

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

PRINTED: 07/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/09/2022
NAME OF PROVIDER OR SUPPLIER BERMUDA VILLAGE RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006		
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E 004 SS=F	<p>Develop EP Plan, Review and Update Annually CFR(s): 483.73(a)</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop 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:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency</p>	E 004		7/7/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/28/2022

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 004	<p>Continued From page 1</p> <p>Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to conduct and maintain a comprehensive emergency preparedness training program required to meet the health, safety and security needs of the resident population and staff during an emergency and or disaster situation. This failure had the potential to affect all staff and residents.</p> <p>Findings included:</p> <p>A review of the facility's Emergency Preparedness (EP) Plan occurred on 6/9/22 at 1:30 PM with the Nursing Home Administrator (NHA).The NHA indicated he was newly hired to the facility and was unaware the EP plan did not include participation in community-based training or tabletop exercises required. The NHA stated he expected this to be completed at least annually per requirement. The NHA explained the only EP training the facility has maintained in the past year was basic fire safety procedures during new hire orientation and computer-based learning module. The EP Plan was last reviewed on 5/25/22.</p> <p>An interview was conducted on 6/9/22 at 1:45 PM with the Maintenance Director. When asked if he had conducted annual training exercises to demonstrate all staff knowledge of EP procedures, he stated none have been done</p>	E 004	<p>Administrator held Disaster plan tabletop in-service on June 22, 2022 with staff. In-service included the following importance of Emergency plan, reviewed duties, and roles for each position, evaluated calendar of activities to ensure compliance.</p> <p>Compliance shall be ensured by the administrator or designee adhering to the defined schedule and reporting disaster-related activities to the QA committee for assessment, further discussion, and recommendations.</p> <p>Administrator or designee will hold drills and table-top exercise throughout the year to ensure compliance with monitoring and audits.</p>		

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E 004	Continued From page 2 except monthly fire drills. He also stated he had conducted no EP training exercises or in-services in the past 5 years of working as the Maintenance Director at the facility. He was unable to provide documentation to show staff knowledge and response analysis of required EP.	E 004			
F 000	INITIAL COMMENTS	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		7/7/22	

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F 550	<p>Continued From page 3 residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide a dignified dining experience for residents on the 200, 400, and 600 halls by providing them with foam cups and plastic bowls during four observed meals.</p> <p>On 6/6/22 at 12:15 PM, during an observation of lunch at the facility, residents on the 600 hall were served drinks in foam cups and fruit in plastic bowls.</p> <p>Interview with the kitchen cook on 6/6/22 at 12:35 who stated he was not sure how long the facility had been using disposable cups and bowls but stated they had been using them for "a while".</p> <p>On 6/7/22 at 8:25 AM, residents on the 200 and 400 hall were observed during breakfast to have foam cups with juice and plastic bowls with fruit</p>	F 550	<p>Director of Nursing (DON) in serviced all team members on June 22, 2022 regarding Resident Rights and the necessity of upholding the dignity of the residents. DON reviewed the importance of residents as it pertains to dining and the importance of using non-disposables.</p> <p>Administrator or designee will ensure compliance by conducting routine monitoring and audits. All adverse findings will be addressed immediately.</p>		

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F 550	Continued From page 4 for those who requested fruit with their breakfast. Observations made during lunch on 6/7/22 and breakfast on 6/8/22, showed that foam cups and disposable bowls were again used on the 400 and 600 halls. Interview with the food and beverage director on 6/8/22 at 10:53 AM in reference to the observed use of foam cup & plastic bowls, stated the facility has been attempting to purchase more non-disposable glasses and bowls from their contracted vendor since February, but the vendor was out of stock. He revealed he purchased non-disposable beverage tumblers & bowls from a local store on 6/6/22 after the Surveyors dining observation. Interview with the administrator and director of nursing on 6/8/22 at 11:45 AM who were not fully aware that some residents were consistently being served with disposable cups and bowls. The administrator and director of nursing both agreed that all residents should be given the same dignified dining experience regardless of their location in the facility.	F 550			
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 732		7/7/22	

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F 732	<p>Continued From page 5</p> <p>resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews the facility failed to ensure daily nurse staffing information was maintained for a minimum of 18 months. The facility maintained daily nurse staffing sheets for 6 out of 18 months.</p> <p>Findings included:</p> <p>In an interview on 6/7/22 at 11:30 am with the Director of Nursing (DON), she revealed she</p>	F 732	<p>Director of Nursing (DON) in serviced all team members on June 22, 2022 to include the importance of retaining documentation for 5 years.</p> <p>All new team members will be in serviced upon hire of policy to retain documentation for 5 years.</p> <p>Administrator or designee will ensure compliance by conducting routine audits.</p>		

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F 732	Continued From page 6 began her role at the facility in March 2022 and could not locate the nurse staffing sheets from dates prior to 1/1/22. The DON indicated she was aware of the requirement to maintain these records and expected them to be maintained for a minimum of 18 months. An interview was conducted on 6/8/22 at 12:24 pm with the Administrator. He indicated he was new to the facility as of May 2022 was not aware the facility had not maintained the nurse staffing sheets for less than 18 months. The Administrator further indicated the facility failed to keep record of the minimum of 18 months of nurse staffing sheets and expected the facility to maintain these records as required. In an interview on 6/8/22 at 1:15 pm with the Staffing Coordinator (SC), she revealed she began the responsibility of posting the nurse staffing sheets on 1/1/22. The SC indicated the previous DON had completed this task, however the facility could not locate the nurse staffing sheets for dates prior to 1/1/22. The SC further indicated she planned to make sure the nurse staffing sheets were maintained for a minimum of 18 months.	F 732	All adverse findings will be addressed immediately.		
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	F 812		7/7/22	

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F 812	<p>Continued From page 7 and local laws or regulations.</p> <p>(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.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§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:</p> <p>Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the main kitchen, satellite kitchen, and food storage areas of the facility: by not ensuring food items and food service supplies were not stored on the floor; by not ensuring resealed food items were dated and labeled during storage; by not maintaining the food service equipment in clean and debris-free condition; by not ensuring pots/pans and other dishware were stacked clean and dry; by not ensuring staff were wearing hair coverings on their heads and chin guards for facial hair during food preparations; and by not preventing cross contamination of cleaned dishware when using the dishwashing machine.</p> <p>Findings included:</p> <p>1a. During the initial tour of the kitchen on 6/6/22 at 10:38 AM, the following observations were made:</p> <p>2-unclean handwashing sinks; 2-brooms and 1-mop propped against wall with the heads on the floor; 1-deep fryer full with dark black/brown oil and with</p>	F 812	<p>Dietary manager in-service all team members on June 24, 2022 to include new daily cleaning schedules as well proper food procurement and storage.</p> <p>Food Service Director in-serviced all team members on June 22, 2022 regarding the proper use of hairnets/hair covering and beard nets during food preparation, handling and serving as well as its importance for safety and hygiene.</p> <p>Dietary and Director of Maintenance conducted a thorough kitchen walkthrough to initiate a punch list of items needing cleaned, repaired or replaced.</p> <p>New team members will be in serviced upon hire on proper use of hairnets/hair covering and beard nets.</p> <p>Dietary manager or designee will ensure compliance by conducting routine monitoring and audits. All adverse findings will be addressed immediately.</p>		

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F 812	<p>Continued From page 8</p> <p>food particles; -inside of a food warmer proofer with dried stains and dried food particles; -the inside and doors of 3-convection ovens consisted of dark, black grease build-up and crumbs; -floor beneath and surrounding the convection ovens had thick, dark brown, grease build-up; -the filters of the hood over the stoves full of thick white and gray lint; -the walk-in freezer contained white ice on the compressor fans and on the bags and cases of food items; -the floor of the walk-in cooler was rusted and there were pieces of paper and food scattered throughout.</p> <p>2-missing ceiling tiles and 5-damaged ceiling tiles in the paper supply storage room; -the floor of the cleaning supplies/broom area was stained emitting a foul odor and were brooms propped up against the wall with the heads on the floor.</p> <p>On 6/8/22 at 11:50 AM, observations in the satellite kitchen revealed 1-styrofoam cup flushed in the sugar in the Bin; the floor of the ice cream freezer was dirty with red/brown dried stains and the inside of the lid was stained with dark brown substances.</p> <p>1b. On 6/08/22 at 4:00 PM follow-up tours of the kitchen and food storage areas were conducted with the Administrator. There were 2-large bins containing white substances (appeared to be sugar and flour) which were not labeled, and a square shaped plastic item was lying in the substance of one of the 2-bins. The walk-in freezer consisted of large amounts of white ice</p>	F 812			

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F 812	<p>Continued From page 9</p> <p>covering food items and there was water dripping from the ceiling. There were 2-large missing ceiling tiles and 5-damaged ceiling tiles in the paper supply storage room. Chemical/broom area: There were opened cardboard boxes scattered on the floor throughout the chemical/broom storage area; several opened cases of soap and bleach were also scattered on the floor; 2-brooms were propped up against the wall with the heads on the floor; and the floor was stained with a foul odor.</p> <p>During an interview on 6/09/22 at 9:31 AM, the Administrator revealed the Food Service Director informed him that the Food Service Department did not have an assigned cleaning schedule, the dietary staff working in a particular food service area were responsible for cleaning that area. The Administrator stated these findings were not acceptable and would be taken care of immediately.</p> <p>2a. During a tour of the kitchen on 6/06/22 at 10:38 AM, four male dietary staff with facial hair were observed performing food preparation duties. The four males were not wearing chin guards or facial coverings.</p> <p>2b. During the meal tray preparation observation in the satellite kitchen on 6/06/22 at 12:06 PM, 1-nursing assistant was observed scooping soup into plastic bowls. The Activity Director and a second nursing assistant entered the kitchenette area and prepared beverages for residents as the dietary cook was plating the food at the steamtable in the kitchenette. The Activity Director and the 2-nursing assistants were not wearing hair coverings while in the meal</p>	F 812			

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F 812	<p>Continued From page 10 preparation area.</p> <p>3a. During the kitchen tour on 6/6/22 at 10:38 AM, there was 1-large dirty muffin tin with brown stains crumbs, 1-4" deep steamtable pan stacked wet and 1-4" deep steamtable pan with white residue stacked on the clean pots/pans storage rack.</p> <p>3b. On 6/8/22 at 12:45 PM, during the meal tray preparation in the satellite kitchen 24-bowls were stacked wet on the steamtable trayline.</p> <p>4. On 6/6/22 at 10:40 AM, during the initial kitchen tour one dietary staff was observed operating the high temp dishwashing machine. She was observed wearing plastic gloves and placing dirty dishware into the dishwasher then crossing to the end of the dishwasher and removing the cleaned dishware from the dishwasher, placing the cleaned items on the drying rack without removing her gloves and washing her hands. The dietary cook revealed one staff operated the dishwasher in the morning and one staff operated it in the evening.</p> <p>5a. During the initial tour of the kitchen's storage areas on 6/6/22 at 10:38 AM, the walk-in freezer consisted of multiple cases of food items stored in the middle of the floor and beneath the storage racks (some of these cases were open); 1-large case of hinged trays were stored on the floor in the paper supply storage room; and in the dry food storage room there was 1-case of canned sodas and 2-cans of food items stored on the floor beneath the storage racks.</p>	F 812			

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F 812	Continued From page 11 5b. On 6/08/22 at 4:00 PM follow-up tours of the kitchen and food storage areas were conducted with the Administrator. Multiple cases of food items were observed in the middle of the floor and on the floor beneath the storage racks in the walk-in freezer; and there were 7-cases of cooking oiled stored on the floor in the dry food storage room. 6a. During the initial tour of the kitchen and food storage areas on 6/6/22 at 10:38 AM, the dry food storage room contained the following: 2-large opened and not dated bags of cornmeal; 1-large opened bag of dry beans that were not dated; and resealed food items that were not date/labeled: 2-bags of rice, 1-bag of noodles, 1-bag of long grain rice, 2-bags of quinoa, 1-bag of cracker crumbs, 1-bag of dried apricots, 1-bag of cocoa powder, and 1-bag of pudding mix. 6b. On 6/8/22 at 11:50 AM, observation of the refrigerator in the satellite kitchen revealed 1-resealed pack of sliced cheese that was not dated; 1-resealed bottle of prune juice that was not dated; and 1-resealed pack of sliced bread that was not dated. 6c. On 6/8/22 at 11:55 AM, the observation of the residents' refrigerator revealed 1-20 ounce bottle of soda not labeled with the resident's name, room number and date stored; 2-plastic grocery bags containing multiple single-serve yogurt containers not labeled with a resident's name, room number and date stored; and 2(17 ounce)-bottles of flavored water with a room number but no resident's name or date of storage.	F 812			

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NAME OF PROVIDER OR SUPPLIER BERMUDA VILLAGE RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006		
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F 814 SS=F	<p>Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)</p> <p>§483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and an interview with the Administrator, the facility failed to ensure the area surrounding 1 of 1 trash compactor remained free from garbage, refuse and foul odors, and failed to ensure the side door of the compactor remained closed when not in use.</p> <p>Findings included:</p> <p>1a. During the tour of the food service areas on 6/8/22 at 10:38 AM, the area surrounding the trash compactor was littered with food particles, paper and had a foul odor.</p> <p>1b. On 6/8/22 at 4:00 PM a follow-up tour of the area containing the trash compactor was conducted with the Administrator. The side door of the trash compactor was open, food particles, pieces of paper and a foul odor were observed throughout the area. Also, there was a large bag of trash on the floor less than five feet from the trash compactor. The Administrator discarded the bag of trash into the compactor and closed the</p> <p>During an interview on 6/09/22 at 9:31 AM, the Administrator revealed the Food Service Director informed him that the Food Service Department did not have an assigned cleaning schedule, the dietary staff working in a particular food service area were responsible for cleaning that area.</p>	F 814	<p>Dietary manager scheduled thorough cleaning of basement and compactor by a 3rd party provider scheduled for June 24, 2022.</p> <p>Dietary manager in serviced all team members on proper disposal of trash and waste. Policy implemented that all trash will be collected in a portable container beside the compactor and disposed away at the end of each shift to maintain a clean area.</p> <p>Dietary manager or designee will ensure compliance by conducting routine monitoring and audits. All adverse findings will be addressed immediately.</p>	7/7/22	
F 867	QAPI/QAA Improvement Activities	F 867		7/7/22	

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F 867 SS=F	Continued From page 13 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 observations, record review and staff interviews, the facilities Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor their interventions that the committee put into place following the recertification and complaint survey conducted on 2/26/20. This was for two deficiencies that were originally cited in the areas of Develop Emergency Preparedness Plan, Review and Update Annually (E004), Food Procurement, Store, Prepare/Serve-Sanitary (F812) in February 2020 and recited on the current recertification and complaint investigation survey of 6/9/2022. The duplicate citation during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. Findings included: This tag is cross referenced to: 1. E004-Develop Emergency Preparedness Plan, Review and Update Annually-Based on record review and staff interviews, the facility failed to conduct and maintain a comprehensive emergency preparedness training program required to meet the health, safety and security needs of the resident population and staff during an emergency and or disaster situation. This	F 867	Administrator had a meeting with the Interdisciplinary Team on June 22, 2022 to reinforce the importance and necessity of a thorough QAPI review in process. Next QAPI meeting set to discuss the repeat tags and to implement a process to remediate these deficiencies. Executive Director will attend QAPI meetings going forward to ensure compliance and thorough corrections are being made. Executive Director or designee will ensure compliance by conducting routine monitoring and audits. All adverse findings will be addressed immediately.		

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F 867	<p>Continued From page 14</p> <p>failure had the potential to affect all staff and residents.</p> <p>A review of the facility's Emergency Preparedness (EP) Plan occurred on 6/9/22 at 1:30 PM with the Nursing Home Administrator (NHA). The NHA indicated he was newly hired to the facility and was unaware the EP plan did not include participation in community-based training or tabletop exercises required. The NHA stated he expected this to be completed at least annually per requirement. The NHA explained the only EP training the facility has maintained in the past year was basic fire safety procedures during new hire orientation and computer-based learning module. The EP Plan was last reviewed on 5/25/22.</p> <p>An interview was conducted on 6/9/22 at 1:45 PM with the Maintenance Director. When asked if he had conducted annual training exercises to demonstrate all staff knowledge of EP procedures, he stated none have been done except monthly fire drills. He also stated he had conducted no EP training exercises or in-services in the past 5 years of working as the Maintenance Director at the facility. He was unable to provide documentation to show staff knowledge and response analysis of required EP.</p> <p>A review of the minutes from the facility QAA meetings dated 7/2020 through the present show that the facility was working on fall, infection control, and wounds. There was no mention of emergency preparedness or kitchen sanitation. An interview conducted with the current Administrator and Director of Nursing (DON) on 6/9/22 at 2:08 PM, both of whom started working at the facility a few weeks prior to the current</p>	F 867			

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F 867	<p>Continued From page 15</p> <p>survey, revealed the facility did have an active Quality Assessment and Assurance Committee and they usually met quarterly. The administrator revealed the committee is due to meet next month and he and the DON will be attending for the first time. They both state that these two items will be addressed.</p> <p>2. Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the main kitchen, satellite kitchen, and food storage areas of the facility: by not ensuring food items and food service supplies were not stored on the floor; by not ensuring resealed food items were dated and labeled during storage; by not maintaining the food service equipment in clean and debris-free condition; by not ensuring pots/pans and other dishware were stacked clean and dry; by not ensuring staff were wearing hair coverings on their heads and chin guards for facial hair during food preparations; and by not preventing cross contamination of cleaned dishware when using the dishwashing machine.</p> <p>A review of the minutes from the facility QAA meetings dated 7/2020 through the present show that the facility was working on fall, infection control, and wounds. There was no mention of emergency preparedness or kitchen sanitation. An interview conducted with the current Administrator and Director of Nursing (DON) on 6/9/22 at 2:08 PM, both of whom started working at the facility a few weeks prior to the current survey, revealed the facility did have an active Quality Assessment and Assurance Committee and they usually met quarterly. The administrator revealed the committee is due to meet next month and he and the DON will be attending for the first time. They both state that these two</p>	F 867			

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F 867	Continued From page 16 items will be addressed.	F 867			