STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING _____ B. WING _____	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILAS CREEK REHABILITATION CENTER	3350 SILAS CREEK PARKWAY WINSTON-SALEM, NC 27103

(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 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, interviews with the Hospice representatives and interview with the attending physician the facility delayed obtaining a Hospice referral for 1 of 1 resident who were reviewed for Hospice services. (Resident #107) Findings included: Resident #107 was readmitted to the facility on 4/27/17 status post hospitalization due to severe protein and calorie malnutrition, progressive dementia and acute cystitis. Review of the hospital discharge summary dated 4/27/17 revealed resident's legal guardian was contacted prior to discharge from the hospital to affirm the return to the nursing facility with Hospice care. Review of the medical record at the time of the survey revealed a significant change Minimum Data Set (MDS) assessment was in progress. There was not a revised care plan developed associated with the significant change. Review of the physician orders dated 4/28/17 revealed "hospice referral---after SNF [skilled nursing facility] eval [evaluation]."	F 250	The statements included in this plan of correction are not an admission and do not constitute an agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE Immediate Corrective Action: Resident #107 had an order for Hospice services faxed to Winston Salem Hospice and Palliative on 5-2-17 and she was admitted into the Hospice program on 5-3-17 while in the facility. Residents Affected by This Practice: Because all newly admitted residents are potentially affected by the cited deficiency, on 5/2/17, the Director of Nursing and Social Worker, reviewed all previous admissions to ensure no other medically related social services orders were	5/28/17

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

Electronically Signed | 05/27/2017

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F 250	Continued From page 1 Record review of the physical therapy (PT) and occupational therapy (OT) service screening form dated 4/28/17 revealed resident recently discharged from therapy on 4/7/17 and exhibits the same presentation as at discharge. The resident had met maximal potential and would not benefit from therapy services. According to the screening form the services of the PT and OT were not indicated. Review of the social work progress notes dated 4/28/17 at 11:17 AM revealed the social worker spoke with the guardian about Hospice services. The guardian indicated that she desired to waive Medicare benefits at this time and to transition resident to full Hospice services. Continued record review revealed the guardian preferred _____ (name of Hospice). Interview on 05/03/2017 at 9:14 AM with the Director of Nurses (DON) revealed she called the Liaison person of _____ [name of the Hospice services) on Monday 5/1/17 and was not able to make a direct contact with the Liaison person of the Hospice program. Further interview revealed the Hospice nurse will be in today referring to 5/3/17. Interview on 05/03/2017 at 9:15 AM with Nurse #4 revealed the usual practice was to inform the Social Worker (SW) of a Hospice referral but cannot remember whether she or someone else informed the SW of the Hospice referral. Interview on 05/03/2017 at 9:23 AM with the Director of SW revealed she was responsible for setting up the Hospice referral then call the family. During this initial interview the SW indicated that she had faxed (unsure of date) the	F 250	missed. No other resident were affected. Systemic Changes: To enhance currently compliant operations and under the direction of the Director of Nursing or Staff Development Coordinator, all administrative nursing staff and the Social Worker will receive in-service training regarding state and federal requirements for medically related social services by 5-28-17. The training will emphasize the importance of the facility's responsibilities to follow medically related social services orders to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with medically related social services. Monitoring: Effective 5-28-17, a quality-assurance monitoring tool was implemented by the Director of Nursing to ensure all orders for medically related social services are being followed as written. The Director of Nursing and Social Worker will conduct the quality assurance audit daily during clinical meeting using the quality assurance tool. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action until substantial compliance is achieved. Completion Date: 5-28-17	

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F 250	Continued From page 2	F 250		

referral papers to _____ [name of the Hospice services).

Interview on 05/03/2017 at 10:48 AM with the Director of SW, DON and Regional Clinical Director was held. The DON stated during the 5/1/17 stand-up meeting with the interdisciplinary team, she noted that there was a new order for Hospice services and called the Liaison person from Hospice on 5/1/17 with no response. Continued interview the DON indicated on 5/3/17 she called the Hospice services. During this interview the Director of SW stated she knew about the referral on Friday (4/28/17) but could not answer why the information was not faxed or called into the Hospice service. The Director of SW stated "I had to verify the order and make sure the family was in agreement." Continued interview the DON stated "I did fax the information on 5/2/17" to the Hospice services.

Interview on 05/03/2017 at 11:19 AM with the intake supervisory representative from the Hospice Services revealed she had not received a referral for Resident #107 until a facsimile was received on 5/2/17. The Hospice representative indicated the receipt confirmation for the fax was "5/2/17 at 11:39 AM." Continued interview with the Hospice representative revealed Hospice referrals are done during the week and weekends.

Interview on 05/03/2017 at 12:02 PM with the Hospice admission nurse revealed she assessed Resident #107 today 5/3/17 and admitted the resident into the Hospice program. The Hospice admission nurse stated that a nursing assistant will be scheduled 2-3 times a week to assist with direct care and services.

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F 250	Continued From page 3 An attempt to interview Resident #107 on 05/03/2017 at 12:24 PM was unsuccessful due to the medical decline and declined cognition. Interview on 05/04/2017 at 9:42 AM with the attending physician revealed the Hospice referral should have been done sooner than 5/3/17.	F 250		
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 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	F 280		5/28/17

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F 280	Continued From page 4 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. (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	F 280		

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F 280	Continued From page 5 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 record review, observations and interviews the facility failed to update the resident's care plan to reflect the resident's pressure ulcer status for 1 of 3 resident's reviewed for pressure ulcers (Resident #9). Findings included: Resident #9 was admitted on 9/13/15. The current diagnoses included a history of stage 4 pressure ulcers, hypertension, and torticollis. The resident had a care plan updated 3/1/17 for potential impairment of skin integrity. The goal stated that the resident would not develop any new areas of skin breakdown through next review and staff would have interventions in place to prevent altered skin integrity. Interventions included encourage good nutrition, hydration, follow facility protocols for treatment of injury, identify/document potential causative factor and eliminate/resolve issues where possible and keep skin clean and dry. The resident had a quarterly Minimum Data Set (MDS) dated 3/3/17. It revealed the resident was cognitively intact and did not have any pressure	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Immediate Corrective Action: For resident #9, the Resident Care Specialist developed an individualized care plan that addresses prevention, care and treatment of existing pressure ulcers, including specific interventions, measurable objectives and approximate time frames. Residents Affected by This Practice: Because all residents receiving care for pressure ulcers are potentially affected by the cited deficiency, on 5/11/17, the Director of Nursing audited the wound report for those residents to ensure that care plans were initiated, reviewed and revised as needed. No other resident were affected. Systemic Changes: To enhance currently compliant	

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F 280	Continued From page 6 ulcers but was at risk for a pressure ulcer. There was nothing on the care plan that indicated it had been reviewed after the completion of the 3/3/17 MDS. The resident's wound assessment dated 3/27/17 identified that the resident had a wound on her coccyx that measured 2 cementers (cm) x 2.6 cm and was a stage 3 pressure ulcer. A note from dietary dated 3/29/17 stated the resident was noted to have a wound to her coccyx. The dietary note indicated there would be a discussion with the resident about adding a supplement. Resident #9's quarterly Minimum Data Set (MDS) dated 3/31/17 revealed the resident was cognitively intact. The resident had a stage 3 pressure ulcer that measured 2.0 cm x 2.6 cm x 0 cm and had eschar tissue present. There was nothing on the care plan that indicated it had been reviewed after the completion of the 3/31/17 MDS. The MDS nurse was interviewed on 5/3/17 at 11:44 AM. She stated the resident developed a pressure ulcer after her annual assessment. She stated when they do a quarterly MDS, she would update the resident's care plans that were talked about in morning meetings. She stated on 3/27/17, the resident developed another pressure ulcer. She stated she did the MDS assessment on 3/31/17 and did not update the resident care plan at that time. She wasn't sure why it was not updated. She stated the care plan for pressure ulcers should have been updated on 3/31/17. The wound care nurse was interviewed on 5/3/17	F 280	operations and under the direction of the Director of Nursing or Staff Development/Infection Preventionist, all administrative nursing staff will receive in-service training regarding state and federal requirements for comprehensive care plans by 5-28-17. The training will emphasize the importance of the facility's responsibilities to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The care plan will reflect intermediate steps for each outcome objective if identification of those steps will enhance the residents' ability to meet his/her objectives. The interdisciplinary team will meet weekly to use these objectives to monitor resident progress. The interdisciplinary team includes, the Director of Nursing, Staff Development/Infection Preventionist, Resident Care Specialist, Unit Managers, Dietary Manager, Wound Care Nurse, and Social Worker. Monitoring: Effective 5-28-17, a quality-assurance tool was implemented by the Director of Nursing to ensure comprehensive care plans were developed, reviewed, and/or revised for residents that have developed pressure ulcers. The Director of Nursing or Staff Development/Infection Preventionist will conduct the assurance audit weekly using the quality assurance tool. Any deficiencies will be corrected on	

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F 280	Continued From page 7 at 2:46 PM about Resident #9. She stated the most recent pressure ulcer was found on 3/20/17 and the Wound Care Nurse was aware the resident was admitted from home with 14 stage 4 pressure ulcers. The Wound Care Nurse stated she usually didn't update the care plans. She stated she would usually give wound care updates to the MDS nurse so that she could update the care plans. The DON was interviewed on 5/4/17 at 12:40 PM. She stated the resident was on an air mattress and refused to offload weight or be turned by staff. The resident also had treatment orders in place for the current ulcer. She would expect the care plan to be individualized for each resident and updated quarterly.	F 280	the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action until substantial compliance is achieved. Completion Date: 5-28-17	
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. (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	F 371		5/28/17

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F 371	Continued From page 8 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 observations, record reviews and staff interviews the facility failed to ensure cookware, service ware and storage containers were clean, air dried and in good repair; freezer unit was free from an accumulation of ice; and food items were dated when opened. This had the potential to impact 69 of the 75 residents that resided in the facility. Findings included: Observation on 5/1/2017 at 11:15 AM with the interim Food Service Manager (FSM) during the initial tour of the kitchen revealed: " The walk in freezer had a heavy accumulation of ice and frost on the shelves. " An open ½ full (32 ounce) container of liquid whole eggs that was not dated when opened. " In the prep refrigerator an open jar of garlic which was undated when opened. " The green colored tops of plastic containers that stored dry cereal were sticky and soiled with a brown colored substance. Observation on 5/3/17 at 7:01 AM with Registered Dietitian (RD) #1 and the FSM (frequently joining and leaving during the observation) revealed Dietary Aide (DA) #2 was located at the steam table and used a towel to wipe dry (3) three wet food trays to be used for the breakfast meal. Further observations revealed 26 of 28 food trays were stacked wet. Fifteen (15) of thirty five (35)	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY Immediate Corrective Action: The ice build up in the walk in freezer was removed completely on 5-1-17. The walk in freezer was checked each day following and no further evidence of build up was discovered. On 5-1-17, the undated eggs were discarded and the jar of garlic was discarded. On 5-1-17 an in-service with all kitchen staff was conducted by the Certified Dietary Manager in regards to labeling and dating, open date for all food items. On 5-3-17, the single cracked divided plate discovered was discarded and the single round blue colored container (lip plate), was cleaned and stored. On 5-4-17, the (1) plastic container with cooking utensils were all rewashed immediately and the cup, 1/3 cup, cup and 1 cup measures were immediately rewashed. Residents Affected by This Practice: All residents have the potential to be affected by this practice. On 5-1-17 an in-service with all kitchen staff was	

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F 371	Continued From page 9 plate bases were stacked wet and in circulation for use. Six (6) of the (28) food trays were chipped. Four (4) of the fifteen (15) saucer dishes were stacked wet. One (1) of the four (4) divided plates were cracked. There was a round blue colored container stored with the divided plates on the steam table with brown particles inside the base of the dish similar to crumbs. This round blue colored container was sticky when touched. Interview on 05/03/2017 at 2:11 PM with DA #3 who stated after the dishes, utensils and cook wear have been washed, rinsed and sanitized, we (referring to the staff) should let them air dry. Interview on 05/03/2017 at 2:17 PM with DA #4 revealed any item washed should be air-dried. Interview on 05/03/2017 at 2:30 PM with the interim FSM who stated she expected staff to dispose of cracked dishes, items should be air dried and not stacked wet. Interview on 05/03/2017 at 3 PM with DA #2 who stated the food trays were stacked wet because there were not enough slots to air dry the food trays and was "just not paying attention." Interview on 05/03/2017 at 3:09PM with the Director of Maintenance (DOM) revealed an expert came out and repair air holes in the freezer system. Continued interview with the DOM who stated there might be air holes in another part of the freezer system. Observation on 05/04/2017 at 10:10 AM witnessed by the FSM revealed the clean cooking utensils were stored in plastic containers. One (1) of the plastic containers had cooking utensils	F 371	conducted by the Certified Dietary Manager in regards to labeling and dating, open date for all food items. On 5-3-17, the Certified Dietary Manager audited the dietary department to ensure food will be procured, stored, prepared and served satisfactory by federal, state or local authorities. Immediate twice daily monitoring was implemented to ensure these practices. No other concerns, issues were revealed. Systemic Changes: To enhance currently compliant operations and under the direction of the Certified Dietary Manager, by 5-5-17, all dietary staff were re-inserviced in regards to monitoring the freezer for ice build up, air drying trays, domes, bases and all utensils, monitoring for chipped, cracked plates, bowls, cups, serving glasses, discarding items with no open date as well as sanitation. A twice daily ongoing monitoring tool for opening and closing was put into place on 5-5-17 by the Certified Dietary Manager to monitor for ice build up in the walk in freezer, trays, domes, bases and all utensils are being air dried, monitoring for chipped, cracked plates, bowls, cups, serving glasses, discarding items with no open date as well as overall kitchen sanitation. Eastern Food Equipment was called on 5-8-17 to come and re-assess the walk in freezer. A new closure was ordered and should be in place by 6-2-17. All plastic containers previously used for cereal storage have been discarded. New serving trays were	

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F 371	Continued From page 10 mixed with a dried fruit similar to a cranberry and pieces of a substance similar to crumbs. Another plastic container had ¼ cup, 1/3 cup, ½ cup and 1 cup measurers that were stacked wet. Interview on 5/04/2017 at 10:30 AM with the interim FSM who stated she had information from the administrator of the action plan regarding the dietary department and then pointed toward her office. Continued interview with the FSM indicated the action plan was posted on the bulletin board in her office. Immediately, an observation and record review of the board with the interim FSM revealed a list of environmental repairs and painting to be done in the kitchen. There was no evidence that the action plan addressed the storage of wet utensils, stacking of wet dishes or labeling of opened food items. Interview on 05/04/2017 at 2:45:21 PM with the administrator and corporate representative was held. The administrator indicated he initiated an action plan based on the county inspection dated 10/19/2016 and the last federal survey ending 6/30/16. Review of the action plan provided at the time of the survey revealed no interventions or systematic changes to address the storage of wet items or cracked dishes. Interview on 05/04/2017 at 2:55 PM with the administrator revealed he expected racks be used so that wet cooking utensils, dishes and trays could be air dried. Record review of facility documents included in the May 8, 2017 mailing from the administrator revealed: " The Quality Assurance & Performance Improvement (QAPI) current and outgoing form	F 371	ordered to replace all chipped trays and should be received and in service by 6-2-17. A new rack for drying of all trays has been ordered and should be received and in service by 6-15-17. The Certified Dietary Manager will meet daily with the Administrator and update him as to when all new equipment has arrived and is in place. The Director of Maintenance will meet with the Administrator daily and update him as to when the new closure for the walk in freeze is complete as well as brief him on any new issues identified. Monitoring: Effective 5-5-17, a quality-assurance tool was implemented by the Certified Dietary Manager (twice daily ongoing monitoring tool for opening and closing) to ensure and monitor for any ice build up in the walk in freezer, trays, domes, bases and all utensils are being air dried, monitoring for chipped, cracked plates, bowls, cups, serving glasses, discarding items with no open date as well as overall kitchen sanitation. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action until substantial compliance is achieved. Completion Date: 5-28-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345003	A. BUILDING _____ B. WING _____	05/04/2017

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F 371	Continued From page 11 dated 12/6/16 instructed the previous FSM to correct and then monitor to stay in compliance (as it related to the citations from the county and recertification survey of 2016. The previous FSM indicated this would be completed by 12/14/16. " The QAPI review of current and outgoing form dated 1/24/17 revealed in service training was completed. The training was held on 1/20/17 which included drying pots, pans and to label and date open food products. " The QAPI review of current and outgoing forms dated 2/14/17, 3/14/17and 4/14/17 included environmental concerns in the kitchen and did not reference storage of wet items, air drying and/or cracked dishes. The 4/14/17 date indicated on 4/11/17 the FSM no longer was employed at the facility and on 4/17/2017 an interim FSM was hired. " A handwritten notation "added to QAPI 4/18/17" indicated a problem of multiple chips in plates and bowls with a goal for all plates and bowls be free from cracks and chips for service. The targeted date for completion was immediately and ongoing.	F 371		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		5/28/17

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F 520	Continued From page 12 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions that the committee put into place on August 3, 2016. This was for recited deficiency, which was originally cited in Dietary Service (F371) on a Recertification and complaint survey on June 30, 2016. The deficiency was in the area of F371.This deficiency	F 520	F520 QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Immediate Corrective Action: On 5-11-17, the Quality Assurance Committee, consisting of the Administrator, Director of Nursing,	

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F 520	Continued From page 13 was cited again on 5/4/2017 on a Recertification Survey. The continued failure of the facility during two surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. This tag is cross referenced to Findings included: F-371: Based on observations, record reviews and staff interviews the facility failed to ensure cookware, service ware and storage containers were clean, air dried and in good repair; freezer unit was free from an accumulation of ice; and food items were dated when opened. This had the potential to impact 69 of the 75 residents that resided in the facility. During the recertification and complaint survey of June 30, 2016 the facility was cited for Dietary Services (F 371). Based on observations, record reviews and staff interviews the facility failed to label and date food items stored in the freezer, walk in refrigerator and nourishment refrigerator. (2) Failed to properly store a scoop used to obtain flour. (3) Failed to maintain clean floors and walls. (4) Failed to replace or repair broken water faucet, cracked or missing floor tiles, crumbling walls and missing cove molding. (5) Ten of fifty eight serving bowls were chipped. (6) Failed to maintain a clean nourishment refrigerator and repair partially detached door gasket. (Unit B). During an interview with the Administrator, on 5/4/2017 at 4:30 PM he wanted to discussed the Quality Assurance and performance Improvement Action Plan for the kitchen was done on	F 520	Medical Director, Human Resources Coordinator, Certified Dietary Manager, Rehabilitation Program Manager, LPN/MDS, Director of Admissions, Staff Development Coordinator and Social Worker, met and discussed current and ongoing Quality Assurance Performance Improvement plans. Residents Affected by This Practice: All residents have the potential to be affected by this practice. No other concerns/issues were revealed. Systemic Changes: The Plan of Correction from the most recent Annual Re-certification Survey by the Department of Health and Human Services will be added to the Quality Assurance Committee once approved by the Department of Health and Human Services. Monitoring: Effective 5-28-17, all Quality Assurance tools for monitoring cited deficient practices from the most recent Annual Re-certification Survey by the Department of Health and Human Services have been put into place as well as all staff re-education within those affected departments. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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F 520	Continued From page 14 12/1/2016, he stated that kitchen: hire CDM repair all items list on the health department inspection dated 10/19/2016 and items list during 2016 annual Re-certification survey. Additionally, fix and paint all cracks in the ceiling, walls and throughout the entire kitchen. Replace hand was sink. Place hand wash sink. Place roller wheels on racks in the dry storage room and then re-paint floor and ceiling and walls. Replace worn out seals on coolers. Replace hanging pot rack. Replace or paint rusted metal on hoods and legs of all tables. Replace al racked tile on floor and wall. Repair walls in chemical closet ad kitchen bathroom. Replace any and all rusted trash cans. Replace and broken plastic trash cans. Update as 4/1/ 2017 I changed o Nutritious Lifestyles for RD services due to ongoing RD issues. Update On 4/11/2017 the CDM quit WON and I got an interim CDM to start 4/17/17 through Nutritious Lifestyles. Continuous Interview with the Administrator revealed that his expectation for the kitchen was that we have 100% (per cent) of compliance in the kitchen.	F 520	further review or corrective action until substantial compliance is achieved. Completion Date: 5-28-17	