance/Process Improvement (QAPI) Committee that meets monthly that includes physician, Administrator, Director of Nursing, Nursing Managers, and Departments Managers. The center meets to identify issues with respect to which quality assessment and assurance activites that are necessary and develop and implement Process Improvement Performance (PIP) plans to correct identified quality issues. The Staff Development Coordinator completed staff education on the QAPI Program to all departments on December 25, 2015. The Executive Director completed staff education on the QAPI Program with department managers on December 29, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 8 for 1 of 4 residents (Resident #89) reviewed for nutrition. During the previous recertification survey on 2/12/15, the facility was cited for F279 for failure to develop a care plan with measurable goals for 1 of 5 residents reviewed for unnecessary medications who was receiving an antipsychotic medication and failed to care plan for target behaviors for 2 of 5 residents receiving antipsychotic medications. F 371 - Food Service Sanitation - Based on observation, record review and staff interviews the facility failed to keep 1 of 2 ice machines free from mold build up. During the previous recertification survey on 2/12/15, the facility failed to provide a barrier between ready to eat foods and bare hands for 2 of 6 staff members who picked up bread with their bare hands. An interview was conducted with the facility's Administrator on 12/10/15 at 2:15 PM. The Administrator reported she was the contact person for the Quality Assurance and Performance Improvement Committee (QAPI). She stated the QAPI committee met monthly and included all the department managers except the business office. She added that they discuss Process Improvement Plans (PIPs) where they identify areas of concern and put action plans into place. The Administrator also stated they identify concerns from the Standards of Care committee meetings and try to be proactive to put interventions into place as soon as possible for high risk concerns. She also reported the process improvement for the previous citations which included audits and reeducation were completed.	F 520	The QAPI Committee will add F ag 279 to the QAPI Program. On December 10, 2015 the Dietary Manager and the Staff Development Coordinator began an audit on nutritional care plans. 100% of care plans were completed in the audit on December 18, 2015. Center was found to be in compliance with nutritional care plans. All active resident's care plans were entered into the Electronic Medical Records (EMR) by the Dietary Manager and Staff Development Coordinator. All new admission care plans will be entered in the EMR. Care Plan Focus Summary Report will be pulled up weekly by the Staff Care Plan Coordinator to ensure compliance. The Interdisciplinary Team (Adminstrator, Director of Nursing, Minimum Data Set Nurse, Care Plan Coordinator, Dietary Manager, Activity Director, Mood and Behavior RN and therapy) meeting weekly in Standards of Care will review all new admissions for 4 weeks to ensure care plan is current and entered into the EMR. the Care Plan Coordinator will run weekly the Care Plan Focus Summary Report to ensure compliance. Any areas of non-compliance will result in re-education of staff. A Process Improvement Performance (PIP) was started as part of the plan of correction, the PIP Committee did goal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET RICH SQUARE, NC 27869**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 9	F 520	setting on December 24, 2015. The results of the Care Plan Focus Summary Report will be reviewed by the PIP Committee (Committee members are Dietary Manager, Director of Nursing, Care Plan Coordinator and Staff Development Coordinator) monthly and those results will be presented by the Care Plan Coordinator to the Quality Assurance/Process Improvement (QAPI) monthly meeting for 3 months or until PIP goals are met. The Regional Nurse Consultant will provide additional oversight to ensure compliance with F tag 279. The QAPI Committee will add F tag 371 to the QAPI Program All dietary and housekeeping staff were in-serviced on December 12, 2015 on proper cleaning of ice machines by the Dietary Manager. The cleaning list for both ice machines was revised by the Dietary Manager and staff were inserviced on the new cleaning schedule. This was completed on December 24, 2015. A Process Improvement Performance (PIP) was started as part of the plan of correction, the PIP Committee did goal setting on December 24, 2015. The ice machines are monitored daily by the assigned dietary aide and cleaned weekly by the assigned dietary aide. The Housekeeping Supervisor will be doing a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING ______ B. WING ______	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	**300 NORTH MAIN STREET** **RICH SQUARE, NC 27869**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 10	F 520	weekly audit of the cleaning schedule and inspection of the ice machines. The results of this audit will be reviewed by the PIP Committee (Committee members are Housekeeping Supervisor, Dietary Manager, Staff Development Coordinator) monthly and those results will be presented by the Housekeeping Supervisor to the Quality Assurance/Process Improvement (QAPI) monthly meeting for 3 months or until PIP goals met. The Regional Nurse Consultant will provide additional oversight to ensure compliance with F tag 371. The QAPI Committee will follow the QAPI schedule for audits (part of the QAPI toolkit)and the QAPI aduit will be performed monthly by Administrator or designee and the results will be reported to the QAPI Committee on a monthly basis.	