STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27330

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview and records review, the facility failed to notify the responsible party (RP) of a resident fall for 1 of 3 (Resident #118)	F 157	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	2/12/16

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

Electronically Signed | 02/12/2016

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F 157	Continued From page 1 residents reviewed for accidents. Findings included: Resident #118 was admitted to the facility on 12/2/2015 with cumulative diagnoses of anemia, Coronary Artery Disease (CAD), Hypertension, Diabetes and Parkinson's disease. The admission Minimum Data Set (MDS) dated 12/9/2015 indicated the resident's cognitive status was intact, no behavioral problems, required extensive assistance with physical assist and bed mobility with 2 staff. Resident also required extensive assist using 1 staff with dressing and personal hygiene. A review of the incident report dated 12/28/15 indicated at 10:09 AM, resident was found lying on the floor by housekeeping staff. Resident # 118 was assessed and there were no injuries noted. Further review of the incident report revealed the responsible party was not notified of the fall incident. The nurse who was assigned to the resident the day he (Resident # 118) was found on the floor was not interviewed due to the fact that she was no longer employed at the facility per the Director of Nursing (DON) interview. During an interview on 1/28/2016 at 2:30 PM, the DON stated it was her expectation that the staff call the responsible party each time a resident was found on the fall to report a fall incident.	F 157	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F157 Corrective Action for Resident Affected: It was identified that on 12/28/15, Resident #118's family was not notified after the resident fell in the facility. At the time of the fall, proper medical care was provided, and the patient suffered no adverse outcome related to the notification. Corrective Action for Residents Potentially Affected: All residents in the facility have the potential to be affected by this practice. The following steps were taken to correct the deficient practice: a. All licensed staff were educated by the DON and/or ADON on the company's policy requiring legal representatives or responsible parties to be notified following a fall. This was initiated on 1/29/16 and was completed on 2/1/16. b. All licensed staff have shown evidence of their understanding of this policy. This was completed on 2/1/16. Systematic Changes: Between 1/29/16 and 2/1/16, the DON	

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F 157	Continued From page 2	F 157	and/or ADON inserviced all full-time, part-time and PRN staff on the company's policy related to notification of legal representatives or responsible parties after a fall. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that changes have been sustained. Quality Assurance: The DON, ADON or Weekend Supervisor will audit all falls investigations within 24 hours to ensure that staff notification to the responsible party or legal representative have occurred. Should any notification not be identified, the correct party will be notified, the staff member will be re-educated and the staff member will be disciplined as necessary to ensure compliance. The DON, ADON, Weekend Supervisor or Designee will monitor the audits daily for 7 days, weekly for 4 weeks and monthly for 5 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action initiated was appropriate. Compliance will be monitored and the ongoing auditing program will be reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, ADON, Therapy, HIM, Dietary Manager and Administrator. Compliance Date: February 1, 2016	

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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 on observation, record review and staff interview, the facility failed to protect the resident ' s dignity by failing to cover an indwelling urinary catheter bag for 1 of 2 residents (Resident #51) reviewed for dignity. Findings included: Resident #51 was admitted 8/8/2011. Diagnoses included: Dementia, Neurogenic Bladder and Urinary Retention. The Minimum Data Set (MDS) dated 11/18/15 indicated the resident has severe cognitive impairment, required extensive assistance with her activities of daily living (ADLs). Her MDS indicated she had an indwelling urinary catheter. On 1/27/16 at 12:53 PM an observation was made of resident #46 lying in her bed eating lunch. Her uncovered indwelling urinary catheter bag was positioned on the left side of her bed, visible to the hallway. On 1/28/16 at 9:44 AM an observation was made of the resident lying in her bed. Her uncovered indwelling urinary catheter bag was positioned on the left side of her bed, visible to the hallway. On 1/28/16 at 12:04 PM an observation was made of the resident sitting in the main dining room. Her indwelling urinary catheter bag was positioned hanging from her wheelchair, wrapped in a clear plastic trash bag. On 1/28/16 at 3:15 PM an observation was made	F 241	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F241 Corrective Action for Resident Affected: It was identified multiple times between 1/27/16 and 1/29/16 that Resident #51's indwelling catheter bag was not covered in violation of the resident's dignity. Upon identification on 1/29/16, a privacy cover was placed over the catheter bag. Resident #51 did not suffer any adverse outcomes as a result of this issue. Corrective Action for Residents Potentially Affected: All residents in the facility who have an	2/12/16

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F 241	Continued From page 4 of the resident in the activity room. Her indwelling urinary catheter bag was positioned hanging from her wheelchair, wrapped in a clear plastic trash bag. On 1/29/16 at 11:15 AM an observation was made of the resident lying in her bed. Her uncovered indwelling urinary catheter bag was positioned on the left side of her bed, visible to the hallway. An interview was conducted with nursing assistant (NA) #1 on 1/29/16 at 11:15 AM. The NA indicated that "none of her resident's with catheters have privacy covers." She indicated the facility used to have them, but she "had not seen one in a while." On 01/29/2016 11:42 AM the Assistant Director of Nursing (ADON) indicated the facility did have indwelling urinary catheter privacy bags in stock, and she would replace the resident's catheter bags with privacy bag covers. She indicated she did not know why the residents who had indwelling urinary catheters did not have privacy bags in place. On 01/29/2016 11:43 AM an interview with the Director of Nursing (DON) was conducted. She indicated her expectation was for the nurse assigned to a resident with a catheter to provide a privacy bag. She stated "the nurses know better than this."	F 241	indwelling catheter have the potential to be affected by this practice. The following steps were taken to correct the deficient practice: a. A review of the MDS Care Plans was completed on 1/29/16 by the MDS Nurse, ADON and DON to identify all residents who could be potentially affected by this practice. b. All residents with the potential to be affected were assessed by the licensed nursing staff to ensure privacy bags were in place. This was completed on 1/29/16. c. Privacy bags were put in place by the licensed nurses and CNAs as needed. This was completed on 1/29/16. Systematic Changes: All direct care staff members, including full-time, part time and PRN RNs, LPNs and CNAs) were re-educated by the DON and/or ADON to ensure their understanding of maintaining a resident's dignity by keeping catheter bag covers in place. This training was initiated on 1/29/16 and was completed by 2/1/16. The Central Supply Coordinator was educated by the ADON on maintaining appropriate inventories of catheter bag covers to ensure the availability of privacy bags. This was completed on 1/29/16. A monitoring sheet for the interdisciplinary leadership team was developed to include a list of all resident's with an indwelling catheter so that placement of privacy bags can be monitored daily during room rounds. This was completed on 1/29/16. The monitoring sheets are updated Monday through Friday daily as changes	

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F 241	Continued From page 5	F 241	occur. Quality Assurance: The Interdisciplinary Leadership Team will monitor the placement of privacy covers daily during room rounds to ensure covers remain in place. This was initiated on 2/1/16. All care plans have been updated to ensure all CNAs check for the placement of privacy bags when providing care for residents. This was initiated on 1/29/16. A review of results of the Interdisciplinary Leadership Teams monitoring tools will be reviewed Monday through Friday in morning meeting to ensure compliance is maintained. The DON, ADON, Weekend Supervisor or Designee will complete a random audit of no less than 20% of potentially affected residents daily for 7 days, weekly for 4 weeks and monthly for 5 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action initiated was appropriate. Compliance will be monitored and the ongoing auditing program will be reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, ADON, Therapy, HIM, Dietary Manager and Administrator. Compliance Date: February 1, 2016	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		2/12/16

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F 242	Continued From page 6 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to provide 1 of 1 sampled residents with showers/whirlpool. (Resident # 118). Findings included: Resident #118 was admitted to the facility on 12/2/2015 with cumulative diagnoses of anemia, Coronary Artery Disease (CAD), Hypertension, Diabetes and Parkinson's disease. The admission Minimum Data Set (MDS) dated 12/9/2015 indicated the resident's cognitive status was intact, no behavioral problems, required extensive assistance with physical assist and bed mobility with 2 staff. Resident also required extensive assist using 1 staff with dressing and personal hygiene. Review of Resident # 118 personal care log beginning 11/6/2015 until 11/23/2015 and 12/3/2015 until 1/10/2016 revealed the resident was getting bed bath regularly but did not get showers on her shower days. Interview with Nursing Aide (NA) # 2 on 1/29/2016 at 11:27 AM revealed Resident #118 was assigned to get two showers weekly on Mondays and Thursdays. NA # 2 stated she did not recall whether she gave the resident showers on his showers days because she may have been	F 242	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F242 Corrective Action for Resident Affected: It was identified that during the time periods of 11/6/15 through 11/23/15 and 12/3/15 through 1/10/16, Resident #118 received bed baths regularly, but it is unclear as to whether the resident received showers on scheduled shower days. Resident #118 did not suffer an adverse outcome related to bed baths being provided in place of showers. At the time of identification, Resident #118	

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F 242	Continued From page 7 assigned to work on another hall. Interview with the Director of Nursing (DON) on 1/29/2016 at 11:49 PM revealed 2 showers were schedule for the resident on Mondays and Thursdays. The DON also stated according the personal care log there was no way to indicate the resident was getting showers on his scheduled shower days. DON further reported her expectation was for the staff to give showers to the resident on his shower days.	F 242	was discharged and so no shower could be offered. Corrective Action for Residents Potentially Affected: All residents in the facility who have an indwelling catheter have the potential to be affected by this practice. The following steps were taken to correct the deficient practice: a. The shower schedule was audited by the DON and ADON to ensure all residents (based on room number) have assigned shower days. This was completed on 2/1/16. b. All licensed nurses were educated to review CNA assignments at the start of each shift to include verification of showers to be completed during the shift. This was completed on 2/1/16. c. A new daily assignment sheet was developed by the DON and ADON that spells out which showers should be provided by shift. This was completed on 2/2/16. d. All full-time and part time CNAs were educated by the DON and/or ADON to provide all needed showers daily as per the assignment sheets. This was completed on 2/2/16. e. All full-time and part time CNAs were educated by the DON and/or ADON to document all showers and baths appropriately as given. This was completed on 2/2/16. f. The licensed nurse supervising each CNA was educated by the DON and/or ADON to ensure all ADL care is documented for each CNA in their	

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F 242	Continued From page 8	F 242		

assigned area before the end of each shift. In addition, the licensed nurses were educated by the DON/ADON to ensure all showers for the assigned CNA were given before the end of each shift to ensure all showers were provided.

Systematic Changes:
All direct care staff members, including full-time, part time and PRN RNs, LPNs and CNAs) were re-educated by the DON and/or ADON to ensure their understanding of the shower schedule, assignment sheet and responsibilities of each discipline as described above to ensure resident showers are provided. This training was initiated on 2/1/16 and was completed by 2/2/16 by the DON and/or ADON.

Quality Assurance:
The DON, ADON, Weekend Supervisor or Designee will audit ADL documentation to ensure showers were provided as scheduled. Should any shower be identified as not given, the shower will immediately be provided, the CNA and supervising nurse will be re-educated by the DON, ADON or Designee, and will be disciplined as necessary to ensure compliance. The DON, ADON or Weekend Supervisor will monitor the audits daily for 7 days, weekly for 4 weeks and monthly for 5 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action initiated was appropriate. Compliance will

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F 242	Continued From page 9	F 242	be monitored and the ongoing auditing program will be reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, ADON, Therapy, HIM, Dietary Manager and Administrator. Compliance Date: February 1, 2016	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to update the care plan for 1 of 3 residents (Resident # 46) reviewed for pressure	F 280	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the	2/12/16

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F 280	Continued From page 10 ulcers, by failing to include the current interventions for a pressure ulcer. Findings include: A record review indicated Resident #46 was admitted to the facility on 12/14/15. Diagnoses included: Cellulitis of right and left lower extremities, History of Falls, Hypertension and Lymphedema. Her Minimum Data Set (MDS) dated 12/21/15, indicated she is alert and oriented with some memory impairment with a Brief Interview for Mental Status (BIMS) of 13. Her MDS indicated she required extensive assistance with transfers and bed mobility, and two person physical assistance. Her MDS indicated she had functional limited range of motion in her bilateral lower extremities. The MDS also indicated she was a risk for development of pressure ulcers. Her current care plan dated 12/15/15 indicated she was a risk for pressure ulcer development. Interventions included: apply moisture barrier with each incontinence episode, assist with frequent turning and repositioning, assist with shifting weight while in chair, weekly skin assessments, notify nurse of new skin areas and keep the bed flat to prevent shearing. A physician order dated 1/7/16 indicated to apply skin prep to the resident's left heel twice per day, and "protective heel cover to left heel while in bed." . A care plan entry update, dated 1/8/16 read "I currently have a pressure ulcer to my left heel and potential for pressure ulcer development."	F 280	alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F280 Corrective Action for Resident Affected: It was identified on 1/29/16 that Resident #46's care plan was not updated with all interventions in place to prevent skin breakdown. The Care Plan was immediately updated by the MDS Nurse with input from the licensed nurse. Corrective Action for Residents Potentially Affected: All residents in the facility who mobility issues have the potential to be affected by this practice. The following steps were taken to correct the deficient practice: a. A review of MDS care plans was completed on 2/3/16 by the MDS Nurse and ADON to identify all residents who could potentially be affected by this practice. The review sought out residents who had high risk factors for skin breakdown. b. All residents with the potential to be affected were assessed to ensure no skin breakdown occurred. No additional concerns were identified. This was completed on 2/4/16. c. The MDS Nurse, DON, ADON and	

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F 280	Continued From page 11 Interventions included: administer treatments as ordered, apply moisture barrier with each brief change, educate "me, family and caregivers" as to causes of skin breakdown, apply moisturizer daily and as needed, do not massage over bony prominences and use mild cleansers for peri-care and washing, keep bed as flat as possible during bed mobility, confer with interdisciplinary team if resident refuses treatment, notify nurse of new areas of skin breakdown, and obtain lab work as ordered, treat pain and weekly body assessments. On 1/29/2016 at 9:38 AM an interview was conducted with the treatment nurse. She indicated resident #46 received skin prep to her heel twice a day. She indicated that pressure relief boots are applied to the resident while she is in bed and a pillow is placed on her wheelchair foot pedals for pressure relief while she is in the wheelchair. An interview was conducted on 1/29/16 at 1:44 PM with the Director of Nursing (DON). She indicated her expectation is the for the care plan to be updated with current interventions.	F 280	Treatment Nurse met to ensure all interventions to prevent skin breakdown were correctly placed on the Care Plan. This was completed on 2/4/16. Systematic Changes: The MDS Nurse was educated by the DON to ensure all interventions for residents are included on Care Plans. This was completed on 2/3/16. All direct care staff members (including full-time and part-time RNs, LPNs and CNAs) were re-educated by the DON, ADON and MDS Nurse to ensure their understanding of care plans and the responsibility to follow care plans to ensure interventions remain in place. This was completed on 2/5/16. Quality Assurance: The DON, ADON, MDS or Nurse Designee will audit all Care Plans by 2/5/16 to ensure interventions for all residents at risk of skin breakdown are in place. Should any care plan be identified as not updated or correct, the care plan will be immediately corrected. The DON, ADON or Weekend Supervisor will monitor the audits daily for 7 days, weekly for 4 weeks and monthly for 5 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action initiated was appropriate. Compliance will be monitored and the ongoing auditing program will be reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, ADON, Therapy, HIM,	

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	345532	A. BUILDING _____ B. WING _____	C 01/29/2016

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F 280	Continued From page 12	F 280	Dietary Manager and Administrator. Compliance Date: February 5, 2016	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.	F 285		2/12/16

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F 285	Continued From page 13 For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to renew the expired Preadmission Screening Resident Review (PASRR) for 1 of 1 (Resident # 2) sampled resident. Findings included: Resident # 2 was admitted to the facility on 7/11/2015 with multiple diagnoses including Cancer, Anemia, intellectual disabilities and Hemiplegia. A review of the Preadmission Screening Resident Review (PASRR) Level II Determination Notification was conducted. The PASRR Expiration Date was noted to be 7/21/2009. An interview was conducted with Social worker on 1/29/2016 at 11:00 AM. She stated the application for the renewal of the PASSR level II was late for Resident # 2. She added the resident was admitted from another facility but his PASSR level II was never renewed. She also reported that in the future the PASSR Level II application for the residents at the facility will be placed in a timely manner to make sure the application was not	F 285	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F285 Corrective Action for Resident Affected: It was identified on 1/29/16 that Resident #2 was admitted to the facility with an expired Level II PASSR. The PASSR was immediately updated with a permanent Level II PASSR and the resident suffered no adverse outcome as a result. Corrective Action for Residents Potentially Affected:	

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F 285	Continued From page 14 late. An interview was conducted with Administrator on 1/29/2016 at 11:30 AM. He stated the social worker did not submit a renewal application for PASSR Level II for resident # 2 after the resident was admitted on 7/11/2015. He also stated his expectation was for the Social worker to submit the renewal application of the PASSR in a timely manner before the expiration date.	F 285	All residents in the facility who have a Level II PASSR (3 in total) have the potential to be affected by this practice. The following steps were taken to correct the deficient practice: a. An audit of all residents who could potentially be affected was completed on 1/29/16 by the Social Worker and Business Office Manager. No other expired PASSRs were identified. b. A permanent Level II PASSR for the identified patient was requested on 1/29/16 and was received as approved on 1/29/16. Systematic Changes: The Social Worker was educated by the Administrator to ensure all residents in the facility have a current and unexpired PASSR. This was completed on 1/29/16. The Social Worker will audit all new admissions for Level II PASSR screens. No resident with an expired PASSR will be allowed admission into the facility. Quality Assurance: The DON, ADON or Designee will monitor the audits daily for 7 days, weekly for 4 weeks and monthly for 5 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action initiated was appropriate. Compliance will be monitored and the ongoing auditing program will be reviewed at the weekly QA meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, ADON, Therapy, HIM,	

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F 285	Continued From page 15	F 285	Dietary Manager and Administrator. Compliance Date: January 29, 2016	