STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		7/14/16

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

Electronically Signed | 08/04/2016

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F 156	Continued From page 1	F 156		

funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post accurate contact information for the State Agency on 2 of 2 posting areas in the facility. Findings included: On 7/11/16 at 12:48 PM during an observation of the facility and residents during the first meal after entry, it was observed that the State posting information located on the wall of the 1000 Hall, between the men's restroom and the wheelchair and lifts storage closet. All of the State contact information for the Medicaid Fraud Unit, the Complaint Intake Unit, and the Division of Health Service Regulation was out of date and incorrect for the names and contact numbers. The numbers listed were called and all returned a message that the numbers had been disconnected or were no longer in services. At 1:35 PM on 7/11/16, observation of the other information board, located at the front entrance of the facility, was made and revealed that the State information posted there was also outdated and incorrect. Random observations were made throughout the remainder of the survey to see if the information was updated while surveyors were in the building and it was not. On 7/14/16 at 11:44 AM, the Administrator stated that she would be the person responsible for all of the posting information for the State and Ombudsman going forward. She was new to the	F 156	Willow Creek Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quali-ty of care of residents. The plan of correction is submit-ted as a written allegation of compliance. Willow Creek Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Willow Creek Nursing And Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal pro-ceeding. F156	

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F 156	Continued From page 3 facility and reported that she did not know who was responsible for keeping it updated prior to her arrival, but she would be the one from now one. She reported that, to the best of her knowledge, the information that was posted was correct and that she had planned to check it for accuracy every 6 months to keep it up to date. She was not aware that the names and contact numbers of the State Agency were incorrect and would get them updated immediately.	F 156	The postings were changed to reflect the correct numbers required for the local department of social services, NC Complaint intake unit, Ombudsman program, Medicare (Social Security Office) and Medicaid Offices and verified by calling the numbers on 7/14/16 by the Regional Vice President of Operations. The postings were re-hung on 7/14/16 by the Administrator with the correct numbers. All areas in the facility with postings of state agency in-formation were checked by Regional Vice President of Operations on 7/14/16 to ensure correct information to include contact information was posted. The Regional Vice President of Operations corrected and re-posted and information found to be inaccurate dur-ing the audit. The Administrator and Director of Nursing were re-educated on 7/14/16 by the RN nurse consultant and Regional Vice President of Operations on the required postings for the state agency for resident utilization. The Administrator or Director of Nursing will review state agency information posting in all areas of the facility monthly X 3 months to ensure correct information to include contact information is posted utilizing a State Agency Posting QI Tool. The Administrator or Director of Nursing will cor-rect and repost any information	

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F 156	Continued From page 4	F 156	found to be inaccurate during audit. The Executive QI committee will meet monthly and review the state agency posting QI audit tool and address any issues, concerns, and/or trends and make changes as needed, to include continued frequency of monitoring monthly X 3 months.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observations, record review, and staff and resident interviews, the facility compromised the dignity of a resident by failing to assess for and maintain a toileting plan for one of one resident reviewed for urinary incontinence services, Resident #213. Findings included: The facility's Minimum Data Set (MDS) annual assessment dated 06/06/2016 indicated Resident #213 was cognitively intact and displayed no behaviors such as rejection of care or wandering. The same assessment documented that Resident #213 had a diagnoss of a cerebral vascular accident (stroke), that she required extensive assistance with toileting, and that she was frequently incontinent of the bladder. The annual assessment of 06/06/2016 also indicated Resident #213 was not on a scheduled toileting plan and that she had strong preferences for her	F 241	F241 Resident #213 was assessed on 7/14/16 by Registered Nurse Minimum Data Set Coordinator for potential for Bowel/Bladder re-training and was placed on a scheduled toileting program on 7/14/16 by Registered Nurse Minimum Data Set Coordinator. On 7/14/16 resident #213 care plan and Resident Care Guide (RCG) were updated for the addition of the scheduled toileting program and resident preference in wearing adult depends by Registered Nurse Minimum Data Set Coordinator. 100% of alert and oriented residents, to include resident #213, that are incontinent, will be interviewed using	8/11/16

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F 241	Continued From page 5 customary routine. A review of Resident #213's nursing care plan initiated on 08/20/2014 and last revised on 06/10/2016 revealed there was a measurable goal with interventions in place to address urinary incontinence related to her impaired mobility. One of the interventions to address her urinary incontinence was to praise and encourage all attempts to comply with toileting. In an interview with Resident #213 on 07/12/2016 at 9:20 AM, she stated she did not feel she was treated with respect and dignity by the nursing staff members, and that she did not get assistance with urinary toileting as needed. Resident #213 stated one of the nursing assistants told her she did not have time for helping her with her incontinent care, and that the nursing assistant's statement made her feel embarrassed and ashamed. During the interview with Resident #213at 9:20 AM on 07/12/2016, she was observed sitting up in bed wearing a short sleeve top and an adult disposable brief. During an observation of the resident on 07/13/2016 at 11:35 AM, Resident #213 was observed sitting up in bed wearing a long sleeve shirt and an adult disposable brief. Nursing Assistant (NA) #1 stated in an interview on 07/13/2016 at 2:10 PM that she provided incontinent care for her assigned residents every 2 hours. NA #1 also stated that none of her assigned residents, including Resident #213, was on a toileting plan. In an interview with MDS Nurse #1 on 07/13/2016, she stated that the minimum data set assessment (an assessment required by federal regulation) information was based upon assessments provided by nurses. She stated that criteria for initiating a toileting plan included	F 241	questions: Are you aware when you need to go to the bathroom?; Is it your preference to wear a brief?; Would you like to try a toileting program?, using the "Initiation of Toileting Program Interview tool", interviews to be conducted by Quality Indicator RN and LPN, RN Supervisor, RN Staff Facilitator, RN-ADON by 8/10/16. Those determined to meet the criteria will be placed on a scheduled toileting program. Care plans and RCG will be updated to reflect the toileting program by Registered Nurse Minimum Data Set Coordinator and completed by 8/11/16. 100% of Nursing staff, RN, LPN, and C.N.A.'s, will be in-serviced on the scheduled toileting program to include documentation in the POC and identifying residents on scheduled toileting per the Resident Care Guide by RN Staff Facilitator. "Scheduled Toileting Program: (Toilet before meals, after meals, qHS, and as needed)",and Treat residents with Dignity and Respect in-services were initiated August 2, 2016 by RN-ADON. All nursing new hires will receive these in-services re-garding scheduled toileting program to include documentation in POC and identifying residents on scheduled toileting per the resident care guide by staff facilitator. "Scheduled Toileting Pro-gram: Toilet before meals, after meals, qHS, and ass needed", and Treat Residents with Dignity and Respect, during orientation. During the Quarterly MDS assessment,	

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F 241	Continued From page 6 an assessment of the resident to determine whether he/she wanted to be on a toileting program and whether the resident had sufficient cognition to follow a toileting program. In an interview with MDS Nurse #2 on 07/13/2016 at 2:35 PM, she stated that Resident #213 was not placed on a toileting program, but that it was an option for her. MDS Nurse #2 stated that all residents on a toileting program should be toileted before meals, after meals, and as needed throughout the shift. MDS #2 also stated that a care plan meeting was planned for 06/21/2016 according to a social services note, but did not know whether toileting had been discussed at the meeting, as the social worker was not available, and there were no minutes from the care plan meeting. In an interview with Resident #213's day shift nurse, Nurse #1 on 07/13/2016 at 3:31 PM, she stated she thought Resident #213 used to be on a toileting program, but was not sure why it had been stopped. She explained Resident #213 was cognitively capable of following a toileting plan and that she was functionally able to transfer to the bedside commode or walk to the bathroom. In an interview with Resident #213's evening nurse, Nurse #2 on 07/13/2016 at 3:33 PM, she stated she felt the resident was capable of handling a toileting program, as she was cognitively intact. Nurse #2 stated she had not referred her for a toileting plan. Resident #213 stated in an interview on 07/14/2016 at 9:40 AM that she was on a toileting plan months ago and that she had no idea why it was stopped. Resident #213 also stated it made her feel embarrassed to wear a diaper and for no one to assist her to the bathroom. Resident #213 stated she used the call bell to call for assistance to the bathroom or the bedside commode, but	F 241	the Registered Nurse Minimum Data Set Coordinator will review all current in-house residents including resident #213 for changes and updates to current status for toileting program, with updates to care plan and care guides made by Registered Nurse Minimum Data Set Coordinator utilizing the RAI/MDS assessment. Documentation of residents on scheduled toileting, to include resident #213, will be reviewed daily during clinical meeting by the DON, ADON, RN Supervisor, MDS Nurse and/or QI nurses for resident's progression in toileting program Monday through Friday X 4 weeks then weekly X 4 weeks then monthly X 3 months. At that time those residents will be re-evaluated, to include resident #213, for continuation on scheduled toileting or discontinuation of scheduled toileting program, using the re-evaluation for Toileting Program Tool. Care plans and RCG will be updated to reflect the continued toileting program by Registered Nurse Minimum Data Set Coordinator, and completed ongoing for updates and changed to the resident's toileting program. Documentation of residents that continue on scheduled toileting program, to include resident #213, if applicable, will be reviewed daily during clinical meeting by DON, ADON, RN supervisor, MDS nurse and/or QI nurses for resident's progression in toileting program weekly X 4 weeks, then monthly X 3 months.	

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F 241	Continued From page 7 staff often did not respond. In an interview with the Assistant Director of Nursing on 07/14/16 at 1:29, PM, she stated that any nurse could refer a resident for a toileting program screening. The ADON stated the nurse would contact any of the administrative nurse to make the referral. In an interview with MDS Nurse #1 on 07/14/2016 at 1:45 PM, she stated she could not establish whether a toileting plan had been initiated for Resident #213 in the past and that she would initiate one.	F 241	The Executive QI committee will meet monthly and review audits and address any issues, concerns, and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X 3 months.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based upon observations, record review, and staff and resident interviews, the facility failed to evaluate a resident for participation in toileting program for 1 of 1 sampled resident, Resident # 213, reviewed for urinary incontinence care. Findings included: The annual Minimum Data Set (MDS) assessment dated 06/06/2016 indicated Resident	F 315	F315 Resident #213 was assessed on 7/14/16 by Registered Nurse Minimum Data Set Coordinator for potential for Bowel/Bladder re-training and was placed on a scheduled toileting program on 7/14/16 by Registered Nurse Minimum Data Set Coordinator. On 7/14/16 resident #213 care plan and Resident Care Guide	8/11/16

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F 315	Continued From page 8 #213 was cognitively intact and displayed no behaviors such as rejection of care or wandering. The same assessment documented that Resident #213 had a diagnosis of cerebral vascular accident (stroke), that she required extensive assistance with toileting, and that she was frequently incontinent of the bladder. The annual assessment of 06/06/2016 also indicated Resident #213 was not on a scheduled toileting plan and that she had strong preferences for her customary routine. A review of Resident #213's nursing care plan initiated on 08/20/2014 and last revised on 06/10/2016 revealed there was a measurable goal with interventions in place to address her urinary incontinence related to her impaired mobility. The stated goal was to keep the resident free from a urinary tract infection. One of the interventions to address her urinary incontinence was to praise and encourage all attempts to comply with toileting. Other goals and interventions included on the nursing care plan addressed Resident #213's need for assistance with the potential to restore or maintain maximum function with her activities of daily living, including personal hygiene. Interventions were also in place regarding her risk for skin breakdown and her risk for falls. In an interview with Resident #213 on 07/12/2016 at 9:20 AM, she stated she did not did not receive assistance with toileting as needed. Resident #213 stated she knew when she had to urinate, but a nursing assistant told her she did not have time for helping her with her toileting needs. Nursing Assistant (NA) #1 stated in an interview on 07/13/2016 at 2:10 PM that she provided incontinent care for her assigned residents every 2 hours. NA #1 also stated that none of her assigned residents, including Resident #213, was	F 315	(RCG) were up-dated for the addition of the scheduled toileting program and resident preference in wearing adult depends by Registered Nurse Minimum Data Set Coordinator. 100% of alert and oriented residents, to include resident #213, that are incontinent, will be interviewed using questions: Are you aware when you need to go to the bathroom?; Is it your preference to wear a brief?; Would you like to try a toileting program?, using the “Initiation of Toileting Program Interview tool”. Interviews were conducted by Quality Indicator RN and LPN, RN Supervisor, RN Staff Facilita-tor, RN-ADON by 8/10/16. Those determined to meet the criteria will be placed on a scheduled toileting pro-gram. Care plans and RCG will be updated to reflect the toileting program by Registered Nurse Minimum Data Set Coordinator and completed by 8/11/16. 100% of Nursing staff, RN, LPN, and C.N.A.’s, will be in-serviced on the scheduled toileting program to include documentation in the POC and identifying residents on scheduled toileting per the Resident Care Guide by RN Staff Facilitator. “Scheduled Toileting Program: (Toilet before meals, after meals, qHS, and as needed)”, Treat residents with Dignity and Respect in-services were initiated August 2, 2016 by RN-ADON. All nursing new hires will receive these in-services re-garding scheduled toileting program to include documentation in POC	

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F 315	Continued From page 9 on a toileting plan. In an interview with Minimum Data Set (MDS) Nurse #1 on 07/13/2016 at 2:30 PM, she stated that the minimum data set assessment (an assessment required by federal regulation) information was based upon assessments provided by nurses. She stated that criteria for initiating a toileting plan included an assessment of the resident to determine whether he/she wanted to be on a toileting program and whether the resident had sufficient cognition to follow a toileting program. In an interview with MDS Nurse #2 on 07/13/2016 at 2:35 PM, she stated that Resident #213 was not placed on a toileting program but it was an option for her. MDS Nurse #2 stated that all residents on a toileting program should be toileted before meals, after meals, and as needed throughout the shift. MDS #2 also stated that a care plan meeting was planned for 06/21/2016 according to a social services note, but did not know whether toileting had been discussed at the meeting, as the social worker was not available, and there were no minutes from the care plan meeting. In an interview with Resident #213's day shift nurse, Nurse #1 on 07/13/2016 at 3:31 PM, she stated she thought Resident #213 used to be on a toileting program, but was not sure why it had been stopped. She explained Resident #213 was cognitively capable of following a toileting plan, that she was functionally able to transfer to the bedside commode or walk to the bathroom, and that she could benefit by scheduled toileting. In an interview with Resident #213's evening nurse, Nurse #2 on 07/13/2016 at 3:33 PM, she stated she felt the resident was capable of handling a toileting program and that she was cognitively intact. Nurse #2 stated she had not	F 315	and identifying residents on scheduled toileting per the resident care guide by staff facilitator. “Scheduled Toileting Program: Toilet before meals, after meals, qHS, and ass needed”, and Treat Residents with Dignity and Respect, during orientation. During the Quarterly MDS assessment, the Registered Nurse Minimum Data Set Coordinator will review all current in-house residents including resident #213 for changes and updates to current status for toileting program, with updates to care plan and care guides made by Registered Nurse Minimum Data Set Coordinator utilizing the RAI/MDS assessment. Documentation of residents on scheduled toileting, to include resident #213, will be reviewed daily during clinical meeting by the DON, ADON, RN Supervisor, MDS Nurse and/or QI nurses for resi-dent’s progression in toileting program Monday through Friday X 4 weeks then weekly X 4 weeks then monthly X 3 months. At that time those residents will be re-evaluated, to include resi-dent #213, for continuation on scheduled toileting or discontinuation of scheduled toileting program, using the re-evaluation for Toileting Program Tool. Care plans and RCG will be updated to reflect the continued toileting program by Registered Nurse Minimum Data Set Coordinator, and completed ongoing for updates and changed to the resident’s toileting program. Documentation of residents that continue on scheduled	

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F 315	Continued From page 10 referred her for a toileting plan. Resident #213 stated in an interview on 07/14/2016 at 9:40 AM that she was on a toileting plan months ago and that she had no idea why it was stopped. Resident #213 also stated it made her feel embarrassed to wear a diaper and for no one to assist her to the bathroom. Resident #213 stated she used the call bell to call for assistance to the bathroom or the bedside commode, but staff often did not respond. In an interview with the Assistant Director of Nursing on 07/14/16 at 1:29, PM, she stated that any nurse could refer a resident for a toileting program screening. The ADON stated residents who were cognitively intact were good candidates for a toileting program and that any nurse could contact one of the administrative nurses to make the referral. In an interview with MDS Nurse #1 on 07/14/2016 at 1:45 PM, she stated she could not establish whether a toileting plan had been initiated for Resident #213 in the past and that she would be initiating an one for her. On 07/14/2016 at 2:10 PM, MDS Nurse #2 provided a copy of a Screen/Referral to Rehab Services for Resident #213. The referral sheet was dated 07/14/2016 and documented the following: "Please evaluate resident for bowel/bladder retraining to implement scheduled toileting program."	F 315	toileting program, to include resident #213, if applicable, will be reviewed daily during clinical meeting by DON, ADON, RN supervisor, MDS nurse and/or QI nurses for resident's progression in toileting program weekly X 4 weeks, then monthly X 3 months. The Executive QI committee will meet monthly and review audits and address any issues, concerns, and/or trends and to make changes as needed, to include continued frequency of monitoring monthly X 3 months.	
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	F 520		8/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 11 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 upon staff interview and record review, the facility's Quality Assurance (QA) committee failed to prevent the reoccurrence of deficient practice for urinary incontinence care which resulted in a repeat citation at F 315 in its annual recertification survey of 07/14/2016. The citing of F 315 during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This citation is cross-referenced to: F 315: Urinary Incontinence: Based upon observations, record review, and staff and resident interviews, the facility failed to assess a resident for participation in toileting program for 1 of 1 sampled resident, Resident # 213, reviewed	F 520	F520 The Administrator, DON, and QI Nurse will be educated by the Corporate Nurse Consultant on 8/10/16 on the QI process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QI process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include for urinary incontinence care. The Administrator, DON, and QI Nurse will be educated by the Corporate consultant on 8/10/16 on the QA process to include identifying issues that warrant development and establish a system to	

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F 520	Continued From page 12 for urinary incontinence care. Review of the facility's survey history revealed F 315 was cited during the 08/07/2016 annual recertification survey of 08/07/2015, and was re-cited during the 07/14/2016 annual recertification survey. During an interview with the Administrator on 07/14/2016 at 3:19 PM, she stated that the QA committee met on a quarterly basis to focus on solutions for identified areas of concern. She explained the facility's department managers (QA members) provided reports at each meeting based upon their audit tools, and if problems were not being resolved, then a performance improvement plan was initiated. She added that she was new to the facility and that she had initiated a new tool for identifying quality of care issues by establishing "guardian angel" rounds for all residents in the facility. The Corporate Vice President stated in an interview at 3:25 PM on 07/14/2016 he understood that QA committee had not been successful if there was a repeat deficiency for urinary incontinence care. He stated that the facility corporation had recently hired new management for the facility, including a new Administrator and Director of Nursing, in order to help stabilize the facility and bring about positive changes regarding quality of care concerns.	F 520	monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program. The RN Assistant Director of Nursing completed 100% audit of previous citation and action plans within the past year to include urinary incontinence to ensure that the QI committee has maintained and monitored interventions that were put in place. Action plans will be revised and updated and will be presented to the QI Committee by the RN Assistant Director of Nursing on 8/11/16 for any concerns identified. All data collected for identified areas of concerns to including urinary incontinence will be taken to the Quality Assurance Committee for review monthly X 4 months by the Quality improvement Nurse. The Quality Assurance Committee will review the data and determine if plans of correction are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of Quality Assurance Committee will be documented monthly at each meeting by the RN QI nurse. The Corporate consultant will ensure the facility is maintaining and effective QA program by reviewing and initialing the Executive Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include, urinary	

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F 520	Continued From page 13	F 520	incontinence and all current citations and QI plans are followed and maintained Quarterly X 2. The facility consultant will immediately retrain Administrator, DON,and QI Nurse for any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the executive Committee Quarterly X 2 for review and identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	