STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide incontinence care to residents who required assistance with activities of daily living for 2 of 5 residents sampled for activities of daily living (Resident #5 and #3). The findings included: 1) Resident #5 was admitted to the facility on 03/03/15 with diagnoses which included cerebral vascular accident (stroke). Review of the Minimum Data Set (MDS) dated 03/09/15 indicated Resident #5 was cognitively intact and was able to understand and was capable of making her needs known. Resident #5 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included toileting and personal hygiene, was always incontinent of bowel and bladder, and had no documented behaviors or refusal of care. A review of care plans dated 03/09/15 revealed Resident #5 had a physical functioning deficit related to self-care impairment with approaches for staff to assist with ADLs. During an interview on 04/08/15 at 9:29 AM	F 312	It is the practice of this facility to provide services for residents who are unable to carry out activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. Resident #5 has and will continue to be provided timely incontinence care. Resident #3 has and will continue to be provided timely incontinence care. An audit of all current residents was completed on 4/29/15 by the Interdisciplinary team inclusive of the Director of Clinical Services, Minimum Data Set Nurse, and Social Worker to identify any residents that require assistance with incontinence care. Each identified residents care plan and kardex have been updated to indicate the residents individual level of assistance required with incontinence care. An audit of all current residents was completed 4/28/15 by the Interdisciplinary team inclusive of the Director of Clinical Services, Minimum Data Set Nurse, and Social Worker to identify those residents	5/6/15

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

Electronically Signed | 05/01/2015

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F 312	Continued From page 1 Resident #5 stated she had laid in bed for 4 hours on 04/02/15 in feces and urine before her adult brief was changed. Resident #5 reported she put on her call light, requested for staff to have changed her soiled brief, and staff had informed her they would as soon as they had time. She indicated she was aware of the specific time by the clock on her wall and that she was not changed until the nurse aide (NA) came in on 3rd shift. During an interview on 04/08/15 at 10:33 AM Nurse #2 stated she was the nurse assigned to care for Resident #5 on 04/02/15 from 3:00 PM until 11:00 PM and she was made aware that the resident had laid in a soiled brief for 4 hours and it was reported to the Director of Nursing (DON). Nurse #2 stated it was her expectation that residents were to be changed every 2 hours and there were times when the NAs were unable to keep the residents clean and dry and she has had to change residents because they had laid wet/soiled for 2 to 3 hours. During an interview on 04/08/15 at 10:57 AM NA #3 confirmed she was assigned to care for Resident #5 on 04/02/15 from 3:00 PM until 11:00 PM. She stated she was unable to recall if Resident #5 had laid wet/soiled for 4 hours and that there were times when the residents were not changed and would have to wait. She further stated there were times when she would answer the call lights, turn the call light off, tell the resident she would be back, and she would attempt to go back but there were times she was so busy she could not get back to the residents room in a timely manner to assist them or met their needs. NA #3 indicated she was unable to remember the date but she probably was the NA	F 312	that are alert and oriented. The identified panel of alert and oriented residents was interviewed by the Social Worker on 4/28/15 and 4/29/15 in regards to staff providing timely assistance for their individualized continence needs. Grievance and Concern forms will be initiated where indicated by resident interviews and reviewed by the Executive Director and Director of Clinical Services for resolution. Licensed Nurses and Certified Nurse Aides received training by the Director of Clinical Services on providing timely assistance with activities of daily living specific to incontinence care on 4/28/15 and 4/29/15. Newly hired nurses and certified nurse aides will receive education during classroom training and mentored orientation. The Director of Clinical Services, Nursing Supervisor, and/or licensed nurse designee will complete Quality Improvement monitoring/observations for timely response and performance of needed assistance with incontinence care. Quality Improvement monitoring/observations will be completed on 5 residents requiring assistance with incontinence care 5 times per week for one month, 3 times a week for 1 month, 2 times a week for 2 months, 1 time a week 2 months, and/or until substantial compliance is obtained. Grievances and Concerns will be reviewed weekly by the Director of Clinical Services, Executive Director, and Social Services Director for	

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F 312	Continued From page 2 that had not gotten back to Resident #5's room to have changed her soiled brief because she was so busy. She further indicated the hall she was assigned to work was considered the heaviest hall for resident care and there were numerous times when the residents were not changed and/or had other ADLs that were not met, especially when there was only 2 NAs on the hall. During an interview on 04/08/15 at 2:34 PM NA #4 confirmed she was assigned to Resident #5's hall on 04/02/15 and was expected to assist in the care of the residents on the hall. NA #4 stated she was unaware if Resident #5 had laid wet/soiled for 4 hours but there were times when the residents were not changed in a timely manner and/or every 2 hours because there was not enough time to meet the ADLs of all of the residents on the hall because the NAs were so busy. During an interview on 04/08/15 at 3:32 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident as quickly as possible but at least every 2 hours. She further stated she had identified problems with staffing but was unaware the residents ADLS were not being met in a timely manner. There were 3 calls made with messages left on the telephone number provided by the facility for the 3rd shift nurse aide to be interviewed and the nurse aide had not returned the telephone calls by the end of the survey. 2) Resident #3 was admitted to the facility on	F 312	any assistance with incontinence care concerns. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and the Minimum Data Assessment Nurse.	

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F 312	Continued From page 3	F 312		

12/01/14 with diagnoses which included heart failure and high blood pressure. Review of the Minimum Data Set (MDS) dated 04/05/15 indicated Resident #3 was cognitively intact and was able to understand and make self-understood. Resident #3 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included transfers and toileting, was frequently incontinent of bowel and bladder, and had no documented behaviors or refusal of care.

A review of care plans for incontinence care dated 04/06/15 indicated approaches to assist Resident #3 with ADLs.

During an interview on 04/07/15 at 9:38 AM Resident #3 stated she did not like to have to wait more than 15 to 30 minutes to have her wet and/or soiled adult brief changed. The resident stated she would usually look at her clock on the wall when they would come in, turn her call light off, and inform her they would change her as soon as they had time. Resident #3 further stated she has had to wait 1 to 2 hours before staff would change her brief and that she thought the staff were just too busy to assist her. Resident #3 indicated there was not enough NAs on the hall sometimes during the weekdays but that the weekends were much worse and that was usually when she had to wait the longest to have her brief changed.

During an interview on 04/08/15 at 12:05 PM Nurse Aide (NA) #2 stated she had been assigned to care for Resident #3 and confirmed the resident required assistance with incontinence care. NA #2 further stated there was not enough time and it was impossible to

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F 312	Continued From page 4 complete all resident care with 2 NAs. NA #2 indicated there were times when residents would have to wait 1 to 2 hours and/or even longer to have their brief changed. NA #2 stated she was unaware if Resident #3 had laid wet/soiled for 1 to 2 hours but there were times when the residents were not changed every 2 hours because there was not enough time to meet the ADLs of all of the residents on the hall because the NAs were so busy. During an interview on 04/08/15 at 1:18 PM Nurse #1 stated it was her expectation that residents should be toileted and/or have their brief changed every 2 hours and more often if requested or needed. She further stated she was aware of times when residents had to wait more than an hour to be changed and the NAs worked hard to keep the residents clean and dry but there were times when the ADLs were not getting done. During an interview on 04/08/15 at 3:32 PM the DON stated it was her expectation that all ADL care to be provided to the resident. She further stated she was unaware the residents ADLs were not being provided in a timely manner.	F 312		
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		5/6/15

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F 353	Continued From page 5 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide assistance with activities of daily living due to insufficient nursing staff for 2 of 5 residents (Resident #5 and #3). The findings included: 1) Resident #5 was admitted to the facility on 03/03/15 with diagnoses which included cerebral vascular accident (stroke). Review of the Minimum Data Set (MDS) dated 03/09/15 indicated Resident #5 was cognitively intact and was able to understand and was capable of making her needs known. Resident #5 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included toileting and personal hygiene. A review of care plans dated 03/09/15 revealed Resident #5 had a physical functioning deficit related to self-care impairment with approaches for staff to assist with ADLs.	F 353	It is the practice of this facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. Resident #5 has and will continue to receive timely assistance with activities of daily living. Resident #3 has and will continue to receive timely assistance with activities of daily living. An audit of all current residents was completed on 4/29/15 by the interdisciplinary team inclusive of the Director of Clinical Services, Minimum Data Set Nurse, and Social Worker to identify each residents individual assistance needs for activities of daily living inclusive of bathing, dressing, grooming and hygiene, and incontinence	

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F 353	Continued From page 6 During an interview on 04/08/15 at 9:29 AM Resident #5 stated she had laid in bed for 4 hours on 04/02/15 in feces and urine before her adult brief was changed. Resident #5 reported she put on her call light, requested for staff to have changed her soiled brief, and staff had informed her they would change her as soon as they had time. A review of the staffing assignments for 03/01/15 to 04/08/15 revealed 15 out of 39 days on 1st shift there were 2 NAs on each hall to provide ADL care to as many as 32 residents. A review of the Resident Council Meeting minutes dated for the month of January 2015 revealed concerns for needing more NA staff, especially on the weekends, because their needs were not being met. The action taken was the Nursing Administration was actively recruiting for NAs. A review of the monthly grievance log dated for the months of October 2014 through March 2015 revealed complaints regarding call bell response times, the promptness of resident assistance with care needs which included being dressed in the mornings, being assisted with toileting and/or being changed in a timely manner, and staffing of nurse aides. The action taken was the Nursing Administration was actively doing audits and meetings to address the call bell response times and the facility was actively recruiting nurse aides. An interview with Nurse #2 on 04/08/15 at 10:33 AM stated there were times when the NAs were unable to keep the residents clean and dry and she has had to change residents because they	F 353	care. Each identified residents care plan and kardex have been updated to indicate the residents individual levels of assistance required for the various activities of daily living. An audit of all current residents was completed on 4/28/15 by the Interdisciplinary Team inclusive of the Director of Clinical Services, Minimum Data Set Nurse, and Social Worker to identify those residents that are alert and oriented. The identified panel of alert and oriented residents was interviewed by the Social Worker on 4/28/15 and 4/29/15 in regards to staff providing assistance timely for the individualized activities of daily living needs. Grievance and Concern forms will be initiated where indicated by resident interviews and reviewed by the Executive Director and Director of Clinical Services for resolution. Licensed nurses and certified nurse aides received training by the Director of Clinical Services on providing timely assistance with activities of daily living on 4/28/15 and 4/29/15. Licensed nurses and certified nurse aides received training by the Minimum Data Set Nurse on completion of documentation for assistance provided for activities of daily living on 4/28/15 and 4/29/15. Newly hired licensed nurses and certified nurse aides will received education during classroom training and mentored orientation. The Director of Clinical Services, Nursing Supervisor, and/or licensed nurse	

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F 353	Continued From page 7 had laid wet/soiled for 2 to 3 hours. Nurse #2 further stated residents showers were not done every week, oral care was rarely done for residents, and some residents had to wait long periods of time to be changed when wet due to the facility being short staffed. An interview with NA #3 on 04/08/15 at 10:57 stated the NAs worked short staffed most days. NA #3 indicated with 2 NAs the work could be done but it was impossible to complete all care such as shaving, oral care, showers, toileting, and changing residents briefs every 2 hours, and/or more often with some residents, plus making and changing beds. NA #3 further indicated the 300 hall was considered the heaviest hall for resident care and there were numerous times when the residents were not changed and/or had other ADLs that were not met. An interview with Unit Manager (UM) #1 on 04/08/15 at 1:53 PM indicated the 300 hall was considered the heaviest hall, with the largest population of residents, and a more clinically active hall due to the ADL needs of the residents. UM #1 stated there were times when incontinent care was not met in a timely manner and residents would have to wait 2 or more hours to be changed, and showers were not done weekly, and residents have complained about not getting put to bed at the time they had requested to go to bed. UM #1 further stated it was a "ripple" effect with being short staffed on all of the halls. An interview with NA #4 on 04/08/15 at 2:34 PM stated there were times when the residents were not changed in a timely manner and/or every 2 hours because there was not enough time to	F 353	designee will complete Quality Improvement monitoring/observations for timely response and performance of needed assistance with activities of daily living inclusive of bathing, dressing, grooming and hygiene, and incontinence care. Quality Improvement monitoring/observations will be completed on 5 residents requiring assistance with activities of daily living 5 times per week for one month, 3 times per week for one month, 2 time a week for 2 months, 1 time a week for 2 months, and/or until substantial compliance is obtained. Grievance and Concern forms will be reviewed weekly by the Director of Clinical Services, Executive Director, and Social Worker for any activities of daily living related concerns. Resident shower completion logs will be reviewed weekly by the Director of Clinical Services for twelve weeks to ensure residents are receiving appropriate care and services for grooming and hygiene. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly the by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance	

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F 353	Continued From page 8 meet the ADLs of all of the residents on the hall because the NAs were so busy it was impossible to complete all care such as showers and oral care. The interview further revealed the 300 hall was supposed to have 3 to 4 NAs on 1st shift (7:00 AM to 3:00 PM) and at least 3 NAs on 2nd shift (3:00 PM to 11:00 PM). NA #4 further stated there were days when there were only 2 NAs on the 300 hall and it was difficult to change briefs, give showers, and provide residents the assistance needed with ADLs. During an interview on 04/08/15 at 3:32 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident as quickly as possible but at least every 2 hours and if certain areas were missed they should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. She further stated she had identified problems with staffing and that staff was asked to work over or come in early if there were call outs. During an interview on 04/08/15 at 4:28 PM the Administrator stated she had identified problems with staffing and they were in the process of offering retention bonuses, recruiting bonuses, and had nurse aid students to fill out applications for potential hires once they became certified. She further stated she was actively working to maintain staff stability and was actively recruiting nurse aides and nurses. 2) Resident #3 was admitted to the facility on 12/01/14 with diagnoses which included heart failure and high blood pressure. Review of the	F 353	Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, and the Minimum Data Assessment Nurse.	

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Minimum Data Set (MDS) dated 04/05/15 indicated Resident #3 was cognitively intact and was able to understand and make self-understood. Resident #3 required extensive assistance with 2 or more staff for activities of daily living (ADLs) which included transfers and toileting.

A review of care plans for incontinence care dated 04/06/15 indicated approaches to assist Resident #3 with ADLs.

During an interview on 04/07/15 at 9:38 AM Resident #3 stated she did not like to have to wait more than 15 to 30 minutes to have her wet and/or soiled adult brief changed. The resident stated she would usually look at her clock on the wall when they would come in, turn her call light off, and inform her they would change her as soon as they had time. Resident #3 further stated she has had to wait 1 to 2 hours before staff would change her brief and that she thought the staff were just too busy to assist her. Resident #3 indicated there was not enough nurse aides on the hall sometimes during the weekdays, the weekends were much worse, and that was usually when she had to wait the longest to have her brief changed.

A review of the staffing assignments for 03/01/15 to 04/08/15 revealed 15 out of 39 days on 1st shift there were 2 NAs on each hall to provide ADL care to as many as 32 residents.

A review of the Resident Council Meeting minutes dated for the month of January 2015 revealed concerns for needing more NA staff, especially on the weekends, because their needs were not being met. The action taken was the Nursing

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Administration was actively recruiting for NAs.

A review of the monthly grievance log dated for the months of October 2014 through March 2015 revealed complaints regarding call bell response times, the promptness of resident assistance with care needs which included being dressed in the mornings, being assisted with toileting and/or being changed in a timely manner, and staffing of nurse aides. The action taken was the Nursing Administration was actively doing audits and meetings to address the call bell response times and the facility was actively recruiting nurse aides.

An interview with NA #2 on 04/08/15 at 12:05 PM stated there was not enough time and it was impossible to complete all resident care with 2 NAs. NA #2 further stated the NAs could not keep the residents clean and dry and showers and activities of daily living (ADLs) were not getting done due to lack of staffing.

An interview with Nurse #1 on 04/08/15 at 1:18 PM stated it was her expectation that residents should be toileted and/or incontinence care be provided every 2 hours and more often if requested or needed. She further stated she was aware of times when residents had to wait more than an hour to be changed and the NAs worked hard to keep the residents clean and dry but there were times when the ADLs were not getting done due to lack of staffing.

During an interview on 04/08/15 at 3:32 PM the Director of Nursing (DON) stated it was her expectation that all care should be provided to the resident as quickly as possible but at least every 2 hours and if certain areas were missed they

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(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 353	Continued From page 11 should be reported for the next shift to do. The DON stated if there were call outs they did what they had to do to take care of the residents. She further stated she had identified problems with staffing and that staff was asked to work over or come in early if there were call outs. During an interview on 04/08/15 at 4:28 PM the Administrator stated she had identified problems with staffing and they were in the process of offering retention bonuses, recruiting bonuses, and had nurse aid students to fill out applications for potential hires once they became certified. She further stated she was actively working to maintain staff stability and was actively recruiting nurse aides and nurses.	F 353		
F 520 SS=D	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 except insofar as such disclosure is related to the compliance of such committee with the	F 520		5/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 04/08/2015

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F 520	Continued From page 12 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, staff, and resident interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place in January of 2015. This was for one recited deficiency which was originally cited in December of 2014 on a follow up and complaint investigation survey and on a current complaint investigation survey. The deficiency was in the area of activities of daily living. The continued failure of the facility during the two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to: 1a. F 312: Activities of Daily Living: Based on observations, record review, staff and resident interviews, the facility failed to provide assistance with toileting and incontinence care for 2 of 5 sampled residents who required extensive assistance for activities of daily living (Resident #5 and #3). During a follow up and complaint investigation	F 520	The facility maintains a Quality Assessment and Assurance Committee consisting of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment nurse. The Executive Director, Director of Clinical Services, and other facility members of the Quality Assessment and Assurance Committee have been re-educated on the Federal Regulation F520 QAA Committee and the facility's Policy and Procedure for Quality Assurance and Performance Improvement by the Regional Director of Clinical Services on 4/28/15. Newly hired Interdisciplinary Team Members will be educated during classroom training and mentored orientation. An audit of all current residents was completed 4/29/15 by the Interdisciplinary team inclusive of the Director of Clinical Services, Minimum Data Assessment Nurse, and Social Worker to identify each residents individual assistance needs for	

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F 520	Continued From page 13 survey of December, 2014 the facility was cited for F 312 for failing to provide assistance with toileting and personal hygiene for residents who required extensive assistance for activities of daily living. On the current complaint investigation the facility was again recited for failing to provide assistance with toileting and incontinence care to residents who required extensive assistance for activities of daily living. During an interview on 04/08/15 at 5:27 PM the Administrator, Regional Clinical Coordinator, and the Director of Nursing stated their expectation was for the facility staff to complete random audits to measure effectiveness of their action plans which had been driven by the plan of correction they developed as a result of the previous survey of December 2014. The Director of Nursing stated the action plans were not specific to incontinent care but was more specific to answering the call lights and ensuring dignity and respect of the residents. The Administrator explained it was a work in progress and acknowledged they were still not in compliance in some areas. She explained they had tried to focus on the specific issues that were previously cited but had not considered other potential problems related to citations found during the current complaint investigation survey.	F 520	activities of daily living inclusive of bathing, dressing, grooming and hygiene, and incontinence care. Each identified residents care plan and kardex have been updated to indicate the residents individual levels of assistance required for the various activities of daily living. An audit of all current residents was completed 4/28/15 by the Interdisciplinary team inclusive of the Director of Clinical Services, Minimum Data Assessment nurse, and Social Worker to identify those residents that are alert and oriented. The identified panel of alert and oriented residents was interviewed by the Social Worker on 4/28/15 and 4/29/15 in regards to staff providing assistance timely for their individualized activities of daily living needs. Grievance and Concern forms will be initiated where indicated by resident interviews and reviewed by the Executive Director and Director of Clinical Services for resolution. Licensed nurses and Certified Nurse Aides received training by the Director of Clinical Services on providing timely assistance with activities of daily living on 4/28/15 and 4/29/15. Licensed nurses and certified nurse aides received training by the Minimum Data Assessment Nurse on completion of documentation for assistance provided for activities of daily living on 4/28/15 and 4/29/15. Newly hired licensed nurses and certified nurse aide will receive education during classroom training and mentored orientation.	

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F 520	Continued From page 14	F 520	The Ombudsman for Buncombe County is scheduled to provide education to Licensed Nurses, Certified Nurse Aides, and Administrative Personnel on May 13, 2015, for sensitivity training when providing care, time management techniques, and resident to staff interactions. This education was scheduled prior to the substantiation of F520. The Director of Clinical Services, Nursing Supervisor, and/or licensed nurse designee will complete Quality Improvement monitoring/observations for timely response and performance of needed assistance with activities of daily living inclusive of bathing, dressing, grooming and hygiene, and incontinence care. Quality Improvement monitoring/observations will be completed on 5 residents requiring assistance with activities of daily living 5 times per week for 1 month, 3 times a week for 1 month, 2 times a week for 2 months, 1 time a week for 2 months, and/or until substantial compliance is obtained. Grievance and Concern forms will be reviewed weekly by the Executive Director, Director of Clinical Services, and Social Worker for any activities of daily living related concerns. Resident shower completion logs will be reviewed weekly by the Director of Clinical Services for twelve weeks to ensure residents are receiving appropriate care and services for grooming and hygiene. Executive Director to request permission, at the discretion of the council members,	

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F 520	Continued From page 15	F 520	to attend the monthly Resident Council Meeting. The results of these audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary to obtain substantial compliance. When substantial compliance is obtained the QAPI team will continue to review and discuss citations during subsequent meetings to maintain compliance and identify new or reoccurring issues. The Regional Vice President of Operation, Regional Director of Clinical Services, and/or Regional Case Mix Coordinator will attend the monthly QAPI committee and review Quality Improvement monitoring results for three months for substantial compliance and/or revision of corrective actions. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Pharmacy Consultant, Social Services Director, Activities Director, Maintenance Director, Dietary Director, and Minimum Data Assessment Nurse.	