STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 08/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to provide the results of the most recent survey conducted by Federal or State surveyors. The findings included: Observation on 08/08/16 at 12:45 PM revealed a binder located in the facility's entrance lobby entitled "Survey Results." Review of the contents of the survey results binder revealed a survey dated 01/05/16 was the most recent survey contained in the binder. Review of the state agency database revealed the state agency conducted a recertification and complaint investigation survey on 05/06/16 and a complaint investigation on 07/01/16. Review of Resident #8's quarterly Minimum Data Set dated 07/06/16 revealed an assessment of intact cognition.	F 167	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 167 RIGHT TO SURVEY RESULTS – READILY ACCESSIBLE Corrective Action: On August 8, 2016, the facility updated the survey book to include the most recent annual recertification survey and all subsequent surveys, and including approved plan of corrections, if any. The	9/1/16

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

Electronically Signed | 09/01/2016

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F 167	Continued From page 1 Interview with the resident council president, Resident #8, on 08/08/16 at 1:21 PM revealed the most recent survey should be available to read. Resident #8 explained she wondered about the delay for the May 2016 survey but thought it might take several months now. Interview with the Administrator on 08/08/16 at 1:52 PM revealed the omission of the facility's most recent survey was an oversight and would be immediately corrected.	F 167	survey book was placed back into the lobby where it will remain. The Administrator met with the resident council president, resident #8, and explained the survey book had been updated to include the most recent annual recertification survey and all subsequent surveys, and including approved plan of corrections, if any. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this practice. Systemic Changes: As of 8/31/2016 all staff were re-educated / in-serviced by the Administrator regarding the location of the facility's survey book. Monitoring: The Receptionist will monitor this issue using the QA Survey Tool that will review to insure the survey book is available and complete on a daily basis. Any identified issues will be immediately reported to the Administrator for appropriate action. This will be done on a daily basis and then documented on the QA Survey Tool. This will be documented daily for 2 weeks, then weekly for 1 month and then monthly until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator, DON or designee to ensure	

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F 167	Continued From page 2	F 167	corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, Wound Care Nurse, MDS Coordinator, RN Unit Managers, Support Nurse, Therapy Director, HIM, Dietary Manager and the Administrator. Date of Compliance: August 31, 2016	
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 an observation, a resident interview, staff interviews and medical record review, the facility failed to honor food preferences for 1 of 5 sampled residents observed during dining (Resident #5). The findings included: Resident #5 was admitted to the facility on 08/25/15. Diagnoses included hypertension, chronic kidney disease, coronary artery disease, diabetes mellitus adult onset (DM 2), and hyperlipidemia.	F 242	F 242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES Corrective Action: On August 9, 2016, the Dietary Manager spoke to resident #5 and updated resident #5's food preferences. Additionally, by 8-18-16, the Dietary Manager had re-inserviced her staff on tray card accuracy and maintaining that accuracy throughout a tray line service. Identification of other residents who may	9/1/16

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F 242	Continued From page 3 Resident #5's care plan, reviewed in April 2016, identified a potential for nutritional and DM 2 complications due to the need for a therapeutic diet. Interventions included provision of a therapeutic diet as ordered and to offer meal substitutes for foods not eaten. A quarterly Minimum Data Set assessment dated 05/13/16 assessed Resident #5 with intact cognition, clear speech, able to understand and be understood and independent with eating after tray set up assistance from staff. Resident #5 had a physician's order dated 06/08/16 for a regular no added salt, low concentrated sweets diet. During an interview with Resident #5 on 08/07/16 at 3:50 PM, she stated that she often received foods that staff knew she did not eat. Resident #5 stated "Sometimes I get turkey bacon and grits, these are on my tray ticket as dislikes. I have told them this during Food Council, but nothing gets done. The very next morning after I told them again that I don't eat scrambled eggs, I prefer boiled eggs, no turkey bacon, and no grits, guess what I got for breakfast? Scrambled eggs, turkey bacon and grits." Resident #5 also stated "I don't eat fish but I get fish, don't ever give me fish of any kind, but they give me tuna, that's fish isn't it? " Resident #5 further stated that since she was admitted, she reminded staff at least 10 times about her food preferences, but nothing had changed. Resident #5 stated that her tray card listed the following food preferences: · Prefers pork sausage patty, no turkey to include turkey bacon/sausage and no fish · Send peanut butter, bread, and oatmeal	F 242	be involved with this practice: All residents have the potential to be affected by this practice. On 8-10-16, the Dietary Manager conducted a resident food council meeting to determine if other residents had concerns regarding meal services. Systemic Changes: By 8-18-16, the Dietary Manager had re-inserviced all dietary staff on tray card accuracy and maintaining that accuracy throughout a tray line service. Topics included: How to correctly read tray card tickets and identify variances, and, what action steps to take if concerns are identified. This information has been integrated into the dietary department's standard orientation training for all newly hired staff. Monitoring: The Dietary Manager and or District Manager will randomly monitor tray accuracy using the QA Tray Monitoring Tool. Any identified issues will be immediately corrected and a reeducation of dietary staff completed by the Dietary Manager and or District Manager. This will be documented daily for 2 weeks, then weekly for 1 month and then monthly until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the Administrator, DON or designee to ensure	

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F 242	Continued From page 4 instead of grits; hard cooked eggs/boiled eggs instead of scrambled eggs On 08/08/16 at 8:50 AM, Resident #5 was observed eating breakfast in her room. Review of her breakfast tray card revealed Resident #5's preferences were recorded as she had previously stated. Resident #5 received French toast, a boiled egg, and a pork sausage patty. Resident #5 did not receive oatmeal or peanut butter. Resident #5 stated that a nurse aide (NA) left to get her oatmeal, but had not yet returned, she stated "I don't think I will get my oatmeal, if it doesn't come on the tray I usually don't get it." Resident #5's breakfast tray was removed by staff on 08/08/16 at 8:58 AM and the oatmeal and peanut butter were not provided. An interview with NA #1 occurred on 08/08/16 at 08:59 AM. NA #1 stated that Resident #5 wanted the same thing for breakfast each morning and that she preferred oatmeal, but usually received grits. NA #1 further stated that Resident #5 did not receive her oatmeal that morning for breakfast. NA #1 stated she told Resident #5 that she would go get her oatmeal, but because she had to feed another resident, NA #1 stated "I didn't get back to her (Resident #5)." NA #1 also stated that there were other times Resident #5 did not receive her oatmeal for breakfast and that she had never observed Resident #5 get peanut butter with her breakfast. An interview with the Certified Dietary Manager (CDM) occurred on 08/08/16 at 5:20 PM. The CDM stated that resident food preferences printed on the traycard and dietary staff were responsible for monitoring the tray line to make sure preferences were honored. The CDM stated that at each meal she monitored the tray line for	F 242	corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, Wound Care Nurse, MDS Coordinator, RN Unit Managers, Support Nurse, Therapy Director, HIM, Dietary Manager and the Administrator. Date of Compliance: August 31, 2016	

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F 242	Continued From page 5 correct food temperatures, trayline accuracy, portions and resident preferences. The CDM further stated that meal trays should come from the kitchen according to the traycard and include the correct diet and resident preferences. The CDM stated she was not sure how Resident #5's food preferences were being missed, but that she would speak to the Resident to make sure her preferences were up-to-date and re-educate staff on following the traycards. The CDM stated that she expected dietary staff to plate meals according to the tray card and if something was missed, dietary staff should be made aware for re-education and revision of practices. An interview with the Administrator occurred on 08/08/16 at 5:33 PM and revealed that the new dietary contract company had "their hands full" since they started. The Administrator stated he would have to review minutes from Resident Council and Food Committee to see if and when Resident #5 brought her dietary concerns to staff's attention. The Administrator stated that the facility was in the planning stages for a new ambassador dining program that would reduce some of the current concerns in that department previously identified. He stated that the facility had made corrections, but the corrections did not always work which required further revision of practices. He stated things were better in the dietary department, but not 100% yet.	F 242		
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.	F 312		9/1/16

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F 312	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to provide incontinence care to 1 of 3 sampled residents who required assistance with incontinence care (Resident #3). The findings included: Resident #3 was admitted to the facility on 01/26/16 with diagnoses which included hypertension and dementia. Review of Resident #3's quarterly Minimum Data Set (MDS) dated 07/06/16 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #3 required the extensive assistance of 2 persons with toilet use and was always incontinent of urine. Review of Resident #3's care plan dated 07/06/16 revealed interventions for bladder incontinence with increased risk for skin breakdown and infection included checks for incontinence every 2 hours and report to the nurse if refusal occurred. Observation on 08/07/16 at 3:25 PM revealed Resident #3 seated in a wheelchair next to the bed. Resident #3 shouted, "You have to get me out of these wet pants." Observation on 08/07/16 at 3:30 PM revealed Nurse Aide (NA) #3 entered Resident #3's room. Resident #3 announced to NA #3, "I know it is not your fault but I have not been changed since this	F 312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Corrective Action: Resident #3: Was provided assistance with activities of daily living by a C.N.A. on 8/7/16 which included perineal/incontinence care to ensure resident was clean and dry. C.N.A. #5 was re-educated on 8/8/16 by the Director of Nursing on providing services to the residents in accordance with the resident's written plan care to include perineal/incontinence care. Identification of other residents who may be involved with this practice: All residents who are determined to be incontinent have the potential to be affected by the alleged practice. On 8/7/16 all residents identified to be incontinent were checked by the Nurse Management Team and designees to ensure incontinence care was provided as required. Residents were provided incontinence care as needed. Systemic Changes: On 8/15/16 all RN, LPN, and C.N.A's were re-educated by the Director of Nursing or	

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F 312	Continued From page 7 morning." NA #3 explained she came on duty at 3:00 PM and would provide incontinence care and a change of clothing. NA #3 reported incontinence care should be provided regularly and she checked residents every 2 hours. Observation on 08/07/16 at 3:43 PM revealed NA #3 and NA #4 transferred Resident #3 with a mechanical lift to the bed. Resident #3's seat cushion and pants were wet. Observation of incontinence care revealed Resident #3's disposable brief was saturated with urine. Interview with Nurse #1 on 08/07/16 at 3:48 pm revealed NA #5 assigned to Resident #3 on the day shift, had left for the day. Nurse #1 explained Resident #3 received incontinence care in the morning but did not know if Resident #3 received any incontinence care after the lunch meal. Nurse #1 did not receive a report of incontinence care refusal. Interview with NA #5 on 08/08/16 at 2:55 PM revealed she provided incontinence care to Resident #3 one time before the lunch meal on 08/07/16. NA #5 reported Resident #3 did not receive any incontinence care after lunch. NA #5 explained this was the usual routine for Resident #3 since Resident #3 did not like to go back to bed after lunch. Interview with the Director of Nursing (DON) on 08/08/16 at 3:24 PM revealed Resident #3 should receive incontinence care on a regular basis, approximately every 2 hours. The DON explained Resident #3 could receive incontinence care and remain up in the wheelchair.	F 312	designee pertaining to maintaining good personal care, including incontinence care for residents that need assist with activities of daily living. Any in-house staff member who did not receive this in-service training will not be allowed to work until training has been completed. The education focused on: The importance of timely incontinence care to prevent skin breakdown, infection and dignity. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that he change has been sustained. Monitoring: To ensure compliance, the Director of Nursing or Designee will conduct a review using the QA Incontinence Care Tool. Five residents identified as requiring incontinence care as part of their ADL's will be assessed that care was provided timely. This will be completed weekly on all shifts and weekends weekly for 4 weeks, and then monthly for three months. Any identified issues will be reported immediately to the Director of Nursing, Assistant Director of Nursing, Unit Manager or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager,	

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F 312	Continued From page 8	F 312	Support Nurse, Therapy, HIM, Dietary Manager, Social Service, Administrator and other members as needed. Date of Compliance: August 31, 2016	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on 5 sampled resident interviews (Residents #3 #4, #5, #6 and #7), a test tray, staff interviews, and record review, the facility failed to provide food at resident preferred temperatures during an observed breakfast meal. The findings included: 1. Review of the breakfast menu for 08/08/16 revealed menu items included eggs and French toast. Review of the temperature log revealed the egg temperature measured 175.5 degrees Fahrenheit. Observation on 08/08/16 at 8:31 AM revealed Cook #1 plated a pasteurized fried egg with French toast on a test tray. Steam rose from the bagged French toast when opened from the warmer box prior to placement on the plate. The tray was placed on the 600 hall insulated food cart and arrived on the 600 hall at 8:37 AM.	F 364	F 364 NUTRITIVE VALUE / APPEAR, PALATABLE / PREFER TEMP Corrective Action: Multiple residents were affected. Resident #5's concerns were immediately resolved on 8-8-16 via CNA reheating of resident tray per resident satisfaction. Identification of other residents who may be involved with this practice: All residents residing in the facility have the potential to be affected. On 8-10-16, the Dietary Manager conducted an open resident food council meeting to determine if other residents had concerns regarding meal services. All menu items	9/1/16

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F 364	Continued From page 9 Continuous observation on 08/08/16 from 8:37 AM to 9:07 AM revealed residents received the breakfast meal with the last resident tray delivered at 9:07 AM. Observation of the test tray on 08/08/16 at 9:08 AM with the Senior District Manager (SDM) revealed butter did not melt on the French toast. Taste of the French toast and egg revealed both items were not warm. The tray was tested 37 minutes after plated. Interview with the SDM on 08/08/16 at 9:09 AM revealed the egg and French toast were time sensitive food items which should be served 15 to 20 minutes after plating. The SDM explained the length of time from plating to delivery negatively impacted the food temperatures and caused the egg and French toast to cool down. Interview with Cook #1 on 08/08/16 at 9:17 AM revealed she measured the temperature of the eggs at the point of service and the warmer temperature was 212 degrees Fahrenheit. Interview with Nurse Aide (NA) #6 on 08/08/16 at 9:30 AM revealed 600 hall tray delivery of the breakfast meal usually took approximately 30 minutes to complete. 2. a.) Review of Resident #3's quarterly MDS dated 07/06/16 revealed an assessment of moderately impaired cognition. Resident #3 resided on the 500 hall. Observation on 08/08/16 at 8:34 AM revealed Resident #3 received French toast and sausage. The butter did not melt on the French toast.	F 364	are to be prepared according to recipe and tasted. Endpoint and serving temperatures are taken. Temperatures are logged on temp form. Meals will be delivered using appropriate insulated service ware and on scheduled. Compliance will be monitored by the Administrator and Dietary Manager. Systemic Changes: On August 18, 2016, an inservice was completed by the Dietary services manager. All cooks and dietary aides, FT, PT & PRN employed by Health Care Services Group have completed that inservice. The inservice included: Serving residents palatable food by ensuring that items are prepared according to recipe, tasted and served at appropriate temperature. Trays are served attractively in appropriate service ware and delivered according to meal schedule. Monitoring: To ensure compliance, the Dietary Services Manager will monitor this issue using the QA Audit Tool and any issues will be reported to the Administrator. This will be done weekly for three months until resolved by the main Quality Assessment and Assurance Committee. Reports will be presented to the weekly QA&A Committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the	

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F 364	Continued From page 10 Resident #3 reported the French toast and sausage were cold. Resident #3 explained "every day I get a cold breakfast." Observation on 08/08/16 at 8:37 AM revealed Nurse Aide (NA) #2 removed Resident #5's plate for reheating and returned with the reheated plate at 8:45 AM. Interview with NA #2 on 08/08/16 at 8:46 AM revealed Resident #3 would "sometimes" ask for food to be reheated. b) Review of Resident #5's quarterly MDS dated 05/13/16 revealed an assessment of intact cognition. Resident #5 resided on the 200 hall. Observation on 08/08/16 at 8:50 AM revealed Resident #5 received French toast. Resident #5 announced butter was not desired and the French toast was cold. Interview with Nurse Aide #1 on 08/08/16 at 8:59 AM revealed Resident #5 requested reheating of food "sometimes." c) Review of Resident #7's quarterly Minimum Data Set (MDS) dated 05/09/16 revealed an assessment of moderately impaired cognition. Resident #7 resided on the 600 hall. Interview with Resident #7 on 08/08/16 at 9:15 AM revealed the French toast and eggs were "almost cold to me." Resident #7 explained he did not like to complain. d) Review of Resident #6's quarterly MDS dated 07/10/16 revealed an assessment of intact cognition. Resident #6 resided on the 600 hall.	F 364	weekly QA&A Committee. The weekly QA&A meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and the Administrator. Date of Compliance: August 31, 2016	

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(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 364	Continued From page 11 Interview with Resident #6 on 08/08/16 at 9:21 AM revealed the French toast and egg were "cold." Resident #6 explained she could not eat the items since they were cold. Resident #6 reported she no longer requested staff to reheat her tray because she got "tired of asking every day." e) Review of Resident #4's admission MDS dated 07/01/16 revealed an assessment of intact cognition. Interview with Resident #4 on 08/08/16 at 9:31 AM revealed the breakfast meal "could have been warmer" and changed her order from scrambled eggs to a hard boiled one to avoid receipt of cold eggs. Interview with the dietary services manager (DSM) on 08/08/16 at 1:30 PM revealed she was not aware of any resident complaints regarding food temperatures. The DSM provided resident surveys conducted with 10 sampled residents on 06/27/16 and 07/20/16 which indicated no resident complaints regarding hot food temperatures.	F 364		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490		9/1/16

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	345026	A. BUILDING _____ B. WING _____	C 08/08/2016

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F 490	Continued From page 12 by: Based on observations, interviews with residents and staff, and review of medical and facility records, the facility's administration failed to sustain an effective Quality Assessment Program through implemented procedures and monitoring of these interventions that the committee put into place during 2 federal surveys of record for 4 repeat deficiencies in the areas of choices, activities of daily living, palatable foods and and Quality Assessment and Assurance. The findings included: This tag is cross referred to: F 520: Quality Assessment and Assurance (QAA). Based on observations, resident and staff interviews and medical record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2016. This was for four recited deficiencies which were originally cited in May 2016 during the recertification and complaint investigation survey and again on the current complaint investigation survey. The deficiencies were in the areas of choices, activities of daily living, palatable foods and Quality Assessment and Assurance. The continued failure of the facility during two federal surveys of record demonstrate the facilities inability to sustain an effective Quality Assurance Program. During 2 federal surveys of record, May 2016 recertification and complaint investigation survey and the facility's current complaint investigation survey of August 2016, the facility's Administrator failed to sustain an effective QAA Program due to	F 490	F 490 EFFECTIVE ADMINISTRATION / RESIDENT WELL-BEING Corrective Action: No specific residents were mentioned in the 2567. Identification of other residents who may be involved with this practice: All residents residing in the facility have the potential to be affected. Systemic Changes: On August 23rd 2016, the QA Nurse Consultant in-serviced the Administrator. Topics included: The need to continue all plan of correction quality assurance monitors until full compliance is sustained for 3 months. Once sustained for 3 months the survey monitor will be completed quarterly until after the next survey cycle to ensure compliance on the next survey. Monitoring: The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Quality Assurance Audit tools identified in this plan of correction will be reviewed monthly to ensure that audits are completed until compliance is sustained for 3 months. Then audits should be completed quarterly to ensure on-going compliance	

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F 490	Continued From page 13 repeat deficiencies in the areas of choices, activities of daily living (ADL), palatable foods and QAA. The Administrator was interviewed on 08/08/16 at 5:33 PM. The interveiw revealed that the Administrator expressed that the new dietary company had "their hands full". He stated that when the new contractor started they discussed the plan of correction that would require ongoing monitoring. He stated he discussed starting a new ambassador dining program with the new dietary contractor. He stated that the ambassador dining program was still in the development phase and required more staff training prior to implementation. The Adminstrator also stated that due to repeated dietary concerns, he had a "pre-resident council" meeting to discuss any dietary concerns with residents. The Administrator stated that although some progress had been made he knew the facility still had some mistakes to correct. The Administrator stated that in May 2016, the facility had not implemented the new dietary contract yet and that all of the problems identified in that department could not be fixed all at once. The Administrator stated that concerns with food choices he felt would be resolved once the new dining room ambassador program started. He stated the concerns with activities of daily living (ADL) could be resolved with family involvement to encourage some residents who refused nursing care to allow staff to care for them. The administrator also stated that the QAA Committee was aware of concerns related to choices, ADL, and palatable foods, and worked diligently on correction, but the correction did not always work, which would require continued revision until they reached 100 percent.	F 490	until the next annual survey reveals compliance. Any issues will be reported to the Administrator and the Regional Operations Manager for corrective actions. Date of Compliance: August 31, 2016	

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F 520	Continued From page 14	F 520		
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, resident and staff interviews and medical record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2016. This was for four recited deficiencies which were originally cited in May 2016 during the recertification and complaint	F 520	F 520 QAA COMMITTEE – MEMBERS / MEET QUARTERLY / PLANS Corrective Action: No specific residents were mentioned in the 2567.	9/1/16

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F 520	Continued From page 15 investigation survey and again on the current complaint investigation survey. The deficiencies were in the areas of choices, activities of daily living, palatable foods and Quality Assessment and Assurance. The continued failure of the facility during two federal surveys of record demonstrate the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 242: Allow Choices About Significant Aspects of Life: Based on an observation, a resident interview, staff interviews and medical record review, the facility failed to honor food preferences for 1 of 5 sampled residents observed during dining (Resident #5). During the the facility's recertification and complaint investigation survey of May 2016, the facility failed to allow residents their choice of personal hygiene products and to choose the number of weekly showers per their preference. On the current complaint investigation, the facility failed to honor a resident's food preferences. 1b. F 312: Provide Assistance with Activities of Daily Living (ADL): Based on observation, resident and staff interviews, and record review, the facility failed to provide incontinence care to 1 of 3 sampled residents who required assistance with incontinence care (Resident #3). During the the facility's recertification and complaint investigation survey of May 2016, the facility failed to remove facial hair for a resident. On the current complaint investigation, the facility	F 520	Identification of other residents who may be involved with this practice: All residents residing in the facility have the potential to be affected. Systemic Changes: On August 23rd 2016, the QA Nurse Consultant in-serviced the Administrator. Topics included: The need to continue all plan of correction quality assurance monitors until full compliance is sustained for 3 months. Once sustained for 3 months the survey monitor will be completed quarterly until after the next survey cycle to ensure compliance on the next survey. Monitoring: The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Quality Assurance Audit tools identified in this plan of correction will be reviewed monthly to ensure that audits are completed until compliance is sustained for 3 months. Then audits should be completed quarterly to ensure on-going compliance until the next annual survey reveals compliance. Any issues will be reported to the Administrator and the Regional Operations Manager for corrective actions. Date of Compliance: August 31, 2016	

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F 520	Continued From page 16	F 520		

failed to provide incontinence care to a resident.

1c. F 364: Provide Palatable Food at the Proper Temperature: Based on 5 sampled resident interviews (Residents #3 #4, #5, #6 and #7), a test tray, staff interviews, and record review, the facility failed to provide food at resident preferred temperatures during an observed breakfast meal. During the facility's recertification and complaint investigation survey of May 2016, the facility failed to prepare foods to preserve nutritional value and provide foods per resident preference for taste and temperature. On the current complaint investigation, the facility failed to provide food at resident preferred temperatures.

1d. F 520: Quality Assessment and Assurance (QAA) Committee: Based on observations, resident and staff interviews and medical record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2016. This was for four recited deficiencies which were originally cited in May 2016 during the recertification and complaint investigation survey and again on the current complaint investigation survey. The deficiencies were in the areas of choices, activities of daily living, palatable foods and Quality Assessment and Assurance. The continued failure of the facility during two federal surveys of record demonstrate the facilities inability to sustain an effective Quality Assurance Program.

During the facility's recertification and complaint investigation survey of May 2016, the facility's QAA committee failed to maintain implemented procedures and monitor these interventions that

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F 520	Continued From page 17	F 520		

the committee put into place in June 2016. This was for four recited deficiencies in the areas of choices, activities of daily living, palatable foods and QAA that were originally cited in May 2016 and subsequently recited during the current complaint investigation.

The Administrator was interviewed on 08/08/16 at 5:33 PM. The interveiw revealed that the Administrator expressed that the new dietary company had "their hands full". He stated that when the new contractor started they discussed the plan of correction that would require ongoing monitoring. He stated he discussed starting a new ambassador dining program with the new dietary contractor. He stated that the ambassador dining program was still in the development phase and required more staff training prior to implementation. The Adminstrator also stated that due to repeated dietary concerns, he had a "pre-resident council" meeting to discuss any dietary concerns with residents. The Administrator stated that although some progress had been made he knew the facility still had some mistakes to correct. The Administrator stated that in May 2016, the facility had not implemented the new dietary contract yet and that all of the problems identified in that department could not be fixed all at once. The Administrator stated that concerns with food choices he felt would be resolved once the new dining room ambassador program started. He stated the concerns with activities of daily living (ADL) could be resolved with family involvement to encourage some residents who refused nursing care to allow staff to care for them. The administrator also stated that the QAA Committee was aware of concerns related to choices, ADL, and palatable foods, and worked diligently on correction, but the correction

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F 520	Continued From page 18 did not always work, which would require continued revision until they reached 100 percent.	F 520		