DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING ______ B. WING ______	C 12/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# IU1X11.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		12/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/20/2016

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

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F 272	Continued From page 1	F 272		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes and contributing factors for the areas of urinary incontinence, falls, nutritional status, dental care, pressure ulcers and pain for 1 of 22 sampled residents reviewed for comprehensive assessments (Resident #139).

The findings included:

Resident #139 was readmitted to the facility on 10/02/16 with diagnoses including; muscle weakness, difficulty walking, lack of coordination, chronic obstructive pulmonary disease, diabetes mellitus, obesity and heart failure.

The admission Minimum Data Set (MDS) assessment dated 10/09/16 coded Resident #139 as requiring extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, personal hygiene and bathing. The MDS also coded the resident as not walking in room or in corridor during the past seven days, experiencing occasional urinary incontinence, experiencing almost constant pain over the last five days, having a fracture as a result of a fall in the six months prior to admission to the facility, being at risk for developing pressure ulcers, receiving a therapeutic diet and having no natural teeth or tooth fragments.

The Oaks of Brevard is committed to upholding the highest standards of care for our residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of North Carolina Department of Health and Human Services toward the best interest of those who require the services we provide.

While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted November 29 through December 2, 2016. This Plan of Correction is the facility□s recognition of compliance with Federal and State requirements

1. A Care Area Assessment (CAA) was completed for Resident # 139 which included individual information explaining why the areas of urinary incontinence, falls, nutritional status, dental care pressures ulcers and pain affected the resident□s day to day routine and an analysis of each of these areas.

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F 272	Continued From page 2 Review of the Care Area Assessments (CAA) completed by MDS Nurse #1 on 10/14/16 for Resident #139 revealed no individual information explaining why the areas of urinary incontinence, falls, nutritional status, dental care, pressure ulcers and pain were a problem for the resident, how the problems affected the resident's day to day routine and no analysis of each of these areas. Interview with MDS Coordinator #1 on 12/02/16 at 11:40 AM revealed she did not complete a review or an analysis of the triggered areas noted on the 10/14/16 CAA summary for Resident #139 which included; urinary incontinence, falls, nutritional status, dental care, pressure ulcers and pain. MDS Coordinator #1 stated that she just missed completing an analysis of these triggered areas for Resident #139.	F 272	2. All current residents comprehensive assessments were audited by the MDS Coordinator on December 19, 2016 to assure that CAAs were completed as indicated. No additional missing CAAs were identified. 3. The MDS Director #1 was reeducated by a Corporate MDS Consultant on the comprehensive assessment process. A daily monitor was established to record completion of each day assessments and if a CAA was completed if indicated. This form will be completed daily for four weeks, then weekly for four weeks and monthly thereafter for three months. The monitor will be completed by the MDS Director and reviewed by the Corporate MDS Consultant weekly times eight weeks then monthly thereafter. 4. Results of the monitoring will be presented to the Quality Assurance Performance Improvement Committee by the MDS Director for review monthly for the five months or until compliance is achieved Changes will be made to the plan by the committee as indicated.	
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the	F 283		12/30/16

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F 283	Continued From page 3 consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a discharge summary that described residents' facility stay or the residents' status at discharge for 2 of 8 residents reviewed with anticipated discharges (Residents #53 and #141). The findings included: 1. Resident #53 was admitted to the facility 09/23/16 with diagnoses which included transient ischemic attacks (mini stroke) and debility. An admission Minimum Data Set dated 09/03/16 the resident expected to be discharged back to the community after receiving rehabilitation services. A review of Resident #53's medical record revealed both physical and occupational therapies were received during the facility admission. The medical record indicated the resident was discharged to her home 10/21/16. A post discharge plan of care dated 10/21/16 addressed the resident's needs after discharge. There was no summary that provided a description of services Resident #53 received while in the facility. An interview was conducted with the Director of Nursing (DON) on 12/02/16 at 2:27 PM. She stated the facility used to have a nurse that did discharge summaries. The DON explained with the changes in management staff, this position had gone by the wayside. The DON stated it was her expectation that the regulation regarding	F 283	Recapitulations of the residents #53 and #141 stay at the facility were completed by the Director of Health Services stating services received during their stay and where they resided after discharge. Residents with anticipated discharges in the past 30 days were monitored and recapitulation summaries Completed by the Director of Health Services as indicated on December 19, 2016. The Director of Health Services reeducated the Senior Care Partner, Clinical Care Coordinator and Wound Nurse on completion of recapitulations of residents stays. All discharged residents will be monitored for completion of recapitulations of Resident stays weekly by the Director of Health Services for four weeks, then biweekly for four weeks and monthly thereafter for three months. Audits will be submitted to the Quality Assurance Performance Improvement Committee for Review, monthly by the Director of Health Services for five months or until compliance is achieved. The committee will make changes to the plan as indicated.	

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F 283	Continued From page 4 discharge summaries be followed. 2. Resident #141 was admitted to the facility 09/22/16 with diagnoses which included aftercare of a hip fracture and chronic pain with a history of narcotic dependence. An admission Minimum Data Set dated 09/29/16 indicated the resident expected to be discharge back to the community after receiving rehabilitation services. A review of Resident #141's medical record revealed physical, occupational, and speech therapies were received during the facility admission. The medical record did not indicate where the resident would reside after discharge. An undated post discharge plan of care specified the resident required physical and occupational therapies by a home care agency. There was no summary that provided a description of services Resident #141 received while in the facility. An interview was conducted with the Director of Nursing (DON) on 12/02/16 at 2:27 PM. She stated the facility used to have a nurse that did discharge summaries. The DON explained with the changes in management staff, this position had gone by the wayside. The DON stated it was her expectation that the regulation regarding discharge summaries be followed.	F 283		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		12/30/16

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard milk and bread products in the kitchen storage areas with expired use by or best buy dates, completely close foods products in kitchen freezer storage and discard yogurts with expired expiration dates stored in one of three facility nourishment refrigerators. The findings included: 1. Observations on 11/29/16 from 9:10 AM to 9:35 AM of foods stored in the facility's kitchen revealed the following problems: a. Observations on 11/29/16 at 9:13 AM of items stored in the kitchen's walk-in refrigerator revealed three half gallon containers of buttermilk with expired expiration dates of 11/14/16. Interview with the Dietary Manager (DM) on 11/29/16 at 9:15 AM revealed dietary staff should check the expiration dates of milk products, stored in kitchen refrigeration units, everyday and discard any items with expired expiration dates. b. Observations on 11/29/16 at 9:18 AM of food stored in the kitchen's walk-in freezer revealed the following food items were stored open to air and unprotected from possible contamination; one bag of cookie dough, one bag of chicken tender fritters, one bag of carrot coins and one bag of chicken fried patties.	F 371	1. The three half gallon containers of buttermilk were discarded. Cookie dough, chicken tender fritters carrot coins and chicken fried patties were appropriately sealed or discarded if they had be open to air. The three loafs of bread with expired past best use by dates were discarded. The three six ounce yogurts in the Memory Card Unit refrigerator were discarded. 2. A complete audit of all refrigerators, freezers, food storage areas and Nourishment Room Refrigerators was completed by the Administrator and Cook, on December 19, 2016 and items discarded as indicated. 3. Dietary staff were reeducated by the Dietary Manager on Food Storage, preparation, distribution and serving food under sanitary conditions. Nursing Staff were reeducated by the Clinical Care Coordinator on discarding of expired food Items and proper food storage. Nourishment room refrigerators will be audited twice daily by the Administrator or Manager on Duty and the 11-7 shift nurse for four weeks, once daily for four weeks and weekly thereafter for three months Freezers, refrigerators, and dry storage areas in the kitchen will be audited twice	

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F 371	Continued From page 6 Interview with the Dietary Manager (DM) on 11/29/16 at 9:22 AM revealed all foods should be completely covered when stored in the freezer by staff. c. Observations on 11/29/16 at 9:25 AM of food stored in the kitchen's dry storage room revealed three loaves of bread with expired best buy dates of 11/20/16 and one loaf of bread with an expired best buy date of 11/21/16. Interview with Cook #1 on 11/29/16 at 9:28 AM revealed the evening dietary staff should check the best buy dates on bread products which are stored in the kitchen everyday to ensure no products had expired dates. 2. Observations on 11/29/16 at 9:50 AM of foods stored in the refrigerator on the facility's Memory Secured Unit (MSU) revealed the unit's locked refrigerator contained three six ounce yogurts with expired expiration dates of 11/02/16. Interview with the Dietary Manager on 11/29/16 at 9:50 AM revealed it was the housekeeping department's responsibility to check the expiration dates of foods stored in the MSU refrigerator. Interview with the facility's Housekeeping Director on 12/02/16 at 1:25 PM revealed it was the housekeeping department's responsibility to check the expiration dates of foods stored in the MSU refrigerator every day and to discard any foods with expired expiration dates.	F 371	daily by the Administrator or Manager on Duty and Dietary Manager or Cook for four weeks, then once daily for four weeks and weekly thereafter for three months. 4. Monitors will be presented to the Quality Assurance Performance Improvement Committee by the Administrator for review monthly for six months or until the issue is resolved. The Committee will make revisions to the plan as deemed necessary.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		12/30/16

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Continued From page 7

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 8	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to follow infection control practices by repeatedly placing a box of gloves and a small plastic container from medication cart to residents' furniture and back to medication cart without cleaning the container while checking blood sugars and administering medications for 3 of 6 residents observed during medication administration (Residents #71, #78, and #29).

The findings included:

1. Review of facility policy for disinfection of noncritical care equipment revised October, 02, 2015 defined noncritical resident care equipment as items that come in contact with intact skin. These items may contribute to secondary transmission by contaminating the hands of health care workers or by coming in contact with other medical equipment that will contact mucous membranes or non-intact skin. It is important to regularly clean and disinfect reusable noncritical resident care items on a regular schedule as determined by the facility.

On 11/30/16 at 4:17 PM Nurse #4 was observed placing a glucometer and supplies used for performing finger sticks to obtain a blood sample for a blood sugar reading into a small plastic container. Nurse #4 took the plastic container and a box of gloves and placed them on Resident #71's over bed table. Nurse #4 used the articles in the plastic container to obtain a blood sample to check the resident's blood sugar. When the task was completed Nurse #4 disposed of the testing strip and placed the glucometer back into the plastic container. She then took the plastic

Nurse #4 was reeducated on infection control and the spread of infection. Use of the plastic container was discontinued by Nurse #4.

Nurses and Nursing Assistants were reeducated on, the spread of infection by the use of non-critical care equipment by the Clinical Care Coordinator.

Med pass observations to assure there are no deficient infection control practices will be conducted three times weekly by the Director of Health Services for four weeks, weekly for four weeks and monthly thereafter for three months.

Audits will be presented to the Quality Assurance Performance Improvement Committee for review by the Director of Health Services monthly for five months or until compliance is met. The Committee will make revisions to the plan as indicated

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F 441	Continued From page 9 container and box of gloves and placed them directly on the work area of the medication cart. Nurse #4 disinfected the glucometer correctly. Continued observation on 11/30/16 at 4:32 PM revealed Nurse #4 prepared medication for Resident #78 by placing pills in a medicine cup that sat on the work area of the medication cart. She put the medication cup in the same plastic container. Nurse #4 proceeded to Resident #78's room and started to place the plastic container on the resident's over bed table. She stopped and stated she forgot something and returned to the medication cart while holding the plastic container. During an interview at this time Nurse #4 stated she always took the plastic container from resident room to resident room. The nurse added she kept the container on the medication cart. Nurse #4 stated she should clean the container before taking it from room to room for infection control purposes. Nurse #4 was observed cleaning the bottom of the plastic container using the same procedure as disinfecting the glucometer. She did not clean the work area of the medication cart. Further observation on 11/30/16 at 4:41 PM revealed Nurse #4 placed items needed for a blood sugar check into the same plastic container and took it into Resident #29's room along with the same glove box taken into Resident #71's room. She placed these items on Resident #29's over bed table next to a stack of used tissues. Resident #29 was observed coughing and spitting into a tissue then adding this tissue to the stack of used tissues. Nurse #4 was observed taking the last glove from this glove box. She left the room and returned with a new box of gloves which she placed where the empty box had been. After the	F 441		

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F 441	Continued From page 10 procedure of checking Resident #29's blood sugar, Nurse #4 took the plastic container and glove box back to the medication cart with the intent of placing these items directly on the cart. When asked did she realize where the glove box had been, she returned the newly opened glove box to Resident #29's room. Nurse #4 was unaware of placing the glove box next to the soiled tissues on Resident #29's over bed table and the lack of cleaning the medication cart that had come in contact with the plastic container and glove box that had been in direct contact with residents' over bed tables. During an interview with the Director of Nursing (DON) on 11/30/16 at 5:17 PM the DON stated staff education regarding infection control practices was ongoing. The DON added she expected all staff to follow infection control practices to avoid spreading of germs from resident to resident.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		12/30/16

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F 514	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on medical observation, record review, and resident/staff interviews, the facility failed to document administered medications in the medical records for 1 of 6 residents reviewed for pharmacy services (Resident #29). The findings included: Resident #29 was admitted to the facility on 09/17/14. Her diagnoses included end stage renal disease (ESRD), type 2 diabetic mellitus (DM), and depression. Review of Resident #29's care plans dated 10/28/16 revealed that she was on dialysis 3 times weekly (Monday, Wednesday, and Friday) and at risk for dialysis related complications. The goal was for Resident #29 to maintain renal functions within the scope of disease and free of dialysis-related discomfort or complications through the next review date. Interventions included administering medications and monitoring shunt site for signs and symptoms of infection as ordered, documented noncompliance, and conducted labs as ordered by physician. Review of physician order dated 12/29/15 indicated that Resident #29 was on calcium acetate 667 milligram (mg), 2 capsules by mouth 3 times daily to be administered on 6:00 AM, 12:00 PM, and 5:00 PM for dialysis days. On non-dialysis days, the first dose was ordered to be administered at 8:00 AM. According to manufacturer's specification, calcium acetate helped to bind phosphate in the digestive tract for	F 514	1. Nurse #3 was reeducated on charting administered medications on the MAR 2. Licensed Nurses were reeducated on charting administered medications on resident MARs by the Clinical Care Coordinator. MARs for all residents were audited by nursing staff December 18, 2016 to identify charting omissions of administered medications. 3. During shift change, licensed nurses will monitor MAR documentation for the previous shift and the previous shift nurse will make corrections as indicated. Both nurses will sign an audit form to verify that the monitor has been completed. An audit of charting on administered medications of ten residents will be conducted by the Director of Health Services three times weekly for four weeks and weekly for four weeks and monthly thereafter for three months. 4. Monitors and audits will be presented to the Quality Assurance Performance Improvement Committee by the Director of Health Services monthly for five monthsor until compliance is achieved.	

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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 514	Continued From page 12	F 514		

dialysis patients. This medicine was used to treat high levels of phosphate in patients with chronic renal failure.

Review of Resident #29's Medication Administration Record (MAR) revealed that the nurse(s) who were supposed to administer calcium acetate to Resident #29 failed to complete the MAR entries for all three shifts on 09/14/16 and 10/16/16. The columns were completely blank without the nurse's initials and the charting codes.

A review of the progress notes from 09/10/16 to 10/20/16 revealed that no entries related to Resident #29's calcium acetate administration on 09/14/16 and 10/16/16 were charted. Review of facility staffing log for the second shift of 09/14/16 revealed Resident #29 was under the care of Nurse #3; she was on duty from 3:00 PM to 11:00 PM that evening.

In an interview on 11/30/16 at 2:49 PM, Resident #29 stated that the dietary staffs prepared her lunch on the dialysis days. The nursing staffs had administered her medications as ordered in a timely manner, monitored her shunt site for signs and symptoms of infection at least once per shift, and checked her bruit and thrills before & after dialysis. She was satisfied with the level of care received so far.

In an observation conducted on 11/30/16 at 2:57 PM, Resident #29's shunt was intact. The surrounding skins were in normal color and no redness, swelling, or any signs of infection was noted.

An interview was conducted on 12/02/2016 at

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	345462	A. BUILDING ______ B. WING ______	C 12/02/2016

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F 514	Continued From page 13 3:03 PM. Nurse #3 admitted that she was the nurse responsible for administering Resident #29 two capsules of calcium acetate 667 mg at 5:00 PM on 09/14/16. She was 100% sure that the medications were administered to Resident #29. Due to distractions during medication administration, she forgot to chart the administered medication in the MAR. Nurse #3 added she did not have a history of the above errors in the past. In an interview with Directing of Nursing (DON) on 12/02/2016 at 3:14 PM, she stated it was her expectation for all the entries in MAR to be filled regardless if the medications were administered to the Resident or not. If the medications were not administered, the nurse had to initial and chart the reason for not administrating the medications. According to the DON, it was unacceptable for any nurse to just leave a "blank" in the MAR.	F 514		
F 520 SS=F	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.	F 520		12/30/16

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F 520	Continued From page 14 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, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in October 2015. This was for one recited deficiency that was originally cited in October 2015 and subsequently cited in December 2016 on the recertification survey. The repeated deficiency was in the areas of food procurement, storage, preparation, and distribution. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tags were cross referred to: F 371: Food procurement, storage, preparation, and distribution: Based on observations and staff interviews, the facility failed to remove expired foods in several food storage areas and failed to cover foods completely in the walk-in freezer.	F 520	1. The Quality Assurance, Performance Improvement Committee was reeducated on the purpose and function of the committee by the Administrator. The committee consists of the Medical Director, the Administrator, the Director of Health Services, the Financial Counselor, the Social Worker, the Clinical Care Coordinator, the Senior Care Partner, the MDS Director, Medical Records and the Director of Maintenance. Expired food items in food storage areas and uncovered items in the freezer were discarded. 2. The QAPI committee will meet on a monthly basis and the agenda will include the developing of a retrospective effort to examine certain facility standards and determine the reasons for failure to meet any standards. Subcommittees will be developed to react to the committee□s findings and develop consistent compliance. All food areas were audited for expired and uncovered items. Staff	

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F 520	Continued From page 15 The facility was recited for F 371 for failing to remove expired milks in walk-in refrigerator, expired breads in dry storage area, and expired yogurts in refrigerator located of Memory Support Unit (MSU). F371 was originally cited during the October 2015 recertification survey for failing to keep food preparation equipment clean and failed to date an opened container of a supplemental beverage. An interview was conducted with the Administrator on 12/02/16 at 4:55 PM. The Administrator stated that she had assumed the position since July 2016. The facility's Quality Assurance (QA) Committee had met monthly to discuss the monitoring and progress for all the citations. In regards to the failure to remove expired foods in kitchen/MSU and failure to cover foods completely in walk-in freezer, the Administrator stated it was mainly due to lack of systematic procedures and human errors. The dietary staff were expected to check for expired food items daily in the kitchen, while the maintenance manager was responsible to check for expired food items in the hallway refrigerators daily. It was her expectation for the Dietary Manager (DM) to develop a plan, monitor and recheck the procedures on regular basis until the issues being corrected. The DM would then conduct random audit to ensure proper plan implementation. The goal was to avoid repeating the same deficiency in the future.	F 520	were reeducated to identify and discard potentially unsafe foods. 3. The QAPI Committee will develop systemic procedures and new approaches to repair causes of failed procedures. A double check system was devised to include two audits daily to identify and discard expired foods and foods that have been open to air. 4. Senior Nurse Consultant and the Registered Dietitian will review the QAPI Committees progress and make changes to the committees approaches as deemed necessary.	