STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	C 06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

(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 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a surety bond in an amount large enough to secure all the monies the facility managed in the residents' personal fund account. The facility handled 67 residents' monies. The findings included: Review of the last 3 months of bank statements for the resident trust fund revealed that in February 2016 the daily amounts in the account ranged from $62,506.51 to $105,767.14. The daily amounts in the account for March 2016 ranged from $66,754.19 to $106,824.44. The daily amounts in the account for April 2016 ranged from $62,337.98 to $118,806.97. Review of a listing of all residents' personal fund accounts revealed that on 06/02/16, the facility handled the personal monies of 67 residents. The total amount currently held in this account was $62,340.71. Review of the surety bond maintained for the residents with monies managed by the facility in a resident trust account was for $60,000.00. Interview with the Accounts Payable staff on 06/02/16 at 12:03 PM revealed she would have to	F 161	1. On 6-6-2016 the general surety bond for the resident trust account was increased to $120,000.00. 2. All residents may have been potentially impacted. 3. The Administrator will monitor the resident trust account balances each month. Any resident trust account balances above $120,000.00 will be immediately reported to the Administrator. The Administrator will contact the corporate office to make increased surety bond coverage as needed. 4. The Administrator will report to the Quality Assurance committee each month for 3 months the ranges of the resident trust account balances and the amount of the general surety bond. The Administrator will assure the effectiveness of the POC.	7/7/16

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

Electronically Signed | 06/24/2016

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 161	Continued From page 1 contact the corporate office to have the surety bond increased.	F 161		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interviews and staff interviews, the facility failed to maintain 1 of 2 sampled residents right to be free from abuse (Resident #36). The findings included: 1. Resident #165 was admitted to the facility on 05/25/16. Her diagnoses included surgical aftercare, panic disorder, major depressive disorder and long term current use of anticoagulants (blood thinners). Admission nursing notes dated 05/26/16 stated Resident #165 was alert and oriented times 4 spheres. Review of a grievance dated 05/30/16 revealed Resident #165 stated that nurse aide (NA) #2 came to put her to bed Sunday night (05/29/16). She explained to NA #2 that he had to use the lift to transfer her because when he lifted her by	F 223	1. NA #2 left the facility on 5-28-16 directly after the incident with resident #165. He did not return to work and was terminated from employment on 6-7-16. 2. The Social Services Director conducted one on one interviews on 5-31-16 with other residents deemed interviewable to detect any other signs of abuse or neglect. The interviews did not produce any other incidents of abuse or neglect. 3. Employees including subcontracted staff will be re-educated on the facility□s policy and procedure for resident abuse prevention and reporting. The Director of Social Services will attend resident council meetings each month for 3 months to educate residents that they have the right to be free from physical, sexual, verbal and mental abuse including corporal punishment and involuntary seclusion.	7/7/16

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MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

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F 223	Continued From page 2 hand he had caused skin tears. After asking him twice to use the lift, he slung the lift, which was in the room, into the wall and told Resident #165 "Fine, then you can just sit there and think about it." NA # 3 was in the room and told NA #2 to stop and use the lift like he was supposed to and he just got madder. Then NA #3 got Nurse #2 and NA #2 got into Resident #165's face and talking very loudly told her she was telling lies on him. Review of the written statement by NA #3 who was in the room during this incident revealed that on Sunday 05/29/16 at 11:30 PM NA #2 attempted to transfer Resident #165 under the arms. The resident stated he hurt her twice transferring her that way and told him to use the lift. He proceeded to tell her he was certified by the state to lift manually. She again asked him to use the lift which was in the room. He did not and told the resident she could just sit there. She was upset, crying and screaming. Resident #165 then asked for an antianxiety medication and NA #3 went to get Nurse #2. In the presence of Nurse #2, NA #2 got into the resident's face and loudly told Resident #165 he did not like being lied on. He went on and on very belligerently before leaving the room. NA #3 was interviewed via phone on 06/02/16 at 9:35 AM. She stated that around 11:30 PM on 05/29/16, NA #2 asked her to help him transfer Resident #165. She brought the lift into the room but NA #2 tried to transfer the resident without the lift. Even though Resident #165 told NA #2 she wanted him to use the lift as he had caused skin tears to her skin by lifting manually, he told her he was certified to lift her manually. She got very upset and was crying. NA #2 then pushed the lift	F 223	The Director of Social Services or her designee will conduct random one on one interviews with residents and/or family members each week for four weeks and then monthly for 3 months to detect any signs of abuse or neglect. 4. The Social Services Director will submit a summary of the one on one interviews to the QA committee each month for 3 months. The Administrator will submit all DHHS self reports to the Quality Assurance committee for review each month for 3 months. The Administrator and the Quality Assurance committee will assure the effectiveness of the POC.	

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F 223	Continued From page 3	F 223		

away and told her to just sit there. NA #2 then left the room. When Nurse #2 came in with the requested antianxiety medication, NA #2 came back in the room and got in the resident's face and stated she was lying on him and he was tired of being lied on and he was just getting a battery for the lift. NA #3 stated she felt he was being abusive when he got into the resident's face and told her to just sit there. The resident had been upset. NA #3 stated she told everyone she could think of including the nurses and nurse aides about what occurred.

Review of the statement by Nurse #2 revealed on 05/29/16 NA #2 called her to Resident #165's room because she misunderstood him and she wanted something for her nerves. When the nurse got to the room, Resident #165 was crying loudly and screamed at NA #2 that she did not want him taking care of her anymore and when she told him he ripped her skin and wanted him to use the lift he just pushed it up against the wall and walked out. NA #2 then spoke up that he had to get a battery for the lift.

A phone interview with Nurse #2 on 06/02/16 at 9:02 AM revealed she may have misunderstood the situation and was surprised when she was asked to write a statement of the events involving Resident #165 and NA #2. She stated she did not think NA #2 abused the resident as both the resident and NA #2 were upset. She further stated the facility policy was to use the lift and the nurse felt the resident was not accusing him of abuse but just wanted him to use the lift. He did not seem rude to the resident just aggravated. Nurse #2 spoke with the other nurse in the facility and they decided to send NA #2 home.

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F 223	Continued From page 4 During interview on 05/31/16 at 3:25 PM Resident #165 answered yes to the question if she had ever been abused in the facility and stated that a male nurse aide (NA) was rough with her during a transfer causing her to have skin tears. She stated she reported it to staff and they were investigating the incident. On follow up interview with Resident #165 on 06/01/16 at 2:50 PM, Resident #165 stated NA #2 refused to use the lift to transfer her to bed even though the lift was in the room. She stated she tried to explain that he had caused skin tears previously when he transferred her manually and he accused her of lying. NA #2's refusal to use the lift and accusing her of lying got her so upset she needed some antianxiety medications. She stated she was shaking so badly and told the nurse she did not want him in her room anymore. On 06/02/16 at 1:56 PM an interview was conducted with the Administrator, Social Worker (SW), interim Director of Nursing (DON) and Unit Manager (UM). The SW, UM and DON spoke with Resident #165 who was "scared" of NA #2 and didn't want him back in her room. The SW, DON and UM all stated that Resident #165 acted and looked fearful of NA #2 when they spoke with her.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		7/7/16

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F 225	Continued From page 5 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews and resident interviews, the facility failed to submit a 24 hour initial report to the Health Care Personnel Registry (HCPR) for an allegation of abuse made by 1 of 2 sampled residents (Resident #36).	F 225	1. During a visit by the Community Advisory Committee on 5-12-16, a dignity and/or abuse concern was reported about resident #36. The Administrator immediately addressed the concerns and determined that the allegations were not	

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F 225	Continued From page 6 The findings included: 1. Resident #36 was admitted to the facility on 04/23/15. Her diagnoses included Alzheimer's Disease, brief psychotic disorder, anxiety disorder, bipolar disorder, panic disorder and major depressive disorder. Her most recent quarterly Minimum Data Set dated 03/09/16 coded her as sometimes understanding and sometimes being understood, and having severely impaired cognitive skills. She required extensive to total assistance with all activities of daily living skills. Nursing notes dated 05/12/16 at 10:46 AM revealed the resident stated "that boy crawled in bed with me this morning." Reassurance was provided to the resident. The writer spoke with the nurse aides and instructed them to only have female nurse aides provide care to the resident this date. The note continued that Resident #36 wanted to go home this date for her kids. This note was written by Nurse #4. Interview with Nurse #4 on 06/01/16 at 2:29 PM revealed that on 05/12/16, she overheard Resident #36 tell a visitor in the hall that a boy climbed in bed with her that morning. She was taken care of that morning by a male nurse aide (NA) #5. She stated the resident had not made such statements before and she informed the Social Worker (SW) immediately. Review of a grievance dated 05/12/16 revealed Nurse #4 reported to the SW that she overheard resident tell a gentleman that NA #5, and she pointed to NA #5 during this conversation, got in bed with her this morning. The grievance	F 225	substantiated. Resident #36 was not exposed to any abuse. A 24 hour DHHS self report for an allegation of abuse was not submitted. 2. The Director of Social Services reviewed the facility'□s self report log and did not find any self reports for the past year without a 24 hour DHHS initial report. 3. The Administrator will be re-educated by the Corporate Clinical Nurse Consultant on the state regulations on submitting 24 hour and 5 day DHHS self reports. 4. The Administrator will submit all DHHS self reports each month to the QA committee for three months for review. The Administrator and Quality Assurance committee will assure the effectiveness of the POC.	

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F 225	Continued From page 7	F 225		

investigation revealed that NA #5 stated he changed Resident #36's brief this am but there was another nurse aide (NA #6) in the room providing care to the roommate. NA #6 was interviewed and stated she was in the room providing care for the roommate and nothing inappropriately occurred.

The facility provided a 5 working day report of the investigation for resident abuse sent to the Health Care Personnel Registry (HCPR) which unsubstantiated this allegation. This form marked that there was no 24 hour initial report sent to HCPR. This form noted Adult Protective Services had investigated on 05/16/16.

An interview with the Social Worker (SW) and Administrator was conducted on 06/02/16 at 1:56 PM. The SW stated that she was informed by Nurse #6 that Resident #36 told a visitor about a nurse aide crawling in bed with her. She stated she identified NA #5 as the accused and asked him what care he provided and he stated he changed her. She then asked NA #6 who was in the room about the care that was provided and she reported NA #5 changed Resident #36 as she was helping the roommate. SW asked if there was anything unusual that occurred that would bother NA #6 to which she replied no. SW stated she then explained the situation to the corporate nurse and the previous administrator who stated there was no need to submit a 24 hour initial report regarding an allegation of abuse since it was determined immediately that the allegation was unsubstantiated. Therefore a 24 hour report was not sent to HCPR. She further stated that the following Monday, APS came to the facility to investigate an allegation of abuse with Resident #36 regarding this same issue so

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F 225	Continued From page 8 they decided to submit a 5 day report to the HCPR.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews and resident interviews, the facility failed to follow their abuse policy for 2 of 2 sampled residents. A nurse failed to report to administration allegations of abuse made by Resident #165. The facility failed to submit a 24 hour report to the Health Care Personnel Registry and conduct a thorough investigation for an allegation of abuse made by Resident #36. The findings included: The facility's undated Abuse Policy included: Identification: "C. Staff are to immediately report allegations and/or observations of abuse to their immediate supervisor, manager on duty or director of nursing. Reports of allegations and/or observations of abuse will be made to the administrator."; Investigation: "C. The facility will investigate and report	F 226	1. NA #2 left the facility on 5-28-16 at about 11:30 PM directly after the incident with resident #165. He did not return to work and was terminated from employment on 6-7-16. The Administrator submitted a 24 hour DHHS report to the state on 5-31-16 at 5:10 PM. During a visit by the Community Advisory Committee on 5-12-16, a dignity and/or abuse concern was reported about resident #36. The Administrator addressed the concerns and determined that the allegations were not substantiated. Resident #36 was not exposed to any abuse. 2. The Social Services Director conducted one on one interviews on 5-31-16 with other residents deemed interviewable to detect any other signs of abuse or neglect. The interviews did not produce any other incidents of abuse or neglect. 3. Employees including subcontracted staff will be re-educated by the	7/7/16

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F 226	Continued From page 9 incidents or occurrences in accordance with federal and state regulations and guidelines."; Report/Response: "A. Report all alleged violations and all substantiated incidents to the State Agency and to all other required agencies as required." 1. Resident #165 was admitted to the facility on 05/25/16. Her diagnoses included surgical aftercare, panic disorder, major depressive disorder and long term current use of anticoagulants (blood thinners). Admission nursing notes dated 05/26/16 stated Resident #165 was alert and oriented times 4 spheres. During interview on 05/31/16 at 3:25 PM Resident #165 answered yes to the question if she had ever been abused in the facility and stated that a male nurse aide (NA) was rough with her during a transfer causing her to have skin tears. She stated she reported it to staff and they were investigating the incident. On follow up interview with Resident #165 on 06/01/16 at 2:50 PM, Resident #165 stated NA #2 refused to use the lift to transfer her to bed even though the lift was in the room. She stated she tried to explain that he had caused skin tears previously when he transferred her manually and he accused her of lying. NA #2's refusal to use the lift and accusing her of lying got her so upset she needed some antianxiety medications. She stated she was shaking so badly and told the nurse she did not want him in her room anymore. Review of a grievance dated 05/30/16 revealed	F 226	Administrator or his designees on the facility'□s policy and procedure for resident abuse prevention and reporting. The Director of Social Services will attend resident council meetings each month for 3 months to educate residents that they have the right to be free from physical, sexual, verbal and mental abuse including corporal punishment and involuntary seclusion. The Director of Social Services or her designee will conduct random one on one interviews with residents and/or family members each week for four weeks and then monthly for 3 months to detect any signs of abuse or neglect. The Administrator will be re-educated By the corporate Clinical Nurse Consultant on conducting thorough abuse investigations and the state regulations on submitting 24 hour and 5 day DHHS self reports. 4. The Social Services Director will submit a summary of the one on one interviews to the QA committee each month for 3 months. The Administrator will submit all DHHS self reports including all investigation documents to the Quality Assurance committee for review each month for 3 months. The Administrator and the Quality Assurance committee will assure the effectiveness of the POC.	

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Resident #165 stated that nurse aide (NA) #2 came to put her to bed Sunday night (05/29/16). She explained to NA #2 that he had to use the lift to transfer her because when he lifted her by hand he had caused skin tears. After asking him twice to use the lift, he slung the lift, which was in the room, into the wall and told Resident #165 "Fine, then you can just sit there and think about it." NA # 3 was in the room and told NA #2 to stop and use the lift like he was supposed to and he just got madder. Then NA #3 got Nurse #2 and NA #2 got into Resident #165's face and talking very loudly told her she was telling lies on him.

The facility provided a 24 hour initial report dated 05/31/16 for the allegation of neglect for an incident that allegedly occurred on 05/30/16 at 1:00 AM when NA #2 failed to use a lift or second person assist while transferring Resident #165 and caused a skin tear to the resident. The incident report was submitted to the Administrator on 05/31/16.

A phone interview with Nurse #2 on 06/02/16 at 9:02 AM revealed she may have misunderstood the situation and was surprised when she was asked to write a statement of the events involving Resident #165 and NA #2. She stated she did not think NA #2 abused the resident as both the resident and NA #2 were upset. She further stated the facility policy was to use the lift and the nurse felt the resident was not accusing him of abuse but just wanted him to use the lift. He did not seem rude to the resident just aggravated. Nurse #2 spoke with the other nurse in the facility and they decided to send NA #2 home. She did not report the incident to anyone again.

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On 06/02/16 at 1:56 PM an interview was conducted with the Adminstrator, Social Worker (SW), and Unit Manager (UM). This interview revealed that the incident between Resident #165 and NA #2 actually occurred on 05/29/16 around 11:30 PM but was not brought to management's attention until 5/30/16 at 7:27 PM. It was brought to administration's attention on 05/30/16 at 7:27 PM by Nurse #3 who heard about the incident from NA #4. During this interview, UM stated with the transition involving a new Administrator and new interim DON, staff were unsure who to call for such allegations. She stated NA #3 did report the problem to Nurse #2 immediately but Nurse #2 did not follow through by alerting management. All confirmed that Nurse #2 failed to follow the policy on reporting allegations of abuse/neglect to administration.

2. Resident #36 was admitted to the facility on 04/23/15. Her diagnoses included Alzheimer's Disease, brief psychotic disorder, anxiety disorder, bipolar disorder, panic disorder and major depressive disorder.

Her most recent quarterly Minimum Data Set dated 03/09/16 coded her as sometimes understanding and sometimes being understood, and having severely impaired cognitive skills. She required extensive to total assistance with all activities of daily living skills.

Nursing notes dated 05/12/16 at 10:46 AM revealed the resident stated "that boy crawled in bed with me this morning." Reassurance was provided to the resident. The writer spoke with the nurse aides and instructed them to only have female nurse aides provide care to the resident this date. The note continued that Resident #36

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wanted to go home this date for her kids. This note was written by Nurse #4.

Interview with Nurse #4 on 06/01/16 at 2:29 PM revealed that on 05/12/16, she overheard Resident #36 tell a visitor in the hall that a boy climbed in bed with her that morning. She was taken care of that morning by a male nurse aide (NA) #5. She stated the resident had not made such statements before and she informed the Social Worker (SW) immediately.

Review of a grievance dated 05/12/16 revealed Nurse #4 reported to the SW that she overheard resident tell a gentleman that NA #5, and she pointed to NA #5 during this conversation, got in bed with her this morning. The grievance investigation revealed that NA #5 stated he changed Resident #36's brief this am but there was another nurse aide (NA #6) in the room providing care to the roommate. NA #6 was interviewed and stated she was in the room providing care for the roommate and nothing inappropriately occurred.

The facility provided a 5 working day report of the investigation for resident abuse sent to the Health Care Personnel Registry (HCPR) which unsubstantiated this allegation. This form marked that there was no 24 hour initial report sent to HCPR. This form noted Adult Protective Services had investigated on 05/16/16.

An interview with the Social Worker (SW) and Administrator was conducted on 06/02/16 at 1:56 PM. The SW stated that she was informed by Nurse #6 that Resident #36 told a visitor about a nurse aide crawling in bed with her. She stated she identified NA #5 as the accused and asked

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him what care he provided and he stated he changed her. She then asked NA #6 who was in the room about the care that was provided and she reported NA #5 changed Resident #36 as she was helping the roommate. SW asked if there was anything unusual that occurred that would bother NA #6 to which she replied no. SW stated she then explained the situation to the corporate nurse and the previous administrator who stated there was no need to submit a 24 hour initial report regarding an allegation of abuse since it was determined immediately that the allegation was unsubstantiated. Therefore a 24 hour report was not sent to HCPR. She further stated that the following Monday, APS came to the facility to investigated an allegation of abuse with Resident #36 regarding this same issue so they decided to submit a 5 day report to the HCPR.

Review of the facility's investigation revealed the grievance form and 2 statements in the Clinical Alerts Listing Report (for nurse aide documentation). One note dated 05/12/16 at 2:12 PM stated "I was in the room with (NA #5) this morning while he was getting (Resident #36) ready for the day. While he was dressing (Resident #36) I was getting (name of roommate) out of bed, and ready for the day." Another note dated 05/12/16 at 2:59 PM "resident stated cna (nurse aide) 'climbed in bed with' her. cna had another cna in the room at time of incident working with resident's roommate. nurse alerted." SW stated during interview on 06/02/16 at 1:56 PM that she obtained a statement from the roommate, NA #5 and NA #6 but no other statements. The new Administrator, present during this interview, stated he expected statements would be gathered and documented

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F 226	Continued From page 14 as part of the investigation. SW stated that an allegation of a man getting in bed with a resident was considered an allegation of abuse. The Administrator stated there was a missing piece in how this incident was handled.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to repair scuffed walls with missing paint and torn wall paper on 3 of 5 halls, failed to repair resident room doors with broken and splintered wood on 1 of 5 halls, failed to repair fixtures including toilet paper holders in bathrooms and power outlet covers behind the bed on 2 of 5 halls. The facility also failed to repair scraped and frayed wheelchair arm rest for 2 of 14 observed residents' wheelchairs (Residents #2 and #17) and failed to replace chairs with frayed vinyl for 17 of 17 chairs in main dining room and activity room. Findings included: The findings included: 1. a. The following observations were related to scuffed dry walls with missing paint and torn wall paper: Observation of room 206 on 06/01/16 at 2:27 PM revealed a 4 inch (in.) x 4 in. spot of torn wall paper behind the headboard of bed B. This was observed again on 06/02/16 at 4:21 PM and on 06/03/16 at 2:27 PM.	F 253	1. The wall paper will be removed and the wall was repainted in room 206. The scuffed wall behind bed B in room 210 will be repaired and painted. The four exposed drywall areas behind bed A in room 405 will be repaired and painted. The hole and scuffed wall behind bed A in room 510 will be repaired and painted. The rough edges on room doors 503, 505, 512 and 513 will be sanded down and filled in with wood filler. The toilet paper holder in the bathroom of room #206 was replaced and fastened to the wall on 6-3-16. The broken electrical outlet cover in room 511 was replaced on 6-3-16. The frayed armrests on the wheelchairs for residents #17 and #2 will be replaced. The vinyl seats in the main dining room will be re-covered with new vinyl upholstery. These specified repairs will be completed by 7-7-16. 2. Other resident rooms and wheelchairs	7/7/16

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F 253	Continued From page 15 Observation of room 210 on 06/01/16 at 2:30 PM revealed the wall behind bed B was scuffed across from the bed. This was observed again on 06/02/16 at 4:22 PM and on 06/03/16 at 2:28 PM. Observation of room 405 on 06/01/16 at 2:45 PM revealed four round 4 in. areas on the wall behind bed A with exposed dry wall and missing paint. This was observed again on 06/02/16 at 4:27 PM and on 06/03/16 at 2:33 PM. Observation of room 510 on 06/01/16 at 3:06 PM revealed the wall behind bed A was scraped by the bed resulting in a 2 in. x 1 in hole in the wallpaper and multiple long scuffs. This was observed again on 06/02/16 at 4:40 PM and on 06/03/16 at 2:45 PM. b. The following resident room doors were observed with broken and splintered wood and visible rough edges: On 06/01/16 from 2:50 PM to 2:48 PM, the edges of the room door for rooms 503, 512, and 513 were observed splintered at both ends of the door with rough edges noted. This was observed again on 06/02/16 from 4:30 PM to 4:46 PM and on 06/03/16 from 2:41 PM to 2:48 PM. On 06/01/16 at 2:55 PM, the edges of the room door for room 505 were observed chipped mainly around the door knob area with rough edges noted. This was observed again on 06/02/16 at 4:31 PM and on 06/03/16 at 2:42 PM. c. The following observations were related to facility's failure to repair fixtures including toilet paper holders in bathrooms and power outlet cover behind the bed: Observation of the bathroom in room 206 on 06/01/16 at 2:27 PM revealed the toilet roll holder was missing components. A roll of toilet paper was observed sitting on top of the hand rails. This was observed again on 06/02/16 at 4:21 PM and on 06/03/16 at 2:27 PM.	F 253	will be inspected by the Administrator and Maintenance Director for similar issues and repair as needed. 3. The Administrator will educate all Department Heads how to use the Tels work order system on the company□s website to create new work orders for the Maintenance Department. The Department Heads will be assigned and make daily room rounds to detect and report any needed repairs to the Maintenance. 4. The Maintenance Director will submit a summary report of completed and pending Tels work orders each month for 3 months to the Quality Assurance committee for review. The Administrator will assure the effectiveness of the POC.	

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Observation of room 511 on 06/01/16 at 3:10 PM revealed a power outlet cover behind bed B with half of the plastic cover missing and cracked. This was observed again on 06/02/16 at 4:42 PM and on 06/03/16 at 2:46 PM.

d. The following observations were related to wheelchair with scrapped frayed arm rest:

On 06/01/16 at 2:55 PM, the right arm rest of Resident #17's wheelchair was observed frayed and ripped. This was observed again on 06/02/16 at 4:31 PM and on 06/03/16 at 2:42 PM.

In an interview with Resident #17 on 06/01/16 at 2:55 PM, he stated that the wheelchair right arm rest had been ripped and frayed for a few months. It bothered him as the ripped arm rest could sometimes lead to skin irritation.

On 06/01/16 at 3:10 PM, both arm rest of Resident #2's wheelchair was observed frayed and scrapped. This was observed again on 06/02/16 on 4:42 PM and on 06/03/16 at 2:46 PM.

e. The following observations were related to chairs with frayed vinyl in the main dining room and activity room:

Observations of the chairs in main dining room and activity room on 06/01/16 at 4:55 PM revealed all the chair seats covered in vinyl were frayed at the front and side edges. This was observed again on 06/02/16 at 4:48 PM and on 06/03/16 at 2:50 PM.

An interview was conducted with the Maintenance Manager on 06/03/16 at 1:55 PM. He stated the maintenance department consisted of him and his assistant. The Maintenance Manager reported he worked according to a priority of resident safety first, resident requests and then work orders. He normally made rounds and checked for new work orders several times daily.

After the interview, the Maintenance Manager

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F 253	Continued From page 17 was on a walking tour with the surveyor to residents' rooms identified with maintenance issues. The Maintenance Manager indicated he was unaware of all the issues. He stated that he was unable to complete proper maintenance in the facility if he was unaware of the problems requiring his attention. He further stated that the room doors were constantly being bumped into by wheelchairs and resident care equipment which made it difficult to keep up with painting and repairs. According to the Maintenance Manager, his current priority was to fix the wheelchairs as it could affect the Residents' quality of life. Regarding the chairs with frayed vinyl, he stated that he was fully aware of the issue and he was waiting for the pending authorization from corporate office to order new chairs. During an interview and walking tour on 06/03/16 at 3:02 PM, the Administrator stated that it was his expectation for residents' rooms, furniture, and fixtures to be in appropriate repair. He added that the communication system for work orders in the facility needed to be reviewed and strengthened to ensure its effectiveness.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278		7/7/16

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F 278	Continued From page 18 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to code the Minimum Data Set accurately to reflect dental status for 1 of 3 sampled residents reviewed for dental status and services (Resident #10). The findings included: Resident #10 was admitted on 04/18/16 with diagnoses including dementia. Review of the admission Minimum Data Set (MDS) dated 04/30/16 revealed Resident #10 was coded in the dental status section as not having and dental problems during the 7-day look back period. Possible options for coding in the dental status section included: broken or loosely fitting full or partial denture.	F 278	1. The initial MDS dental assessment for resident #10 was reviewed and it will be corrected on the next quarterly dental assessment by the MDS Director or her designee to reflect the missing tooth. 2. The MDS Director will review the dental assessments of 25 other residents for accuracy. Upcoming quarterly dental assessments will reflect any corrections. The MDS Director will re-educate the MDS assistant on doing accurate dental assessments. 3. The QA Nurse will review monthly for 3 months any new dental assessments done by the MDS assistant to assure accuracy.	

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F 278	Continued From page 19 Observations of Resident #10 on 06/02/16 at 11:09 AM revealed her top denture had a missing tooth. An interview with MDS Nurse #1 on 06/03/16 at 11:35 AM revealed when she completed the Oral/Dental Status section of the MDS she talked with the resident and examined the resident's oral cavity and their teeth or dentures for any abnormal findings. MDS Nurse #1 confirmed she had completed Resident #10's admission MDS including the Oral/ Dental Status section and coded Dental section as "none of the above were present." MDS Nurse #1 reviewed her notes from Resident #10's assessment and stated she had observed Resident #10 had a top denture and a few bottom teeth. MDS Nurse #1 observed Resident #10's teeth and denture at 11:40 AM and stated the lower teeth were worn and the top denture had a missing tooth. MDS Nurse #1 stated she should have coded the admission MDS to reflect the missing tooth from the top denture.	F 278	4. The QA Nurse will submit a summary of new dental assessments to the QA committee each month for 3 months for review. The Administrator will assure effectiveness of the POC.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to provide nail care for 1 of 3 residents reviewed for	F 312	1. The fingernails and toenails of resident #15 were trimmed by a LPN on 6-2-16.	7/7/16

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F 312	Continued From page 20 activities of daily living (Resident #15). The findings included: Resident #15 was admitted to the facility on 05/07/16 with diagnoses of heart failure, respiratory failure, diabetes and arthritis. Review of the admission Minimum Data Set dated 05/14/16 revealed Resident #15 was cognitively intact and required limited assistance with personal hygiene and extensive assistance with bathing. Review of the care plan dated 05/14/16 revealed Resident #15 had an activities of daily living (ADL) deficit related to recent functional decline due to acute illness and respiratory insufficiency. The goal was for Resident #15 to improve her current level of function in ADL, transfers, toileting and bed mobility with a goal of returning home with family. The interventions included bathing/showering with extensive assistance by staff 2 times each week and as necessary or requested by the resident and extensive assistance with personal hygiene and oral care. Observations made of Resident #15's fingernails and toenails throughout the survey revealed: · 05/31/16 10:40 AM - Fingernails on both hands were approximately ½ inch long. · 06/01/16 9:30 AM - Fingernails on both hands were approximately ½ inch long. · 06/02/16 1:59 PM - Fingernails on both hands approximately ½ inch long. Toenails on both feet were approximately ¼ inch long with the big toe and 3rd toe on both feet being approximately ½ inch long.	F 312	2. The fingernails and toenails of all other diabetic residents were trimmed by staff and/or referred to the Podiatrist. 3. The SDC Nurse will re-educate all C.N.A.s to communicate in a timely manner to the Charge Nurses any diabetic residents who need their fingernails or toenails trimmed. The QA Nurse will monitor the length fingernails and toenails of all diabetic residents each week for 4 weeks, then monthly for 3 months. 4. The QA Nurse will submit a summary of the monitoring results to the QA committee each month for 3 months. The Administrator will assure the effectiveness of the POC.	

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An interview was conducted on 05/31/16 at 10:34 AM with Resident #15. She stated she would like to have her fingernails and toenails trimmed because they were too long. She further stated they had not offered to trim her fingernails or toenails since being admitted to the facility.

During a follow up interview with Resident #15 on 06/02/16 at 1:59 PM she stated staff gave her a shower on 06/01/16 but did not offer to trim her fingernails or toenails.

An interview conducted on 06/02/16 at 2:30 PM with Nurse Aide (NA) #1 revealed she gave Resident #15 a shower on 06/01/16 but did not notice that her fingernails and toenails needed to be trimmed. NA #1 stated fingernails should be cleaned and trimmed on shower days and as needed, but she was running behind and didn't notice they needed to be trimmed. She further stated if a resident had diabetes, the NAs could not trim their toenails, but they report to the nurse that they needed to be trimmed.

An interview conducted on 06/02/16 at 4:32 PM with the West Unit Supervisor revealed the NA should provide nail care on shower days and as needed for residents and if a resident had diabetes, they should report to the nurse when their toenails need to be trimmed. She further stated residents should not have to ask to have nail care provided.

During an interview conducted on 06/02/16 at 4:45 PM the Director of Nursing (DON) revealed it was her expectation that nail care be provided to residents on their shower days and as needed without the resident having to ask.

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F 325	Continued From page 22	F 325		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and Dietary Manager and Registered Dietitian interviews the facility failed to evaluate and revise interventions for a resident with significant weight loss for 1 of 3 sampled residents reviewed for nutrition (Resident #49). The findings included: Resident #49 was admitted on 02/09/09 with diagnoses including dementia, Alzheimer's disease, thyroid disorder, dysphagia, and gastroesophageal reflux disease. Review of physician's orders revealed on 02/24/16 Resident #49 was ordered to receive 120 cc's (cubic centimeters) of a high protein/high calorie supplement at bedtime daily and a 4 ounce high calorie nutritional shake at bedtime daily.	F 325	1. The care plan for resident #49 was reviewed and updated by the facility□s interdisciplinary team to address the unplanned weight loss of more than 6.5% in one month. 2. All other resident weights were reviewed to detect any other significant weight losses in one month. As needed, facility□s interdisciplinary team updated the care plans to address any other significant weight losses in one month. 3. The Director of Nursing or her designee will re-educate the facility□s interdisciplinary team to address and implement interventions that will stabilize residents with significant weight loss. The QA Nurse or her designee will monitor all weekly and monthly weights for 3 months and report any significant weight losses	7/7/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

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F 325	Continued From page 23 Review of the significant change Minimum Data Set (MDS) dated 02/25/16 revealed Resident #49 had severely impaired cognition and required limited assistance with eating. The significant MDS further revealed Resident #49 weighed 143 pounds and there was no weight loss noted. The significant change MDS also indicated Resident #10 was edentulous and received a mechanically altered diet. Review of a care plan dated 03/04/16 revealed Resident #49 had the potential for nutritional problems due to her modified diet and and leaving more than 25% of food uneaten. The goal was for Resident #49 to maintain current weight within ideal body weight range and consuming at least 50 to 75% of at least 2 meals daily through the next review date. The care plan noted Resident #49's current weight was 143.8 pounds and she received a pureed diet with 3 slices of bread at every meal. Interventions included in part: invite the resident to activities that promote additional intake, monitor/record/report to the physician any significant weight loss of greater than 5% in one month, monitor and record intake every meal, and for the Registered Dietitian to evaluate and make diet change recommendations as needed. Review of the medical record revealed the following recorded weights for Resident #49: *03/04/16 - 144 pounds *04/05/16 - 144 pounds *05/05/16 - 135 pounds (6.25% weight loss in 30 days) Continued review of the medical record revealed a weight warning note entered by the Dietary Manager (DM) on 05/16/16. The DM noted	F 325	for the interdisciplinary team to address. 4. The QA Nurse will submit a summary of the monitoring results to the QA committee each month for 3 months. The Administrator will assure the effectiveness of the POC.	

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F 325	Continued From page 24	F 325		

Resident #49 weighed 135 pounds decline was expected due to dementia. There was no review of meal consumption or current interventions to prevent further weight loss.

Review of a nutrition noted dated 06/01/16 revealed the DM documented Resident #49 currently received a pureed diet, nutritional supplements at bedtime, and ate her meals in the assisted dining room. The DM noted Resident #49 had some weight loss from the previous month but decline was expected due to the progression of dementia and Alzheimer's disease. The plan was to continue the ordered diet and supplements and to continue to monitor intake, weights and laboratory test results.

An interview with the DM on 06/03/16 at 3:03 PM revealed residents were weighed at least monthly and she typically reviewed the monthly weights by the 5th of every month. The DM further stated the Registered Dietitian (RD) came to the facility every Wednesday and typically assessed new admissions, readmissions and residents with tube feedings, wounds, dialysis, and significant weight loss. The DM explained that she highlighted residents with significant weight loss on the weekly and monthly weight summaries and gave this information to the RD during her weekly visits. The DM reviewed Resident #49's monthly weight summary and confirmed there was a significant weight loss of greater than 5% in 30 days noted on 05/05/16. The DM stated she documented the weight warning note on 05/16/16 so there was a record of the weight loss. The DM further stated she did not consider making any changes to Resident #49's diet or supplements when she wrote the weight warning note on 05/16/16 because Resident #49 was already in

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F 325	Continued From page 25 the assisted dining room for meals, received 3 slices of bread with every meal, and had supplements at bedtime. The DM could not recall if she alerted the RD to Resident #49's significant weight loss after she reviewed the 05/05/16 weight summary. The DM reviewed the medical record and confirmed the RD had not documented on Resident #49 since the weight loss was noted on 05/05/16. During a telephone interview on 06/03/16 at 3:39 PM the RD stated she came to the facility every Wednesday and the DM gave her the weekly/monthly weight summaries to review for significant weight loss. The RD did not have access to the facility's weight summaries during the interview but did not recall assessing Resident #49 for significant weight loss recently. Resident #49's weights recorded on 04/05/16 and 05/05/16 were relayed to the RD over the phone and she confirmed the weight loss would represent a significant weight loss of greater that 5% in 30 days. The RD could not explain how she had missed Resident #49's significant weight loss but stated she would need to assess Resident #49, review her current diet and supplement orders, and decide what additional interventions were needed to prevent further weight loss.	F 325		
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	F 371		7/7/16

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F 371	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to air dry 13 out of 13 observed cups and 19 out of 19 observed bowls to prevent bacterial growth. The findings included: On 06/02/16 at 10:02 AM kitchen observations were made which included observations of the drying system for dishes, bowls and cups. There were 19 bowls stored upside down and 13 cups stored upside down directly on flat plastic trays. Observation revealed that each bowl and each cup was wet inside and not receiving air flow to help them dry. The dietary aide in the dishwashing area stated at this time that the cups and bowls were always stacked wet, upside down to dry on the trays. She further stated that they used to have mats that lined the trays that the cups and bowls sat on but not any more. A follow up interview at this time with the Dietary Manager revealed that a few months ago the drying mats were thrown out due to excessive wear and tear and replacements had not been reordered. At this time she instructed staff to leave the cups and bowls in the dishwasher crates they were washed in until they were dry.	F 371	1. The bowls and cups coming out of the dishwasher were left in the dishwashing crates until dry rather than storing them on plastic trays while being wet. 2. The Dietary Manager assessed all other items coming out of the dishwasher to assure that all items were dry before being stored on any trays or shelves. 3. The Dietary Manager ordered the purchase of 11 drying racks to be used for drying and storing all cups and bowls after being washed in the dishwasher. The Dietary Manager will educate dietary staff on how to use the drying racks. The QA Nurse will monitor the use of the drying racks daily for 4 weeks and then monthly for 3 months. 4. The QA Nurse will submit a summary of the monitoring results to the QA committee each month for 12 months. The Administrator will assure the effectiveness of the POC.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		7/7/16

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F 431	Continued From page 27 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to discard an expired over the	F 431	1. The over the counter aspirin with an expiration date of April 2016 was removed	

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F 431	Continued From page 28 counter medication ready for use in 1 of 4 medication carts. The findings included: Observations made on 06/03/16 at 11:00 AM of the 500 hall medication cart revealed 1 opened bottle of aspirin 325mg with an expiration date of 04/2016. The aspirin 325mg had an opened for use handwritten date of 04/04/16 on the bottle. An interview conducted on 06/03/16 at 11:07 AM with Nurse # 1 revealed she did not have any residents on the 7:00 AM to 7:00 PM shift that received the aspirin 325mg. Nurse #1 stated the expiration date should be checked each time a medication was given. She stated she had checked the medication cart for expired medications, but must have missed the aspirin. She further stated they date the bottle of medications when they are opened and the bottle of aspirin 325mg should have been sent back to the pharmacy instead of being opened on 04/04/16 since it was due to expire at the end of 4/2016. An interview conducted on 06/03/16 at 3:28 PM with the Director of Nursing (DON) revealed the pharmacy checked the medication carts once a month for expired medications. She further stated it was the nurse's responsibility to check their carts each day for expired medications and discard them.	F 431	from the 500 hall medication cart and disposed. 2. All other medication carts and med rooms were audited by the facility's Pharmacy Consultant on 6-29-16 for any expired medications. No other expired medications were found. 3. The facility policy and procedure for Medication Administration was reviewed by the Clinical IDT and Medical Director. The Director of Nursing will in-service the licensed nursing staff on the policy and procedure for monitoring for expired medications. * During med passes, medications will be assessed to determine that the medications are still within use dates. * Any medications that are expired will be pulled from stock and reordered or replaced (this includes pharmacy supplied and house stock). * Each week, the DON or her designee will review the medication carts and medication rooms for any expired medications/supplies using a QA tool for 4 weeks, then monthly thereafter for 12 months. * Pharmacy Consultant will perform random audits during facility visits to monitor for expired medications. The Pharmacy Consultant reports will be reviewed with the DON. 4. The DON will provide the results of the expired medication QA tools and Pharmacy Consultant reports to the QA Committee for review. The Administrator	

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F 431	Continued From page 29	F 431	will assure the effectiveness of the POC.	
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 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, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in July 2015. This was for two recited deficiencies that were originally	F 520	1. The POC for F 371 and F 431 shown above requires the QA Nurse to submit to the QA committee a summary of monitoring results for air drying wet bowls and cups and expired medications each month for 12 months.	7/7/16

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F 520	Continued From page 30 cited in July 2015 and subsequently cited in June 2016 on the recertification survey. The repeated deficiencies were in the areas of food procurement, storage, preparation, and distribution and labeling and storage of drugs. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tags were cross referred to: 1a. F 371: Food procurement, storage, preparation, and distribution: Based on observations and staff interviews, the facility failed to air dry 13 out of 13 observed cups and 19 out of 19 observed bowls to prevent bacterial growth. The facility was recited for F 371 for failing to air dry cups and bowls properly in kitchen to prevent bacterial growth. F371 was originally cited during the July 2015 recertification survey for failing to label or date breaded meat patties and sweet potato fries in plastic bag during an observation in the walk-in freezer. b. F 431: Labeling and storage of drugs: Based on observations and staff interviews the facility failed to discard an expired over the counter medication ready for use in 1 of 4 medication carts. The facility was recited for F 431 for failing to remove an opened bottle of expired aspirin from a medication cart. F 431 was originally cited during the July 2015 recertification survey for failing to discard one expired vial of Tuberculin aplisol, two bottles of glucosamine sulfate, one bottle of aspirin, and one bottle of Magnesium oxide. An interview was conducted with the Administrator on 06/03/16 at 5:14 PM. The	F 520	2. The facility□s COR review process each month will focus on potential issues pertaining to F 371 and F 431. 3. The Administrator or his designee will monitor the audits of air drying of bowls, cups the kitchen each month. The Director of Nursing or her designee will monitor expired medication audits each month. 4. The monthly QA committee minutes will be submitted to the company□s corporate office each month for 12 months for additional oversite.	

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F 520	Continued From page 31 Administrator stated the facility's Quality Assurance (QA) Committee had met monthly since the 2015 recertification survey to discuss the monitoring and progress for all the citations. In regards to the wet cups/bowls in the kitchen, the Administrator stated it was his expectation for the Dietary Manager to reorder the drying mats instead of instructing staff to leave the cups and bowls in the dishwasher crates for drying. According to the Administrator, the pharmacy checked the medication carts for expired medications once a month. It was the nurse ' s responsibility to check their respective carts daily for expired medications and discard them. The Administrator added the recent transitions in management had compromised the effectiveness of QAA committee.	F 520		