STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING ______ B. WING ______	C 10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

(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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to honor a resident's choice of having weekly showers for 1 of 3 residents reviewed for choices (Resident #6). The findings included:	F 561	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	11/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 11/02/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 Resident #6 was admitted to the facility on 10/03/17 with multiple diagnosis including osteoarthritis, muscle weakness, difficulty in walking, hypertension, edema, diabetes mellitus, overactive bladder, major depressive disorder, pain, insomnia and gout. Review of the Annual Minimum Data Set dated 09/24/18 revealed Resident #6 was cognitively intact. Resident #6 was coded as activity did not occur for transfer and locomotion off the unit, activity occurred only once or twice for dressing and locomotion on unit with 2 plus person physical assist. Resident #6 required extensive assistance with bed mobility with 2 plus persons physical assist, total dependence for toilet use with 2 plus persons physical assist, supervision for personal hygiene with 2 plus persons physical assist and activity itself did not occur for bathing. Resident #6 was incontinent of bladder and bowel. A review of her care plan dated on 07/27/18 revealed there were appropriate interventions about Activities of Daily Living for Resident #6 to provide assistant with all ADLs care except eating. During an interview with Resident #6 on 10/09/18 at 9: 20 AM, she revealed that she was not getting her showers on Wednesday's and Saturday's. Record review reveals that the resident shower days are on Wednesday's and Saturday's. Review of the of the ADL documentation sheet for September 2018 revealed that the resident did not receive a shower on the following days: 1st,	F 561	regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F561 How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #6 was offered a shower and preference reviewed with resident upon notification to ensure preferences were met going forward. The Director of Nursing(DON)/Unit Manager or designee will ensure nursing documentation reflects resident preferences for showers, bed baths, or refusals. How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing(DON)/Unit Manager or designee will audit all residents for choices/preferences for showers. The Director of Nursing(DON)/Unit Manager or designee will audit nursing documentation daily for completeness Monday through Friday for a month and weekly x 2 months. Measures to be put in place or systemic changes made to ensure that deficient practice will not recur The Administrator	

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F 561	Continued From page 2 5th, 8th, 12th, 15th, 19th, 22nd, 26th and 29th. There was no documentation in the nurse's notes for the month September 2018 that indicated the resident refused her showers. Review of the of the ADL documentation sheet for October 2018 revealed that the resident did not receive a shower on the following days: 3rd and 6th. There was no documentation in the nurse's notes for the month October 2018 that indicated the resident refused her showers. During an interview with NA #3 on 10/10/18 at 11:20AM, she revealed that she did not usually work with Resident #6 and when she refused a shower she would document in the computer and offer the resident a bed bath and notify the nurse. During an interview with NA #4 on 10/10/18 at 3:23 PM, she revealed that the resident did refuse a shower in September 2018 and she could not remember what day. She further stated she gave the resident a bed bath and she forget to document in the computer and notify the nurse. During an interview with Resident #6 on 10/10/18 at 3:30 PM, she revealed that she got a shower on today. During an interview with the Administrator on 10/10/18 at 5:00 PM, she revealed that it was her expectation that all residents get showers on their assigned days. The Administrator further stated that if a resident refuses a shower the nursing assistant (NA) should verbally notify the nurse and document in Point of Care under bathing and the nurse document in the nurse's notes.	F 561	will interview 10% of resident census weekly x 4 weeks and monthly thereafter to assure showers are being given as scheduled. Any deficient practice will result in re-education and/or discipline as needed. Administrator will in-service the DON and designees on expectations of nursing documentation to reflect care given to residents. How facility plans to monitor its performance to make sure that solutions are sustained The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings x 3 months and Quarterly Quality Assurance Meetings x 1 for further problem resolution.	
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		11/7/18

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F 580 SS=D	Continued From page 3 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 4 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the resident and the resident's representative of two room changes for 1 of 3 residents reviewed for notification of changes (Resident #10). The findings included: Resident #10 was admitted to the facility on 04/20/18 with diagnoses which included influenza with unspecified type of pneumonia, congestive heart failure and chronic obstructive pulmonary disease. A review of Resident #10's admission Minimum Data Set (MDS) revealed Resident #10 was moderately cognitively impaired. A review of Resident #10's Care Plan revealed Resident #10 had been resistive to nursing care related to anxiety and confusion. A record review of Resident #10's progress notes from 04/23/18 through 09/19/18 revealed no documentation of notification to the resident and resident's representative of the two room	F 580	F580 How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #10 is no longer a resident at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice The Discharge planner or designee will complete a room change notification form for all room moves going forward that provides a signature line for the residents or responsible parties to acknowledge room changes. Measures to be put in place or systemic changes made to ensure that deficient practice will not recur The Administrator will audit 100% of resident room changes weekly x 4 weeks and 10% monthly thereafter to assure notifications are given for all room changes. Any deficient practice will result in re-education and/or	

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F 580	Continued From page 5 changes. During an interview with the Admissions Director on 10/09/18 at 9:10 a.m., the Admissions Director stated Resident #10 had been admitted into Room 604 on 04/20/18. The Admissions Director stated Resident #10 had been transferred to Room 303B on 05/22/18 and then to room 801B on 07/30/18. The Admissions Director stated when a room change was to occur, she completed a form which included information about the resident and the room change. The Admissions Director stated she had completed this form, had informed Resident #10 and the different departments in the facility of the room change. When asked if she had informed the resident's representative of the room change as Resident #10 had been assessed as moderately cognitively impaired, the Admissions Director stated she had not. The Admissions Director stated she had been informed by the therapists and nursing staff Resident #10 had been able to make her own decisions and therefore had been her own responsible party. The Admission's Director stated she had not gotten Resident #10 to sign the room transfer forms for the two room changes. During an interview with the Administrator on 10/10/18 at 4:00 p.m., the Administrator stated it was her expectation the resident and resident's representative would be notified of room changes and the notification documented.	F 580	discipline as needed. Administrator will in-service the Discharge Planner and designees on expectations of room change notifications. How facility plans to monitor its performance to make sure that solutions are sustained The results of these audits will be reviewed in weekly Quality Assurance Risk Meetings x 3 months and Quarterly Quality Assurance Meetings x 1 for further problem resolution.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		11/7/18

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F 609	Continued From page 6 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to report an abuse allegation of a resident being punch by a staff member immediately to the administrator for 1 of 1 resident to staff physical abuse investigations reviewed. (Resident # 8) The findings included: Resident #8 was admitted to the facility on	F 609	F609 How corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #8 was assessed for injury at the time of incident notification and abuse investigation completed by facility staff on 9/19/18. No injuries were noted at the time of assessment.	

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F 609	Continued From page 7 5/31/2017 with diagnoses which included hypertension, Parkinson disease and muscle weakness. The quarterly Minimum Data Set (MDS) dated 07/23/18 revealed that the resident was cognitively intact with extensive assistance needed for bed mobility, personal hygiene, eating and dressing. MDS indicated also Resident # 8 was total dependent on staff with transfer and toileting. No behavioral problems were documented. A review of Resident # 8's Care Plan, last revised 7/23/2018, indicated Resident #8 had an ADL(activity of daily) self- care performance deficit due to limited mobility, Parkinson's and Hemiplegia. A review of the facility's abuse investigation revealed on 9/18/18 Resident #8 reported an allegation of physical abuse that occurred on 9/16/2018 to Nurse # 1. Further review of the investigation revealed the Administrator and Director of Nursing (DON) were not notified by Nurse # 1 of the allegation of physical abuse by Resident # 8 until on 9/19/2018. A document titled "24-Hour Initial Report" with a facsimile confirmation date of 9/19/18 at 7:54PM revealed the date of the alleged report of incident to staff occurring on 9/18/18 at 4:00PM and was not reported to administrative staff until 9/19/18. During an interview on 10/9/2018 at 3:00PM, Nurse # 1 stated Resident # 8 reported to her on 9/18/2018 that over the weekend (9/16/2018) Nurse Aide(NA) # 1 "punched him" in his stomach. Nurse # 1 stated she forgot to report the allegation to her supervisor until on 9/19/2018 when Assistant Director of Nursing (ADON)	F 609	How the facility will identify other residents having the potential to be affected by the same deficient practice All staff were educated by the Administrator/Director of Nursing (DON) on the abuse policy and procedure and timely reporting for all residents. Measures to be put in place or systemic changes made to ensure that deficient practice will not recur Regional Nurse Consultant and Administrator educated nurse #1 on abuse policy and timely reporting guidelines on October 9, 2018. Administrator and Department Heads educated entire staff of abuse policy and timely reporting guidelines. How facility plans to monitor its performance to make sure that solutions are sustained Any abuse allegations will be reviewed in weekly Quality Assurance Risk Meetings x 3 months and Quarterly Quality Assurance Meetings x 1 for further problem resolution.	

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F 609	Continued From page 8	F 609		

interviewed her about the Resident # 8's allegation of physical abuse which had been reported by Resident # 8's family member to ADON.

During an interview with the Assistant Director of Nursing (ADON) on 10/10/18 at 9:49 AM, She stated her expectation was Nurse # 1 should have reported the allegation of physical abuse immediately to her supervisor. ADON reported she was unsure why Nurse # 1 waited so long to report the alleged incident.

During the observation on 10/10/2018 at 9:55 AM, Resident # 8 was in bed watching television. He stated he was doing fine and he was not interested in having any discussion about the allegation that he had reported to the staff at the facility.

The Administrator was interviewed on 10/10//2018 at 11:05 AM. She reported it was her expectation that allegations of abuse were reported immediately to her and the investigation of abuse allegations were completed according to the regulations. In relation to the allegation of staff physically abusing Resident # 8 she would have expected to have been notified immediately of this allegation. The Administrator added the day they were notified on 9/19/2018 by Resident # 8's family about the allegation of physical abuse they suspended Nurse Aide # 1 immediately. She added they completed the 24 hour and 5 days report then faxed the information to the state agency.

Director of Nursing (DON) was not present at the facility and was unavailable for an interview.

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F 641	Continued From page 9	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set to reflect a resident's diagnosis of a contagious intestinal infection for 1 of 3 residents reviewed for infection control (Resident #12). The findings included: Resident #12 was admitted to the facility on 09/12/18 with diagnoses which included, in part, enterocolitis due to clostridium difficile (a contagious infection in the intestinal tract) and urinary tract infection. A review of Resident #12's admission Minimum Data Set (MDS), dated 09/19/18, revealed Resident #12 had been severely cognitively impaired and had been frequently incontinent of her bowels and bladder. The MDS indicated Resident #12 had a urinary tract infection. A review of Resident #12's Care Plan revealed the Care Plan had been initiated on 09/21/18 and did not include Resident #12's diagnosis of enterocolitis due to clostridium difficile. The Care Plan had been updated on 09/25/18 to reflect Resident #12 had a urinary tract infection with an intervention for contact precautions. During an interview with MDS #1 on 10/08/18 at 11:15 a.m., MDS #1 stated she had reviewed	F 641	F641 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #12s Admission MDS ARD 9/19/18 did not include the active diagnosis for enterocolitis due to clostridium difficile in Section I. The MDS was modified on 10/8/18 to correctly code the active diagnosis clostridium difficile. How the facility will identify other residents having the potential to be affected by the same deficient practice- All current residents, with an active diagnosis for enterocolitis due to clostridium difficile, MDS will be reviewed to ensure the contagious intestinal infection is correctly coded on their MDS in Section I by 11/3/18. Any issues identified as being coded incorrectly, will be modified by the MDSC. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Education will be provided to MDSC by the MDSC Regional Consultant on the RAI requirements for coding Section I for any residents with an active diagnosis for enterocolitis due to	11/7/18

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Resident #12's diagnoses list to code Section I (diagnoses) on Resident #12's admission MDS. MDS #1 stated she had not included enterocolitis due to clostridium difficile on Resident #12's admission MDS as the diagnoses list in the facility's electronic health record had not included enterocolitis due to clostridium difficile at the time she completed the MDS assessment. MDS #1 stated she had not reviewed Resident #12's hospital discharge summary because the date of the hospital discharge summary had not been within the dates of the MDS assessment window.

During an interview with Nurse #5 on 10/08/18 at 4:18 p.m., Nurse #5 stated she had entered Resident #12's diagnoses into the electronic health record upon Resident #12's admission into the facility. Nurse #5 stated she had reviewed Resident #12's hospital history and physical which had been provided in the Admission Packet to obtain Resident #12's diagnoses. Nurse #5 stated the Admission Packet contained medical records from Resident #12's hospital stay and admitting orders. Nurse #5 stated she did not have access to Resident #12's hospital discharge summary at the time of Resident #12's admission to the facility.

A review of Resident #12's Admission Packet included a preliminary hospital discharge summary, dated 09/10/18, which indicated a discharge diagnosis of clostridium difficile. The Admission Packet also included an infectious disease progress note, dated 08/31/18, which indicated an assessment of recurrent clostridium difficile colitis with sepsis.

During an interview with the Administrator on 10/10/18 at 4:00 p.m., the Administrator stated it

clostridium difficile on 10/30/18. All new MDSC employees will be educated during orientation on proper coding of enterocolitis due to clostridium difficile in Section I.
The MDS Consultant or designee will audit 5 residents with enterocolitis due to clostridium difficile to ensure their diagnosis is correctly coded in Section I of their MDS according to the documentation from the residents medical records once weekly for 4 weeks, twice a month for one month, and monthly x 1 month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC.

How facility will monitor its performance to make sure that solutions are sustained:
Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.

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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 641	Continued From page 11 was her expectation the nursing staff accurately code the MDS assessments.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		11/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING ______ B. WING ______	C 10/10/2018

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F 655	Continued From page 12 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of a resident's admission to the facility for 1 of 12 residents reviewed (Resident #12). The findings included: Resident #12 was admitted to the facility on 09/12/18 with diagnoses which included, in part, enterocolitis due to clostridium difficile (a contagious infection in the intestinal tract) and urinary tract infection. A review of Resident #12's admission Minimum Data Set (MDS), dated 09/19/18, revealed Resident #12 had been severely cognitively impaired and had been frequently incontinent of her bowels and bladder. The MDS indicated Resident #12 had a urinary tract infection. A review of Resident #12's Care Plan revealed the Care Plan had been initiated on 09/21/18. During an interview with MDS #1 on 10/08/18 at 11:15 a.m., MDS #1 stated the "date initiated" associated with the Care Plan in the electronic health record would have indicated when a	F 655	F655 How corrective action will be accomplished for those residents found to have been affected by the deficient practice Care plan for Resident #12 was updated to reflect diagnosis of enterocolitis due to clostridium difficile on October 9, 2018. Resident #12 is no longer at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice 100% audit of all remaining residents was completed to ensure a baseline care plan was implemented on October 10, 2018. Measures to be put in place or systemic changes made to ensure that deficient practice will not recur Regional Nurse Consultant and Administrator educated Nurse Administration on baseline care plan expectations. 100% of all admissions will be reviewed by Director of Nursing or designee weekly x 4 weeks for baseline care plans then 10% of all admissions will be reviewed monthly x 2	

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F 655	Continued From page 13 resident's Care Plan had been developed. MDS #1 stated the nurses on the floor are responsible for initiating the baseline care plan. MDS #1 stated no baseline care plan had been developed within 48 hours of Resident #12 having been admitted to the facility as the Care Plan's "date initiated" reflected 09/21/18. During an interview with Nurse #6 on 10/08/18 at 2:10 p.m., Nurse #6 stated they had 48 hours to complete a baseline care plan on new residents therefore several nurses may participate in the development of the baseline care plan. Nurse #6 stated they now had a second shift nursing supervisor who participated in Resident #12's admission process. During an interview with Nurse #5 on 10/08/18 at 4:18 p.m., Nurse #5 stated she had been informed by nursing management of the components she would be responsible for related to the baseline care plan upon a resident's admission to the facility. When asked why she had not initiated a baseline care plan for Resident #12, Nurse #5 stated she did not know. During an interview with the Administrator on 10/10/18 at 4:00 p.m., the Administrator stated it was her expectation nursing staff complete a baseline care plan on residents within 48 hours of their admission to the facility.	F 655	months for baseline care plan completion. How facility plans to monitor its performance to make sure that solutions are sustained Audits of baseline care plans will be reviewed in weekly Quality Assurance Risk Meetings x 3 months and Quarterly Quality Assurance Meetings x 1 for further problem resolution.	