STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION CENTER	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation event ID DYNK11.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		1/14/16

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

Electronically Signed | 01/14/2016

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F 225	Continued From page 1 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident and staff interviews the facility failed to notify the administrator and failed to investigate and submit a 24 hour report to the North Carolina Health Care Personnel Registry (state agency) of a resident's complaint that a staff pinched her arm during incontinence care and caused a bruise for 1 of 2 residents sampled for abuse (Resident #82). The findings included: Resident #82 was admitted to the facility on 02/17/15 with diagnoses which included muscle weakness, dementia, heart failure, difficulty in walking, and kidney disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 10/25/15 revealed Resident #82 was mildly impaired in cognition for daily decision making. The MDS also revealed Resident #82 required extensive assistance with toileting and was always incontinent of bowel and bladder. A review of facility abuse investigations revealed there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Registry for Resident #82. A review of the weekly skin assessments for Resident #82 indicated there had been no skin assessments completed since 11/27/15.	F 225	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. F225 Investigate Allegations A 24 hour and a 5 day report for resident #82 were completed and faxed to the state on 12/17/15 and 12/22/15 respectively. All residents could potentially be affected by the cited deficiency. The facility's policies and procedures related to abuse prohibition and allegation reporting were reviewed and revised. The reporting section of the "Reporting Allegations of Abuse" policy was revised to indicate: 1) If the Administrator is in the building, he/she must be notified immediately of abuse allegations. 2) In the absence of the Administrator, the Director of Social Services or the administrative nurse on call must be notified immediately regardless of time of day/night.	

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F 225	Continued From page 2 A review of the nurse's notes from 11/28/15 through 12/17/15 indicated no nurse entries in Resident #82's medical record since 11/28/15. Further review of the nurse's notes revealed no documentation in regards to the allegation of abuse and/or the bruise on Resident #82's right forearm. During an interview on 12/15/15 at 8:32 AM with Resident #82 she stated a nurse aide (NA) pinched her right arm and made a bruise during incontinence care the night before but could not recall the NA's name. Resident #82 explained while the NA was changing her brief the NA became mad at her because she was unable to turn herself from side to side quickly and the NA pinched her arm. Resident #82 further explained the NA that pinched her right arm was black and had long fingernails. A bruise was observed on Resident #82's right forearm approximately 4 inches above the wrist area. Resident #82 stated she reported it to a nurse but did not know the nurse's name because she was a newer nurse at the facility. She stated she had also told NAs who had provided care to her about what had happened. She further stated she did not feel staff had listened to her concerns because no one had followed up with her or had asked her any questions about what had happened. During an interview on 12/15/15 at 2:50 PM with Nurse #1 she stated Resident #82 had told her that a nurse aide had pinched her right arm but couldn't remember the NAs name. She stated she reported it to the Assistant Director of Nursing (ADON) and to the Director of Nursing (DON). Nurse #1 indicated she had not filled out an incident/accident report and had not documented the incident in the nurse's notes.	F 225	3) The Director of Social Services or the administrative nurse on call must immediately notify the Administrator of allegation. The Social Services Director/Designee trained all staff on the Abuse Prohibition and reporting policies, including the revisions on 1/12 and 1/13/16. The Administrator trained the DON, ADON's/Administrative Nurses, department heads and key staff on the revised reporting policy concerning allegations of abuse, neglect, misappropriation, mistreatment of residents on 1/13/16. In-services for Resident Rights and Abuse Prohibition will be held quarterly. Audits will be completed by the Administrator on the next 10 allegations to ensure compliance with policy and regulations. Citation will be placed in the QAPI program for monthly monitoring/evaluation until resolved but no less than 6 months. Completion Date: 1/14/16	

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F 225	Continued From page 3	F 225		

During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #82 had complained to him that an NA had pinched her arm during incontinence care. He explained he did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had talked about it several times and he thought Resident #82 had reported it to a nurse.

During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had told her that an NA on night shift was changing her and pinched her arm. NA #5 further stated she had observed a bruise on the resident's arm and she had reported it to Nurse #1.

During an interview on 12/17/15 at 6:55 AM with Nurse #2 she confirmed she was the 3rd shift charge nurse and anytime there was an allegation of abuse she was responsible for calling the on-call administrator for instructions/directions on what needed to be done. Nurse #2 indicated Resident #82 reported the incident to her that an NA had pinched her arm during incontinence care. Nurse #2 further stated she called the on-call administrator by telephone and reported that Resident #82 had informed her that an NA had pinched the resident's arm and that a bruise was noted to the resident's right forearm. Nurse #2 indicated the on-call administrator, which was the ADON, had advised her to complete an incident/accident report and to slide it underneath the ADON's office door. Nurse #2 confirmed she had not documented what Resident #82 had told her in the resident's medical record because she was not advised to do so by the ADON during the telephone conversation. Nurse #2 further

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F 225	Continued From page 4	F 225		

confirmed she had completed an incident/accident report and she did slide it underneath the ADON's office door as she had been instructed.

During an interview on 12/17/15 at 8:07 AM with NA #6 she stated Resident #82 had told her on 12/14/15 that an NA had pinched her arm and had left a bruise. NA #6 indicated she had observed the bruise on Resident #82's right forearm. NA #6 further stated she reported what the resident had told her immediately to her supervisor, Nurse #2.

During a telephone interview on 12/17/15 at 8:52 AM with NA #7 she confirmed she had provided incontinent care to Resident #82 on Sunday night 12/13/15. NA #7 stated she had not pinched a resident's arm and was unaware of where that information would be coming from. NA #7 further confirmed she had worked her entire shift on 12/13/15. NA #7 indicated that no one from administration had asked her any questions and/or advised her of an allegation of abuse. She further indicated she had not spoken with the DON until the morning of 12/17/15.

During a telephone interview on 12/17/15 at 9:45 AM with the ADON she confirmed she assisted with investigations of grievances, abuse, and neglect. She stated if a resident reported a staff member had been pinched or had been rough with them staff was expected to report it immediately and the DON was to be notified. The ADON confirmed that Nurse #2 had reported to her on 12/14/15 via a telephone conversation that Resident #82 had complained that an NA had pinched her during incontinence care. She further confirmed she had advised Nurse #2 to complete

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F 225	Continued From page 5	F 225		

an incident/accident report and to slide it underneath her office door. She indicated she and the DON had talked with Resident #82 on Tuesday morning 12/15/15. The ADON further indicated a 24 hour report had not been completed because they did not see the allegation as abuse and/or an injury of unknown origin.

During an interview on 12/17/15 at 12:35 PM with the Director of Social Work she confirmed she assisted with investigations of grievances, abuse, and neglect. She stated if a resident reported a staff member had pinched them the staff was expected to report it immediately and the DON and the Administrator were to be notified. She explained it was her expectation when Resident #82 complained staff had pinched her the staff should have reported it immediately so that an investigation could have been done. She further stated she was informed of the incident and that the DON had obtained the information and was handling the investigation of the allegation. She revealed she was unaware the 24 hour report had not been completed.

During an interview on 12/17/15 at 12:57 PM with the DON she confirmed there had been no abuse or neglect investigations related to Resident #82 and there was no 24 hour report submitted to the North Carolina Health Care Personnel Registry. She stated she was made aware of Resident #82's complaint on Tuesday morning 12/15/15. She further stated a 24 hour report should have been submitted but she did not see the resident's complaint of being pinched by staff as abuse or as an injury of unknown origin.

During an interview on 12/17/15 at 5:20 PM the

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F 225	Continued From page 6 Administrator stated no one had reported to her that staff had pinched Resident #82 during incontinent care. She further stated she was made aware of the incident the morning of 12/17/15. She indicated it should have been reported to her so an investigation could have been done and it was her expectation for staff to report immediately when a resident reported staff pinched and/or was rough with them so she could investigate it. The Administrator further indicated she considered the incident in regards to Resident #82 being pinched by staff as an allegation of abuse.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews the facility failed to follow their abuse policy and procedure to investigate a resident's complaint that a staff had pinched her arm during incontinent care and caused a bruise for 1 of 2 residents sampled for abuse (Resident #82). The findings included: A review of an undated policy and procedure titled Administrative Policy and Procedure: Abuse, Neglect, Misappropriation, Mistreatment Policy and Procedure revealed in part it was the policy	F 226	F 226 Develop/Implement Abuse/Neglect Policies A 24 hour and a 5 day report for resident #82 were completed and faxed to the state on 12/17/15 and 12/22/15 respectively. All residents could potentially be affected by the cited deficiency. The facility's policies and procedures related to abuse prohibition and allegation reporting were reviewed and revised. The reporting section of the "Reporting	1/14/16

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F 226	Continued From page 7 of the facility that all residents have the right to be free and protected from physical abuse. A section labeled policy indicated in part the residents of the facility would not be subjected to abuse by anyone, including but not limited to, facility staff. A section labeled physical abuse read in part that physical abuse included hitting, slapping, and pinching. A section labeled reporting revealed in part it was the policy of the facility to report and investigate any suspected or alleged violation that has occurred in the nursing facility, and on the grounds, and events such as bruising of unknown source, unusual occurrences, patterns/trends that present a reasonable suspicion by the appropriate staff. The policy indicated in part the Administrator would provide notice to all appropriate state and regulatory agencies. Resident #82 was admitted to the facility on 02/17/15 with diagnoses which included muscle weakness, dementia, heart failure, difficulty in walking, and kidney disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 10/25/15 revealed Resident #82 was mildly impaired in cognition for daily decision making. The MDS also revealed Resident #82 required extensive assistance with toileting and was always incontinent of bowel and bladder. A review of facility abuse investigations revealed there were no 24 hour or 5 working day reports submitted to the North Carolina Health Care Personnel Registry for Resident #82. A review of the weekly skin assessments for Resident #82 indicated there had been no skin assessments completed since 11/27/15. A review of the nurse's notes from 11/28/15	F 226	Allegations of Abuse" policy was revised to indicate: 4) If the Administrator is in the building, he/she must be notified immediately of abuse allegations. 5) In the absence of the Administrator, the Director of Social Services or the administrative nurse on call must be notified immediately regardless of time of day/night. 6) The Director of Social Services or the administrative nurse on call must immediately notify the Administrator of allegation. The Social Services Director/Designee trained all staff on the Abuse Prohibition and reporting policies, including the revisions on 1/12 and 1/13/16. The Administrator trained the DON, ADON's/Administrative Nurses, department heads and key staff on the revised reporting policy concerning allegations of abuse, neglect, misappropriation, mistreatment of residents on 1/13/16. In-services for Resident Rights and Abuse Prohibition will be held quarterly. Audits will be completed by the Administrator on the next 10 allegations to ensure compliance with policy and regulations. Citation will be placed in the QAPI program for monthly monitoring/evaluation until resolved but no less than 6 months. Completion Date: 1/14/16	

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through 12/17/15 indicated no nurse entries in Resident #82's medical record since 11/28/15. Further review of the nurse's notes revealed no documentation in regards to the allegation of abuse and/or the bruise on Resident #82's right forearm.

During an interview on 12/15/15 at 8:32 AM with Resident #82 she stated a nurse aide (NA) pinched her right arm and made a bruise during incontinent care the night before but could not recall the NA's name. Resident #82 explained while the NA was changing her brief the NA became mad at her because she was unable to turn herself from side to side quickly and the NA pinched her arm. Resident #82 further explained the NA that pinched her right arm was black and had long fingernails. A bruise was observed on Resident #82's right forearm approximately 4 inches above the wrist area. Resident #82 stated she reported it to a nurse but did not know the nurse's name because she was a newer nurse at the facility. She stated she had also told NAs who had provided care to her about what had happened. She further stated she did not feel staff had listened to her concerns because no one had followed up with her or had asked her any questions about what had happened.

During an interview on 12/15/15 at 2:50 PM with Nurse #1 she stated Resident #82 had told her that a nurse aide had pinched her right arm but couldn't remember the NAs name. She stated she reported it to the Assistant Director of Nursing (ADON) and to the Director of Nursing (DON). Nurse #1 indicated she had not filled out an incident/accident report and had not documented the incident in the nurse's notes.

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During an interview on 12/16/15 at 4:30 PM with NA #1 he stated Resident #82 had complained to him that an NA had pinched her arm during incontinent care. He explained he did not know the exact date it happened but thought it happened the previous weekend because Resident #82 had talked about it several times and he thought Resident #82 had reported it to a nurse.

During an interview on 12/16/15 at 5:25 PM with NA #5 she stated Resident #82 had told her that an NA on night shift was changing her and pinched her arm. NA #5 further stated she had observed a bruise on the resident's arm and she had reported it to Nurse #1.

During an interview on 12/17/15 at 6:55 AM with Nurse #2 she confirmed she was the 3rd shift charge nurse and anytime there was an allegation of abuse she was responsible for calling the on-call administrator for instructions/directions on what needed to be done. Nurse #2 indicated Resident #82 reported the incident to her that an NA had pinched her arm during incontinence care. Nurse #2 further stated she called the on-call administrator by telephone and reported that Resident #82 had informed her that an NA had pinched the resident's arm and that a bruise was observed to the resident's right forearm. Nurse #2 indicated the on-call administrator, which was the ADON, had advised her to complete an incident/accident report and to slide it underneath the ADON's office door. Nurse #2 confirmed she had not documented what Resident #82 had told her in the resident's medical record because she was not advised to do so by the ADON during the telephone conversation. Nurse #2 further confirmed she had

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completed an incident/accident report and she did slide it underneath the ADON's office door as she had been instructed.

During an interview on 12/17/15 at 8:07 AM with NA #6 she stated Resident #82 had told her on 12/14/15 that an NA had pinched her arm and had left a bruise. NA #6 indicated she had observed the bruise on Resident #82's right forearm. NA #6 further stated she reported what the resident had told her immediately to her supervisor, Nurse #2.

During a telephone interview on 12/17/15 at 8:52 AM with NA #7 she confirmed she had provided incontinent care to Resident #82 on Sunday night 12/13/15. NA #7 stated she had not pinched a resident's arm and was unaware of where that information would be coming from. NA #7 further confirmed she had worked her entire shift on 12/13/15. NA #7 indicated that no one from administration had asked her any questions and/or advised her of an allegation of abuse. She further indicated she had not spoken with the DON until the morning of 12/17/15.

During a telephone interview on 12/17/15 at 9:45 AM with the Assistant Director of Nursing (ADON) she confirmed she assisted with investigations of grievances, abuse, and neglect. She stated if a resident reported a staff member had been pinched or had been rough with them staff was expected to report it immediately and the DON was to be notified. The ADON confirmed that Nurse #2 had reported to her on 12/14/15 via a telephone conversation that Resident #82 had complained that an NA had pinched her during incontinent care. She further confirmed she had advised Nurse #2 to complete an

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incident/accident report and to slide it underneath her office door. She indicated she and the DON had talked with Resident #82 on Tuesday morning 12/15/15. The ADON further indicated a 24 hour report had not been completed because they did not see the allegation as abuse and/or an injury of unknown origin.

During an interview on 12/17/15 at 12:35 PM with the Director of Social Work she confirmed she assisted with investigations of grievances, abuse, and neglect. She stated if a resident reported a staff member had pinched them the staff was expected to report it immediately and the DON and the Administrator were to be notified. She explained it was her expectation when Resident #82 complained staff had pinched her the staff should have reported it immediately so that an investigation could have been done. She further stated she was informed of the incident and that the DON had obtained the information and was handling the investigation of the allegation. She revealed she was unaware the 24 hour report had not been completed.

During an interview on 12/17/15 at 12:57 PM with the DON she confirmed there had been no abuse or neglect investigations related to Resident #82 and there was no 24 hour report submitted to the North Carolina Health Care Personnel Registry. She stated she was made aware of Resident #82's complaint on Tuesday morning 12/15/15. She further stated a 24 hour report should have been submitted but she did not see the resident's complaint as abuse or as an injury of unknown origin.

During an interview on 12/17/15 at 5:20 PM the Administrator stated no one had reported to her

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F 226	Continued From page 12 that staff had pinched Resident #82 during incontinent care. She further stated she was made aware of the incident the morning of 12/17/15. She indicated it should have been reported to her so an investigation could have been done and it was her expectation for staff to report immediately when a resident reported staff pinched and/or was rough with them so she could investigate it. The Administrator further indicated she considered the incident in regards to Resident #82 being pinched by staff as an allegation of abuse.	F 226		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews the facility failed to assess residents regarding the number of showers preferred per week for 3 of 3 residents reviewed for choices (Resident #35, #123, #3). The findings included: 1. Resident #35 was admitted on 11/04/15 with diagnoses including dementia, history of hip fracture, and chronic obstructive pulmonary disease.	F 242	F242 Right to Make Choices The Social Services Director/Designee has interviewed all resident's, including resident #'s 35, 123 and 3, for their preference in number of showers each week. The shower schedule has been updated with resident's preferences for the number of showers per week and timing of showers. When a resident could not answer for themselves, the	1/14/16

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F 242	Continued From page 13 Review of the admission Minimum Data Set (MDS) dated 11/11/15 revealed Resident #35 had severely impaired cognition and was totally dependent on staff with bathing. An interview was conducted with Resident #35's family member on 12/15/15 at 2:32 PM. During the interview the family member stated Resident #35 received 2 showers a week and she would like for him to have 3 showers a week. The interview further revealed the family member had not been asked how many showers a week Resident #35 preferred. During an interview on 12/17/15 at 8:13 AM Nurse Aide (NA) #1 stated residents were scheduled 2 to 3 showers a week and he checked the daily assignment sheet at the beginning of the shift to see which of his residents were scheduled for showers that day. NA #1 further stated if a resident requested additional showers he tried to accommodate the request. An interview with NA #2 on 12/17/15 at 8:20 AM revealed residents were scheduled 2 to 3 showers a week and if they requested additional showers the NAs tried to accommodate the request. An interview with the Director of Nursing (DON) on 12/17/15 at 10:32 AM revealed the Social Worker (SW) had recently interviewed residents regarding day or evening shower preference and gave the list to the Staff Scheduler so the information could be placed on the master shower list. The DON further stated residents were not assessed for how many showers they preferred every week and residents that were not	F 242	family/responsible party was asked. Shower preferences has been added to the admission packets. New residents will be asked about their preferences, frequency and time of day, upon admission. If the resident is unable to answer a family member/responsible party will be asked. Admissions Director will be responsible for relaying the information to the Staffing Coordinator so showers can be scheduled according to preference. The Staffing Coordinator is responsible for updating the master schedule and the schedule on each unit. Audits will be completed by the DON/Designee at a rate of 25% of residents every week for four weeks, then every two weeks for one month, then monthly for two months at a minimum. Citation will be placed in the QAPI program for monthly monitoring/evaluation until resolved but no less than six months. Completion Date 1/14/16	

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able to verbalize a preference were scheduled for 2 showers a week.

During an interview on 12/17/15 at 11:16 AM the SW stated she and her assistant had recently interviewed all current residents and asked them if they preferred a shower after breakfast, after lunch, or after supper and gave this information to the Staff Scheduler for the master shower list. The residents were not asked how many showers they preferred every week and family members were not contacted for residents that were not able to voice a preference. The SW noted when a resident requested more than 2 showers a week she notified the Staff Scheduler so this could be placed on the master shower list. The interview further revealed new admissions were being asked if they preferred a shower after breakfast, after lunch, or after supper.

An interview with the Staff Scheduler on 12/17/15 at 12:32 PM revealed the SW had recently interviewed all current residents and asked them if they preferred a shower after breakfast, after lunch, or after supper and gave this information to her to be added to the master shower list. The residents were not asked how many showers they preferred every week. The Staff Scheduler stated she was typically notified by the SW when a resident requested more than two showers a week and she changed the master shower list accordingly.

An interview conducted on 12/17/15 at 4:45 PM with the Administrator revealed it was her expectation for residents to receive as many showers a week as they wanted. She stated residents or their family members should be asked how many showers they wanted a week

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when they were admitted to the facility.
2. Resident #123 was admitted to the facility on 01/14/14 with diagnoses including diabetes, chronic kidney disease, ad hypertension.

His most recent Minimum Data Set, a quarterly dated 09/29/15, coded Resident #123 with intact cognition, having no behaviors, and requiring total assistance with bathing but only set up to limited assistance with other activities of daily living skills.

During an interview on 12/15/15 at 8:51 AM, Resident #123 stated that he was not able to choose the number of showers he preferred each week. He stated he was given showers twice a wee, on Wednesday2. Resident #123 was admitted to the facility on 01/14/14 and most recently on 07/16/14. His and Saturday but would prefer 3 showers each week.

Interview with Nurse Aide #3 on 12/16/15 at 2:37 PM revealed the showers were assigned to the nurse aides by nursing supervisors.

During follow up interview on 12/16/15 at 4:18 PM, Resident #123 stated that he was never asked how many showers he would like a week. He further stated he never asked for more showers because he was told he would get 2 showers a week. If given a choice, Resident #123 stated he would like to have 3 showers per week.

Nurse Aide (NA) #4 stated during interview on 12/17/15 at 10:47 AM that showers are provided per the printed shower schedule. She stated Resident #123 will occasionally get irritated if his showers are late, but then once he gets his

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shower he is happy. If a resident requests an additional shower, NA #4 stated staff try to accommodate the request if there are enough staff on duty.

Social Worker (SW) was interviewed on 12/17/15 at 12:50 PM. SW stated that she and her assistant went to each alert and oriented resident and asked them what time of day the resident preferred to receive the shower. SW stated the options included before or after meal times. She further stated neither she nor her assistant asked residents how many showers they wanted to take per week, only what time of day they preferred to receive a shower. SW also stated that residents would be scheduled for more than two showers per week if they initiated the request.

3. Resident #3 was admitted to the facility on 11/06/14 with diagnoses of heart failure hypertension and osteoporosis. The annual Minimum Data Set (MDS) dated 10/15/15 revealed Resident #3 was cognitively intact and required extensive assistance with bathing.
An interview conducted on 12/16/15 at 8:32 AM with Resident #3 revealed she received 2 showers a week and she would like to have at least 3 to 4 showers a week. Resident #3 stated she had been asked what time she preferred her showers to be but had never been asked how many showers a week she would like to have. She further stated she had told the nurses and nurse aides (NAs) she would like to have more showers.
During an interview on 12/17/15 at 8:13 AM

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Nurse Aide #1 stated residents were scheduled 2 to 3 showers a week and he checked the daily assignment sheet at the beginning of the shift to see which of his residents were scheduled for showers that day. NA #1 further stated if a resident requested additional showers he tried to accommodate the request.

An interview with NA #2 on 12/17/15 at 8:20 AM revealed residents were scheduled 2 to 3 showers a week and if they requested additional showers the NAs tried to accommodate the request.

An interview with the Director of Nursing (DON) on 12/17/15 at 10:32 AM revealed the Social Worker (SW) had recently interviewed residents regarding day or evening shower preference and gave the list to the Staff Scheduler so the information could be placed on the master shower list. The DON further stated residents were not assessed for how many showers they preferred every week and residents that were not able to verbalize a preference were scheduled for 2 showers a week.

During an interview on 12/17/15 at 11:16 AM the SW stated she and her assistant had recently interviewed all current residents and asked them if they preferred a shower after breakfast, after lunch, or after supper and gave this information to the Staff Scheduler for the master shower list. The residents were not asked how many showers they preferred every week and family members were not contacted for residents that were not able to voice a preference. The SW noted when a resident requested more than 2 showers a week she notified the Staff Scheduler so this could be placed on the master shower list. The

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F 242	Continued From page 18 interview further revealed new admissions were being asked if they preferred a shower after breakfast, after lunch, or after supper. An interview with the Staff Scheduler on 12/17/15 at 12:32 PM revealed the SW had recently interviewed all current residents and asked them if they preferred a shower after breakfast, after lunch, or after supper and gave this information to her to be added to the master shower list. The residents were not asked how many showers they preferred every week. The Staff Scheduler stated she was typically notified by the SW when a resident requested more than two showers a week and she changed the master shower list accordingly. An interview conducted on 12/17/15 at 4:45 PM with the Administrator revealed it was her expectation for Resident's to receive as many showers a week as they wanted. She stated Resident's or their Responsible Party should be asked how many showers they wanted a week when they were admitted to the facility.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;	F 272		1/14/16

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F 272	Continued From page 19 Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to comprehensively assess the triggered area related to falls for 1 of 3 sampled residents reviewed for falls. (Resident #86). The findings included: Resident #86 was admitted to the facility on 03/28/11. Her diagnoses included Alzheimer's Disease, chronic pain, major depressive disorder,	F 272	272 Comprehensive Assessments The IDT reviewed/analyzed falls for the last 5 months for resident # 86 on 1/14/16. The care plan was reviewed and updated as indicated. Residents who fall have the potential to be affected by the cited deficiency.	

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F 272	Continued From page 20 spinal stenosis and a history of falling. The annual Minimum Data Set (MDS) dated 11/20/15 coded Resident #86 with intact cognitive impairment, requiring limited assistance with bed mobility, transfers, toileting and bathing, and having had 2 or more falls since the previous MDS (which was a quarterly dated 09/29/15). The Fall Care Area Assessment (CAA) was dated 11/26/15. The Analysis of Findings stated "The resident has had a fall since the last MDS assessment. There was no injury at the time of the fall." Under physical performance limitations, staff had noted the resident had difficulty with balance. The CAA included conditions that can contribute to her fall risk such as agitation, cognitive impairment, and pain from arthritis. The fall CAA did not analyze the circumstances of her falling to adequate assess Resident #86's individual strengths, weaknesses and any associated causes of the falling and effects the fall has had on Resident #86. Interview with MDS Nurse #1 on 12/17/15 at 3:19 PM revealed she had been doing MDSs since July 2015. She stated that the MDS staff has been working with the MDS consultant who has read all of her CAAs. She stated she had been working on being more indepth with the information placed in the CAA and stated that Resident #86's fall CAA did not have any information to determine the cause and effect of the fall identified on the MDS. The QA nurse interjected during this conversation explaining that each fall was discussed in morning meeting to review the circumstances of the fall and the intervention to follow.	F 272	The QAPI Director in-serviced/trained the Interdisciplinary Team on the CAA process on 1/13/16. Training included: 1) Rationale for completing/working CAA's 2) The CAA process 3) Linking risk factors with carry-over to the care plan 4) Using appendix C of the RAI manual 5) Analyzing data of triggered CAA's 6) Care plan decision making and writing the CAA Summary narrative. The QAPI Director will review fall CAA's prior to the closing of the MDS to evaluate/audit the process for compliance. This will be done weekly for eight weeks then monthly for one month at a minimum. Citation will be placed in the QAPI program for monthly monitoring/evaluation until resolved but no less than six months. Completion Date 1/14/16	

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F 278	Continued From page 21	F 278		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) and have accurate information in the Care Area Assessment for 1 of 3 residents sampled for falls. (Resident #86).	F 278	F278 Assessment Accuracy A modification was made to resident # 86's MDS of 9/29/15 to correct the coding error for number of falls. This was done	1/14/16

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F 278	Continued From page 22 The findings included: Resident #86 was admitted to the facility on 03/28/11. Her diagnoses included Alzheimer's Disease, chronic pain, major depressive disorder, spinal stenosis and a history of falling. a. A quarterly Minimum Data Set (MDS) was dated 0731/15 for Resident #86. A Falls Investigation Worksheet revealed Resident #86 had fallen on 08/13/15 at 9:24 AM. The nursing note dated 08/13/15 at 11:38 AM revealed a restorative aide found Resident #86 on the floor in front of the commode. A Falls Investigation Worksheet revealed Resident #86 had fallen on 08/26/15 at 8:15 AM. The nursing note dated 08/26/15 at 8:33 AM revealed the resident was found on the floor next to her bed and she stated she was trying to transfer herself to the wheelchair to go to the bathroom. A quarterly MDS dated 09/29/15 coded Resident #86 with moderately impaired cognitive skills, wandering behaviors, being nonambulatory and requiring limited assistance with bed mobility, transfers and toileting. The MDS indicated Resident #86 had had no falls since the prior assessment. B. Review of additional Falls Investigation Worksheets and nursing notes revealed Resident #86 had the following falls: *on 10/02/15 at 7:30 PM the resident was found on the floor and stated she was on her knees cleaning the floor and got tired so she laid down.	F 278	on 1/11/16. On 1/14/16, the Administrator completed an MDS accuracy audit of 30% of residents who fell in October, November and December 2015. The QAPI Director trained/educated the Interdisciplinary Team on 1/12/16 and 1/13/16 on the CAA process and care planning. The team was also educated on MDS accuracy by the QAPI Coordinator. New MDS's will be audited by the Administrator if the resident had a fall since the previously completed assessment. Audit will be completed once a week for four weeks then twice a month for 1 month then once a month for one month to assess coding accuracy related to falls. Citation will be placed in the QAPI program for monthly monitoring/evaluation until resolved but no less than six months. Completion Date 1/14/16	

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No injuries were documented.
*on 10/10/16/15 at 2:55 AM the resident was found on the floor by the bed, attempting to toilet herself. She sustained a bruise on her lower left leg and left arm.
*on 10/26/15 at at 5:50 PM the resident was found on the floor next to her bed, lying on her back. She stated she was trying to put her shoes on. No injuries were documented.
*on 11/14/15 at 10:30 PM the resident was found on the floor beside her bed. She stated she was trying to transfer herself from the bed to her wheelchair. There were no injuries documented.
*on 11/15/15 at 9:30 PM the resident was found on her back, on the floor in front of the toilet. She sustained an abrasion to her hip, 2 skin tears to her lower leg, and a bruise to her leg.

The annual Minimum Data Set (MDS) dated 11/20/15 coded Resident #86 with intact cognitive impairment, requiring limited assistance with bed mobility, transfers, toileting and bathing, and having had 2 or more falls with no injury since the previous MDS (which was a quarterly dated 09/29/15).

The Fall Care Area Assessment (CAA) was dated 11/26/15. The Analysis of Findings stated "The resident has had a fall since the last MDS assessment. There was no injury at the time of the fall." The fall CAA did not analyze the circumstances of her falling to adequate assess Resident #86's individual strengths, weaknesses and any associated causes of the falling and effects the fall has had on Resident #86.

Interview with the MDS Nurse #1 on 12/17/15 at 3:19 PM revealed she had completed the MDSs dated 09/29/15 and 11/20/15 She stated that

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F 278	Continued From page 24 when completing a MDS, she gathered data from the chart, the point click care system completed by the nurse aides, therapy notes and information gathered during interviews with the staff, residents and/or family. She further stated that falls were discussed at the morning clinical meetings and a notebook was kept in the MDS office referencing each fall which she could refer to when completing each MDS. In referring to this book, the fall on 08/13/15 was noted in the fall book, however, the fall for 08/26/15 was not recorded in the fall book. MDS Nurse #1 further stated she did not know how she missed coding Resident #86's falls accurately on the 09/29/15 MDS. MDS Nurse #1 stated the MDS dated 11/20/15 inaccurately identified that Resident #86 had 2 or more with no major injury. She further stated the CAA dated 11/26/15 did not accurately reflect Resident #86 had multiple falls with no-major injuries. She was unable to explain how she made this error.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		1/14/16

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F 279	Continued From page 25 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop individualized care plans for 2 of 6 sampled residents that required assistance with activities of daily living (Residents #91 and #3). The findings included: 1. Resident #91 was readmitted on 07/05/15 with diagnoses including Alzheimer's disease, muscle weakness, chronic respiratory failure, and congestive heart failure. Review of the significant change Minimum Data Set (MDS) dated 10/21/15 revealed Resident #91 had severely impaired cognition and required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. The significant change MDS noted one upper extremity had impaired range of motion. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) Functional/Rehabilitation Potential dated 10/21/15 stated Resident #91 had the risk of functional decline secondary to immobility, urinary incontinence, weight loss, and depression. The CAA Summary noted Resident #91 required extensive assistance with most ADL and was	F 279	F279 Comprehensive Care Plans Resident #'s 91 and 3 have care plans addressing their ADL needs. All residents have the potential to be affected by cited deficiency. The QAPI Coordinator educated the MDS Coordinators and Interdisciplinary Team on 1/13/16 on developing care plans based on CAA information, specific resident risks, strengths, weaknesses, etc. and to ensure if CAA says "will proceed to care plan" that a care plan actually is developed or the current care plan is reviewed and revised if needed. Once comprehensive assessments are completed, the MDS Coordinators will print the CAA Summary and compare the care plan decision against the actual care plans to ensure none are missed. They will then sign and date it and turn it in to the QAPI Director for review/verification. This will be done for three months. The MDS Coordinator will complete an initial audit of 100% of care plans to verify	

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F 279	Continued From page 26 unsteady with her balance. The goal was to prevent decline in ability to bathe and to achieve the highest level of practical self-sufficient bathing. The CAA Summary further stated ADL Functional/Rehabilitation Potential had triggered and would be addressed in a care plan. Review of Resident #91's medical record revealed no care plan that addressed ADL. An interview was conducted with MDS Nurse #1on 12/17/15 at 11:22 AM. MDS Nurse #1 stated if the ADL Functional care area triggered it should be addressed in a care plan. MDS Nurse #1 reviewed Resident #91's significant change MDS during the interview and confirmed she had completed the assessment. MDS Nurse #1 could not locate a care plan plan that addressed ADL for Resident #91 and stated she had missed it when she completed Resident #91's other care plans. 2. Resident #3 was admitted to the facility on 11/06/14 with diagnoses of heart failure hypertension and osteoporosis. The annual Minimum Data Set (MDS) dated 10/15/15 revealed Resident #3 was cognitively intact and required extensive assistance with most activities of daily living (ADL). Review of the Care Area Assessment dated 10/12/15 revealed ADLs would proceed to care plan for Resident #3. Review of the care plan with next review date of 01/2016 revealed there was no ADL care plan for Resident #3. An interview conducted on 12/17/15 at 4:05 PM with the MDS Coordinator revealed there should have been an ADL care plan for Resident #3. He stated he was behind on updating care plans and had not had time to update Resident #3's care	F 279	all residents have a care plan addressing their ADL needs. The MDS coordinator will also verify care plans are present/developed according to the care plan decisions on the CAA summary. The DON/Designee will audit the care plans for four weeks then twice a month for one month then monthly for one month to monitor continued compliance. Citation will be placed in the QAPI program for monthly monitoring until resolved but no less than three months. Completion Date 1/14/16	

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F 279	Continued From page 27 plan to include ADLs. An interview conducted on 12/17/15 at 4:30 PM with the Director of Nursing (DON) revealed it was her expectation for all care plans to be up to date. She stated Resident #3's care plan should have been updated in 10/2015 after the last review.	F 279		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, posted facility procedures, and staff interviews the facility failed to keep track of perishable food by not labeling and dating food items from 1 of 2 nourishment room refrigerators. The findings included: Initial observations of the 100/200 hall's nourishment room on 12/14/15 at 10:33 AM revealed the following notices were posted in large capital letters on the front of the refrigerator: - "Please do not put healthshakes in this refrigerator!! Bring them to dietary. Thanks," The notice was signed by the Dietary Manager (DM).	F 371	F371 Food Storage The Dietary Manager in-serviced the dietary staff on the food storage policy on 12/14/15, including disposing of out of date foods, not leaving health shakes in the refrigerators and cleaning of refrigerators. Health shakes will be labeled with a “discard by” date when taken out of the freezer. Discard date to be 14 days. The nourishment room refrigerators will be checked twice a day by the dietary aide. The aide will dispose of out of date foods,	1/14/16

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F 371	Continued From page 28 - A second notice stated in part: "For the safety of our residents please label and date foods placed in this refrigerator. Cooked/prepared foods placed in this refrigerator can remain for 72 hours or 3 days. Use by dates will be honored until date and then disposed of. This refrigerator is for resident food only!!" The notice was signed by the DM. Observations of the contents of the 100/200 hall's nourishment room refrigerator on 12/14/15 at 10:33 AM revealed the following: Eleven (11) 4 ounce cartons of nutritional supplement shakes with no resident name or date to discard noted on any of the cartons. One paper bag of partially consumed fast food with a resident name written on the bag but no room number or date indicating when it was placed in the refrigerator. The receipt in the bag indicated the food was purchased on 11/19/15. One plastic grocery store bag which contained a partially consumed bunch of green grapes. The majority of the grapes were yellow, brown in color. There was no name, room number or date noted on plastic bag indicating when they were placed in the refrigerator. One plastic grocery store bag which was labeled on the outside with a resident name and room number but had no date indicating when it was placed in the refrigerator. The bag contained deli sliced sandwich meat and cheese and the grocery store label on the packages indicated the items were purchased on 11/05/15. Green colored mold was noted on the sliced cheese. One plastic grocery store bag which contained one partially consumed and one whole boxed pumpkin pie. The store label indicated a sell by date of 11/20/15. There was no name, room	F 371	take any health shakes left in refrigerator back to the kitchen and will clean the refrigerator per policy. After the refrigerators are checked, the dietary aide is to initial on the date of a dedicated calendar. The Dietary Manager in-serviced nursing staff on the food storage policy on 1/12 and 1/13/16. To ensure compliance, the Dietary Manager will check the nourishment room refrigerators twice daily, Monday through Friday for four weeks then twice a week for two weeks then once a month for two months. The Dietary Manager will initial the calendar behind the dietary aide. Citation will be placed in the QAPI program for monthly monitoring until resolved but no less than six months. Completion Date 1/14/16	

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number or date noted on the plastic bag or either box indicating when the pies were placed in the refrigerator.

A subsequent observation in the 100/200 hall's nourishment pantry on 12/14/15 at 11:24 AM revealed Dietary Aide #1 checking over the contents of the refrigerator and discarding a few items. Dietary Aide #1 handled several of the nutritional supplement shakes, and the bags containing the fast food, grapes, pies, and sliced meat/cheese but did not discard any of the items. An interview was conducted with Dietary Aide #1 during the observation and he stated he was discarding any snacks with a resident label from the previous evening. When asked about resident's personal food stored in the refrigerator Dietary Aide #1 stated when he noticed something had been there awhile he threw it out.

An interview with the Director of Nursing (DON) on 12/14/15 at 3:29 PM revealed she expected the kitchen staff to monitor the contents of the nourishment room refrigerators and discard out of date food items and beverages as needed daily. The DON stated resident's personal food items should be labeled with their name and date it was placed in the refrigerator. The DON observed the contents of the 100/200 halls refrigerator during the interview and confirmed the fast food bag, grapes, pies, and sliced meat/cheese should have been discarded per the posted procedure.

During an interview on 12/14/15 at 3:37 PM the DM stated daily monitoring of the nourishment room refrigerators was an assigned task for dietary staff twice a day and she expected them to discard resident's snacks from the previous evening. The DM further stated resident's

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F 371	Continued From page 30 personal food stored in the refrigerator should be labeled with a name and the date it was placed in the refrigerator and would be discarded by dietary staff after 7 days. The interview further revealed the nutritional supplement shakes were not supposed to be stored in the nourishment room refrigerator because they were only good for 14 days after they were thawed and there was no way to know what day the shake was thawed when it was placed in a nourishment room refrigerator. The DM confirmed the nutritional supplement shakes, fast food bag, grapes, pies, and sliced meat/cheese should have been discarded per the posted procedure by dietary staff including Dietary Aide #1. The DM could not explain why these items had not been discarded and noted all dietary staff had been inserviced regarding the nutritional supplement shakes and discarding out of date foods. During a follow up interview on 12/15/15 at 8:10 AM the DM stated residents' and family members could actually store cooked or prepared foods in the nourishment room refrigerators for 7 days and she needed to change the notice on the front of the refrigerator. An interview with the Administrator on 12/17/15 at 3:32 PM revealed she expected the dietary staff to remove any unlabeled food, nutritional supplement shakes, and out of date food items from the nourishment room refrigerators when they made their morning and evening rounds.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		1/14/16

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F 520	Continued From page 31 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February of 2015. This was for three recited deficiencies which were originally cited in February 2015 on the recertification survey and on the current recertification survey. The deficiencies were in the areas of reporting an abuse allegation, comprehensive assessments and food procurement/storage. The continued failure of the facility during two federal surveys of	F 520	F520 QAA Committee Quality Assurance Performance Improvement Committee members and key staff were in-serviced on what QAPI is, why it is important and the basic principles of the five elements of a QAPI program on 1/13/16 by the QAPI Director. The five elements are as follows: 1) Design and Scope 2) Governance and Leadership 3) Feedback, Data Systems and Monitoring	

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F 520	Continued From page 32 record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: 1. F225 Reporting abuse allegations. Based on record reviews and resident and staff interviews the facility failed to notify the administrator and failed to investigate and submit a 24 hour report to the North Carolina Health Care Personnel Registry (state agency) of a resident's complaint that a staff pinched her arm during incontinence care and caused a bruise for 1 of 2 residents sampled for abuse (Resident #82). F225 was originally cited during the February 2015 recertification survey for failure to investigate an injury of unknown origin and file a 24 hour and 5 working day report to the North Carolina Health Care Personnel Registry (NCHCPR). During an interview conducted on 12/17/15 at 5:15 PM the Administrator stated the Quality Assessment and Assurance (QAA) Committee were continuing to work on areas of concern from the recertification survey conducted in February 2015. She stated they had a large staff turnover and were continuing to educate staff on a daily basis. She further stated the QAA Committee was working very hard to make improvements. 2. F279 Comprehensive assessments. Based on record review and staff interview, the facility failed to comprehensively assess the triggered area related to falls for 1 of 3 sampled residents reviewed for falls. (Resident #86). F272 was originally cited during the February 2015 recertification survey for failure to comprehensively assess 10 of 33 residents sampled for assessments including residents'	F 520	4) Performance Improvement Projects 5) Systematic Analysis and Systemic Action The QAPI Director/Designee will hold additional training sessions for the committee members/key staff to provide more in-depth training of the five elements. Training will be completed over the next five weeks. The five elements will be incorporated into the QAA program so as to transition to a QAPI program. The QAA/QAPI program will meet monthly to evaluate compliance for cited deficiencies for no less than six months. The facility Administrator will ensure training and meetings occur. The Administrator and Risk Manager will monitor compliance of the committee regarding implemented processes and interventions for no less than six months.	

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strengths and weaknesses, how the area impacted functionality and the analysis of the information determining the direction of the care plan.
During an interview conducted on 12/17/15 at 5:15 PM the Administrator stated the Quality Assessment and Assurance (QAA) Committee were continuing to work on areas of concern from the recertification survey conducted in February 2015. She stated they had a large staff turnover and were continuing to educate staff on a daily basis. She further stated the QAA Committee was working very hard to make improvements.
3. F371 Food storage. Based on observations, posted facility procedures, and staff interviews the facility failed to keep track of perishable food by not labeling and dating food items from 1 of 2 nourishment room refrigerators. F371 was originally cited during the February 2015 recertification survey for failure to maintain the cleanliness of the exterior door panels of the reach-in refrigerator, knife rack, coffee machine, and microwave.
During an interview conducted on 12/17/15 at 5:15 PM the Administrator stated the Quality Assessment and Assurance (QAA) Committee were continuing to work on areas of concern from the recertification survey conducted in February 2015. She stated they had a large staff turnover and were continuing to educate staff on a daily basis. She further stated the QAA Committee was working very hard to make improvements.