STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(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 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 incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		6/13/16

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

Electronically Signed | 06/13/2016

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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's abuse and neglect investigations, the facility failed to notify the Health Care Personnel Registry of an abuse allegation within 24 hours and of the investigative findings of an abuse investigation within 5 business days for 1 of 5 abuse and neglect investigations reviewed (Resident #167). The findings included: Resident #167 was admitted to the facility on 01/05/16. Diagnoses included left hip fracture, left pubis fracture, and osteoporosis, among others. An admission Minimum Data Set (MDS) dated 01/12/16 assessed Resident #167 with intact cognition and frequently incontinent of bladder. Review of the facility's abuse investigation revealed that on 01/13/16 at 08:45 AM, Resident #167 was observed by staff to have on a urine soaked brief and stated she was sore and irritated. Resident #167 reported to staff that during the night, staff did not provide incontinence care but rather, she was encouraged by a nurse aide to use her brief instead of requesting toileting assistance. Review of the 24-Hour Initial Report revealed an incident date of 01/13/16 for an allegation of neglect. The fax confirmation revealed the facility submitted the 24-Hour Initial Report to the Health Care Personnel Registry (HCPR) on 01/15/16, 48 hours after the facility was notified of the allegation of neglect and submitted the 5-Working Day Report on 01/21/16, 6 business days after the facility was notified of the alleged abuse. During an interview on 05/20/16 at 03:47 PM, the	F 225	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F Tag 225-Investigate/Report Allegation/Individuals Resident Affected Resident # 167 the facility failed to notify Health Care Personnel Registry of an abuse allegation within 24 hours and of the investigation findings of an abuse investigation within 5 business days for 1 of 5 abuse and neglect investigations reviewed on 01/05/2016. Corrective Action for Resident Affected and Potentially Affected All residents have the potential to be affected by this alleged deficient practice. All 24 hour report and 5 day investigations in the last three months were reviewed by Administrator, Director of Nursing and Social Worker on 5/24/2016. That all alleged violations involving mistreatment, neglect, or abuse, including injuries of	

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F 225	Continued From page 2 Administrator stated that it was the facility's practice to report allegations of abuse to the HCPR in 24 hours and the investigation of the allegation in 5 working days. The Administrator stated that she often delegated this task and expected staff to follow it. The Administrator stated that if she delegated the task of reporting to the HCPR, she would follow up to make sure it was done, but that she could not explain the delay in reporting to the HCPR. During an interview on 05/20/2016 at 04:09 PM with the MDS Consultant revealed she provided assistance to the facility with reporting abuse allegations to the HCPR. The MDS Consultant stated that it was the facility's practice to notify the HCPR in 24 hours of an allegation of abuse, but in this abuse investigation, this was not done. The MDS Consultant stated that she assisted the facility with the allegation of abuse for Resident #167. The MDS Consultant stated that once she was made aware, she faxed the 24-Hour Initial Report to the HCPR, but up until she was notified, nothing had been done.	F 225	unknown origin/source and misappropriation of resident□s property are reported to the Administrator and a 24 hour report and 5 day investigation is completed and faxed to Health Care Personnel Registry within the designated time frame. Systemic Changes An in-service was conducted on Monday 6/13/2016- by Nurse Consultant who provided education with the Director Nursing, Nursing Administrative team, Administrator and Social Worker on proper reporting and filing of 24 hour and 5 day investigations with the Health Care Personnel Registry. Education included: Review of the 24 hour report and criteria that substantiates the need for the 24 hour report. That the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin/source and misappropriation of resident□s property are reported immediately to the administrator-The facility□s abuse officer. The 24 hour report must be completed thoroughly within 24 hours of the allegation and the 5 day thoroughly investigated and completed within 5 days and faxed to the Health Care Personnel Registry. A copy of the fax transmission sheet should be kept and filed along with the report faxed. Quality Assurance The Director of Nursing and the Director of Social Work will monitor this issue	

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F 225	Continued From page 3	F 225	using the "Survey QA Tool for Abuse and Grievances". The monitoring will include verifying that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin/source and misappropriation of resident□s property are reported to the Administrator and a 24 hour report and 5 day investigation is completed and faxed to Health Care Personnel Registry. See attached monitoring tool. This will be done daily Monday thru Friday including weekends for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. Completion date: 6/15/2016	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		6/15/16

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F 323	Continued From page 4 Based on observations, staff interviews, and facility record review, the facility failed to remove or dispose of a broken clay vase for 1 of 1 residents (Resident #21) to promote a safe environment. The findings included: Observation of the bathroom in room 210 on 05/18/16 at 10:00 AM revealed a brownish colored broken clay vase sitting on the sink ledge of resident's bathroom. The bathroom was unlocked and accessible to ambulatory and wandering residents. The one-piece vase contained rough and sharp edges, but no jagged edges. The broken pieces had been removed and were not observed. Observation of the bathroom in room 210 on 05/20/16 at 11:16 AM revealed many items were on the ledge of the sink, but no vase was noted. A return observation on 05/20/16 at 6:26 PM revealed multiple items observed on the sink ledge previously had been removed, except for the one piece broken vase. The vase had been placed back on the sink ledge. Resident #21 residing in room 210, was admitted to the facility on 03/19/15. Diagnosis included hypertension, neurogenic bladder, and manic depression. Review of assessments, care plan, and nurse's notes for Resident #21 revealed a quarterly Minimum Data Set dated 04/05/16 which assessed resident with impaired cognition, verbal inappropriate behaviors directed towards others and at times inappropriate behaviors directed towards self. Resident required extensive assistance from staff (2+ person) with most activities of daily living. An interview was conducted with Nurse Aid (NA) #6 on 05/20/16 at 6:26 PM. She stated she was unaware of how long the vase in the bathroom of room 210 had been there, but stated it had been	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F Tag 323- Free of Accident Hazards/Supervision/Devices Corrective Action for Resident Affected Resident # 21, the facility failed to remove or dispose of a broken clay vase for 1 of 1 residents to promote a safe environment. Permission was given by POA to remove vase from resident□s room. The vase was then removed and given to the social worker until the family could come to the facility to retrieve the vase. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. All resident□s rooms were examined by facility staff on 5/20/2016 to verify that the resident□s environment remains as free of accident hazards as possible. Systemic Changes An in-service was initiated on 6/08/2016 -	

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F 323	Continued From page 5 there for a while. NA#6 had been coming to the facility for approximately 2 weeks and stated the vase had been there since that time. NA #6 stated she did not know where the vase had come from. On 05/20/16 at 6:28 PM, an interview was conducted with NA #7 revealing the broken vase was not in the bathroom of room 210 during her first week of training. NA stated she had been working there for 2 weeks and thought the vase had come from resident's home. An interview was conducted with Nurse #20 on 05/20/16 at 6:37 PM. Nurse #20 was not familiar with the broken vase and knew nothing about the vase. According to the Director of Nursing (DON) during an interview on 05/20/16 at 6:37 PM, she was unaware the broken vase was in Resident #21's bathroom. She stated if a broken vase was discovered in a resident'sroom, she expected it to be discarded. The DON immediately went and retrieved the vase from the resident's room. Upon the DON returning to her office, she was observed holding the broken vase. DON stated she would immediately notify the family and have them take the broken vase home.	F 323	by Nursing Management. All facility staff will be in-serviced. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for temporary assignment. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: Improving Patient Safety in Long Term Care. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.) Quality Assurance The Facility□s Department Heads or designee will monitor this issue using the "Survey QA Tool for Rounds. The monitoring will include verifying that all the resident□s environment remains as free of accident hazards as possible. This will be done daily Monday thru Friday including weekends for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads.	

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F 323	Continued From page 6	F 323	Completion date: June 17th, 2016	
F 371 SS=F	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, staff interviews and record review the facility failed to store foods with correct label and dates in three of three storage area (dry storage, walk in refrigerator, walk in freezer), in 1 of 2 service kitchens, and in 1 of 1 nourishments rooms. The facility failed to clean 1 or 1 convection ovens in the main kitchen. The facility failed to dry 45 of 45 four ounce fluted bowls, 15 of 15 plate domes and 12 of 15 bottom plate holders, and 12 of 18 tray pans before stacking them. The findings included: Review of the facility's food and storage procedures for dry, refrigerated, and frozen storage revised 01/14 revealed food was to be covered, labeled, and dated for the unused portions and open packages. The orange label was to be used and all sections completed on the label. Foods past the "use-by" date should be discarded. Reference to the Food Storage Chart	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F Tag 371-Food Procedure, Storage/Prepare/Serve- Sanitary Corrective Action for Resident Affected None have been affected. The Dietary (Chef) Manager and Sous	6/13/16

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F 371	Continued From page 7 was to be used to determine discard dates. Items for which an expiration date had expired were to be removed from storage. Review of the facility's directions for labeling food revealed that the product name, today's date, expiration date and staff person's initials were to be on the orange label food items. Observation on 05/17/2016 at 09:23 AM in dry storage revealed the following opened items: 1 package of spaghetti, 1 box corn starch, 1 bag cornbread, 1 pancake mix, 1 brownie mix, 1 bag of cookies, 1 thirty pound bag of raisins, 1 rice cereal were not labeled with the date opened and expiration date. Observation on 05/17/2017 at 09:30 AM in the walk in refrigerator revealed a container of French toast mix that was labeled to be used by 05/15/2016. A container of Hot Sauce was opened. It was dated 11/17/2015. Interview with the Dietary Manager (DM) on 05/17/2016 at 09:35 AM revealed that the Hot Sauce was good for 2 months after it was opened and the date on the sauce was the date it was received, not opened. He stated the date was not correct. The Food Storage chart from policy #B006 stated that according to the manufacture's expiration dates the storage time was 60 days. Observation on 05/17/2016 at 9:35 AM in the walk in freezer revealed 1 bag of opened chicken nuggets, 4 loaves of bread, and 1 package of turkey bacon not labeled or dated. One bag of turkey and 1 bag of pork sausage were opened and not dated, 3 bags of sweet potatoes not labeled or dated, 1 bag of potato wedges was opened and not dated. Observation on 05/17/2016 at 10:30 AM of the 300 hall nourishment room revealed a bottle of water and a bottle of Sports drink unlabeled in the freezer. One drink cup from a fast food restaurant	F 371	Chef properly labeled and dated food items in storage and, as necessary, discarded items on 5/16/16 and 5/19/16. The convection oven was cleaned by Sous Chef on 5/17/16. Daily rounds were initiated on 5/23/16 by the Dietary (Chef) Manager and the Sous Chef, An audit tool was put into place 6/9/16 to monitor safe food storage & sanitation practices in the Dietary Department. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by this alleged deficient practice. . The audit tool began on 6/9/16 to monitor safe food storage & sanitation practices. Systemic Changes On 5/19/16 an order was placed with TriMark/Foodcraft for Drying Racks, Dishwasher Racks and additional serviceware. Quotes had previously been obtained by the Dietary Manager during the first week of May. All deliveries of this order were received by 6/9/16 (Invoices attached). The Dietary (Chef) Manager and Sous Chef properly labeled and dated food items in storage and, as necessary, discarded items on 5/16/16 and 5/19/16. The convection oven was cleaned by Sous Chef on 5/17/16. Daily rounds were initiated on 5/23/16 by the Dietary (Chef) Manager and the Sous Chef. The Dietary (Chef) manager held a meeting held with Dietary Staff on 5/24/16 to discuss	

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F 371	Continued From page 8 in the freezer not labeled or dated. Observation on 5/17/2016 at 10:35 AM in the service kitchen on the 100 hall revealed a box of chicken from a fast food restaurant not labeled and dated 05/10/2016. Interview on 05/17/2016 at 10:35 AM with the DM revealed food supplied by the facility was the only food to be in the service kitchen refrigerators. All food should be labeled and dated. Observation on 05/18/2016 at 5:10 PM revealed that the inside of the convection oven and racks in the oven had debris and was dirty. Interview on 05/18/2016 at 5:10 PM with the DM revealed the oven was scheduled to be cleaned weekly, however that was not being done. He was "happy" if it was cleaned monthly. He stated the dirty areas were "non-food contact" areas. The DM stated the dirty areas in the oven needed to be cleaned. Review of the hot line individual cleaning area schedules for the weeks of 03/09/2016-05/15/2016 revealed that 24 or 77 days were not completed. There was not manager's signature and date on 11 weeks of weekly cleaning schedule check sheets that were reviewed. Some of the items included on the check list were steamer, ovens, fryer, griddle, stove cleaned. Observation made on 05/19/2016 at 07:10 AM 45 fluted 4 ounce bowls were stacked wet. There were 15 of 15 domes used on the tray line were stacked wet and 12 of 15 bottoms for entrée plates were stacked wet. Interview on 05/19/2016 at 07:10 AM with dietary staff #1 revealed dishes should be stacked dry. The dishes were washed last evening. Interview on 05/19/2016 at 10:00 AM with the DM revealed that he expected kitchen staff to follow policies and procedures for food storage. He	F 371	completion of cleaning schedules. An in-service on proper labeling and dating was conducted by the Dietary (Chef) Manager on June 6, 2016. Those who attended were all dietary staff. Two additional in-services (prepared by the Senior Nutrition Services Coordinator for Liberty Healthcare & Rehabilitation Services) were conducted by the Dietary (Chef) Manager for Morrison Community Living on June 10, 2016. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Information presented included Food Storage Practices: Labeling & Dating and Food Service Sanitation: Proper Warewashing, Cleaning Equipment and Monitoring completion of Cleaning Schedule Assignments. All monitoring tools/audits will be completed and findings will be reported to the weekly/monthly QOL/QA committee. This information has been integrated into the standard orientation & job-specific training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Dietary (Chef) Manager or Consultant Dietitian for Morrison Community Living will monitor this issue using the "Dietary QA Audit" tool which evaluates Food storage practices in all Food Storage	

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F 371	Continued From page 9 expected the foods to be labeled with the product name, date opened, date to use by, and initial the label. He expects all food items to be properly labeled. Interview on 05/19/2016 at 1:07 PM with dietary staff #2 revealed that when she was hired 8 weeks ago she received no training on kitchen procedures. Interview on 05/19/2016 at 1:19 PM with diertary staff #3 revealed he washed dishes and pots and pans. He stated he tried to let the dishes dry on the line before stacking them. He tried to angle the pots and pans to drip dry and then stack them but space was a problem and there were no racks. Interview with on 05/19/2016 at 3:39 PM with the Administrator revealed that she expected that food service complied with regulations regarding food prep, sanitation, food storage, choices and food service delivery. She reviewed an email documenting the order for drying racks for dishes, pots and pans in the kitchen.	F 371	Areas including Nourishment and Service Kitchens, proper warewashing & storage of serviceware and completion of cleaning assignments. (Refer to attached monitoring tool). This audit will be completed 5 days/week for eight weeks and then weekly times four months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. Results of the audits will then be shared by the Administrator in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads.	
F 520 SS=F	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	F 520		6/13/16

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F 520	Continued From page 10 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, staff interviews, and facility record reviews the facility's Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place on July of 2015. This was for one recited deficiency which was originally cited in June of 2015 on a recertification and complaint survey and on the current recertification survey. The deficiencies were in the area of food procurement/storage/preparation/serve - sanitary conditions. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: The tag is cross referred to: F 371: Food procurement, Store/Prepare/Serve - Sanitary. Based on observations, staff interviews and record review the facility failed to store foods with correct label and dates in three of three storage area (dry storage, walk in refrigerator, walk in freezer), in 1 of 2 service kitchens, and in	F 520	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. FTag-520-QAA Committee-Members/Meet Quarterly/Plans Corrective Action for Resident Affected No specific residents were mentioned in the 2567 Corrective Action for Resident Potentially	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 11 1 of 1 nourishments rooms. The facility failed to clean 1 or 1 convection ovens in the main kitchen. The facility failed to dry 45 of 45 four ounce fluted bowls, 15 of 15 plate domes and 12 of 15 bottom plate holders, and 12 of 18 tray pans before stacking them. During the survey of June 2015 the facility failed to record "use by" dates for opened commercially processed foods, store foods in closed containers, remove expired foods from refrigeration and store perishable and non-perishable foods off the floor. On the present survey the facility was recited for F371 for failing to store foods with correct label and dates in three of three storage areas, in 1 of 2 service kitchens, and in 1 of 1 nourishment rooms, clean a convection oven in the main kitchen, and properly dry assorted dishes before storing them . An interview was conducted with the Administrator on 05/20/16 at approximately 6:20 PM to determine the cause for the QA committee's failure to adequately monitor and implement the prior plan of correction. The Administrator stated she really could not say anything. She could only relate the failure to poor management. She stated "we are going to review everything from the bottom up."	F 520	Affected All residents with have the potential to be affected by this practice. See other plans of corrections cited for F 371. Systemic Changes On June 13th, 2016, the QA Nurse Consultant in-serviced the Administrator. Topics included: The need to continue all plan of correction quality assurance monitors until full compliance is sustained for 3 months. Once sustained for 3 months the survey monitor will be completed quarterly until after the next survey cycle to ensure compliance on the next survey. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The QA Nurse Consultant will monitor this issue using the QA Survey Tool. Quality Assurance Audit tools identified in this plan of correction will be reviewed monthly to ensure that audits are completed until compliance is sustained for 3 months. Then audits should be completed quarterly to ensure on-going compliance until the next annual survey reveals compliance. Any issues will be	

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F 520	Continued From page 12	F 520	reported to the Administrator and the Regional Operations Manager for corrective actions. Date of Completion: June 15th, 2016	