STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and record review, the facility failed to offer showers as scheduled for 1 of 3 sampled resident (Resident # 53) Findings included: Resident # 53 was admitted to the facility on 1/20/2017 with diagnoses of Atrial Fibrillation, Hypertension, Gastro-esophageal reflux disease, Seizures, Depression, and Hypokalemia. The quarterly Minimum Data Set (MDS) dated 2/3/2017 indicated Resident # 53 was severely cognitively impaired with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. In an interview on 2/21/17 at 11:51 AM, Resident # 53's Responsible Party stated the resident was not offered showers on his scheduled shower days of Mondays and Thursdays. The responsible	F 242	It is the policy and practice of the facility for residents to have the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions. The facility has policies and procedures designed to maintain these goals. Monitoring, staff training, resident and resident counsel inquiries, assessment and care plan audits and consultant reviews are examples of the many components utilized 1. Corrective action for Resident: Occupational therapy added a new goal on 2/23/17 to work with resident on showering and safety. The	3/23/17

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

Electronically Signed | 03/16/2017

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F 242	Continued From page 1 party stated having showers was very important to the resident. In an interview on 2/23/2017 at 11:00 AM, Nursing Assistant (NA) # 1 stated she was assigned to take care of Resident # 53 and she did not plan to give the resident the shower since the resident had safety concerns. She also reported Resident # 53 did not refuse his bath in the morning when she gave him a bed bath. A review of the shower schedule for Resident # 53 for the months of January 2017 and February 2017 indicated no refusals but only receiving bed baths. A review of the nursing notes from January 2017 until February 2017 made no mention of Resident # 53 refusing his showers or the resident not receiving showers for safety reasons. In an interview on 2/23/17 at 11:30 AM, the Director of Nursing (DON) stated it was her expectation that Resident # 53 receive his showers as scheduled and the staff will assess the safety of the resident in the shower room. The DON also stated the rehab department will assess the resident and the Nurse's Aide will give showers as scheduled.	F 242	interdisciplinary team determined bed baths would be performed until progress could be made with OT and it was safe for nursing staff to perform showers. Supervisor notified the resident's representative on 2/23/17 of the OT's determination and the recommended bathing status. Resident representative was in agreement with plan. The Kardex and care plan were updated by the DON on 2/24/17 to reflect the recommended bathing status. 2. Corrective actions for Residents with the potential to be affected: Alert and oriented residents were interviewed to determine their shower preferences and Kardex (s) updated for any changes in preference by the Quality Assurance Nurse, Treatment Nurse and RN Supervisor on 3/13/17. Care plans will be updated by the MDS Coordinator and MDS Nurse to reflect any revision. Completion date: 3/23/17 3. Measures/Systems: New shower schedules are being developed and the Kardex form revised to include bathing preferences by the DON by 3/17/17. The C.N.A staff and licensed staff nurses are being in-serviced on the revised schedule and Kardex form by the DON and will be completed by 3/18/17. 4. Monitor: The Administrative Nursing team	

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F 242	Continued From page 2	F 242	consisting of DON, Quality Assurance Nurse, Treatment Nurse and/or Unit Managers will audit ADL sheets on at least 5 residents and interview 1-2 residents on each hall (A, C and D) each week for 4 weeks, then every other week for 3 months. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 280		3/22/17

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F 280	Continued From page 3 right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280		

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F 280	Continued From page 4 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and records review, the facility failed to invite two (2) alert and oriented residents to attend their care plan meeting out of a total sample of 2 of 3 residents reviewed for participation in care planning (Resident #10 and #61). The findings include: 1. On 2/21/17 at 10:00 AM, an interview was conducted with Resident #10. He reported no one had invited him to a care plan meeting since he came to the facility. He stated: "They do not tell me when there is a meeting. They do tell me about my medicine - that ' s all. I have been to no meeting." During an interview on 2/21/17 at 2:25 PM, the Minimum Data Set (MDS) Nurse explained her role was to invite the resident and the Social Worker will send the invitation to the family. She explained care planning data is on the Care Plan Conference Summary Form. She confirmed	F 280	It is the policy and practice of the facility for residents to participate in the development and implementation of his or her person-centered plan of care. The facility has policies and procedures designed to maintain these goals. Meeting invitations to resident and/or resident representative, resident acknowledgement, staff and physician communication, communication regarding plan changes, resident council, and consultant reviews are examples of the many components utilized. 1. Corrective action for Resident: Resident # 10 and Resident # 61 were invited by MDS Coordinator on 3/15/17 to attend care plan meetings scheduled for 3/22/17. Resident #10 stated "it depends on how I feel" and Resident #61 stated " I	

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F 280	Continued From page 5 Resident #10 had not attended any care plan meeting. She admitted she should invite the alert and oriented residents and have the residents sign the Care Plan Conference Summary Form after discussion of the plan of care. During an interview on 2/22/17 at 2:16 PM, the Social Worker explained she schedules the care planning meeting, sends the invitation to the family, receives and copies the response from the invitation, schedules and/or reschedules the care planning meeting according to the response of the family. She acknowledged Resident #10 had not attended any meetings to her knowledge. Review of the Care Plan Conference Summary Form for Resident #10 dated 6/07/16, 8/24/16, and 11/23/16, revealed the family was invited but no indication that the resident was invited, and no signature on the Care Plan Conference Summary Form that Resident #10 agreed with the plan of care established and there was no acknowledgement of attendance or discussion of the plan. 2. On 2/21/17 at 11:00 AM, an interview was conducted with Resident #61. She reported no one had invited her to a care plan meeting since she came to the facility. She stated: "Maybe they told my family, but I have not been to a meeting anywhere." During an interview on 2/21/17 at 2:45 PM, the Minimum Data Set (MDS) Nurse explained her role was to invite the resident and the Social Worker will send the invitation to the family. She explained care planning data is on the Care Plan Conference Summary Form. She confirmed Resident #61 had not attended any care plan	F 280	will attend". 2. Corrective actions for Residents with the potential to be affected: All residents were reviewed by the MDS Coordinator, MDS Nurse and Social Worker to determine the practicality of participation in the care planning process. Those residents determined to be able to participate were interviewed to determine if they had been invited to care plan meetings. Completion date: 3/15/17 3. Measures/Systems: A) The Social Worker or MDS Coordinator will hand deliver a care plan conference invitation to residents capable of participating/contributing/comprehending the care plan process one week prior to their scheduled care conference. B) The Social Worker or MDS Coordinator will also verbally ask the resident(s) if they will attend. C) On the day of the scheduled care plan conference the Social Worker or MDS Coordinator will verbally remind the residents of the scheduled conference. 4. Monitor: The Administrator will interview at least 2-3 practicable residents with scheduled care plan conferences each week x 2 months to determine compliance. Results will be reviewed and discussed in the monthly Quality Assurance	

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F 280	Continued From page 6 meeting. She admitted she should invite the alert and oriented residents and have the residents sign the Care Plan Conference Summary Form after discussion of the plan of care. During an interview on 2/22/17 at 2:16 PM, the Social Worker explained she schedules the care planning meeting, sends the invitation to the family, receives and copies the response from the invitation, schedules and/or reschedules the care planning meeting according to the response of the family. She acknowledged Resident # 61 had not attended any meetings to her knowledge. Review of the Care Plan Conference Summary Form for Resident #61 dated 6/22/16, 11/2/16, and 2/8/17, revealed the family was invited but no indication that the resident was invited, and no signature on the Care Plan Conference Summary Form that Resident #61 agreed with the plan of care established and there was no acknowledgement of attendance or discussion of the plan. During an interview with the Facility Administrator on 2/23/2017 at 11:50 AM, she revealed her expectation was to have Care Plan Conference Summary Forms completed.	F 280	Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 3/15/17	
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371		3/15/17

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F 371	Continued From page 7 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep lighting clean above and to the side of the steam table, failed to air dry kitchenware before stacking it in storage, failed to sanitize emptied meal carts which had been out on resident halls and in dining rooms, failed to keep utensil drawers free of food debris, and failed to label and date stored food items. 1. During initial tour of the kitchen, beginning at 10:23 AM on 02/20/17, the bare fluorescent light bulbs above and to the side of the steam table had a coating of dust and dirt on them. During a follow-up tour of the kitchen, beginning at 9:04 AM on 02/22/17, the bare fluorescent light bulbs above and to the side of the steam table had a coating of dust and dirt on them. At 10:25 AM on 02/23/17 the dietary manager	F 371	It has been the policy and normal practice of this facility to store, prepare, distribute and serve food under sanitary conditions as reflected through the County Sanitation Inspections. The facility has policies and procedures designed to maintain these goals. Ongoing Health Department inspections, NC DHSR inspections, dietician planning, consultant reviews, quality assurance monitoring and staff training are examples of the components utilized. Item #1 – Fluorescent light bulbs with dust and dirt. 1. Corrective action identified: The fluorescent light bulbs above and to the side of the steam table were cleaned immediately on 2/20/17 by housekeeping.	

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F 371	Continued From page 8 (DM) stated the maintenance department was cleaning the vents and light bulbs in the kitchen about every three months, but probably needed to increase the frequency of the cleaning due to the small allotted cooking space in the kitchen. At 10:43 AM on 02/23/17 the AM cook stated she thought the lights and vents in the kitchen were cleaned by the maintenance department. She reported it was important to keep them clean so that dirt and dust did not fall into food at the steam table and onto sanitized kitchenware being used to serve the food on. At 12 noon on 02/23/17 the maintenance manager (MM) stated his department did not do any cleaning in the kitchen. He reported maintenance replaced light bulbs, but did not clean any light bulbs or fixtures. He commented environmental services might help with cleaning in the kitchen. At 12:12 PM on 02/23/17 the environmental services manager stated he had been in his current position or a month, and during that time his department had never done any cleaning in the kitchen. 2. During initial tour of the kitchen, beginning at 10:23 AM on 02/20/17, 6 of 12 tray pans stacked on top of one another on a storage shelf were wet with water/moisture trapped inside of them. At this time the dietary employee working at the three-compartment sink stated these tray pans were washed earlier the same morning. At 10:25 AM on 02/23/17 the dietary manager (DM) stated kitchenware should not be stacked wet because bacteria could grow in the moisture	F 371	These light bulb coverings were changed by the Maintenance Director on 2/22/17. 2. Corrective actions for other areas having the potential to be affected: All other light bulbs in the kitchen were inspected on 2/20/17 by Housekeeping to assure they were clean and free of dirt and dust. All others were clean and free of dirt/dust. 3. Measures/Systems: The cleaning list was updated on 2/27/17 by the Dietary Manager to include monitoring of ceiling light fixtures and light bulbs. Maintenance will be notified when ceiling light fixtures and/or lights blubs need cleaning. The dietary staff was in-serviced on 2/20/17 and 2/27/17 by the Dietary Manager on monitoring of ceiling light fixtures and light bulbs for cleanliness. 4. Monitor: The Dietary Manager and/or Head Cook will monitor the proper cleaning procedures using the audit form monitoring tool daily times 2 weeks, then 3 times a week for 3 weeks, then weekly times 4 weeks, then monthly times 3 months to ensure proper cleaning has occurred. The District Dietary Manager will also monitor the proper cleaning procedures for completion during routine monthly visits. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee	

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F 371	Continued From page 9 and possibly make residents sick. At 10:43 AM on 02/23/17 the AM cook stated before stacking kitchenware in storage it should be air-dried, and staff should check to make sure it was free of dried food particles. 3. At 10:03 AM on 02/22/17 a dietary employee wiped down the outside and inside of two meal carts which were returned to the kitchen after being on resident halls and in the dining rooms. At 10:33 AM on 02/22/17 the same dietary aide wiped down the outside and inside of two more meal carts which were returned to the kitchen after being on resident halls and in the dining rooms. At 10:35 AM on 02/22/17 the dietary aide who was wiping down the meal carts stated there was a dishwashing solution in the bucket where she was keeping her cleaning cloth. At 10:25 AM on 02/23/17 the dietary manager (DM) stated quarternary sanitizing solution from the three-compartment sink system should have been in the bucket so the dietary aide could sanitize emptied meal carts rather than just cleaning them. She reported using a sanitizing solution for wiping down the meal carts helped prevent cross-contamination and the possible spread of germs, bacteria, and sickness. At 10:43 AM on 02/23/17 the AM cook stated meal carts were supposed to be sanitized after coming back into the kitchen from resident care areas and dining rooms. She reported using quarternary solution from the three-compartment sink was the preferred method of sanitization.	F 371	meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance. Item #2 – Tray pans stored with water/moisture. 1. Corrective actions identified: The 6 pans were removed immediately on 2/20/17 from dry storage and re-washed by the Dietary Manager and thoroughly air dried. 2. Corrective actions taken for other areas having the potential to be affected: The Dietary Manager inspected all other pots and pans stored in dry storage on 2/20/17 to assure they were dry. All others were dry. 3. Measures/Systems: The dietary staff was in-serviced on 2/20/17 and 2/27/17 by the Dietary Manager on the process for assuring all cookware is dry before placing the items in dry storage. 4. Monitor: The Dietary Manager and or Head Cook will monitor the cookware stored in dry storage using the audit form monitoring tool daily times 2 weeks, then 3 times a week for 3 weeks, then weekly times 4 weeks, then monthly times 3 months to assure cookware is dry. The District Dietary Manager will also monitor the cookware and dry storage areas during routine monthly visits.	

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F 371	Continued From page 10 She commented use of a sanitizer was the only way to assure germs and bacteria were killed so it was safe to transport more food. 4. During initial tour of the kitchen, beginning at 10:23 AM on 02/20/17, two utensil drawers had spills and food debris in them. At 10:25 AM on 02/23/17 the dietary manager (DM) stated the utensil drawers should be kept clean at all times because spills and dried food particles could contaminate utensils which could then be used to stir foods that were already cooked or did not require cooking, possibly spreading germs and bacteria. At 10:43 AM on 02/23/17 the AM cook stated utensil drawers were supposed to be cleaned daily so spills and dried food particles did not cause cross contamination which could possibly make residents sick. 5. During initial tour of the kitchen, beginning at 10:23 AM on 02/20/17, in the reach-in refrigerator a partially used onion, two one-gallon containers of yellow mustard, a pitcher of tea/lemonade, a gallon container of barbecue sauce, a four-pound jar of grape jelly, and a 30-ounce jar of whipped dressing were found opened but without labels and dates. On a rack in the food preparation area a 57-ounce carton of potato pearls (instant mashed potatoes) was opened but without a label and a date. A pan of fish found in the walk-in refrigerator had labeling which documented it was placed in storage on 02/14/17, and was supposed to be disposed of on 02/18/17. Also in the walk-in refrigerator a box of chicken which was leaking blood and a box containing 3 1/2 rolls of thawing hamburger meat had no facility labeling on them	F 371	Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance. Item #3 – Sanitizing meal carts 1. Corrective actions identified: The emptied meal carts were sanitized using the quaternary sanitizing solution immediately on 2/20/17 by the Dietary Aide. 2. Corrective actions for the potential to be affected: The emptied meal carts were sanitized using the quaternary sanitizing solution immediately on 2/20/17 by the Dietary Aide. 3. Measures/Systems: The dietary staff was in-serviced on 2/20/17 and 2/27/17 by the Dietary Manager on the process for sanitizing emptied meal carts between uses. 4. Monitor: The Dietary Manager and/or Head Cook will monitor the sanitizing of emptied meal carts using the audit form monitoring tool daily times 2 weeks, then 3 times a week for 3 weeks, then weekly times 4 weeks, then monthly times 3 months to ensure meal carts are clean and sanitized. The District Dietary Manager will also monitor this process during routine monthly visits.	

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	345353	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 11 to indicate how long they had been in refrigerated storage or when they were to be disposed of to prevent spoilage. At 9:33 AM on 02/22/17 the labeling on a storage container of baked pork chops documented they were placed in the reach-in refrigerator on 02/19/17 and were safe to reheat for serving until 02/29/17. At 10:25 AM on 02/23/17 the dietary manager (DM) stated at the most leftovers were only kept in refrigerated storage for seven days. She reported her stock person checked labeling and dating in storage areas every Tuesday, and any dietary employee who opened food items or went in and out of storage areas was also supposed to make sure foods were labeled and dated. She commented all opened food items which were not completely used up at one time, foods which were removed from their original packaging, andcooked leftovers placed in storage were supposed to have labels and dates on them. According to the DM, the labeling and dating of meats was important because spoilage could make residents very sick. At 10:43 AM on 02/23/17 the AM cook stated all dietary employees were supposed to monitor labeling and dating in storage areas to make sure the older food items were used up first and meats and leftovers could be used up before they spoiled. She reported the cooks and the dietary management team were supposed to go behind staff daily to make sure food storage was maintained properly. She commented, as a cook, she did not like to keep leftovers more than one day before using them up or disposing of them.	F 371	Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance Item #4 – Utensil drawers 1. Corrective actions identified: The two utensil drawers and utensils in them were cleaned immediately by the Cook on 2/20/17. 2. Corrective actions for the potential to be affected: All other utensil drawers were inspected by the Dietary Manager on 2/20/17 for spills/debris and there were no other areas of concern. 3. Measures/Systems: The dietary staff was in-serviced on 2/20/17 and 2/27/17 by the Dietary Manager on the process on maintaining clean utensil drawers. 4. Monitor: The Dietary Manager and/or Head Cook will monitor the proper cleaning procedures for all utensil drawers using the audit form monitoring tool daily times 2 weeks, then 3 times a week for 3 weeks, then weekly times 4 weeks, then monthly times 3 months to ensure cleanliness. The District Dietary Manager will also monitor this process during routine monthly visits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12	F 371	Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance. Item #5 – Storage/labeling of food 1. Corrective actions identified: As a precautionary measure, the food items listed were disposed of by the Dietary Manager immediately on the day they were identified (2/20/17 and 2/22/17). 2. Corrective actions for the potential to be affected: All food items were inspected to assure proper labeling and within “use by date”. All open items were labeled and within "use by date". 3. Measures/Systems: Dietary Staff was in-serviced by the Dietary Manager on the process and policy for labeling and dating all foods and the use by dates on 2/20/17. 4. Monitor: The Dietary Manager and or Head Cook will monitor for proper food storage protocols, including labeling for dates and the “used by and pull for thawing dates” utilizing the Marking and Dating audit forms daily times 2 weeks, then 3 times a week for 3 weeks, then weekly times 4 weeks, then monthly times 3 months to ensure compliance. The District Dietary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13	F 371	Manager will also monitor this process during routine monthly visits. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The QA Committee will assess and modify the action plan as needed to ensure continued compliance. Completion date: 3/15/17	