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
	345148	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN ROAD GREENSBORO, NC 27410

(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
E 000	Initial Comments An unannounced recertification survey was conducted from 12/4/17 through 12/7/17.	E 000	E001 Friends Homes at Guilford did not have an emergency plan as complete or readily compiled as outlined in the surveyor tool, "Long Term Care Emergency Preparedness Worksheet" CMS Form #### (10/2017) that had specific requirements for Etags related to emergency preparedness. Administration used this form to crosswalk against the manual to ensure all of the components of the plan were in place. Policies, drills, exercises, inservice certificates and forms were all compiled together in a manual by the Administrator using the MedPass "Emergency Preparedness Planning and Resource Manual" as guide and supplementation. The MedPass "Emergency Management Guide" wall-mounted quick access manual was purchased and mounted for the Woolman reception area and the Whittier Security desk. All staff were inserviced on Emergencies and Disasters through Relias Online Training by 12/31/17. All staff was provided badges and inserviced on emergency codes using the Med Pass badges on 1/12/18. All components of emergency plan will be reviewed annually by the Safety Committee at its monthly meetings for ongoing compliance. The Environmental and Safety Director is responsible. We allege compliance as of 1/12/18.	
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to establish and maintain a comprehensive emergency preparedness (EP) which described the facility's comprehensive approach to meeting the health, safety, and security needs of their staff and resident	E 001		

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

Melissa Mayberry, Administrator | LNHA, MHA | 1-24-18

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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E 001	Continued From page 1 population during an emergency or disaster situation. The facility failed to address how the facility would coordinate with other healthcare facilities and whole community during an emergency or disaster. Findings included: Record review of the "Fire, Disaster and evcuation (evacuation) manual " provided by the facility as the EP policies and procedures revealed the manual did not contain a written established comprehensive EP program that met the federal requirements. Interview on 12/6/17 at 3:10 PM with Administrator was held. The Administrator stated the facility focused their efforts on the risk of resident elopement from the facility based on the Safety committee table top results and developed action plan. By 3:45 PM on 12/6/17 further interview with the administrator revealed she would communicate with the Safety committee to obtain additional information regarding the EP policies and procedures. Interview on 12/7/17 at 9:20 AM with the Safety secretary and administrator was held. Continued inquiry was made about the facility's comprehensive EP program. At the time of the interview no comprehensive EP program was provided. The Administrator and Safety secretary repeated that the facility had parts of the requirements for the EP program but had not been placed in a manual. Additionally, the administrator indicated the facility recently (no date provided) obtained a resource book to organize the EP program.	E 001		

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F 641	Continued From page 2	F 641	F641	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failted to accurately code Hospice services on the Minimum Data Set (MDS) for 1 of 3 residents reviewed who recieved Hospice services. (Resident #14) Findings included: Resident # 14 had cummulative diagnoses which included dementia and failure to thrive. Record review revealed Resident #14 was admitted into the Hospice program on 8/28/17. Review of the significant change MDS assessment dated 9/10/17 revealed Section O was not coded for Hospice. Interview on 12/07/17 at 4:25 PM with the MDS coordinator who stated "I forgot. It was a mistake" in not coding Hospice on the MDS assessment. Interview on 12/07/17 at 5:02 PM with the Administrator revealed she expected Hospice to be coded on the MDS assessment.	F 641	MDS Nurse changed MDS on 12/8/17 and submitted correction of this MDS showing correct hospice status. MDS Nurse will take a moment to check her work before submitting all MDSs beginning 12/15/17. Friends Homes has contracted with Peace Church Compliance Program to audit the MDSs for accuracy as part of the compliance and ethics program. Contract begins January 2018. The QA/Infection Control Nurse will be responsible for follow up on identified MDS issues on an ongoing basis through the QAPI program. We allege compliance on or before January 4, 2018.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676	F676 Facility will ensure that resident will be provided services to assure resident's individualized plan of care is met, so that resident can attain or maintain her highest practicable level.	

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F 676	Continued From page 3 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews the facility failed to provide restorative nursing services for 1 of 1 resident	F 676	A. The problem that led to the specific deficiency was that Resident #7 complained that she had not consistently received her restorative therapy services and this was confirmed by the staff that a restorative aide was not providing the resident the OT/PT recommended activity program. Resident requires extensive assist with bed mobility, transfers, toilet use and personal hygiene. A continuation of resident's physical/ occupational therapy exercise program was assigned to restorative aide, without care planning for resident. Restorative aides were being assimilated into the household staffing at this time. The process of having one restorative aide continue all therapy programs indefinitely without Interdisciplinary and restorative nurse care planning was not an effective way to achieve the resident's goals. B. Restorative Services were not outlined in plan of care for resident #7. Resident does have long term diagnosis of hip dislocation and joint derangement that are prior level debilitating issues that are the root to this resident's decline in transfer ability. Resident also has left ventricular ejection fraction of 45%. Resident had suffered from chronic diarrhea and anemia during period in review and this acute complication was	

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F 676	Continued From page 4 that was reviewed for participation in the restorative program (Resident #7). Findings Included: A review of the restorative case load, provided by the Director of Nursing (DON) revealed there were 18 residents scheduled to receive restorative services during the time of the annual recertification survey. Resident #7 was admitted to the facility on 3/7/17 and diagnoses included arthritis, weakness, congestive heart failure, anemia, anxiety and depression. A review of the minimum data set (MDS) dated 11/18/17 for Resident #7 revealed she required extensive assistance with bed mobility, transfers, toilet use and personal hygiene. She had not received any restorative nursing during the look back period and she was alert and oriented. A review of the care plan for Resident #7 dated 11/22/17 identified she needed assistance with personal hygiene, bathing, transfers and could no longer walk. Interventions included to allow resident to use motorized wheelchair and to follow physical therapy (PT) and occupational therapy (OT) instructions for toileting, transfers and locomotion. An interview with Resident #7 on 12/7/17 at 9:55 am revealed the facility had been short staffed and this had resulted in her not consistently receiving her restorative therapy. She stated that the restorative staff would often be pulled to work as a nursing assistant (NA) and they weren ' t available to provide her restorative exercises.	F 676	not addressed in care plan as factors in ADL and restorative care. The procedure for implementing the acceptable plan of correction for the specific deficiency cited is that the Administrator worked with the Recreational Therapist and Director of Nursing on person-centered care planning and developed with resident #7 an ADL/ restorative care plan on 12/22/17. Care Plan was reviewed with resident and found to be acceptable to that resident. ADL/Restorative care plan for resident #7 will be for active range of motion to maintain strength in legs and transfer training so that resident maintains ability to transfer as she is able. This will be achieved by working with recreational therapy or C.N.A. led small group 1:1 ROM exercises with a goal of three times a week to resident's tolerance. Transfer assist/ training will occur with household CNAs daily to resident's tolerance. Care plan will be reviewed quarterly or upon significant change of condition with the Interdisciplinary team and the resident.	

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F 676	Continued From page 5 A review of the restorative referral after discharge from OT dated 9/19/17 for Resident #7 identified she was to receive upper and lower extremity strengthening. A review the restorative treatment administration record (TAR) for Resident #7 identified a start date of 9/20/17. Treatments identified on the TAR were range of motion (ROM) to upper and lower extremities including a 2 to 3 pound weight bilaterally, wheelchair pushups, gluteal squeezes, theraband exercises abduction and retraction, 1 pound weight for flexion / biceps, diagonals and sponge ball treatment. There were no initials or documentation on the restorative TAR that the services had been completed. There was no documentation on the restorative TAR that Resident #7 had refused treatment. An interview on 12/7/17 at 2:30 pm with the restorative aide for Resident #7 revealed that the facility had been short staffed especially in September and she had been scheduled to be a NA about three times a week during that month. She explained that the NAs assigned to residents would try and ambulate and provide ROM for those residents on the restorative case load but she wasn ' t sure if Resident #7 received the restorative exercises she was scheduled for during that time. The restorative aide stated that staffing was better now, but she was still pulled to be a NA one to two times a week. She added that the Assistant Director of Nursing (ADON) provided her with the paperwork that identified who was on restorative and what exercises they were supposed to receive. She confirmed that Resident #7 was on the restorative program. The September 2017 restorative TAR was reviewed	F 676	C. The monitoring system to ensure that this plan of correction remains effective and corrected is that the facility is adapting its restorative program to be nursing driven and integrative and inter-disciplinary, versus therapy driven and restorative aide only. Facility will utilize Point of Care software to track daily restorative and ADL assist provided to residents. A restorative/ ADL Decline PIP will be created in the QAPI program to improve restorative processes on an ongoing basis. This interdisciplinary PIP began meeting weekly on January 9, 2018, and conducted a Fishbone Diagram, and will continue to meet until Plan-Do-Study-Act is complete. They are utilizing the book, "The Long Term Care Restorative Nursing Desk Reference" by Barbara Acello, and the F676 guidelines in the Phase II Long Term Care Survey manual Nov. 17 edition. In addition, the PIP is reviewing the "Activities of Daily Living Critical Element Pathway" CMS 20066 (5/2017). They are also utilizing Matrix Quality Measure reports for any resident that shows ADL decline and will incorporate ADL Decline into the QAPI slide deck. Progress of this PIP will be reviewed quarterly at the QAPI meeting.	

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F 676	Continued From page 6 with her and she stated that if the exercises were completed with the resident she would have put a checkmark on the date they were completed. She acknowledged that the September 2017 restorative TAR was blank. The restorative aide explained that sometimes Resident #7 would refuse her exercises and she would have documented refusal if that had occurred. An interview on 12/7/17 at 2:45 pm with the ADON revealed she received the therapy referrals for restorative and she would transfer this information to the restorative TAR and provide this to the restorative aides. The September 2017 restorative TAR for Resident #7 was reviewed with the ADON and she stated she didn ' t know why it was blank. She added she would expect that if the services were provided the restorative aide would document that they were completed. The ADON stated the restorative aides had been pulled to work as NAs due to some staffing shortages. She added when this happened the residents NAs were supposed to try and provide the restorative care but there was no system in place to communicate the restorative plans for residents to their NAs. An interview on 12/7/17 at 4:30 pm with the DON revealed the restorative staff had been pulled to work assignments because of some staffing shortages. She stated the NAs would try and pick up some of the restorative work load for the residents on their assignment, but she wasn ' t able to say how this was accomplished and there was no documentation of this. The DON stated it was her expectation that residents receive restorative care per their referral from therapy and that provision of the restorative care was documented as being completed.	F 676	D. The Point of Care documentation by the CNAs will be monitored by the MDS Nurse. The ADL Decline PIP will be coordinated by the QA/Infection Control Nurse. The Director of Nursing is responsible for the operation of nursing systems. E. We allege compliance on or before January 4, 2018.	

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F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews and record review the facility failed to provide nursing staffing of sufficient quantity and quality to provide restorative nursing services for 1 of 1 resident that was reviewed for participation in the restorative program (Resident #7). Findings included:	F 725	F725 Facility will ensure that sufficient nursing staff will be provided to assure resident's individualized plan of care is met, so that resident can attain or maintain her highest practicable level. Resident #7 will have her restorative goals achieved by working with recreational therapy, as well as certified nursing assistants. A. This practice was deficient by survey standards in that restorative aides were assigned the extensive list of exercises for the resident (which was a mirror of formal OT/PT program) and pulled to do other tasks, so they were not complete. Because these exercises were not care planned, nor captured on the MDS, nor were the resident's impacting degenerative diagnosis considered, the facility did not consider itself having a formal "restorative" program. The tasks assigned to restorative aides needed to be evaluated and distributed to the interdisciplinary team instead of one aide, which was done by nursing administration in care plan reviews of SNF residents. B. The facility is adapting its restorative program to be nursing driven and integrative and inter-disciplinary provided, versus therapy driven and restorative aide only.	

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F 725	Continued From page 8 This tag is cross referenced to : F-676 Based on record review, resident interview and staff interviews the facility failed to provide restorative nursing services for 1 of 1 resident that was reviewed for participation in the restorative program (Resident #7) An interview with Resident #7 on 12/7/17 at 9:55 am revealed the facility had been short staffed and this had resulted in her not consistently receiving her restorative therapy. She stated that the restorative staff would often be pulled to work as a nursing assistant (NA) and they weren ' t available to provide her restorative exercises. A review of the restorative referral after discharge from OT dated 9/19/17 for Resident #7 identified she was to receive upper and lower extremity strengthening. A review the restorative treatment administration record (TAR) for Resident #7 identified a start date of 9/20/17. Treatments identified on the TAR were range of motion (ROM) to upper and lower extremities including a 2 to 3 pound weight bilaterally, wheelchair pushups, gluteal squeezes, theraband exercises abduction and retraction, 1 pound weight for flexion / biceps, diagonals and sponge ball treatment. There were no initials or documentation on the restorative TAR that the services had been completed. There was no documentation on the restorative TAR that Resident #7 had refused treatment. An interview on 12/07/17 at 2:30 pm with the restorative aide for Resident #7 revealed that the facility had been short staffed especially in	F 725	C/D. Facility will utilize Point of Care software to track and MDS nurse to achieve this purpose through care planning. Point of Care documentation will be monitored by the MDS Nurse with the care planning process to ensure completion. A restorative/ ADL Decline PIP will be created in the QAPI program to improve restorative processes on an ongoing basis. The QA/Infection Control Nurse will be responsible for facilitating this PIP. The Director of Nursing is responsible for Nursing Department operations. E. We allege compliance on or before January 4, 2018.	

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F 725	Continued From page 9 September and she had been scheduled to be a NA about three times a week during that month. She explained that the NAs assigned to residents would try and ambulate and provide ROM for those residents on the restorative case load but she wasn ' t sure if Resident #7 received the restorative exercises she was scheduled for during that time. The restorative aide stated that staffing was better now, but she was still pulled to be a NA one to two times a week. She added that the Assistant Director of Nursing (ADON) provided her with the paperwork that identified who was on restorative and what exercises they were supposed to receive. She confirmed that Resident #7 was on the restorative program. The September 2017 restorative TAR was reviewed with her and she stated that if the exercises were completed with the resident she would have put a checkmark on the date they were completed. She acknowledged that the September 2017 restorative TAR was blank. The restorative aide explained that sometimes Resident #7 would refuse her exercises and she would have documented refusal if that had occurred.	F 725		
	An interview on 12/07/17 at 2:45 pm with the ADON revealed she received the therapy referrals for restorative and she would transfer this information to the restorative TAR and provide this to the restorative aides. The September 2017 restorative TAR for Resident #7 was reviewed with the ADON and she stated she didn ' t know why it was blank. She added she would expect that if the services were provided the restorative aide would document that they were completed. The ADON stated the restorative aides had been pulled to work as NAs due to some staffing shortages. She added when this happened the residents NAs were supposed to			

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F 725	Continued From page 10 try and provide the restorative care but there was no system in place to communicate the restorative plans for residents to their NAs. An interview on 12/07/17 at 4:30 pm with the DON revealed the restorative staff had been pulled to work assignments because of some staffing shortages. She stated the NAs would try and pick up some of the restorative work load for the residents on their assignment, but she wasn ' t able to say how this was accomplished and there was no documentation of this. The DON stated it was her expectation that residents receive restorative care per their referral from therapy and that provision of the restorative care was documented as being completed. During an interview with Administrator on 12/07/17 at 6:30 PM, the Administrator indicated that her expectation for staffing would be that all residents needs are being met and all services are provided by the facility.	F 725	F812 Facility will store, prepare, distribute and serve food in accordance with professional standards. A. The processes that lead to the deficiencies cited were lack of drying racks and insufficient monitoring and accountability of staff by supervisors. B/C. Proper hair restraints will be worn during food preparation and in food prep areas. The male dietary worker, as well as all dietary staff, were inserviced on safe food handler work attire as identified by the Serve Safe guidelines on 12/20/17. The administrative chefs and house supervisors are responsible for monitoring staff during preparation and service. Staff will be disciplined for non-compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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.	F 812	Ovens will be free of build-up and food particles. Staff was inserviced on following the posted cleaning schedule on 12/20/17 by Food Service Director. The administrative chefs and food service director will monitor compliance and follow the disciplinary process for non-compliant staff. Deep cleaning of equipment will be scheduled two times monthly beginning payroll schedule of 12/21/17 to 1/3/18. A rapid PIP with the dining department occurred on 12/18/17 to review root cause of	

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	345148	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN ROAD GREENSBORO, NC 27410

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F 812	Continued From page 11 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure hair restraints were worn while preparing food, failed to maintain clean kitchen equipment and failed to allow cook ware to air dry before being stored. Findings Included: An observation of the kitchen on 12/4/17 at 12:30 pm with the Chef revealed: 1. A male dietary worker with facial hair was dredging raw chicken livers in flour with no hair restraint or beard guard on. 2. The top convection oven had a significant build-up of black, burned on food particles. 3. Eleven steam table pans were stacked together wet on a clean storage shelf ready to be used. An interview with the Chef on 12/4/17 at 1:00 pm revealed the male employee should have had a hair net on while working in the kitchen He added that he did not believe the facility had any beard guards available. He stated the oven had not been cleaned because they had been short staffed. The Chef explained the steam table pans were supposed to be allowed to air dry on a different shelf before they were transferred to the storage shelf in the kitchen.	F 812	wet pans. From that: Dish drying racks were purchased and installed. Dishwashers will be consistently staffed. A Dishwasher Accountability Checkoff form will be completed by dietary supervisors on each shift. Employees who do not comply with dry pan storage will be reprimanded. These forms will be reviewed at the weekly QA meeting. The QAPI Committee will study the results and put further actions in place to correct the process. These dietary processes will be placed on the Quarterly QAPI Agenda for review of continued compliance by the QA/Infection Control Nurse. D. Morrison Food Services will take over dietary management on 1/8/18 and will be responsible. The Executive Chef was responsible from 1/4/18 until 1/8/18. E. We allege compliance on or before January 4, 2018.	

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F 812	Continued From page 12 An interview on 12/7/17 at 1:00 pm with the Director of Dining Services revealed it was her expectation that hair restraints, including those for facial hair were worn by staff while working in the kitchen and especially when they were preparing food. She stated it was also her expectation that all kitchen equipment was clean and that steam table pans were allowed to air dry before being stacked together and put away.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review of the Facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 11/09/17 annual recertification survey. This was for one recited deficiency in the areas of dietary services (F 371). This deficiency was cited again on the annual recertification survey on 12/07/2017. This continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA programs. Findings included: This tag is cross referenced to:	F 867	F867 Friends Homes at Guilford will develop a Quality Assurance and Assessment Program for identified deficient practices. A. The process that led to this deficiency is that the practice of stored wet pans in the kitchen, at the tag of Dietary Sanitation, was cited for two years in a row, indicating the QAA from 2016 was not effective of kitchen supervisors monitoring the situation. (We believe that the original QAA plan mentioned in the CMS 2567 alluded to the plan of 11/9/16 (not 11/9/17 as stated) for the previous year's annual recertification citation for F371.) B. The facility has revamped its QAA processes and moved towards a QAPI format for interdisciplinary and systemic reviews. Root cause of the dining sanitation issues were investigated in a fishbone diagram exercise and a rapid PDSA- PIP on 12/18/17 with dining staff and administration and new interventions have been put into place. An ongoing monitoring of systems has been implemented for wet pans involving drying racks, a check system, disciplinary	

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F 867	Continued From page 13 F- 371 Based on observations and staff interviews the facility failed to ensure: expired foods were discarded in the walk-in refrigerator, opened food items were sealed, labeled and dated in the dry storage room, cookware were not stacked together wet and food preparation equipment was clean. During the recertification survey, the facility was cited for F812 the facility failed to ensure hair restraints were worn while preparing food, failed to maintain clean kitchen equipment and failed to allow cook ware to air dry before being stored. During an interview with the Administrator on 12/07/17 at 6:32 PM, the Administrator indicated her expectattion for repeat tags, we would re-examine system to find the root cause of the the issue and address it with team involvement and buy in to the solution with guidance from field expert.	F 867	procedures, and a review at weekly QA of the check system. C. Morrison Food Service is assuming management of Dietary Department on 1/8/18 and will bring their toolkit of Quality Assurance monitoring systems to bear as well as those identified. D. The Administrator, in conjunction with the QA/Infection Control Nurse is responsible for QAPI systems. E. We allege compliance on or before January 4, 2018.	