STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328

(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 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 observations, record review, and resident and staff interviews, the facility failed to maintain a resident's dignity by not changing a brief soiled with bowel movement for a cognitively intact resident until 3 hours after it was requested (Resident #8). Findings Included: Resident #8 was admitted to the facility on 10/07/15 with diagnoses which included pressure ulcer sacrum, cerebral infarction (stroke), Diabetes Mellitus Type 2 and morbid obesity. A review of the quarterly Minimum Data Set (MDS) dated 12/05/16 indicated Resident #8 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS indicated the resident was always incontinent of bowel and bladder and was at risk for developing pressure ulcers. A review of Resident #8's Care Plan indicated the resident had the potential for pressure ulcer development and a self-care deficit with her Activities of Daily Living (ADLs) and required extensive staff assistance.	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. F 241 A corrective action for affected resident: For resident #8, the nursing assistant provided incontinent care to the resident. All current incontinent residents have the potential to be affected by the alleged deficient practice. All current residents were assessed by the nurse management team for incontinence needs. This audit was completed by reviewing Point of Care documentation for	3/13/17

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

Electronically Signed | 03/10/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 During an interview with Resident #8 on 02/14/17 at 12:30 p.m., Resident #8 stated she had a bowel and bladder incontinent episode around 9:00 a.m. on this date. Resident #8 stated she had always been able to wash her upper body but required assistance for her lower body. Resident #8 stated she pushed her call light at the time of her incontinent episode and her assigned Nursing Assistant (NA) #1 came to her room and informed Resident #8 she would return in a minute. Resident #8 stated she waited until 11:00 a.m. and pushed her call light again. Resident #8 stated NA #1 returned to her room and set up the supplies to begin morning care and left the room. Resident #8 stated she washed her upper body and waited for NA #1 to return to her room to complete ADL and incontinent care. Resident #8 stated NA #1 returned to her room at lunchtime and provided the remaining ADL and incontinent care. During an interview with NA #1 on 02/14/17 at 12:45 p.m., NA #1 stated she had been aware Resident #8 had her call light on and she went to her room and explained she was working with another resident and would be back in a few minutes. NA #1 stated she and another nursing assistant returned to Resident #8's room after the lunch trays arrived on the floor around 12:00 p.m. and completed her ADL and incontinent care. During an interview with Resident #8 on 02/14/17 at 1:00 p.m., Resident #8 stated it felt nasty and sticky when she sat in her bed in a brief soiled with bowel movement for such a long time. Resident #8 stated it made her feel bad. During an interview with the Director of Nursing (DON) on 02/15/17 at 12:50 p.m., the DON stated	F 241	continence over the last 14 days. Residents identified as having incontinence had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their incontinent care needs. This review will be completed by 03/13/2017. Systemic changes made were: In-service education began on 03/06/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included: Resident rights and dignity was discussed and meeting residents request timely. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 03/13/2017 will not be allowed to work until training has been completed. 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 the change has been sustained.	

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F 241	Continued From page 2 her expectation of the nursing staff was to treat the residents with dignity and respect.	F 241	The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will monitor this issue using the Quality Assurance for Residents Rights and Dignity. The monitoring will include observing five resident's residents weekly for incontinence needs being met timely. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES 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 resident, staff interviews and record	F 242	The statements made on this plan of	3/13/17

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F 242	Continued From page 3 review, the facility failed to offer showers as scheduled for 1 of 3 sampled resident.(Resident # 2) Findings included: Resident # 2 was admitted to the facility on 2/3/2017 with the diagnoses of Hypertensive Chronic Disease, end stage renal disease, dependence on renal dialysis, Anemia, peripheral vascular, Atrial fibrillation, Patient's noncompliance with other medical treatment and regiment, unqualified visual loss, both eyes and muscle weakness. The quarterly Minimum Data Set (MDS) dated 1/7/2017 indicated Resident # 2 was cognitively intact with no behaviors. She was coded as requiring extensive assistance for her hygiene and bathing. The most recent care plan revised 12/15/2016 indicated she required assistance with her Activity of daily living (ADLs) and no refusal of showers or other ADLs. In an interview on 2/14/17 at 11:51 AM, Resident # 2 stated he was not offered showers on his scheduled shower days of Mondays, Wednesdays and Fridays. Resident # 2 stated having showers was important to him. In an interview on 2/13/2017 at 11:00 AM, Nursing Assistant (NA) # 1 stated she was assigned to take care of Resident # 2 and she did not plan to give the resident the shower since she was not aware it was his shower day. The NA # 1 reported she depended on residents telling her about their shower days. She also reported Resident # 2 did not refuse his bath in the morning when she gave him a bed bath. NA #1 stated she was supposed to report any refusals to the nurse.	F 242	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. F 242 A corrective action for Affected Resident has been accomplished by: Resident # 2 was interviewed by the Social Worker for his preference regarding showers on 03/07/2017. Once preferences were determined the MDS Coordinator updated resident #2 task in Point of Care. All current residents with shower preferences not currently being met have the potential to be affected by the alleged deficient practice. On 03/07/2017, the two facility Social Workers began discussing with all cognitively intact residents their preferences for shower schedule. For residents not cognitively intact, the responsible party was contacted and discussed shower schedule preferences. This was completed by 03/09/2017. Once preferences were determined, the MDS	

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F 242	Continued From page 4 A review of the shower schedule for Resident # 2 for the months of December 2016, January 2017 and February 2017 indicated no refusals but only receiving bed baths. A review of the nursing notes from 2/3/2017 to present made no mention of Resident # 2 refusing his showers. In an interview on 2/15/17 at 9:00 AM, the Director of Nursing (DON) stated it was her expectation that Resident # 2 receive his showers as scheduled and if she refused, the staff should attempt to address the reason why. The DON stated she also expected the aides to report refusals to the nurses and the nurses and aide document the refusal.	F 242	Coordinator updated each resident's task in Point of Care as indicated with their preference. This was completed by 03/13/2017. Systemic changes made were: In-service education began on 03/06/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included: Honoring resident preferences, facility shower schedules, how to locate resident preferred shower schedules, and how to document refusals of showers. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 03/13/2017 will not be allowed to work until training has been completed. The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will monitor this issue using the Quality Assurance for monitoring shower preference. The	

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F 242	Continued From page 5	F 242	monitoring will include observing five resident's weekly for preference being honored. The shower schedule chosen will be compared with documentation of actual showers given. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews, the facility failed to provide incontinent care for a cognitively intact resident until 3 hours after it was requested for 1 of 3 residents observed receiving care (Resident #8). Findings Included:	F 312	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	3/13/17

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F 312	Continued From page 6 Resident #8 was admitted to the facility on 10/07/15 with diagnoses which included pressure ulcer sacrum, cerebral infarction (stroke) and Diabetes Mellitus Type 2. A review of the quarterly Minimum Data Set (MDS) dated 12/05/16 indicated Resident #8 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS indicated the resident was always incontinent of bowel and bladder and was at risk for developing pressure ulcers. A review of Resident #8's Care Plan, last revised 12/2/16, indicated the resident had the potential for pressure ulcer development and had a self-care deficit with her Activities of Daily Living (ADLs) and required extensive staff assistance. During an interview with Resident #8 on 02/14/17 at 12:30 p.m., Resident #8 stated she had a bowel and bladder incontinent episode around 9:00 a.m. on this date. Resident #8 stated she had always been able to wash her upper body but required assistance for her lower body. Resident #8 stated she pushed her call light at the time of her incontinent episode and stated the Nursing Assistant (NA) assigned to care for her, NA #1, came to her room and informed Resident #8 she would return in a minute. Resident #8 stated she waited until 11:00 a.m. and pushed her call light again. Resident #8 stated NA #1 returned to her room and set up the supplies to begin morning care and left the room. Resident #8 stated she washed her upper body and waited for NA #1 to return to her room to complete ADL and incontinent care. Resident #8 stated NA #1	F 312	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. F 312 A corrective action for affected resident: For resident #8, the nursing assistant provided incontinent care to the resident. All current incontinent residents have the potential to be affected by the alleged deficient practice. All current residents were assessed by the nurse management team for incontinence needs. This audit was completed by reviewing Point of Care documentation for continence over the last 14 days. Residents identified as having incontinence had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their incontinent care needs. This review will be completed by 03/13/2017. Systemic changes made were: In-service education began on 03/06/2017 by the Staff Development Coordinator for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included: Staff will be educated on providing timely incontinence care and meeting resident request timely.	

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F 312	Continued From page 7 returned to her room at lunchtime and provided the remaining ADL and incontinent care. During an interview with NA #1 on 02/14/17 at 12:45 p.m., NA #1 stated she had been aware Resident #8 had her call light on and she went to her room and explained she was working with another resident and would be back in a few minutes. NA #1 stated she had been doing the best she could. NA #1 stated for the past month, administration sent home one NA from each unit at 11:00 a.m. which caused the remaining NAs to pick up additional residents and duties, therefore it took longer to respond to the needs of the residents. NA #1 stated she and another nursing assistant returned to Resident #8's room after the lunch trays arrived on the floor around 12:00 p.m. and completed her ADL and incontinent care. During an interview with the Director of Nursing (DON) on 02/15/17 at 12:50 p.m., the DON stated it was her expectation the nursing staff provide ADL care to the residents as per protocol and when requested.	F 312	The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 03/13/2017 will not be allowed to work until training has been completed. 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 the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing or Staff Development Coordinator will monitor this issue using the Quality Assurance for Residents Rights and Dignity. The monitoring will include observing five resident's residents weekly for incontinence needs being met timely. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at	

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F 312	Continued From page 8	F 312	the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 353 SS=D	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, family and staff interviews, the facility failed to provide sufficient nursing staff to maintain resident ' s dignity by not changing a brief soiled with bowel movement for a cognitively intact	F 353	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	3/13/17

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F 353	Continued From page 9 resident for 1 of 6 sampled residents (Resident #8), to offer showers as scheduled for 1 of 3 sampled resident (Resident #2), and to provide incontinent care for a cognitively intact resident after it was requested for 1 of 3 residents observed receiving care (Resident #8). Findings included: 1. Cross refer F241. Based on observations, record review and resident and staff interviews, the facility failed to maintain a resident ' s dignity by not changing a brief soiled with bowel movement for a cognitively intact resident until 3 hours after it was requested for 1 of 6 residents observed receiving care (Resident #8). 2. Cross refer F242. Based on resident, staff interviews and record review, the facility failed to offer showers as scheduled for 1 of 3 sampled resident. (Resident #2). 3. Cross refer F312. Based on observations, record review and resident and staff interviews, the facility failed to provide incontinent care for a cognitively intact resident until 3 hours after it was requested for 1 of 3 residents observed receiving care (Resident #8). Interview with the Director of Nursing at 2:30 PM on 2/15/2017 revealed her expectations were the resident care will be provided as care planned and with dignity.	F 353	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. F 353 A corrective action for the Affected Residents has been accomplished by: For resident #8, the nursing assistant provided incontinent care to the resident. Resident # 2 was interviewed by the Social Worker for his preference regarding showers on 03/07/2017. Once preferences were determined the MDS Coordinator updated resident #2 task in Point of Care. The staff schedule was reviewed by the Director of Nursing and the Administrator on 02/15/2017 to ensure adequate staff to meet patient needs. A corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: All current residents were assessed by the nurse management team for incontinence needs. This audit was completed by reviewing Point of Care documentation for	

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F 353	Continued From page 10	F 353		

continence over the last 14 days. Residents identified as having incontinence had their care plan reviewed by the MDS Nurse to ensure their care plan was current with their incontinent care needs. This review will be completed by 03/13/2017.

On 03/07/2017, the two facility Social Workers began discussing with all cognitively intact residents their preferences for shower schedule. For residents not cognitively intact, the responsible party was contacted and discussed shower schedule preferences. This was completed by 03/09/2017. Once preferences were determined, the MDS Coordinator updated each resident's task in Point of Care as indicated with their preference. This was completed by 03/13/2017.

Systemic changes made were:

In-service education began on 03/06/2017 for all RNs, LPNs, Med Tech's, Med Aides, and CNAs, FT, PT, and PRN. The in-service topics included:

- Honoring resident preferences, facility shower schedules, how to locate resident preferred shower schedules, and how to document refusals of showers.
- The in-service topics included: Staff will be educated on providing timely incontinence care and meeting resident request timely.

The facility specific in-service was sent to

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F 353	Continued From page 11	F 353	Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for a temporary assignment. Any in-house staff member who did not receive in-service training by 03/13/2017 will not be allowed to work until training has been completed. The facility plans to monitor its performance by: The Administrator will monitor this issue using the Staffing QA Tool for monitoring staffing is adequate to meet resident needs according to preferences. Rounds will occurs 5 times a week across various shifts weekly x 4weeks then monthly x 2 months or until resolved by QOL/QA committee. This is measured by interviewing 5 residents 5 times a week to ensure needs/preferences are being met. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	
F 356	483.30(e) POSTED NURSE STAFFING	F 356		3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 02/15/2017

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F 356 SS=C	Continued From page 12 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of staff schedules, the facility failed to post accurate staffing data on the Daily Staffing Posting for 3 of 43 days reviewed.	F 356	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	

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F 356	Continued From page 13 A review of the Daily Staffing Posting for the dates of 1/17/17, 1/21/17, and 1/23/17 revealed no documentation of the registered nursing staff. An interview on 2/15/17 at 2:30 PM with the Director of Nursing was done regarding no posting of the registered nursing staff on 1/17/17, 1/21/17 and 1/23/17. Interview revealed the registered nursing staff should have been completed for 1/17/17, 1/21/17 and 1/23/17. Copies of the registered nurses time sheets were provided by the Director of Nursing indicated the registered nursing were on duty. The Director of Nursing stated it is her expectation the staff will accurately complete the Daily Staffing Posting each shift.	F 356	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. F 356 A corrective action for affected resident: No specific resident was mentioned. The daily staffing records for 1/17/17, 1/21/17 and 1/23/17 were verified and corrected to include the registered nurse hours accurately. This was performed on 2/15/17 by the Director of Nursing and QA Nurse Consultant. All current residents have the potential to be affected by the alleged deficient practice. The Clinical Nurse Consultant reviewed the Daily Nursing Staff Posting Sheet from 02/15/2017 to 03/13/2017 to ensure that it included the registered nursing hours correctly and all other required components, which includes: • Facility name • Current Date • Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per	

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F 356	Continued From page 14	F 356		

shift:
1. Registered Nurses
2. Licensed Nurses
3. Certified Nursing Assistants
- Resident Census

The required staffing information is posted daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors.

This was completed by 03/13/2017.

Systemic Changes

On 03/06/2017 the Staff Development Coordinator began in servicing the full time, part time and prn RN's and LPN's, Administrator, and Nursing Secretary.

Topics included:

The daily nursing staffing data must be posted daily at the beginning of each shift. The staffing data must include the following components:
- Facility name
- Current Date
- Total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

4. Registered Nurses
5. Licensed Nurses
6. Certified Nursing Assistants
- Resident Census

The required staffing information is posted

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F 356	Continued From page 15	F 356	daily in a clear and readable format. It is located in a prominent place readily accessible for residents and visitors. Any in-house staff member who did not receive in-service training by 03/13/2017 will not be allowed to work until training has been completed. 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 the change has been sustained. The facility plans to monitor its performance by: The Clinical Nurse Consultant will monitor this issue using the Staff Posting Survey Audit Tool. This audit will monitor the daily nursing staffing posting requirement for accurate staffing data weekly for 2 weeks then monthly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator	