STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-HENDERSON	280 SOUTH BECKFORD DRIVE HENDERSON, NC 27536

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility staff failed to prevent a resident ' s skin exposure as observed from the hallway for 1 of 3 residents (Resident #63) reviewed for dignity. The findings included: Resident #63 was initially admitted to the facility on 4/17/12. The resident re-entered the facility on 2/26/16 from the hospital. Her cumulative diagnoses included dementia with behavioral disturbance and muscle weakness. Resident #63 ' s most recent quarterly Minimum Data Set dated 7/5/16 revealed the resident had severely impaired cognitive skills for daily decision making. The resident was totally dependent on staff for all of her Activities of Daily Living (ADLs), with the exception of requiring limited assistance only for eating. An observation was made from the common residence hallway into the Resident #63 ' s room on 8/2/16 at 1:38 PM. The resident was observed to be lying on her back in her bed near the doorway (Bed A). The door to the room was approximately ½-way open. The privacy curtain was not pulled. A blanket was covering the right	F 241	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law. F 241 8/30/16 1. Resident #63 was assessed for any emotional distress after being exposed after resident care was provided. No distress noted. Education was provided to the involved current staff on providing dignity for current residents. 2. In-service provided to staff regarding dignity. Audit conducted of all residents of all residents at risk of having skin exposed. No other residents affected. 3. Ongoing staff reinforcement and education regarding dignity. Designated Nurse Management will conduct weekly audits 5 days a week x 4 weeks: then 3	8/30/16

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

Electronically Signed | 08/26/2016

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F 241	Continued From page 1 side of the resident ' s body only; the left side of her body was uncovered. Resident #63 was observed to have her left leg bent at the knee with her leg, thigh, and left side of her buttock exposed. No clothing or bed coverings were pulled over her exposed body parts. A continuous observation was made from the common hallway on 8/2/16 from 1:38 PM to 2:03 PM. --At 1:38 PM a male staff member walked past Resident #63 ' s room; --At 1:39 PM two female staff members walked by Resident #63 ' s room; --At 1:42 PM a male staff member walked past Resident #63 ' s room; --At 1:46 PM a female staff member walked past Resident #63 ' s room; --At 1:48 PM NA #1 walked past Resident #63 ' s room; --At 1:49 PM NA #1 entered the resident ' s room at 1:49 PM to pick up a dirty lunch tray, then exited the room without covering Resident #63 ' s exposed body; --At 1:50 PM a male staff member walked past Resident #63 ' s room; --At 1:50 PM, NA #1 rolled a high boy containing dirty lunch trays past the resident's room; then went back down the hall in the other direction, passing Resident #63 ' s room a second time; --At 1:54 PM, NA #1 walked past Resident #63 ' s room as she dropped off linens to another resident ' s room; --At 1:55 PM, a male staff member walked past Resident #63 ' s room. On 8/2/16 at 1:55 PM, another surveyor observed Resident #63 from the common residence hallway. The door to the resident ' s room was	F 241	days per week x 4 weeks: then weekly observations to ensure resident's dignity is being maintained. 4. Director of Nursing will report results of audits for review during the monthly Quality Assurance & Performance Improvement Committee Meeting for next 12 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits beyond 12 months.	

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F 241	Continued From page 2	F 241		

approximately ½-way opened. The privacy curtain was not pulled. The resident was observed as having her left leg, thigh, and side of her left buttock exposed.

During the period of continuous observation, one male visitor was observed to be in a resident ' s room across the hallway from Resident #63 ' s room. A second male visitor was seated on a chair in the hallway one doorway down from Resident #63 ' s room.

On 8/2/16 at 1:58 PM, Nurse #1 was observed as she went into Resident #63 ' s room. At 2:00 PM, visitors entered Resident #63 ' s room. At 2:03 PM, Nurse #1 exited the resident ' s room.

An interview and observation was conducted on 8/2/16 at 2:04 PM with Nurse #1. Upon inquiry, the nurse reported she had just attended to the resident in Bed B (Resident #63 ' s roommate). The door to the room remained ½-way opened. At the time of the observation, the resident ' s left leg, thigh, and left side of her buttock continued to be exposed. Nurse #1 stated the resident ' s covers needed to be pulled over her.

An interview was conducted on 8/2/16 at 2:15 PM with NA #1. NA #1 was the 1st shift nursing assistant assigned to care for Resident #63. NA #1 stated she had just finished providing incontinence care to Resident #63 upon request of the resident ' s visitors. The nursing assistant reported the resident was covered when she left the room.

On 8/2/16 at 2:40 PM, Resident #63 was observed to be sleeping quietly in bed. She was covered with a blanket and appeared comfortable

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F 241	Continued From page 3 at the time of the observation. An interview was conducted on 8/4/16 at 2:50 PM with the facility's Administrator. During the interview, the observations made of Resident #63 on the afternoon of 8/2/16 were discussed. The Administration responded, "That's a dignity issue. My expectation is that they (residents) be covered at all times." A follow-up interview was conducted on 8/4/16 at 3:30 PM with NA #1. During the interview, the NA reported Resident #63 uncovered herself on occasions and stated staff needed to cover the resident back up when she was uncovered. Upon further inquiry regarding the resident ' s exposure on the afternoon of 8/2/16, NA #1 stated she did not recall noticing the resident ' s body had been uncovered.	F 241		
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, record review and resident and staff interviews the facility failed to honor Resident #58 choice to be served non sugared dry cereal at breakfast. The facility failed to honor Resident #10 request for apple pie	F 242	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	8/30/16

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F 242	Continued From page 4 served at lunch. This was evident in 2 of 2 residents in the sample reviewed for choices. Findings included: 1. Resident #58 was admitted to the facility on 8/25/11 with cumulative diagnoses which included diabetes mellitus. Review of the physician orders revealed Resident #58 was prescribed a limited concentrated sweets/no added salt diet. Review of the standing orders noted on the meal slip revealed Resident #58 to be served ¾ cup cornflakes on Tuesday, Thursday, Saturday and Sunday and ¾ cups of dry oak cereal on Monday, Wednesday and Friday. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/23/16 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was alert and oriented. Review of the revised care plan dated 7/5/16 revealed at risk for nutritional decline as a focus. One of the interventions included to determine resident ' s food/beverage preferences. Interview on 08/02/2016 at 10:5 AM with Resident #58 revealed he always was served sugar coated corn flakes at breakfast. Resident #58 stated that dietary was informed he wanted plain corn flakes only. Continued interview with Resident #58 who stated " I want to add my own sweetener." Observation on 08/03/2016 at 8:40 AM at breakfast revealed sugar coated corn flakes was	F 242	deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law. F242 1. Resident #58 and #10 food preferences were reviewed with the resident to ensure current. Staff were re-educated regarding honoring food choices. 2. In-services provided to Dietary staff immediately in regards to Food Choices. A random audit of selected residents was performed to evaluate if food choices were honored. Director of Nursing and Dietary Manager will review with residents their food preferences. Culinary Staff will perform daily rounds with random and affected residents to ensure food choices are being honored. 3. Culinary Manager will perform weekly audits 5 days a week x 4 weeks: then 2 days a week x 2 weeks, then weekly to assess if food choices are being honored. 4. Culinary Manager will report results of audits for review during the Quality Assurance and Performance Improvement Committee for next 3 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits beyond 3 months.	

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served on Resident #58 ' s tray.

Observation on 08/04/2016 at 9:05 AM revealed Resident #58 again received sugar coated corn flakes. Interview with Resident #58 at the time of this observation stated he was served sugar coated corn flakes at breakfast all week.

An interview was conducted on 8/4/16 at 9:24 AM with the facility ' s Social Worker. Upon request, the Social Worker provided a list of residents within the facility who were interview candidates and considered to be good historians. Resident #58 was listed as one of the residents identified as interviewable.

Interview on 08/04/2016 at 9:20 AM with the Food Service Manager (FSM) revealed Resident #58 wanted to add his own sweetener and she expected staff to serve unsweetened corn flakes. The FSM stated " We (referring to the facility) may have been out of the plain cornflakes.

Interview on 08/04/2016 at 10:38 AM with the administrator revealed she spoke with Resident #58 who indicated he went to the kitchen to get the correct cereal of choice this week. The administrator indicated she expected the resident's choice be honored and be served the cereal of his choice.

2) Resident #10 was initially admitted to the facility on 4/4/13. She re-entered the facility on 5/18/16 from a hospital with a cumulative diagnoses which included Type 2 diabetes.

A review of the resident's medical record revealed Resident #10 was ordered the following diet on 5/18/16: Limited Concentrated Sweets, No

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Added Salt, Regular textures.

Resident #10's most recent quarterly Minimum Data Set (MDS) assessment dated 6/28/16 revealed the resident had intact cognitive skills for daily decision making. The resident ' s assessment of her Activities of Daily Living revealed she required extensive assistance for bed mobility, transfers and toileting; supervision for walking, locomotion and eating; and was independent for dressing and personal hygiene. Section K of the MDS assessment indicated the resident received a therapeutic diet.

An interview was conducted on 8/4/16 at 9:24 AM with the facility ' s Social Worker. Upon request, the Social Worker provided a list of residents within the facility who were interview candidates and considered to be good historians. Resident #10 was listed as one of the residents identified as interviewable.

Upon Resident #10 ' s request, an interview was conducted with the resident in her room on 8/4/16 at 1:10 PM. During the interview, the resident stated she had diabetes and was served unsweetened applesauce for dessert at her noon meal in the Dining Room today. The resident reported she noticed some residents in the Dining Room were served a slice of apple pie for dessert. She stated she requested a small piece of apple pie for dessert and was told she could not have it. The resident reported she felt she should be able to make that choice because, "I'm in my right mind. I should be able to get what I want to eat."

An interview was conducted with Nursing Assistant (NA) #2 on 8/4/16 at 1:13 PM. NA #2

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had been working in the Dining Room during the lunch meal service. Upon inquiry, NA #2 recalled another nursing assistant (NA #3) had actually gone to the kitchen to get Resident #10 a piece of pie and was reportedly told the resident couldn't have it.

An interview was conducted on 8/4/16 at 1:14 PM with NA #3. NA #3 confirmed she requested a piece of pie from the kitchen for Resident #10 and was told by a kitchen staff member the resident could not have it. Upon inquiry, NA #3 identified Dietary Aide #1 as the employee in the kitchen who told her the resident could not have the pie.

At 1:14 PM on 8/4/16, the facility ' s Administrator was observed as she carried a piece of pie down the residence hallway and entered Resident #10 ' s room.

An interview was conducted with Dietary Assistant #1 on 8/4/16 at 1:15 PM. During the interview, inquiry was made in regards to Resident #10's request for pie at lunchtime. The dietary assistant confirmed she told the nursing assistant who came to the kitchen for the pie that Resident #10 could not have a piece of pie because she was on a diabetic diet. She acknowledged she did not send out a piece of pie for the resident when it was requested.

A follow-up interview was conducted with Resident #10 on 8/4/16 at 1:18 PM in her room. The resident was observed to be eating a piece of apple pie the facility ' s Administrator had just delivered to her. Upon entry into the room, the resident smiled and said, "Thank you." Resident #10 reiterated her concern about the facility not

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honoring her " choices " and stated she felt strongly she should be able to get a dessert if she requested it. Upon inquiry, the resident stated she had been denied food items under similar circumstances "a lot." She reported this had been a particular problem over the past two months or so.

An interview was conducted with the Administrator on 8/4/16 at 1:23 PM. During the interview, the Administrator stated the concern regarding resident food choices was " an education issue with the staff. " The Administrator reported her expectation was for the Dietary Department to honor residents ' choices for food.

An interview was conducted with the Culinary Manager on 8/4/16 at 1:48 PM. During the interview, the Culinary Manager reported food items on resident meal trays were sent out in accordance with the resident ' s therapeutic dietary restrictions. However, the Culinary Manager also stated that food choices needed to be honored for residents able to make their own decisions, even if the food item was not on his/her therapeutic diet. The Culinary Manager stated she herself typically handled a resident ' s request for food items not on his/her therapeutic diet, but noted she was not involved in the situation at lunchtime with Resident #10. The Manager stated if she would have received Resident #10 ' s request for pie, she would have gone out to the dining room and talked with the resident. The Manager reported she would have provided education to Resident #10 and if the resident still wanted the apple pie, she would have given it to her.

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F 273	Continued From page 9	F 273		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within fourteen (14) days of admission for one (1) (Resident #127) of five (5) sampled residents. Findings included: Resident #127 was admitted to the facility on 7/14/16. Admitting diagnoses included hypertension, chronic obstructive pulmonary disease, major depressive disorder, anxiety disorder, and displaced fracture of the lateral malleolus of the right fibula (the right ankle). A review of the 14 Day MDS for Resident #137 dated 7/28/16 revealed the 14 Day MDS was in progress. Sections C, D, and, E were the only sections marked complete. An interview with the MDS Coordinator was conducted on 8/3/16 at 1:15 PM. She stated Social Work completed Sections C, D, and E, but all other sections were completed by the MDS	F 273	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law F273 1. Resident #137 – this 14 day MDS was completed and transmitted. 2. An audit was conducted to ensure 14 day assessments completed timely on Medicare residents. All 14 Day assessment had been completed. MDS team have been in-serviced regarding assessment completion dates. 3. The MDS Coordinator with the IDT team will review the MDS schedule weekly at Medicare meeting to ensure current residents have a scheduled 14	8/30/16

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F 273	Continued From page 10 nurse. She stated she was not available to the facility from 7/8/16 through 7/19/16. She stated, " We are trying to catch up on the MDS records. We are in the process of training a unit supervisor to also do MDS part-time. We also utilize a retired MDS nurse who comes in to help us if we fall behind, and she has been here helping us. That resident (Resident #137) is on the list to get completed. We are doing our best to catch up. I do see the only completed MDS for this resident (Resident #137) was her entry MDS. " An interview was conducted with the facility Administrator on 8/3/16 at 1:25 PM. She stated, " I expect the MDS to be completed accurately and in a timely manner. We have had some challenges training a part-time MDS nurse. She is also a unit supervisor so we have had some issues getting her trained. We will get the 14 day MDS completed for this resident (Resident #137) today. "	F 273	day assessment and that it is completed timely. The schedule will be reviewed and attached to the MDS Medicare audit weekly. Once assessment for the 14 day is competed and transmitted for residents, the Batch results will be reviewed at the following Medicare meeting x 4 weeks: then monthly x 3 months. 4. Monthly for a minimum of 3 months, the MDS Coordinator will report the results of the audits to the Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing , beyond 3 months period.	
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 assessment must sign and certify the accuracy of that portion of the assessment.	F 278		8/30/16

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F 278	Continued From page 11 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 record review and staff interviews, the facility failed to the facility failed to accurately code an antiplatelet drug (Clopidogrel) and coded it as an anticoagulant medication for 1 of 5 residents (Resident #8) reviewed for unnecessary drugs. Findings included: Resident #8 was admitted 10/413. Cumulative diagnoses included: unspecified sequelae of cerebrovascular disease, paraplegia, diabetes mellitus, chronic osteomyelitis, unspecified psychosis, urinary tract infection, and non-pressure chronic ulcer of unspecified foot. A review of the quarterly Minimum Data Set (MDS) dated 7/5/16 revealed Resident #8 was cognitively impaired, has no behaviors or rejection of care, is totally dependent on staff for all activities of daily living (ADLs), and has upper and lower limb impairments on both sides. It was	F 278	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law F278 1. Resident #8 had an MDS modification completed to include Plavix as an antiplatelet. 2. An audit was conducted to ensure current residents with the following medication have been coded correctly. At the conclusion of the audit, no other residents on Plavix were incorrectly coded. An in-service was conducted with	

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	345344	A. BUILDING _____ B. WING _____	08/04/2016

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F 278	Continued From page 12 noted in the medications section of the MDS that Resident #8 received anticoagulants 7 out of 7 days during the look back period. A review of the physician orders dated 7/1/16 through 7/31/16 revealed: Clopidogrel (Plavix) 75 milligrams (mg) by mouth (po) daily (qd). A review of the Medication Administration Records (MAR) dated 7/1/16 through 7/31/16 revealed Resident #8 received Clopidogrel 75mg each day. An interview was conducted on 8/4/16 at 11:15AM with the MDS Coordinator. She stated, "We don't take any classes for medication classifications. I have a list telling me what medications are anticoagulants, antianxiety, and so. If I have a question about a medication, I also look it up on the internet or use the drug book. I can also call the pharmacy. I don't see any anticoagulants for this resident (Resident #8). She's on Plavix (Clopidogrel) which is an anti-platelet, not an anticoagulant. We sometimes bring in a retired MDS nurse (MDS Nurse 1) to help us out, and she completed this MDS. I typically don't review her work." An interview was conducted with MDS Nurse 1 on 8/4/16 at 11:45AM. She stated, "The MDS coordinator told me you wanted to talk to me about coding a resident (Resident #8) for receiving an anticoagulant 7 out of 7 days when she is taking Plavix. I made a mistake. I try not to, but sometimes I make mistakes. She should not be coded for receiving an anticoagulant if she is on Plavix because that is an antiplatelet, not an anticoagulant. I get the information for the MDS from the medical record, activity of daily living	F 278	MDS Coordinators regarding proper coding of Plavix. 3. The MDS Coordinator with the IDT team will review all new admissions at morning clinical meeting to ensure MDS Coordinator has current residents on Plavix are coded correctly. This will be documented on MDS Audit log for residents on Plavix. Once MDS is completed for residents with Plavix, the completed MDS will be reviewed at the weekly Medicare Meeting weekly before transmission x 4 weeks, then monthly x 3 months for accuracy. 4. Monthly for a minimum of 3 months, the MDS Coordinator will report the results of the audits to the Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing: and determine the need for further auditing, beyond the 3 months period.	

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F 278	Continued From page 13 (ADL) sheets, physician progress notes and orders, the computer, discharge summaries, lots of places. We use a list that tells us what classification certain medications are. I also use a drug reference book. I guess I just made a mistake." An interview with the Administrator was conducted on 8/3/16 at 1:25 PM. She stated, "I expect the MDS to be completed accurately and in a timely manner. "	F 278		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility: 1) Failed to maintain sanitary conditions in the kitchen by failing to clean a ceiling vent over one of one steam tables and the outside of one of one range hoods in the kitchen; 2) Failed to remove unlabeled, undated, and discolored meat products stored in 1 of 1 walk-in freezers; 3) Failed to remove an expired food item from refrigeration in 1 of 1 walk-in refrigerators; and, 4) Failed to label, date, and store food products in sealed containers in 1 of 1 dry storage areas.	F 371	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law F371	8/30/16

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F 371	Continued From page 14 The findings included: 1) An observation of the kitchen conducted on 8/3//16 at 10:10 AM revealed a ceiling vent located partially over the steam table had an accumulation of gray particles clinging to and hanging from the vent. An observation was also revealed the top of range hood in the food preparation area had an accumulation of gray-brown matter. The gray-brown matter on the range hood was tacky to the touch. An interview was conducted with the Culinary Manager on 8/3/16 at 10:15 AM. Upon inquiry, the Manager stated the Maintenance Department was responsible to clean the vents and the outside of the range hood in the kitchen. An interview was conducted on 8/3/16 at 10:25 AM with Maintenance Staff Member #2. Upon observation of the vent and range hood, the maintenance staff member stated the gray-brown accumulation on these areas was " collected and accumulated dust. " The staff member stated he had last cleaned the kitchen vents and hood 3 months ago. When asked if he thought the cleaning schedule was frequent enough based on the morning ' s observation, he stated, " No. " The maintenance staff member indicated the cleaning of the outside of the hood and vents was a shared responsibility between the Housekeeping, Maintenance, and Dietary Departments. When asked, both the Culinary Manager and Maintenance Staff Member #2 acknowledged the observations were concerning due to their proximity to the food preparation area.	F 371	1. The following was completed: A. Ceiling vents and range hood were cleaned immediately. B. Hot dogs in question were discarded C. Parmesan cheese was discarded D. Corn meal was discarded E. Biscuit Mix was discarded and container replaced with new containder.. 2. Cooks and Dietary Aides were in-serviced on labeling and dating procedures, storage guidelines, cleaning procedures and the kitchen cleaning schedules by the Culinary Manager. The daily, weekly and monthly cleaning schedules have been reposted and staff has been re-educated on the responsibility of the kitchen staff in regards to cleaning. 3. An audit of the daily and weekly cleaning schedules will be conducted weekly for 12 weeks to ensure compliance and identify area of improvement, as needed. The Dietary Manager will randomly audit for correct storage, labeling and dating in dry storage daily 5 times a week x 4 weeks; then weekly for 4 weeks to ensure compliance and identify areas of improvement. The ED will make weekly rounds with the Culinary Manager of the kitchen to monitor for correct labeling and dating of dry storage and cleanliness through the daily, weekly and monthly schedules for 12 weeks to ensure compliance. 4. The QA Committee will discuss and review the results for a minimum of 3 months. QA committee will review audits to ensure compliance is on-going and to	

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F 371	Continued From page 15 An interview was conducted on 8/3/16 at 11:18 AM with Maintenance Staff Member #1. Based on the observation of the kitchen vent and range hood, the staff member was asked if cleaning these areas once every 3 months was sufficient. Maintenance Staff Member #1 said, " No, there was an accumulation of grease ...probably need to clean it every 6 weeks or so. " An interview was conducted on 8/4/16 at 6:55 AM with the facility ' s Administrator upon her request. The Administrator reported the kitchen vents and range hood would be added to the cleaning schedule once every month. A follow-up interview was conducted on 8/4/16 at 11:45 AM with the Culinary Manager. During the interview, the Manager reported the responsibility for cleaning the vents and outside of the range hood had transitioned over from the Housekeeping Department to the Maintenance Department over the past year, with maintenance assuming the responsibility in the past 3-6 months. The Manager stated a cleaning schedule had been initiated for the hood (outside area) and the vents in the kitchen to ensure they were taken care of on a timely basis. 2) An initial tour of the kitchen was conducted with the Culinary Manager on 8/1/16 at 11:05 AM. During the tour of the walk-in freezer, a large plastic bag containing 6 hot dogs was observed. The plastic bag was not labeled or dated as to when it had been opened. The hot dogs appeared discolored; and, the plastic bag containing the hot dogs had approximately 1/2 cup of ice crystals in the bottom of the bag that covered the hot dogs, making it difficult to visualize and count them. Upon inquiry, the	F 371	determine the need for further audits beyond 3 months.	

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F 371	Continued From page 16 Culinary Manager stated the hot dogs would be thrown away A follow-up interview was conducted on 8/4/16 at 11:45 AM with the Culinary Manager. During the interview, the Manager reported the department ' s policy and practice was to label and date all food items. She stated once a food product was opened, it should be put into the appropriate container, labeled and dated. 3) An initial tour of the kitchen was conducted with the Culinary Manager on 8/1/16 at 11:05 AM. During the tour of the walk-in refrigerator, a 1-gallon plastic storage bag was labeled as containing Parmesan cheese. The plastic bag was dated 6/7/16. Upon inquiry as to what the use-by date was for the Parmesan cheese, the Culinary Manager stated she thought it was one month but would have to check to be sure. A follow-up interview was conducted on 8/4/16 at 11:45 AM with the Culinary Manager. During the interview, the Manager reported the department ' s policy and practice was to label and date all food items. She stated once a food product was opened, it should be put into the appropriate container, labeled and dated. The Culinary Manager reported the company ' s storage guidelines for Parmesan cheese indicated once opened, it should be kept for only 3-4 weeks under refrigeration. She acknowledged the Parmesan cheese found in the walk-in refrigerator (dated as opened 6/7/16) was past the recommended use-by date. 4) An initial tour of the kitchen was conducted with the Culinary Manager on 8/1/16 at 11:05 AM. During the tour of the dry storage area, an	F 371		

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F 371	Continued From page 17 opened 25 pound bag of yellow corn meal dated 7/20/16 was observed to be stored in the original bag with the sack folded over; it was not sealed. Upon inquiry, the Manager stated that the corn meal would be discarded as they were not planning to use it anyway. During the initial tour of the dry storage area, a plastic container with a white flour-like powder was noted as having the lid placed loosely on top of container (not sealed). The container was labeled or dated. Upon inquiry, the Culinary Manager reported the container next to the one in question was the " correct container " for a biscuit mix and the unsealed, undated container would be discarded. A follow-up interview was conducted on 8/4/16 at 11:45 AM with the Culinary Manager. During the interview, the Manager reported the department ' s policy and practice was to label and date all food items. She stated once a food product was opened, it should be put into the appropriate container, labeled and dated.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		8/30/16

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F 520	Continued From page 18 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 and staff interview the facility failed to maintain a Quality Assessment and Assurance (QAA) Committee to maintain implemented procedures and monitor interventions previously put into place on August 27, 2015 in order to achieve and sustain compliance in the area of dignity. This failure was related to a deficiency originally cited in August 27, 2015 on an annual recertification survey and was recited during the facilities annual recertification survey and complaint investigation dated 08/04/2016. The recited deficiency was in the area of resident dignity. The facility ' s continued failure during the recertification and complaint investigation showed a pattern of the facility ' s inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F241: Dignity. Based on record review, observations and staff interviews the facility staff failed to prevent a resident ' s skin exposure as	F 520	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provision of federal and state law F520 1. Current residents have the ability to be affected. 2. A Quality Assurance meeting will held on 8/29/16 to ensure committee addressed dignity and review the ongoing staff reinforcement and education for staff and any newly hired staff. All staff will be in-serviced on Dignity. 3. Monthly Quality Assurance meetings will be conducted to review and discuss facility adherence to maintaining a	

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F 520	Continued From page 19 observed from the hallway for 1 of 3 residents (Resident # 63) reviewed for dignity. During the recertification survey of 08/27/2015, the facility was cited for F 241 for failing to wait, after knocking to receive permission to enter resident rooms to maintain dignity. On the current recertification survey the facility was re-cited for failing to prevent skin exposure of a resident as observed from the hallway. An interview was conducted with the Administrator on 08/04/2016 at 4:50 PM. The Administrator stated her expectation of staff was to promote care for the residents in a manner and in an environment that maintained or enhanced a resident ' s dignity. The Administrator stated staff had been trained and the expectation had always been to be aware of the need for resident ' s to be covered and not exposed from the hallway.	F 520	resident's dignity. Designated Nurse Management will perform dignity audits daily x 4 weeks: then once weekly x 4 weeks; then random checks monthly x 12 months. 4. ED will reports audits for review during the Quality Assurance and Performance Improvement Committee meeting for 12 months. QA committee will review audits to ensure compliance is on-going and to determine the need for further audits beyond 12 months.	