STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE	1700 PAMALEE DRIVE FAYETTEVILLE, NC 28301

(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 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interviews, the facility failed to deliver mail on Saturday to residents in the facility. The findings included: During an interview on 03/09/2016 at 3:49 PM, Resident #100 revealed mail was delivered to the facility on Saturday, but the mail was held until Monday to be delivered to the residents in the facility. She explained, the Activity Director usually delivered mail during the weekdays and although mail was delivered to the facility on Saturday, she did not get her mail until Monday when the Activity Director or Activity Assistant delivered it. During an interview on 03/10/2016 at 3:41 PM, the facility Social Worker revealed she did not know who delivered mail on Saturday to residents. She stated activity staff usually delivered mail to residents on weekdays. She revealed she was the manager on duty during the past weekend and she did not deliver mail to the residents in the facility. During an interview on 03/10/2016 at 3:53 PM, the facility Business Office Manager (BOM) stated usually one of the activity staff worked on weekends. She revealed when she came into	F 170	Preface Highland House Rehabilitation & Healthcare submits this Plan of Correction (PoC) in accordance with the provisions of Health and Safety Code Section 1280 and C.F.R. 405 1907. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that	3/12/16

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

Electronically Signed | 04/07/2016

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 170	Continued From page 1 work during the week, usually the only mail left behind was business mail, so she thought resident's mail was being delivered. She said she thought either activity staff or a nurse delivered mail to residents on Saturday. During an interview on 03/10/2016 at 4:09 PM, the Activity Director revealed she believed the charge nurse or someone else put the mail in the receptionist office on Saturday and mail was sorted and delivered on Monday, because there was no one in the offfice on Saturday to sort the mail. During interview on 03/10/2016 at 4:16 PM, the Administrator revealed she had asked someone about mail delivery on Saturday, and she thought someone told her the mail was put on C- hall after the mail was sorted from business mail and the mail was delivered to residents. She said she thought a nurse used to deliver mail, but the nurse started working third shift three weeks ago. The Administrator said evidently mail was not being delivered to residents on Saturday.	F 170	concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. F170 It is the policy and practice of the facility for residents to have the right to privacy in written communications, including the ability to send and promptly receive unopened mail. This includes Saturday deliveries. The facility has policies and procedures designed to maintain these goals. Monitoring, staff training, resident council inquiries and consultant reviews are examples of the many components utilized. Corrective Action for Resident: Facility implemented steps immediately on 3/10/16 to ensure Resident #100 is delivered any personal mail received on Saturday. The weekend C-Hall nurse and Managers-on-Duty were instructed 3/11/16 through 3/12/16 regarding revised mail procedures to ensure any resident mail delivered to facility on Saturday is	

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F 170	Continued From page 2	F 170	sorted and delivered to residents. All resident mail received for Saturday, March 12th was delivered by C-Hall Nurse around noon. Resident #100 was interviewed by Administrator regarding resident□s mail delivery. Resident #100 stated resident observed mail delivered on Saturdays between 11:30 am and 12:00 pm. Resident #100 stated the nurse that normally works C-Hall on Saturdays has always given me my mail. Corrective Action for Residents with the potential to be affected: Cognitive residents were interviewed by Administrator on 3/10 □ 3/12/16 to determine any concerns with personal mail delivery, including receipt of mail on Saturdays. No concerns were communicated. Measures/Systems put in place to ensure practice does not reoccur: Department Managers and week-end nurses were instructed on 3/11/16 and 3/12/16 concerning the revised procedure to deliver resident□s Saturday personal mail. The Department Manager or the C Hall nurse will sort and deliver all Saturday resident mail to the residents. A sign-off sheet was developed for the Manager-on-Duty (MOD) and/or C-Hall nurse to acknowledge that personal Saturday mail was delivered to the resident.	

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F 170	Continued From page 3	F 170	Monitor: The Administrator will review the sign-off sheet weekly for four (4) weeks and then every other week for a month to monitor and ensure follow through with Saturday mail delivery. The Administrator will attend the April Resident Council meeting to discuss any mail concerns and to address revised procedures for receiving personal mail delivered on Saturday. Activities staff will interview at least 20% of the cognitive residents who are on the sign-off sheet as receiving mail on Saturday to assure desired results. These interviews will be conducted weekly for four (4) weeks to monitor revised system is working. The results of the monitoring will be reviewed and discussed in the monthly QAPI meeting for the next 3 months for concerns or needed adjustments.	
F 315 SS=G	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	F 315		4/4/16

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F 315	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to perform correct procedure for indwelling urinary catheter insertion which resulted in emergency hospitalization for 1 of 2 sampled residents. (Resident # 70). The findings included: Review of facility policy, Catheter Insertion, it was written, "item P. When urine stops flowing, attach the saline filled syringe to the lear lock. Push the plunger and inflate the balloon. Item U. Document the date, time, and observations made pertinent to resident care such as urine color, consistency, odor, sediment, and resident tolerance of the procedure." Resident #70 was admitted on 5/20/2015. The resident's diagnoses included neurogenic bladder. The quarterly minimum data set completed on 2/1/16 indicated Resident #70 had an indwelling catheter for bladder appliance. The care plan revision dated 6/06/15 stated as an intervention, "Catheter: change per MD orders only." On review of physician orders the resident's indwelling catheter was scheduled to be changed on 2/13/2016 as documented on the Treatment Administration Record. A review of nursing notes written by Nurse #2 dated 2/13/16 at 4:00 AM indicated the nurse did not document urine return during or post procedure to change the resident's indwelling catheter. Nursing notes written by Nurse #3 dated 2/13/16 at 11:00 AM "no urine output noted in collection bag. Small amount dried blood noted to penis.	F 315	F315 The facility endeavors to always promote catheter care for residents requiring catheter care to assure appropriate treatment and services. The facility has policies and procedures designed to maintain these goals. Catheter training is one of many components covered in ongoing training. It is the facility□s intent to ensure all new clinical employees are instructed regarding catheter care policies and procedures. Resident and family satisfaction surveys, resident interviews and observations, skills checks, consultant reviews and various quality assurance measures are examples of the many components utilized. Corrective Action for Resident: Resident #70 was sent to the hospital on 2/13/16 as ordered by the Physician for evaluation and treatment of urinary retention. Following return from hospital, a follow-up urology appointment was scheduled by Treatment nurse for 3/24/16. Ensure urine return prior to balloon inflation informational note was added on 2/22/16 to Resident #70□s MAR to alert nursing staff of the procedure. Per 3/31/16 primary care physician	

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F 315	Continued From page 5 RN (Registered Nurse) in building made aware and to come check." Nursing notes written by Nurse #4 dated 2/13/16 at 12:00 PM read "Attempted to flush foley cath (indwelling urinary catheter), met impedance. Replaced foley cath with sterile tech. No urine flow seen. Multiple clots of blood removed. Flushed another time but still no return of flush or urine. Dr. notified. Order given to send to ER (Emergency Room)." Telephone order given to send resident to Emergency Room on 3/13/16. Review of Resident #70's Admission History and Physical from the Emergency Room dated 2/13/16 assessment and plan revealed; "#1 hematuria and urinary retention secondary to blood clot from trauma." Regarding the procedure on 2/13/16 of the nurse and his hospitalization. He had discussed his concerns with administration and the Director of Nursing. He explained his concerns had been resolved. An interview with Nurse #5 on 3/8/16 at 10:00 AM was conducted. Nurse #5 (Quality Assurance Nurse/Helping with Staff Development) stated the night shift normally did catheter changes. She stated Nurse #2 was no longer employed at the facility. She was terminated after an investigation of the incident from 2/13/16. She explained on 2/13/16, Nurse #2 "did not wait for urine return before inflating the balloon" and the Director of Nursing conducted an investigation. She also stated the Director of Nursing recently completed an in-service on Foley catheter placement and on Intake and output for catheter care. Nurse #5 expressed expectation that the licensed staff would report to the nurse in charge if there are problems with indwelling catheters. An interview with Director of Nursing (DON) on	F 315	orders, Resident #70 will have two nurses present during indwelling catheter insertion to verify urine return before inflation of balloon. Corrective Action for Residents with the potential to be affected: All residents with indwelling catheters were assessed by Director of Nursing (DNS), RN Supervisor, QA Nurse, and Treatment Nurse on 2/24/16 to determine if there were any problems with their indwelling catheter (bleeding around urethra, blood in urine, adequate urine flow from catheter, etc.). No concerns were found. Measures/Systems put in place to ensure practice does not reoccur: Clinical nurses were re-trained by DNS and RN supervisor from 2/23/16 through 3/20/16 on the procedure of indwelling catheter insertion. Ensure urine return prior to balloon inflation informational note was added by DNS, QA nurse, Treatment nurse, and RN Supervisor to the MAR of each resident who has an indwelling catheter to alert nursing staff of the procedure. Prior to inserting a catheter, the DNS or RN Supervisor will review procedural steps for proper catheter insertion with clinical nurses and complete a catheter skills check. Catheter insertion technique demonstration was added to the orientation checklist for new hire clinical	

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F 315	Continued From page 6 3/9/16 at 3:00 PM was conducted. She stated indwelling catheter insertion training was not included in their orientation. She stated there was an in-service on Foley Catheter Placement done on 3/7/16 with 11 staff attending. On 3/8/16 she conducted an in-service on Intake & Output for Catheters with 16 staff members. She explained staff training and in-service is done with staff development, through quality improvement processes, and during orientation training. She included that training is on-going. She indicated her expectation was the catheter care would include visualization of urine return prior to the inflation of balloon. During interview with Director of Nursing (DON) on 3/10/16 at 11:05 AM, stated an investigation was done and Nurse #2 was interviewed and asked to demonstrate what occurred on 2/13/16. It was determined Nurse #2 had inflated the balloon prior to getting urine return for Resident #70.	F 315	nurses. Catheter change/insertion procedure amended to include two nurses be present during procedure. Monitor: The DNS and Nurse Supervisors will observe at least 5 catheter insertions/changes for the next 3 months to assure the nurses are using the correct technique. The DNS, RN Supervisor, Unit Nurse Supervisors and QA Nurse will monitor the charts of residents with indwelling catheters monthly for the next 3 months to assure the documentation reflects procedure/technique followed (2 nurses present during the insertion, urine flow was observed prior to inflating the balloon, etc.). Results of the monitoring will be reported to the monthly QA Committee by the QA Nurse. The committee will assess and modify the action plan as needed to ensure continued compliance.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332		3/29/16

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F 332	Continued From page 7 Based on observation, staff interviews and record review, the facility failed to maintain a medication error rate of less than 5% as evidenced by 7 medication errors out of 25 opportunities for 1 of 4 residents (Resident #12) resulting in an error rate of 28%. The problems included the medication dosage was not correct, the medications were crushed, and the medications were omitted. The findings included: Review of the clinical record of Resident #12 indicated the resident was admitted to the facility on 06-08-15 with diagnoses which included anemia, heart failure, hypertension, gastroesophageal reflux disease and diabetes mellitus. During a medication administration observation on 03-09-16 at 8:45 a.m., nurse #1 removed medications for Resident #12 from pre-packaged cards and bottles of house stock medication bottles and placed the medications in a dispensing cup. Included in the cup was metoprolol 25mg Extended Release (ER) 1 tablet, metformin 500mg ER 1 tablet, Ferrous Sulfate 325mg 1 tablet and Glucotrol 10mg ½ tablet. Nurse #1 crushed all of the medications in the cup and mixed the crushed medications in applesauce. Nurse #1 entered the resident's room and administered the medications and applesauce mixture to Resident #12. The resident took the medications by mouth. Review of the physician's orders and the March 2016 Medication Administration Record (MAR) for resident #12 included the following: 1. Metoprolol 25 milligrams (mg) ER tablets 1 tablet by mouth (PO) once daily, do not crush, ordered on 07-23-15 and scheduled on the MAR for 9:00 a.m. 2. Metformin 500 mg ER 1 tablet PO twice a	F 332	F332 It is this facility's normal practice to ensure that the error rate is less than the established 5 percent expectation. The facility has in place developed written policies and procedures. Clinical nurses and Medication Aides are instructed and observed during their orientation period for technique and administration practices. The staff development coordinator (SDC), pharmacy consultant, nurse consultant, other support advisors provide routine refresher training and in-services. Routine medication pass observations by SDC, pharmacy consultant, nurse consultant, quality assurance monitoring and routine staff training are examples of the various components utilized. Corrective Action for Resident: Nurse #1 was immediately removed from the medication cart on 03/09/2016 until additional training and correct medication administration technique could be demonstrated. The Director of Nursing Services (DNS) appointed another staff nurse to resume the medication pass. Medications not administered as ordered were immediately located and given to Resident #12. The attending physician and pharmacist was contacted by QA nurse following the errors and was consulted for potential adverse reactions and monitoring needs. No new orders were given. Medication error reports were completed	

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F 332	Continued From page 8 day, do not crush, ordered on 01-17-16 and scheduled on the MAR for 8:00 a.m. and 5:00 p.m. 3. Ferrous Sulfate 325mg PO three times a day, do not crush, ordered on 10/27/14 and scheduled on the MAR for 9:00 a.m., 1:00 p.m., and 5:00 p.m. 4. Glucotrol 10 mg 1 tablet PO every morning, ordered on 11-20-15 and scheduled on the MAR for 8:00 a.m. 5. Glucotrol 10 mg ½ (5 mg) PO every evening, ordered on 11-20-15 and scheduled on the MAR for 8:00 p.m. 6. Remeron 7.5 mg PO every other day for two weeks and then discontinue, ordered on 03-03-16 and scheduled on the MAR starting on 03-05-16 and scheduled for every other day at 9:00 a.m. 7. Refresh Plus ophthalmic (eye) drops 0.5% instill one drop in both eyes twice daily, ordered on 10/31/14 and scheduled on the MAR for 8:00 a.m. and 8:00 p.m. 8. Multi-vitamin 1 tablet PO once daily, ordered on 12-01-14 and ordered on the MAR for 8:00 a.m. During an observation of the pre-packaged medication card for Resident #12's Glucotrol tablets on 03-09-16 at 8:48 a.m., the card was observed to contain Glucotrol 10 mg tablets that had been cut in half and placed by the facility pharmacy in each bubbled dose unit. In an interview with Nurse #1 on 03-09-16 at 9:38 a.m., Nurse #1 stated there are written instructions on the MAR if medications were not to be crushed. Nurse #1 reviewed the MAR and stated she must have overlooked the instructions of not to crush Metoprolol, Metformin and Ferrous Sulfate because she was nervous. Nurse #1 stated she was aware certain medications should not be crushed as they would not dissolve as they	F 332	by QA nurse on 03/09/16. The DNS provided one-on-one re-training with nurse #1 on 03/09/16 regarding the five rights of medication administration and the importance of following pharmacy directions for do not crush medication. Corrective Action for Residents with the potential to be affected: Re-fresher training, on the five rights of medication administration and the importance of following pharmacy directions for do not crush medication, was conducted by the DNS and RN Supervisors on 03/09/16 through 03/29/16 with the other clinical nurses. The do not crush medication list was reviewed by DNS and QA nurse on 03/09/16 to ensure list current and ensure placement of list in the front of all MAR books. Measures/Systems put in place to ensure practice does not reoccur: Nurse # 1 was re-trained on the five rights of medication administration and the importance of following pharmacy directions on 03/09/16. The DNS, Quality Assurance (QA) nurse, Staff Development Coordinator (SDC), or designee will observe medication pass with nurse #1 for a total of 4 consecutively worked shifts and random observations with two (2) other nurses bi-weekly for 3 months.	

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F 332	Continued From page 9 should. Nurse #1 stated she did not administer the Refresh Plus ophthalmic drops because she thought she was only supposed to administer pills during the observation. When Nurse #1 was asked why she omitted the Remeron, Nurse #1 stated there were four medications for Resident #12 that were not in the medication cart during the observation. When Nurse #1 was reminded she originally stated two medications were not available in the medication cart at the start of the medication administration observation, she stated she was nervous and had forgotten to mention the others. In an interview with the Director of Nursing (DON) on 03-09-16 at 9:57 a.m., the DON stated the expectation of the nursing staff was they follow the five rights of medication administration. The DON stated nursing staff should carefully read the orders three times comparing the MAR with the medication. The DON stated instructions of not to crush medications would be on the MAR if the medications were not to be crushed and stated nursing staff should be able to read those instructions and follow those instructions.	F 332	The consulting pharmacist will observe medication passes with nurse #1 for three months and random for three months with other nurses. The consulting pharmacist will vary their consulting times quarterly to observe various nurses. An in-service on general principles of medication administration to include the 5 rights of medication administration will be completed semi-annually by SDC or designee. Monitor: The DNS, RN Supervisor and Unit Nurse Manager will observe medication administration on two nurses weekly for 4 weeks then one nurse weekly for three months. The nurse consultant from the pharmacy will observe monthly medication administration on at least one nurse. Reports will be provided by the DNS to the Quality Assurance Committee (QAA) regarding each audited nurse□s error rate to monitor effectiveness of the plan.	
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520		4/6/16

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F 520	Continued From page 10 The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in June of 2015. The deficiency was in the area of failure to provide incontinence care. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F315 on the current survey of 3/10/16 - Based on record reviews and staff and resident interviews, the facility failed to perform correct procedure for indwelling urinary catheter insertion which resulted in emergency hospitalization for 1 of 2	F 520	F520 Quality Assurance It is the policy and practice of the facility to maintain a quality assessment and assurance committee (QAA) consisting of the outlined members that meet monthly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action designed to correct identified quality deficiencies. The facility has policies and procedures designed to maintain these goals. Quality assurance monitoring, physician reviews, consultant reviews, and staff training are examples of the many components utilized. Our Quality Assurance monitoring for the cited deficiency in the last federal survey (6/20/15) involved a resident who was not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345353	A. BUILDING _____ B. WING _____	03/10/2016

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F 520	Continued From page 11 residents. (Resident #70). On 3/10/16 at 5:30 PM, an interview was conducted with the Quality Assessment Nurse, Director of Nursing and the Administrator. The facility has a functioning Quality Assessment Committee with committee members representing all departments. The Quality Assessment Nurse revealed that the committee had worked on the areas of wounds developing and implementing a Process Improvement Project (PIP). The committee had discussed behaviors and catheters.	F 520	provided with incontinent care prior to mealtime as requested. The QA monitoring that occurred following the survey indicated compliance with the actions taken to prevent another occurrence. There is no correlation to the previous citation (incontinence care) and the current citation (indwelling catheter insertion) even though they are under the same Federal Tag (315). The following steps were/have been added to the Quality Assurance Monitoring process in response to the current citation. " The DON initiated a four-point plan of correction on 2/23/16. The POC was developed to ensure: 1) Corrective action for the resident was taken, 2) Corrective action for other residents with the potential to be affected by the same practice, 3) Measures/systems put into place to ensure the same issue did not occur again, and 4) A plan was developed for ensuring that correction is achieved and sustained. The POC was integrated into the quality assurance system of the facility. " The facility Quality Assessment and Assurance Program (QAA) was re-assessed by the Administrator and Nurse Consultant on 4/6/16. The following was noted: " Attendees were appropriate and include: Associate Medical Director of QA, Medical Director, Administrator, DON, Quality Assurance Nurse, Charge Nurse, Rehabilitation Nurse, Staff Development	

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F 520	Continued From page 12	F 520	Coordinator, Wound Care Nurse, Social Worker and Dietary Manager. " Agenda items were also reviewed. The following agenda items were added to include audit results for the most recent cited deficiencies: F170 □ Personal mail delivery, F315 □ Indwelling catheter insertions and F332 □ Medication administration observations. " Frequency of meetings is monthly □ no changes or issues identified. " We will continue with the weekly Resident at Risk meetings and report findings in the monthly QA meeting " The QAA committee will continue to analyze trends/possible causal factors and act accordingly to resolve instances of non-compliance and improve overall quality of care.	