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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	1084 US 64 EAST PLYMOUTH, NC 27962

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242 SS=D	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.	F 242		4/25/16
	This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review the facility failed to honor a resident ' s choice of time to get out of bed preventing her from attending an activity for 1 of 3 residents (Resident # 32) reviewed for choices. Findings included: Resident #32 was admitted 10/25/11 with diagnoses which included anxiety, depression, chronic obstructive pulmonary disease, stroke, muscle weakness and peripheral vascular disease. Her most recent quarterly Minimum Data Set (MDS) of 1/18/16 indicated she was cognitively intact with no delirium, hallucinations, delusions or behaviors. She was assessed to have 2-6 days of feeling down, depressed or hopeless and feeling tired or having little energy. She was listed as requiring total care with bathing and dressing and extensive assistance with bed mobility, transfers and personal hygiene. She was noted to have a functional limitation of range of motion on one side for both upper and lower extremities. She utilized a motorized wheelchair for mobility. On her last annual MDS of 8/25/15, she indicated it was very important to her to participate in group		Roanoke Landing Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Roanoke Landing Nursing & Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke Landing Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding F 242 Resident #32 will continue to have her	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/15/2016

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

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F 242	Continued From page 1 activities. A review of care plans indicated Resident #32 experienced feelings of sadness, depression and restlessness. A goal to decrease sighs, pacing and hand wringing/picking was noted. Interventions included encouraging resident to attend group activities. Her care guide posted in the room listed Activities of Choice. An interview was conducted with Resident #32 on 3/28/16 at 2:48 PM. She stated she would like to get up by 9:30 AM on Wednesdays and Fridays so she is able to attend Bingo activities at 10:30 AM. She stated she prefers to be up by 10:30 AM on all other days. She indicated she can only get up whenever staff is available. She reported she did not get up until noon on Saturday, 3/26/16, because the staff gave all the showers before they got her up. She reported she had discussed this with the Administrator on several occasions in the past but " nothing had changed. " On Wednesday, 3/30/16 at 8:54 AM, Resident #32 was observed sitting up in bed eating breakfast. She indicated she had told Nursing Assistant #1 (NA) that she wanted to be up and ready by 9:30 AM for Bingo. On 3/30/16 at 10:10 AM, Resident #32 was observed sitting up in bed in her gown. She stated " that ' s the way it always is. I don ' t know why they can ' t rotate so I ' m not always last. I ' ve complained to the Administrator but nothing changes. " On 3/30/16 at 11:11 AM, an interview was conducted with NA #2 who indicated she often worked with Resident #32. She stated residents were assisted in the following order: those in restorative dining then those who ate in the dining room and any other residents who had doctor ' s appointments or dialysis. She stated the NAs	F 242	choices honored and be assisted out of bed in a timely manner to allow for participation in her activity of choice. An interview was conducted with 100% of all alert and oriented residents to include resident #32 by the Social Workers to be completed by 04-22-16 to determine whether resident choices were being honored to include being assisted out of bed in a timely manner to allow for participation in activity of choice. The MDS nurses immediately addressed all identified areas of concerns by updating the resident care plan and care guide to reflect the residents□ preference by 04-22 -16. The Social Worker and the Activity Director reviewed the federal resident rights to include the right to self-determination and make choices about daily life, such as, choosing activities, daily schedule, and plan of care with all alert and oriented residents to include resident # 32 and a copy of the federal resident□s rights was given to the residents by the Activity Director on 4/14/16. An in-service was initiated on 04-14-16 by the Administrator, Director of Nursing, Staff Facilitator, and Resident Care Coordinator with all staff to include NA #1, NA #2, all CNAs, and all licensed nurses, Social Workers, and Activity, Housekeeping, Dietary, and Therapy staff regarding honoring a residents□ choice to include to be assisted out of bed in time to allow for participation in their preferred activities. All newly hired staff will be in-serviced during orientation by the Staff Facilitator regarding honoring a	

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F 242	Continued From page 2 tried to get residents up in time for activities but that Resident #32 did not always make it to Bingo. On 3/30/16 at 2:13 PM, an interview was conducted with NA #1 who was responsible for Resident #32 ' s care that day. She reported she assisted residents going to restorative dining then the dining room then those that were going out for dialysis. She stated she tried to honor requests to get resident ' s ready before activities but they didn ' t always make it. She stated this morning she had two residents requiring incontinence care and there was no one to assist her if she got tied up. She stated she knew Resident #32 wanted to go to Bingo but there was not a lift available at the time she needed it to get her up. On 3/30/16 at 3:11 PM, an interview was conducted with Nurse #1 who was responsible for Resident #32 ' s care. She stated she had tried to get residents to activities because we know that ' s all they have to do. She stated the nursing staff will assist if they can but there are times that the residents don ' t make it to activities. On 3/30/16 at 3:37 PM, an interview was conducted with the Director of Nursing (DON). She stated the facility only had 2 mechanical lifts (used to assist totally dependent resident in getting out of bed). She indicated 2 more had been ordered. The DON revealed that Resident #32 had come to her today and told her she didn ' t get to go to Bingo today and " I told her we ' re working on that. " She stated Resident #32 was made aware by NA #1 that there was not a lift available at the time she needed it. On 3/30/16 at 4:25 pm, an interview was conducted with the Administrator (Admin). She indicated she was in the process of writing up a grievance report regarding Resident #32 not being able to attend Bingo today. She revealed	F 242	resident□s choice to include to be assisted out of bed in time to allow for participation in their preferred activities. A resident choice questionnaire will be presented to all newly admitted residents upon admission by the Activity Director and the Activity Assistant regarding activity preferences. The MDS nurses will immediately update the resident□s care guide and resident care plan to reflect activity preferences per the questionnaire. An audit will be conducted with 10% of all alert and oriented residents to include resident #32 by the Activity Director and Activity Assistant weekly x 8 weeks then monthly x 2 months to ensure residents preferences are being honored and for any changes in preferences utilizing a QI Resident Choices Audit Tool. The MDS nurses will immediately address any identified areas of concern and update the resident care plan and resident care guide for any changes. The Administrator or DON will review and initial the QI Resident Choice Audit Tool weekly x 8 weeks then monthly x 2 months for completion and to ensure all concerns were addressed. The Quality Insurance Nurse will compile the results of the QI Resident Choice Audit Tool and present to the Executive Quality Insurance Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	

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F 242	Continued From page 3 that the request for 2 new Viking lifts was approved March 8 but that she was just notified today when she called to check on the status that she would need to send a physical purchase order before they would be ordered. She indicated she would take care of that today. On 3/31/16 at 10:12 AM, the Assistant Activity Director was interviewed. She stated most of the residents who like to play Bingo are usually there but sometimes they are late. She stated she would go to the hall and speak to the Nursing Assistants if she knew a resident wanted to be there but the staff did the best they could. She stated sometimes she plays Resident #32 ' s card for her until she can get to the activity room. On 3/31/16 at 10:52 AM, a second interview was conducted with the DON. She stated Resident #32 had not voiced any previous concerns with her regarding missing activities. She stated the resident had discussed earlier this week about not getting up until noon on Saturday. She indicated she had discussed Resident #32 ' s preferences and would reeducate the staff. On 3/31/16 at 10:58 AM, a second interview was conducted with the Admin. She stated she was aware of previous concerns from Resident #32 regarding not getting to Bingo and she had begun working on the NA assignment book with the DON in the past week to address a new order of how residents are assisted out of bed.	F 242		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356		4/25/16

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F 356	Continued From page 4 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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. 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate staffing data by combining nursing facility (NF) residents and skilled nursing facility (SNF) residents for the census and staff hours. The findings included: During the initial tour on 3/28/2016 at 10:38 AM, the " Daily Nursing Staff " posting was visible on a wall at the nursing station. The posting was	F 356	Roanoke Landing Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	

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F 356	Continued From page 5	F 356		

dated 3/23/2016 and the resident census line was blank. Written at the bottom of the page was " Nursing Home Hours - 3 " . The 3 hours were not subtracted from the total actual hours worked column at the right of the page.
On 3/28/2016 at 3:40 PM, the " Daily Nursing Staff " dated 3/28/2016 was posted on the wall at the nursing station. The resident census was listed as 107. " Nursing Home Hours - 3 " was documented at the bottom of the page, but the 3 hours were not subtracted from the total hours worked column.
On 3/29/2016 at 9:40 AM, the " Daily Nursing Staff " dated 3/29/2016 was posted on the wall at the nursing station. The census was listed as 108. Nursing Home Hours - 3 " was documented at the bottom of the page, but the 3 hours were not subtracted from the total hours worked column
On 3/29/2016 at 3:40 PM, an interview was conducted with the Minimum Data Set (MDS) nurse, who stated he was responsible for the staff posting. He indicated he had been out for a week and the posting was not updated while he was gone. A review of the Daily Nursing Staff posting for 3/28/2016 and 3/29/2016 was conducted with the MDS nurse. The MDS nurse stated the census of 107 and 108, respectively, was for the whole facility which included the SNF and the NF. He indicated the actual SNF census for 3/28/2016 was 102, and the census for 3/29/2016 was 103. He indicated the new form his corporation required him to use had no place to separate the SNF census from the NF census, so he had listed them together. He stated he estimated the nursing assistants had spent 3 hours per day on care for the NF residents, and he had documented that at the bottom of the page. He stated he did not subtract the 3 hours for the NF

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F 356 POSTED NURSE STAFFING INFORMATION
The Daily Nursing Staff Hours form was corrected by the Resident Care Coordinator on 3/30/16 so that only the census for the SNF were posted, facility name, current date, total number and the hours worked for licensed and unlicensed staff.
The Director of Nursing and the Resident Care Coordinator were in-serviced by the facility consultant on 4/7/16 regarding accurate and timely posting of nursing staffing hours. All Licensed Nurses were in-serviced by the Director of Nursing and Resident Care Coordinator regarding accurate and timely posting of nursing staffing hours by 04-22-16. The in-service included the need to only post the census and nursing staffing hours for the SNF for their shift. The MDS Nurse is no longer employed at the facility
The 500 Hall Nurse will calculate the census and nursing staffing hours and report on the Daily Nursing Staffing Hours worksheet every shift on a daily basis to

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F 356	Continued From page 6 care from the total SNF care hours. He indicated he had not thought about subtracting any nurse hours spent on NF care. On 3/29/2016 at 3:59 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was aware the form was filled out with the NF beds included in the census, and that was correct as far as she knew. She indicated she would get clarification immediately. On 3/30/3016 at 9:27 AM an interview was conducted with the Administrator. The Administrator stated she had in-serviced the MDS nurse to put only the SNF resident census on the staffing form. A review of the 3/30/2016 " Daily Nursing Staff " post with the Administrator revealed the NF hours had not been deducted from the total hours. The Administrator stated she would recalculate the hours to reflect the posted hours were for the SNF only.	F 356	include weekends. The resident census and nursing staffing hours will only be posted for the SNF. The Director of Nursing will audit posting and accuracy of staffing hours Monday-Friday x 4 weeks, weekly x 4 weeks, then monthly x 2 months to ensure staffing hours posted are accurate using a QI Staffing Hours Audit Tool. Any concerns will be immediately addressed with reeducation of staff and correction of posted nursing staffing hours as needed. The Administrator will review the results of the QI Staffing Hours Audit Tool and initial weekly x 8 weeks and monthly x 2 months. The Administrator will compile the results of the QI Staffing Hours Audit Tool and present to the Executive QI Committee monthly x 4 months. Findings will determine if further monitoring or change in frequency of monitoring will be necessary.	
F 371 SS=E	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	F 371		4/25/16

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F 371

Continued From page 7
by:
Based on observations and staff interviews, the facility failed to: 1) Remove an expired food item from refrigeration in 1 of 1 walk-in refrigerators; and 2) Label and date meat products and cheese sandwiches stored in 1 of 1 reach-in refrigerators.

The findings included:

1) During an initial tour of the kitchen conducted on 3/28/16 at 10:30 AM, an observation of the kitchen ' s walk-in refrigerator revealed an unopened 5-pound container of Sour Dressing had an expiration date of 3/21/16 stamped on top of the container. A delivery sticker of the bottom of the container indicated the Sour Dressing was delivered to the facility on 2/1/16. Upon inquiry, Dietary Assistant (DA) #1 stated she believed this container of sour dressing had been delivered to the facility last week and thought the date stamped on top of the container indicated the delivery date. However, upon further inspection, the delivery date sticker was identified to be present on the bottom of the sour dressing and noted as 2/1/16. At that time, both DA #1 and Cook #1 acknowledged the Sour Dressing was expired and needed to be discarded.

An interview was conducted on 3/30/16 at 3:30 PM with the facility ' s Dietary Manager. During the interview, the Dietary Manager confirmed the sour dressing found in the walk-in refrigerator during the initial tour had been kept past its expiration date. She reported all undated and expired food products identified during the initial tour of the kitchen had been discarded.

2) During an initial tour of the kitchen conducted on 3/28/16 at 10:30 AM, an observation of the

F 371

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F371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY
All food items that were found to be past expiration date or not dated in the reach-in refrigerator and walk-in refrigerator, including meat products and cheeses sandwiches were thrown away by the dietary aid on 03-28-16 and not served to the residents.
100% audit of all foods items was conducted by the Quality Improvement Nurse on 3-31-16 to ensure no further expired items or undated items were

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F 371	Continued From page 8 kitchen ' s reach-in refrigerator revealed an opened, partial ham (approximately 4 pounds in weight) and an opened package containing approximately 2 pounds of sliced ham was not dated. During the initial tour, Dietary Assistant #1 reported both packages of the ham should have been dated as per departmental policy. The observation of the reach-in refrigerator conducted during the initial tour of the kitchen on 3/28/16 at 10:30 AM also revealed 4 cheese sandwiches wrapped in aluminum foil and 1 foil package containing cooked bacon strips were not dated. Upon inquiry, Cook #1 removed these items from the reach-in refrigerator and stated she needed to label/date these packages. The Cook reported she had placed the sandwiches and bacon in the refrigerator earlier in the morning and had forgotten to date them. An interview was conducted on 3/30/16 at 3:30 PM with the facility ' s Dietary Manager. During the interview, the Dietary Manager discussed the department ' s policy on the use and storage of leftovers. The Dietary Manager reported all food items placed in the department ' s refrigerators needed to be dated as to when they were opened. She indicated the departmental policy dictated that opened food items (such as ham, cheese sandwiches, and bacon) should not be kept for more than 5 days. The Dietary Manager reported all undated and expired food products identified during the initial tour of the kitchen had been discarded.	F 371	being stored on dry storage shelves, in the refrigerator, or in the walk in cooler. All foods found past their expiration date or undated were immediately discarded. 100% in-service of all dietary staff including DA #1 and Cook #1 was initiated by the Administrator to be completed by 4-22-16, regarding checking expiration dates and dating foods per dietary guidelines, to include meat products and cheese sandwiches. All new dietary staff will be in-serviced by the Dietary Manager during orientation regarding checking expiration dates and dating foods per dietary guidelines, to include meat products and cheese sandwiches. The Dietary Manager and or dietary aid will regularly check expiration dates of all food items before use and weekly to ensure no food items are served or remain on dry storage shelves, in the reach-in refrigerator, or in the walk-in refrigerator past their expiration date. All prepared foods will be dated with the preparation date prior to storing in the walk in refrigerator or reach-in refrigerator and all meats pulled for thawing will be dated with the date that items were pulled from the freezer. The Quality Improvement Nurse or Central Supply Clerk or Medical Records will monitor to sustain solution by conducting an audit of stored food items to ensure no expired food items, to include meats and cheese sandwiches remain on dry storage shelves, in the reach-in refrigerator, or in the walk-in refrigerator and that all items are dated appropriately per dietary guidelines using a QI Expiration Date	

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F 371	Continued From page 9	F 371	Audit Tool daily, Monday through Friday, x 4 weeks, weekly x 4 weeks, then monthly x 2 months. Any items found to be past their expiration date or undated will be immediately discarded and reeducation of appropriate dietary staff will be conducted regarding expiration dates and or dating of food items. The Administrator will review the QI Expiration Date Audit Tool weekly x 8 weeks and monthly x 2 months and initial to ensure compliance. The Results of the QI Expiration Date Audit Tool will be compiled by the Administrator and taken to the QI Executive Committee monthly x 4 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE LANDING NURSING AND REHABILITATION CENTER	**1084 US 64 EAST PLYMOUTH, NC 27962**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 520

Continued From page 10

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 observation and staff interviews, the facility ' s Quality Assessment and Assurance Committee (QAA) failed to implement, monitor and revise as needed the action plan developed to correct deficiencies in the area of Choices (F242) and Food Storage and Sanitation (F371) during the recertification survey on 6/18/2015. As a result, deficiencies in the areas of Choices and Food Storage and Sanitation were cited again on the current survey.
Findings included:
This tag is cross referenced to:
1. F242: Based on observations and staff interviews, the facility failed to honor a resident ' s choice of time to get out of bed for 1 of 3 residents reviewed for choices.
During the recertification survey of 6/18/2015, the facility was cited for failing to allow the resident to choose to take her medication at a later time.
2. F371: Based on observations and staff interviews, the facility failed to remove an expired food item from refrigeration in 1 of 1 walk in refrigerators and failed to label and date food items in 1 of 1 reach-in refrigerators.
During the recertification survey of 6/18/2015, the facility was cited for failing to provide a barrier between staff hands and ready to eat foods.
An interview was conducted on 3/31/2016 at

F 520

Roanoke Landing Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Roanoke Landing Nursing & Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke Landing Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F520 QAA Committee-Members/Meet Quarterly/Plans
The Administrator, DON and QI Nurse

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F 520	Continued From page 11 11:04 AM with the Administrator and the Quality Improvement Coordinator (QIC). The QIC stated the QAA Committee met monthly and as needed. The QIC stated all staff had been educated on the importance of resident satisfaction. The QIC stated the Social Worker (SW) performed monthly resident interviews for satisfaction of care. The QIC also stated corporate satisfaction surveys were conducted quarterly and were reviewed by the SW and were addressed by the appropriate department head. The QIC stated staff had been educated on how to handle bread items and daily dining room audits were being performed to ensure the staff were following the guidelines.	F 520	were educated by the corporate consultant on the QI process, to include implementation of Action Plans, Monitoring Tools and the Evaluation of the QI process, and modification and correction if needed on 04-14-16. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved. Completion date 04-14-16. The Facility consultant completed 100% audit of previously citation action plans within the past year to include honoring resident choices and labeling and dating food items to ensure that the QI committee has implemented, monitored, and revised as needed. Action plans were revised and updated and presented to the QI Committee by the administrator on 04-15-16 for any concerns identified. All data collected for identified areas of concerns to include honoring resident choices and labeling and dating food items will be taken to the Quality Assurance committee for review monthly x 4 months by the Quality Improvement Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by	

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F 520	Continued From page 12	F 520	Quality Improvement Nurse. The Executive committee Quarterly meeting minutes will be reviewed and initialed by the Facility Consultant to ensure implemented procedures and monitoring practices to address interventions, to include , honoring resident choices and labeling and dating food items and all current citations are followed and maintained Quarterly x 2. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	