STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	**2700 ROYAL COMMONS LANE MATTHEWS, NC 28105**

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation. Event ID# 018P11.	F 000		

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

Electronically Signed | 11/08/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 000	INITIAL COMMENTS On 10/25/18, the Division of Health Service Regulation Nursing Home Licensure and Certification Section completed an onsite follow up survey and complaint investigation. The facility remains out of compliance.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		10/25/18

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

Electronically Signed | 11/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 656	Continued From page 1 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, family member, staff and physician interviews, and record review, the facility failed to implement the care plan intervention of sling application for 1 of 1 sampled resident who required a sling (Resident #2). The findings included: Resident #2 was admitted to the facility on 01/08/18 with diagnoses which included metastatic ovarian cancer, seizure disorder and arthritis. Review of a Nurse Practitioner's note dated 02/28/18 revealed Resident #2 used a sling to relieve right shoulder pain. Review of Resident #2's monthly physician's orders dated 10/01/18 revealed an order for daily right arm sling application when out of bed. Review of Resident #2's quarterly Minimum Data Set (MDS) dated 10/12/18 revealed an assessment of severely impaired cognition. The MDS indicated Resident #2 required the extensive assistance of one person with dressing.	F 656	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 date or dates indicated. F 656 DEVELOP/IMPLEMENT COMPREHENSIVE CARE PLAN Corrective Action: Resident #2 Resident Care plan was reviewed and updated. Identification of other residents who may be involved with this practice: All current residents with physician orders to apply sling have the potential to be affected by the alleged practice. On 10/25/2018 an audit was completed by the Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) support	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 656	Continued From page 2 Review of Resident #2's care plan dated 10/12/18 revealed intervention for an activity of daily living deficit due to right sided weakness included application of a right arm sling every morning with removal at bedtime. Observation on 10/24/18 at 10:05 AM revealed Resident #2 seated in a wheel chair. Resident #2's right arm was not in a sling. Resident #2 followed cues and moved the right arm without pain. Resident #2's right arm was not swollen or red. Observation on 10/24/18 at 11:00 AM and at 11:21 AM revealed Resident #2 seated in a wheel chair. Resident #2's right arm was not in a sling. Observation on 10/24/18 at 12:17 PM seated in wheel chair. Resident #2 held a cell phone in the right hand and did not have a sling. Resident #2's right arm was not swollen or red. Observation on 10/24/18 at 12:36 PM revealed Resident #2 self-propelled a wheel chair with both feet. Resident #2's right arm was not in a sling. Interview with Nurse Aide (NA) #1 on 10/24/18 at 12:45 PM revealed Resident #2 should have a sling on her right arm when out of bed. NA #1 explained she forgot to apply the sling when she assisted Resident #2 with dressing. Observation on 10/24/18 at 1:23 PM revealed Resident #2 consumed the lunch meal and did not wear a sling. Interview with Resident #2's family member on 10/24/18 at 2:00 PM revealed staff did not apply	F 656	nurse and MDS Nurse Consultant, to ensure that a care plan intervention was implemented for current residents with orders for sling application. 3 current residents have physician orders to apply slings. 2 current residents did not have a care plan intervention implemented. Care plans were reviewed and updated for the 3 current residents with physician orders for sling application. This was completed on 10/25/2018. Systemic Changes: On 10/25/2018 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident□s medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. Slings: Physician orders will be placed in the electronic health record for the resident under the Administration Record. A comprehensive care plan will be developed and implemented for residents who use Slings. This in service was completed by 10/25/2018. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 656	Continued From page 3 Resident #2's right arm sling on a regular basis. Resident #2's family member reported she visited Resident #2 frequently and estimated the sling application did not occur 3 to 4 days each week. Observation on 10/24/18 at 2:20 PM revealed Resident #2 seated in a wheelchair. Resident #2 right arm did not have a sling. Interview with Nurse #1 on 10/24/18 at 2:35 PM revealed Resident #2's sling should be applied every morning to the right arm. Nurse #1 explained the nurse aide is responsible for sling application. Nurse #1 reported she did not notice the omission of Resident #2's sling. Interview with Nurse #2, nurse manager, on 10/25/18 at 9:08 AM revealed Resident #2 used a sling on the right arm. Nurse #2 reported the nurse aide should apply the sling each morning as part of morning care. Interview with the Director of Nursing (DON) on 10/25/18 at 10:52 AM revealed Resident #2 should have the sling applied to the right arm each morning. The DON reported she expected staff to implement Resident #2's care plan and apply the sling. Telephone interview with Resident #2's physician on 10/25/18 at 12:12 PM revealed Resident #2's sling could be discontinued but Resident #2's family member desired continuance of sling application.	F 656	in-service training will not be allowed to work until training is completed. 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. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents with orders for slings to ensure that it is implemented as ordered and that is it care planned. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 10/25/2018	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		10/25/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 812	Continued From page 4 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and review of the menu, the facility failed to maintain 19 servings of tossed salad at or below 41 degrees Fahrenheit for 1 of 1 observation of the tray line. The facility failed to serve tossed salads at or below 41 degrees Fahrenheit to 7 residents (Residents #10, 11, 12, 13, 14, 15 and 58). The findings included: A kitchen observation on 10/24/18 at 11:45 AM revealed the lunch meal tray line was in progress. Review of the menu revealed one of the vegetables was a tossed salad. On 10/24/18 at 11:45 AM a tray of 12 covered bowls of tossed salad (iceburg lettuce and carrots) was observed stored on an open cart. Additionally 7 covered bowls of tossed salad were	F 812	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 date or dates indicated. F □Tag 812 Food Procurement, Store/Prepare/Serve/Sanitary " ---Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 812	Continued From page 5 observed stored directly on the steam table and placed on meal trays for delivery to residents. On 10/24/18 at 11:58 AM dietary staff stated the cart of resident trays was ready for delivery to residents, pushed the cart to the kitchen door and opened the kitchen door to exit. At that time, temperature monitoring of the salads that were placed on the delivery cart for delivery to residents was conducted with a digital thermometer by the dietary manager (DM) at the request of the surveyor. The results revealed 2 bowls of tossed salad with temperatures of 45.5 degrees Fahrenheit (F) and 46.9 degrees F. Further observation revealed a total of 7 salads were on the delivery cart for delivery to residents (Residents #10, 11, 12, 13, 14, 15 and 58). An interview on 10/24/18 at 12:01 with dietary aide #1 (DA #1) revealed she stored the 7 bowls of tossed salad on the steam table because she was in a hurry. DA #1 confirmed cold foods should be stored/served at 41 degrees or below. An interview occurred on 10/24/18 at 12:04 PM with district dietary manager (DDM). She revealed that she prepared 80 bowls of tossed salad around 10:30 AM that morning and placed the bowls in the freezer around 11:25 AM to cool down. The DDM confirmed that all cold foods should be maintained at least 41 degrees F or below. An interview occurred on 10/24/18 at 12:09 PM with the dietary manager (DM). He stated that some salads were prepared before 10:00 AM that morning and some were prepared later. The DM further stated that all salads were placed in the freezer to cool down before the lunch tray line began at 11:45 am. The DM also stated that he	F 812	On 10/24/2018 the facility failed to maintain 19 servings of tossed salad at or below 41 degrees Fahrenheit of 1 resident and failed to serve tossed salads at or below 41 degrees Fahrenheit for 7 residents . On 10-24-2018 the dietary manager (DM) removed the salads from potential service to the residents and discarded the salads. No other resident had ordered salad. " ---Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10-24-2018 the Dietary manager obtained new salads made for all of the residents requesting salads for lunch on 10-24-2018 and obtained temperature reading of 33 degrees. On 10-24-2018 the dietary manger completed temperature monitoring of the follow foods :salad, banana pudding, peaches, milk, tea, and water and those findings were that 100% the foods were at a safe service temperature. " ---Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 10/24/2018 Administrator, the Dietary manger and District dietary manger in serviced 100% of food service staff on : Safe Food Handling: Temperatures and Monitoring: SAFE FOOD HANDLING PRACTICE: -North Carolina Rules Governing the Sanitation of Food Services Establishments document which is based on the 2009 FDA model food code and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 812	Continued From page 6 conducted temperature monitoring of the salads that were completed before 10:00 AM and those salads were below 41 degrees, but the salads that were prepared after 10:30 AM were placed in the freezer around 11:30 AM. He stated the salads that were not cold enough yet were placed on the tray line without temperature monitoring in error and did not have sufficient time to cool down before the lunch tray line began at 11:45 AM. He confirmed that cold foods should be stored/served at 41 degrees F or below. An interview with the administrator and the director of nursing occurred on 10/24/18 at 3:35 PM. Both stated during the interview that although they expected foods to be served at the correct temperature and did not expect cold foods to be placed on hot surfaces, the staff in the dietary department were new to the department and required ongoing training and oversight.	F 812	current food science. -All health care center staff involved in the preparation and service of food will adhere to safe food handling techniques. -In incidences where variations in interpretation occur between state and federal guidelines, the strictest regulations will be followed. -All Dietary Services employees will practice the following rules of safe food handling: " Practice proper personal hygiene daily. " Monitor Time and Temperature " Prevent Cross Contamination " Store foods promptly and correctly, resealing, labeling and dating as appropriate " Cook PHF/TCS food to the required endpoint cooking temperature or higher . " Hold PHF/TCS food at 135 degrees F or higher and Cold PHS/TCS food at 41 degrees F or lower " Cool PHF/TCS foods from 135 degrees F to 41 degrees F within a total of 6 hrs. o From 135 degrees F to 70 degrees F within 2 hours o From 70 degrees F to below 41 degrees F within 4 hours " Reheat PHF/TCS food for hot holding to an internal temperature of 165 degrees F for fifteen seconds within 2 hours -Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(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 812	Continued From page 7	F 812	On 10/25/2018 The dietary manager began QA audit of food service temps for cold foods to assure that the food is served in accordance with professional standards for food service safety. On 10/25/2018 The Dietary manger will audit 5 trays with cold foods samples to monitor that the food is at or below 41 degrees Fahrenheit. This audit will be completed weekly x4 then monthly x 3. QA Reports will be presented in the weekly QA meeting by the Dietary Manager or Director of Nursing to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, and Assistant Director of Nursing, MDS co coordinator, Unit Manager, Dietary Manager, Health information Manager, and Activities director. Date of compliance : 10-25-2018	