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	345008	A. BUILDING _____ B. WING _____	C 04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview (Resident #29) and staff interviews, the facility failed to repair and replace floor tiles, repair holes in the wall and a bathroom door, repair a leaking toilet and replace a missing outlet cover for 3 rooms (Rooms 204, 215 and 309) on 2 of 3 units. The findings included: The following items were observed in disrepair on the 200 and 300 units: a. On 04/25/16 at 03:11 PM, the following items were observed in room 204 in need of repair · An electrical outlet cover was observed missing on the wall next to bed 204 A; the bed was plugged into the outlet. · A large hole was observed in the wall next to the air conditioner unit across from bed 204 B. · A large hole was observed in the bathroom door for room 204. · 2 floor tiles were observed missing and 1 floor tile was observed jagged underneath the right side of bed 204 B. b. On 04/26/16 at 09:31 AM, the toilet in the bathroom of room 309 was observed with a large pool of water on the floor surrounding the base of the toilet. Interview with Resident #29 during the observation revealed that her toilet leaked sometimes which left water on the floor in her bathroom.	F 253	Criteria I - To accomplish corrective action for the affected residents the following tasks were completed: 1. Missing outlet covers in 204, 215, and 309 were replaced on April 29, 2016; 2. The large hole in the bathroom door in room 204 was repaired on April 29, 2016; 3. The three damaged floor tiles in 204 were replaced on April 29, 2016; 4. The damaged floor tiles in 215 were repaired on April 29, 2016. Criteria II - To accomplish corrective action for other residents who may have the potential to be affected by the alleged deficient practice, the Maintenance Director will conduct a 100% audit of the entire building by May 27, 2016 to identify any maintenance conditions which require repair. Maintenance director will create a list and instruct the maintenance team on the priority of issues. Criteria III - Education was conducted on May 20, 2016 to accomplish systemic change and empower managers who make rounds on the process for identifying needed repairs on rounds and carrying them through to completion in the building engines automated maintenance	5/27/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2016

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F 253	Continued From page 1 c. On 04/26/16 at 11:22 AM, 2 floor tiles were observed missing to the right of bed 215 A. On 04/28/16 from 5:20 PM to 5:47 PM a follow up observation of rooms 204, 215 and 309 revealed the same items as previously observed on 04/25/16 and 04/26/16 were still in need of repair. On 04/28/16 at 5:47 PM an interview with the maintenance director and observation of rooms 204, 215 and 309 revealed that he completed repairs using an electronic work order system and that he also received verbal work orders. The maintenance director stated the he checked the electronic work orders daily and prioritized the orders based on importance. He stated that he, his assistant and other managers rounded daily and if room repairs were noted staff could enter an electronic work request or tell him directly. The maintenance director stated that he rounded daily to identify any concerns related to the environment, but that he had not identified the concerns in rooms 204, 215 or 309, nor was he aware of the repairs needed in these rooms. He observed the holes in the wall and bathroom door of room 204 to be approximately 6 inches long and 2 inches wide. He observed the toilet in the bathroom of room 309 and estimated there was approximately 2 cups of water on the floor surrounding the toilet. Resident #29 stated during the observation that the toilet had been leaking for a while and that she reported this concern to housekeeping staff. The maintenance director further stated that he had not been made aware. 04/28/16 at 7:45 PM an interview with the administrator revealed that the prior housekeeping director was only employed a few days before he gave notice of termination and	F 253	software. Using the midnight census report form, the maintenance Director will make a house maintenance round to identify repairs needed. Criteria IV - The facility has added a review of the Building Engines Software Summary as a permanent part of the Monthly QAPI meeting. This will include discussion of pending and completed repairs. The QAPI committee will also discuss the identified repairs from the house maintenance round and incorporate this report as a part of the QAPI minutes. For further monitoring, the Executive Director's designee (Business Office Assistant will conduct a monthly audit of 10 random inspected rooms to assure that all issues needing to be addressed were identified in the maintenance rounds. This report will be shared with the Executive Director to assure the further effectiveness of the continuing plan of correction with said effectiveness or corrective action reported to the QAPI committee and will be continued until it is deemed no longer necessary by the QAPI committee. These three systems reviews will serve as a means of monitoring to assure that the alleged deficient practice does not recur. The committee's monitoring and interventions as indicated will assure the continuing effectiveness of the plan.	

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F 253	Continued From page 2 that he may have been the housekeeping director that Resident #29 reported her concerns to, but did not report these concerns to the maintenance director. The administrator stated he was aware of additional repairs needed in the facility, but was awaiting corporate support regarding additional monies that could be allocated for facility repairs.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on physician's standing orders, staff interviews and medical record review, the facility failed to assess and implement care plan interventions for 1 of 4 sampled residents at increased risk for constipation (Resident #76) with no documentation of a bowel movement for 5 consecutive days . The findings included: The facility's Physician's Standing Orders and Medication Orders, undated, recorded in part, "Constipation: Check rectal vault for formed stool, may remove if impacted. Give MOM (Milk of Magnesia) 30 ml (milliliters) po (by mouth) x 1 (one time). If no results by following morning then give Dulcolax Suppository x 1. If no results may	F 309	Criteria I - Resident #76 was the resident affected by the alleged deficient practice as there was no documentation of a bowel movement in 5 days and therefore no bowel protocol implementation. Upon investigation, an employee who recalled the residents having a bowel movement on the second of the cited 5 day period came forth to verify that this took place and gave written statement of such. Implementation of corrective action in the form of the bowel protocol was not necessary. Corrective action did include 1:1 counseling with the employee who failed to document the bowel movement.	5/27/16

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F 309	Continued From page 3 give Fleets enema per rectum. Notify MD if no results." Resident #76 was admitted to the facility on 01/30/16 and re-admitted on 04/21/16 after a mechanical fall. Diagnoses included chronic pain, pseudobulbar affect, major depressive disorder, anxiety, behavior syndrome with physiological disturbances and physical factors, seizure disorder, repeated falls and constipation. An admission Minimum Data Set assessment with Care Area Assessment dated 02/06/16 and a care plan updated 04/21/16 assessed Resident #76 with moderately impaired cognition, functionally incontinent of bowel/bladder, and at risk for potential drug related complications associated with the use of medications that increase the risk for constipation. Interventions included to monitor for drug related side effects, to include constipation and monitor bowel status frequency. Medical record review revealed Resident #76 had a physician's order dated 04/21/16 for Docusate Sodium Liquid 10 ml three times daily for constipation. Review of the April 2016 medication administration record (MAR) revealed this medication was administered daily from 04/21/16 - 04/28/16. Additionally, review of physician's orders and the April 2016 MAR revealed Resident #76 also received the following medications daily from 04/21/16 - 04/28/16 with constipation as a drug related side effect: · Meloxicam 15 mg daily for chronic pain · Peroxetine Hydrochloride 40 mg daily for major depressive disorder	F 309	Criteria II - Due to the nature of the alleged deficient practice, it was determined that all residents had potential to be affected. To accomplish corrective action for residents, an audit of all current residents will be completed by May 25th to assure that bowel protocol has been implemented. All nursing staff will be in-serviced by the Director of Clinical Education and/or her designee on Bowel Protocol and proper bowel and bladder record keeping in the care tracker system. Training will be via demonstration with return demonstration and wil be completed by May 27, 2016. Criteria III - In order to monitor its performance to make sure that solutions are effective and sustained, the Director of Clinical Education and/or her designee will review the No BM list via the care tracker system daily for four weeks, then randomly twice weekly for 8 weeks providing intervention, training and corrective action as needed. Criteria IV - The monitoring of corrective actions will be accomplished via the QAPI committee as reported to them in audits conducted by the Director of Clinical Education. Results of all monitoring will be reported to the QAPI committee at its monthly meeting. The effectiveness of the plans to correct will be determined via discussion of the audit results as well as any necessary corresponding interventions. The committee will also determine the duration of any continuing monitoring once the initial planned period	

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F 309	Continued From page 4 · Nudexta 20 - 10 mg every 12 hours for pseudobulbar affect · Voltaren Gel 1% apply 4 grams transdermally twice daily for chronic pain · Depakote 100 mg three times daily for seizure disorder Further medical record review of nurse's notes and a Bowel and Bladder Detail Report dated 04/22/16 - 04/28/16 revealed documentation that Resident #76 was incontinent of bowel on 04/22/16 and 04/28/16. There was no further documentation in the Resident's medical record or on the Bowel and Bladder Detail Report of a bowel movement from 04/23/16 - 04/27/16, 5 consecutive days. There was no documentation in the Resident's medical record or the April 2016 MAR of the implementation of a bowel protocol for constipation from 04/23/16 - 04/27/16. An interview on 04/28/16 at 5:03 PM with nurse #2 revealed Resident #76 was incontinent of bowel and required staff assistance with incontinence. Nurse #2 stated she worked with Resident on 04/27/16 during the 3 PM - 11 PM shift and Resident #76 did not have a bowel movement during this shift and she not aware of the last time Resident #76 had a bowel movement. Nurse #2 stated she did not implement standing orders for Resident #76 for constipation. An interview on 04/28/16 at 5:39 PM with nurse #3 revealed Resident #76 was incontinent of bowel and required staff assistance with incontinence. Nurse #3 stated she was the nurse for Resident #76 during the 7 AM - 3 PM shifts on Monday, 04/25/16 and Wednesday 04/27/16 and Resident #76 did not have a bowel movement	F 309	is complete. Audits will be complete on when the QAPI committee has deemed that they are no longer necessary.	

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F 309	Continued From page 5	F 309		

during these shifts. Nurse #3 stated the supervisor typically brought a report to the nurses regarding residents who had not had a bowel movement after 3 consecutive days for implementation of the standing order for constipation. Nurse #3 stated she had not been made aware that Resident #76 had not had a bowel movement in more than 3 days and she did not implement a bowel protocol for this Resident.

An interview on 04/28/16 at 5:40 PM with nurse aide (NA) #1 revealed she routinely worked with Resident #76 on the 3 PM - 11 PM shift. NA #1 stated Resident #76 was incontinent of bowel and required staff assistance with incontinence care. NA #1 stated Resident #76 voided each shift she worked with her since she returned from the hospital, but did not have a bowel movement.

An interview on 04/28/16 at 6:07 PM with the Director of Nursing (DON) and the Director of Clinical Education (DCE) revealed that the DCE typically printed a report of residents who had not had a bowel movement in more than 3 consecutive days and gave this report to the nurses for implementation of the physician's standing orders for constipation. Review of the facility's "No BM (bowel movement)/Urinary" report in the last 72 hours as of 04/27/16 revealed Resident #76 was not included in this report. The DON and DCE stated they were not aware that Resident #76 had not had a bowel movement for more than 3 consecutive days. The DCE stated she had trained the nurses on how to generate this report and expected them to also generate and review the report if she did not provide it to them.

An interview on 04/28/16 at 6:50 PM with NA #2

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F 309	Continued From page 6 revealed she worked with Resident #76 on the 11 PM - 7 AM shift on Tuesday 04/26/16 and Wednesday 04/27/16 and documented that Resident #76 did not have a bowel movement. NA #2 further stated that Resident #76 had a bowel movement at the end of the shift on Wednesday 04/27/16 just before 7 AM, but when NA #2 went to document this, the electronic system would not allow her rights to documentation since her shift had already ended. NA #2 stated she did not report this to her nurse. An interview on 04/28/16 at 6:55 PM with the DON revealed she could not explain why the facility's "No BM/Urinary" report as of 04/27/16 did not include Resident #76. The DON stated that the facility should have identified that Resident #76 did not have documentation of a bowel movement for more than 72 hours and the nurses should have implemented the bowel protocol for constipation for Resident #76 on 04/26/16 per physician's standing orders.	F 309		
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 by:	F 371		5/27/16

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F 371	Continued From page 7 Based on observations and staff interviews the facility failed to 1) cool leftover food in an ice bath prior to refrigeration 2) failed to clean the ice scoop holder and 3) failed to identify and repair a missing section of a door sweep on an exterior kitchen door. The findings included: 1. During the initial tour of the facility kitchen on 04/25/16 from 10:00 AM-10:40 AM the following concerns were identified: a. A clear plastic ice scoop holder was observed on the wall, adjacent to the ice machine in the facility kitchen. A removable lipped insert was inside the ice scoop holder and housed the ice scoop; with the base of the ice scoop immersed in water on the interior portion of the insert. The lipped insert was removed from the ice scoop holder and the water which the ice scoop was positioned in was noted with clear debris and a slightly cloudy appearance. With the Food Service Director (FSD) present, the ice scoop was removed from the lipped insert and the wet interior portion of the ice scoop insert was felt and a slimy feel was noted on the majority of the surface area. The FSD also felt the interior of the ice scoop insert and verified there was a slimy feel to touch. The FSD stated she thought the ice scoop holder was cleaned every day by dietary staff and went to check the cleaning schedule. The FSD returned with the cleaning schedule and noted instructions for the ice machine indicated to clean twice a week and to "Wipe down outside, door, and around ice scoop holder. Wipe down inner door liner." The FSD stated she was not aware the cleaning schedule did not include cleaning the ice scoop holder and changed the cleaning schedule to include cleaning the ice	F 371	Criteria I - To accomplish corrective action for those residents found to be affected by the alleged deficient practice, the following were enacted: 1.The noted cooling leftovers were discarded upon being pointed out by the surveyor 2. The ice scoop and holder were taken down and cleaned upon being pointed out by the surveyor and 3. The missing section of door sweep on the exterior kitchen door was repaired upon being identified by the surveyor. Criteria II - The facility has determined that all residents who receive meal trays may have the potential to be affected by the alleged deficient practice. To accomplish corrective action for all residents who receive a meal tray, 100% of dietary staff was in-serviced on sanitation to include proper cooling of leftover food, proper cleaning requirements for ice scoops and holders and identifying and reporting necessary repairs in order to maintain sanitation. Criteria III - As a systemic change to assure that the alleged deficient practice does not recur the facility will perform cooling of leftover items according to ServeSafe practice guides. The cook will complete a cooling temperature log at the end of meal service. Food that is pulled from the tray line that is potentially hazardous will be put in an ice bath and the temperature recorded. Temperature will be recorded again at the 2 hour and 4 hour mark. Food that does not meet the required temperature will be reheated to	

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F 371	Continued From page 8 scoop holder on a daily basis. b. An exterior door inside the kitchen and adjacent to the parking lot and dumpster area had an approximate 6" X 1/2" gap on the door sweep with exposed daylight. The door was in the area of food storage and food preparation. 2. Observations were made in the kitchen on 04/27/16 between 10:30 AM and 10:55 AM and the following concerns were identified: a. A container of fried eggs, a container of boiled eggs and a container of cooked bacon/ sausage were each covered in plastic wrap and stored directly on a metal sheet pan on top of the fryer. The fryer was adjacent to the steamer and the steamer was observed in use by the morning cook. The metal sheet pan that the containers of food were stored on was felt and it was warm to touch. The morning cook was asked about the containers of eggs and bacon/sausage and stated they were taken off the breakfast steam table about two hours prior and were stored for "cooling down". The morning cook stated the items were left out for about two hours after the breakfast meal service was completed in the event extra food items were requested for a resident and also to cool down the food prior to refrigerated storage. At 10:40 AM the Food Service Director (FSD) was asked about the leftover food items stored on the metal sheet pan on the fryer. The FSD stated leftover food items were set aside to cool down and the cook monitored the temperature and put leftovers in refrigeration when they were adequately cooled. The FSD stated the eggs, sausage and bacon would all be placed in refrigeration and available for use as needed for subsequent meals. When asked what temperature the leftover eggs, bacon	F 371	165 degrees or discarded. The cleaning for the ice scoop will be followed by staff resulting in a routine cleaning. Staff will report necessary repairs to Dietary Services Manager. Criteria IV - To incorporate these actions into the facility QAPI process and assure that they do not recur, cumulative data from the cooling log will be reported to the QAPI committee until further action is required or it is deemed no longer necessary by the committee. The cleaning schedule will be audited daily for six weeks with cumulative data reported to the QAPI committee, then 3 times per week for four weeks then twice a week until it is deemed no longer necessary by the QAPI committee. Pending kitchen maintenance items or tasks will be reported to the QAPI committee at its monthly meeting until the committee deems it no longer necessary. Monitoring of this data will be conducted by the QAPI committee through reporting results of the audits. As a further monitoring tool, the consulting Registered Dietician visits the facility approximately weekly and will make visual observation of the preparation and storage of cold and hot foods as well as the cooling of hot foods and the cleanliness of cooking utensils including but not limited to the ice scoops. These observations will be reported to the Executive Director via the report of the consulting Registered Dietician. This information will be reported to the QAPI committee until it is deemed no longer necessary by the committee. The	

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F 371	Continued From page 9 and sausage were being cooled to the FSD left the kitchen to obtain the facility policy. Upon return, the FSD stated the containers should have been placed in an ice bath to cool down the food. The FSD and the cook stated they were aware food should be cooled in an ice bath and could not explain why the leftover containers were not placed in an ice bath. The FSD stated she planned to discard the three containers of food. Prior to discarding, temperatures were obtained of the eggs, bacon/sausage at approximately 10:45 AM and were noted as follows: -the container of bacon/sausage was 116 degrees Fahrenheit -the container of fried eggs was 117 degrees Fahrenheit -the container of boiled eggs was 100 degrees Fahrenheit b. The gap remained on an exterior door inside the kitchen and adjacent to the parking lot and dumpster area with an approximate 6" X 1/2" missing area on the door sweep. The door was in the area of food storage and food preparation. 3. On 04/28/16 from 11:30 AM-12:14 PM observations were made in the facility kitchen. The Food Service Director (FSD) was asked about the approximate 6" X 1/2" gap on the exterior door sweep. The FSD stated she was not aware of the gap on the exterior door sweep. On 04/28/16 at 3:30 PM the maintenance director reported he repaired the door sweep on the exterior kitchen door. The maintenance director stated he was dependent on staff to bring concerns to his attention and was not aware of the missing door sweep on the exterior kitchen door until the FSD reported the concern to him on 04/28/16.	F 371	discussion of the results of the auditing will be used by the committee to determine the effectiveness of the plans of correction as well as any further necessary interventions.	

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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 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 review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in June 2015. This was for three recited deficiencies which were originally cited in May 2015 on a recertification and complaint investigation and again on the current	F 520	Criteria I - A special meeting of the QAPI Committee will be held on May 23 to discuss their role in the corrections process for F253, F309 and F371. Reporting and monitoring as outlined in those plans of corrections respectively will be addressed. Criteria II - The QAPI Committee will	5/27/16

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	345008	A. BUILDING _____ B. WING _____	C 04/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - DARTMOUTH	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(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 11 recertification survey. The deficiencies were in the areas of housekeeping and maintenance services, well-being, and dietary services. The facility's continued failure to implement and maintain procedures from a QAA Committee, during 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: 1 a. F 253: Housekeeping and Maintenance Services: Based on observations, a resident interview (Resident #29) and staff interviews, the facility failed to repair and replace floor tiles, repair holes in the wall and a bathroom door, repair a leaking toilet and replace a missing outlet cover for 3 rooms (Rooms 204, 215 and 309) on 2 of 3 units. During the May 2015 recertification survey and complaint investigation, the facility was cited for failure to keep walls, floors, baseboards and room furnishings in good repair. The facility was recited during the current recertification survey and complaint investigation for failing to repair floor tiles, holes in walls and doors, and a toilet and cover an electrical outlet. b. F 309: Well-being: Based on physician's standing orders, staff interviews and medical record review, the facility failed to assess and implement care plan interventions for 1 of 4 sampled residents at increased risk for constipation (Resident #76) with no documentation of a bowel movement for 5 consecutive days.	F 520	meet more frequently than the required Quarterly meeting, assembling at least monthly. The monthly meeting will include focus on the requirements of the Plans of Correction for cited alleged deficient practice, and the committee will develop plans for process improvement and deficiency correction. Criteria III - All results from the monitoring and action plan steps will be discussed in detail at each QAPI meeting for 3 months, and existing action steps will be revised or added to ensure correction. Criteria IV - The QAPI Committee will determine the scope and span as well as continued necessity of any continuing or expanded monitoring, as well as any further interventions and corrective actions. These activities will be recorded within the minutes maintained by the facility for QAPI. By monitoring the other plans of correction for effectiveness, the committee will continually insure that its goal of quality and performance improvement is accomplished.	

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F 520	Continued From page 12	F 520		

During the May 2015 recertification survey and complaint investigation, the facility was cited for failure to assess a change in condition of increased pain and confusion. The facility was recited during the current recertification survey and complaint investigation for failure to assess and implement interventions for a resident with no documentation of a bowel movement for 5 consecutive days.

c. F 371: Dietary Services: Based on observations and staff interviews the facility failed to 1) cool leftover food in an ice bath prior to refrigeration 2) failed to clean the ice scoop holder and 3) failed to identify and repair a missing section of a door sweep on an exterior kitchen door.

During the May 2015 recertification and complaint investigation, the facility was cited for failure to monitor hot food temperatures, maintain gloves clean, store frozen foods in sealed containers and remove an expired nutritional supplement from cold storage. The facility was recited during the current recertification survey and complaint investigation for failure to cool leftovers prior to refrigeration, maintain ice scoop clean, and repair a door sweep.

During an interview on 04/28/16 at 5:50 PM with the administrator, he stated that the repeat deficiencies in the areas of housekeeping and maintenance services, well-being, and dietary services were performance improvement driven and a performance improvement project was in place for each area. He stated the facility monitored the concerns identified during the May 2015 survey and gradually increased the time

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F 520	Continued From page 13 between audits due to good results. He stated that the department heads were still monitoring the items and the issues identified during the 2015 survey, but the items identified during the current survey were different from the 2015 survey. The administrator stated that due to the nature of quality improvement he expected continued evolving and improving for each identified concern	F 520		