STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING ______ B. WING ______	C 07/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

(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 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		8/4/17

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results of the assessments to develop, review and revise the resident’s comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2017

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 279	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include activities of daily living in a resident ' s Comprehensive Care Plan for 1 of 7 residents reviewed for activities of daily living (Resident #4). The findings included: Resident #4 was admitted to the facility on 10/06/16 and had a diagnosis of anemia, orthostatic hypotension (blood pressure dropped when stood up) and diabetes. The Care Area Assessment (CAA) dated 11/2/16 for Cognitive Status/Dementia noted the resident was able to verbalize her needs and answer questions appropriately. The CAA revealed the resident required extensive assistance with activities of daily living (ADLs), had a contracture	F 279	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 279 Corrective Action for Resident Affected	

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F 279	Continued From page 2 of one hand and was able to feed self. The CAA noted the resident was occasionally incontinent and was at risk for further decline in ADLs. The CAA showed that ADLs would be included in the resident ' s Care Plan. The Quarterly Minimum Data Set (MDS) Assessment dated 4/13/17 revealed Resident #4 was cognitively intact and required extensive assistance with bed mobility, transfers, toileting, personal hygiene and bathing and required set-up help with eating. The MDS revealed the resident was occasionally incontinent of urine and continent of bowel. Review of the Care Plan initiated on admission and last revised on 4/24/17 revealed no information regarding the resident ' s ADL care needs. Review of the current undated NA ' s (Nursing Assistant ' s) care guide included no information regarding how much assistance the resident required with ADLs. On 7/7/17 at 9:30 AM, MDS Nurse #1 was observed to review the resident ' s Care Plan and the NA ' s Care Guide and stated she did not see a care plan for ADLs but could not explain why the information was not included in the resident ' s Care Plan. The MDS Nurse stated the resident should have a care plan for ADLs. On 7/7/17 at 10:45 AM, the Administrator stated she expected the Care Plan to be done per the MDS Assessment.	F 279	On 7-7-17 and again on 07-21-17, resident #4's care plan and Kardex was updated by the MDS Consultant to include how much assistance resident needed for Activities of Daily Living(ADLs) assistance. Corrective Action for Resident Potentially Affected On 07-17- 2017, the MDS Consultant assessed all care plans and kardex to assess if ADLs were care planned and if it was included and how much assistance was needed for clinical staff. 8 of 49 Residents had ADL's updated on the kardex and 39 of 49 Residents had their level of assistance updated on the careplan and the kardex and 8 of 49 Residents had ADL's updated on care plan. This was completed on 7-21-2017 by the MDS Consultant. Systemic Changes On 7-18-2017, the MDS Consultant in-serviced the Administrative Nurses which included the MDS Coordinator and the Director of Nursing. The New Director of Nursing was inserviced by the MDS Coordinator on 07-21-17. Topics included: Reviewing Care Plans Reviewing Kardexes ADL care	

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F 279	Continued From page 3	F 279	Initiating and revising care plans and Kardexes by Registered Nurses 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 IDT staff member who did not receive in-service training by 8-4-2017, 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 nurse managers and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The MDS Consultant and or MDS Coordinator will monitor this issue using the QA ADL Care Plan Survey Tool. The QA tool will be used to audit care plans and kardexes to ensure that ADL care is included and how much care is required for residents. Any issues will be reported to the Administrator. This will be done weekly for one month by the MDS	

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F 279	Continued From page 4	F 279	Consultant. The MDS Coordinator will begin the audit monthly for 2 months or until resolved by the Quality Assurance Committee. Reports will be presented to the weekly QA committee by the MDS Consultant or the MDS Coordinator 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 DON, MDS Coordinator, Therapy Manager, Health Information Manager (HIM), Dietary Manager, Admissions Coordinator, Activity Director and Administrator.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		8/4/17

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(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews, the facility failed to correctly apply incontinent briefs for 2 of 6 residents observed during incontinence care (Resident #1 and Resident #2). This resulted in red friction lines on the resident ' s thighs along the edge of the brief for 1 of 6 residents observed (Resident #1). The findings included:

1. Resident #1 was admitted to the facility on 11/5/15 and had a diagnosis of CVA (Cerebrovascular Accident) with left hemiplegia (paralysis of the left side) and osteoarthritis.

The resident ' s Care Plan dated 5/3/16 noted the resident was incontinent of bladder with increased risk for skin breakdown and infections. The interventions included incontinent briefs at all times and resident required assistance with all incontinence care.

The Care Area Assessment (CAA) for ADLs (activities of daily living) dated 1/31/17 revealed

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F 309

Corrective Action for Resident Affected

Immediately on 07-06-2017, Resident #1 and Resident #2 were assessed by the nurse,Brent Ferebee,RN. A Treatment order for Resident #1 and Resident #2 was obtained by physician and treatment was initiated. Nurse, Brent Ferebee immediately assessed both residents on 7-6-17 for appropriate size briefs.

Corrective Action for Resident Potentially Afected

On 7-17-2017, Central Supply assessed all residents for appropriate sized briefs. 1 of 40 residents were identified to need resizing. This assessment was completed on 07-17-2017. All current residents were

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Continued From page 6

Resident #1 required extensive assistance with bed mobility, transfers and toileting using 2 or more persons physical support. The CAA for Urinary Incontinence noted the resident was incontinent of bowel and bladder, required extensive assistance for toileting and was at risk for skin breakdown.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 4/19/17 revealed the resident was cognitively intact and required extensive assistance with bed mobility and toileting and had limited range of motion of one upper and one lower extremity.

A nursing progress note dated 6/19/17 at 6:00 PM revealed the resident had friction wounds front and back on the left thigh with an order to apply (name of cream) three times a day and as needed. This cream was used as a barrier to protect the skin from moisture and minor irritation.

On 7/6/17 at 11:30 AM, NA (Nursing Assistant) #1 and NA #2 were observed to provide incontinence care for Resident #1. The resident was observed to have reddened lines on the right inner thigh and the back of the right thigh and a red line on the right upper, anterior thigh. There were red lines on the left thigh that went from the front of the thigh to the back. During the observation, NA#1 stated the red lines were from the incontinent brief not being applied correctly. The NA stated the edges of the brief should be positioned in the groin area and not left low around the thighs. The resident did not display signs of discomfort during the care.

On 7/6/17 at 12:10 PM an interview was

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assessed for any redness in groin/thigh areas. This was performed by Brent Ferebee and Monta Bunch, CNA and Central Supply Clerk and completed on 7-21-17.
2 of 40 were identified that the brief was not applied correctly, this was corrected immediately. One Resident had redness to the inner thigh and one Resident had a skin abrasion. MD was notified and Residents have appropriate treatment orders.

Systemic Changes

Inservices took place between the dates of 7-20-17 and 08-04-2017. The Administrator and or Director of Nursing inserviced the full time, part time and prn clinical staff which include licensed nurses, certified nursing assistants and medication aides. Topics included:

Proper sizing of incontinent briefs
How to size briefs
What to do if brief appears to be causing irritation
How to recognize if brief is too small or too big
When should sizing occur (on admission, readmission, with wt loss, wt gain, annually, quarterly)

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

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F 309 Continued From page 7

conducted with Nurse #1 and the Administrator. Nurse #1 stated he had changed the resident to a larger brief (bariatric brief) and wrote an order to make sure the brief came up to the groin area. The Nurse stated he had measured the red areas and the area on the right inner thigh measured 3cm (centimeters) by 2cm and one on the back of the thigh measured 7cm by 0.3cm and a separate area on the right upper thigh measured 1 cm by 0.5cm. The Nurse further stated the area on the resident ' s left inner thigh was 6.5cm by 2cm and the left upper thigh measured 7.5cm by 2cm. The Nurse described the areas as long red lines with defined borders, scant serous drainage and no odor. The Nurse stated he was not aware of any other residents that had this problem with the briefs.

There was a physician ' s order dated 7/6/17 to apply barrier ointment to inner thigh area every shift and as needed with brief change and make sure brief was in place as to not rub on reddened area.

On 7/6/17 at 2:55 PM, Nurse #2 stated in an interview that the resident had a problem with friction and she initiated a standing order for the barrier cream and made a referral to the wound doctor. The Nurse stated the wound doctor ordered a different cream for the resident and to leave the brief open. The Nurse stated after the areas healed they went back to securing the brief and did not realize the friction areas continued to be a problem. The Nurse stated they started using a bariatric brief for the resident and the representative of the company they purchased the briefs from came in and measured all the residents that used a brief and stated Resident #1 did not need a bariatric brief and they went back

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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 08-04-2017 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.

Quality Assurance
The Director of Nursing, MDS Coordinator or and assigned Licensed Nurse will monitor this issue using the QA Well Being/Brief Survey Tool. This audit will monitor that clinical staff correctly apply incontinent briefs. Any issues will be reported to the Administrator. This will be done weekly for one month and then monthly x 2 monthes or until resolved by Quality Assurance Committee. Reports will be presented to the weekly QA committee by the 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, Therapy Manager, Health Information Manager, Dietary Manager, Admissions Coordinator, Activity Director and Administrator.

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F 309	Continued From page 8 to the size brief previously used for the resident. On 7/6/17 at 4:23 PM, Resident #1 stated in an interview that she did not have any pain from the red areas on her thighs. The Administrator stated in an interview on 7/7/17 at 10:10 AM they had a representative to come in to identify the proper sized briefs for residents. The Administrator stated they had not identified an issue with the briefs not being applied properly. 2. Resident #2 was admitted to the facility on 9/22/15 and had a diagnosis of osteoarthritis and diabetes. The Care Plan for Resident #2, dated 9/23/15 noted the resident was incontinent of bladder with an increased risk for skin breakdown and infections. The Care Plan noted the resident wore incontinent briefs at all times and required assistance with incontinence care. The Care Area Assessment for ADLs (activities of daily living) dated 8/5/16 noted the resident required extensive assistance with ADLs and was incontinent of bowel and bladder. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 5/4/17 revealed the resident was cognitively intact and required extensive assistance with toileting and bed mobility and was incontinent of bowel and bladder. On 7/6/17 at 11:30 AM, NA #1 stated the edges of the brief should be positioned in the groin area and not left low around the thighs.	F 309	Compliance date: 08-04-2017	

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F 309	Continued From page 9 On 7/7/17 at 5:30 AM, incontinence care was observed to be provided for the resident. The edges of the brief was observed to be around the resident ' s upper thighs and not in the resident ' s groin area. There were no obvious signs of irritation from the brief. The Administrator stated in an interview on 7/7/17 at 10:10 AM they had a representative to come in to identify the proper sized briefs for residents. The Administrator stated they had not identified an issue with the briefs not being applied properly.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 observation, record review and staff interviews the facility failed to provide personal care for 1 of 7 residents observed to receive incontinence care (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/5/15 and had a diagnosis of cerebrovascular accident with hemiplegia (paralysis of one side) and renal insufficiency. The resident ' s Care Plan dated 5/3/16 revealed the resident was incontinent of bladder with increased risk for skin breakdown and infections. The interventions were to check resident every 2	F 312	F 312 Corrective Action for Resident Affected For resident #1, the nursing assistant provided incontinent care on 07-06-2017. Corrective Action for Resident Potentially Affected All current residents were assessed by the Director of Nursing and the MDS Coordinator for incontinence needs. This audit was completed by reviewing Point of Care documentation for incontinence over	8/4/17

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hours and as needed for incontinence.
The Care Area Assessment (CAA) for Urinary Incontinence dated 1/31/17 revealed the resident required extensive assistance with toileting and was incontinent of bowel and bladder.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 4/9/17 revealed the resident was cognitively intact, required the assistance of 2 persons for bed mobility and toileting and had functional limitation in range of motion of upper and lower extremities on one side. The MDS revealed the resident was incontinent of bowel and bladder.

On 7/6/17 at 11:30 AM, NA#1 and NA#2 were observed to provide incontinence care for Resident #1. The resident was observed to have liquid brown stool that had gone through the brief and the bed pad with 2 large, dried yellow stains on the fitted sheet on the bed. When asked what the yellow stain was, NA #1 stated it was because her brief was saturated through to the bottom sheet. The NAs stated they had just got around to this resident and she had not been checked for incontinence since night shift.

An interview was conducted with MDS Nurse #1 on 7/7/17 at 9:06 AM. The MDS Nurse stated incontinent residents should be checked every 2 hours for incontinence.

On 7/6/17 at 1:28 PM the Administrator stated in an interview that the NAs were supposed to do rounds with incontinence care every 2 hours.

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the last 14 days. Residents identified as having incontinence had their care plan reviewed by the MDS Consultant to ensure their care plan was current with their incontinent care needs. This review will be completed by 7-28-17

Systemic Changes

The Director of Nursing and the Administrator assessed and educated clinical staff on the importance of rounding at the beginning, during and ending of shift on checking residents to determine residents needs. For example, incontinent care versus focusing on getting baths completed on each shift. Staff training including providing resident centered care versus being task oriented. Also assisting licensed staff in assessing how to utilize resources when needed and communicating when assistance was needed to adjust staffing based on residents needs.

In-service education took place between the dates of 07-20-17 and 08-04-17. The Administrator and or Director of Nursing inserviced the full-time, part-time and prn clinical staff which include licensed nurses, certified nursing assistants and medication aides. 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 11	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 08-04-17, 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. Quality Assurance The Director of Nursing, MDS Coordinator or an assigned licensed nurse 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 Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the	

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	345404	A. BUILDING ______ B. WING ______	C 07/07/2017

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F 312	Continued From page 12	F 312	weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, Dietary Manager Admissions Coordinator and the Administrator.	
F 353 SS=D	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 353		8/4/17

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F 353	Continued From page 13 (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to have sufficient staffing to meet the needs of dependent residents for 1 of 3 residents observed during morning care (Resident #1). The findings included: Cross refer to F312. Based on observation, record review and staff interviews the facility failed to provide personal care for 1 of 7 residents observed to receive incontinence care (Resident #1). On 7/6/17 at 10:40 AM, NA (Nursing Assistant) #1 stated in an interview she worked 7 AM to 7 PM. The NA further stated there were 26 residents on the long term care unit and they did not have enough help and just had 2 NAs for the entire hall. The NA further stated a lot of the residents on the hall required 2 person assist so the NAs	F 353	F353 Corrective Action for Resident Affected On 7-6-17 incontinent care was provided to resident #1. The staff schedule was reviewed by the Director of Nursing and the Administrator by 07-28-17 to ensure adequate staff to meet patient needs. Corrective Action for Resident Potentially Affected All current residents were assessed by the Director of Nursing and the MDS Coordinator for incontinence needs. This audit was completed by reviewing Point of Care documentation for continence over the last 14 days. Residents identified as	

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had to work together to complete the care. The NA stated the breakfast trays came out at 7:30 AM and they had to feed residents before they started morning care. The NA stated she had told the Administrator they needed more help.

On 7/6/17 at 2:48 PM an interview was conducted with NA#1 and NA#2. NA#1 stated they have been giving baths and unable to make incontinent rounds every 2 hours until after lunch.

On 7/7/17 at 10:10 AM, The Administrator stated they had had some nursing vacancies but this had improved. The Administrator further stated she preferred to have 4 NAs on the long term care halls but usually just had 3. The Administrator stated she was not aware the staff was not able to get to the residents timely.

F 353

having incontinence had their care plan reviewed by the MDS Consultant to ensure their care plan was current with their incontinent care needs. This review will be completed by 7-28-17. Random rounds will be conducted by the Director of Nursing, MDS Coordinator or an assigned licensed nurse to ensure timely incontinent care and ADL care is met.

The staff schedule and assignments were reviewd for acquity level and residents needs to ensure residents needs were meet. This was completed by the Adminsitrator and the Director of Nursing by 07-28-17.

Systemic Changes

The Director of Nursing and the Administrator has assessed and continues to assess the staffing pattern of the clinical department based on the Residents census and acuity level. It is adjusted residents needs and individual residents plan of care. Staff education will be provided on communicating when staffing patterns need to be adjusted to accommodate residents needs. Also licensed staff will be educated on resources that are available that can be utilized to meet residents needs. This will be monitored in our weekly QA monitoring.

In-service education took place between

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F 353	Continued From page 15	F 353	07-20-17 and 08-04-17. The Administrator and or Director of Nursing inserviced the full-time, part-time and prn clinical staff which include licensed nurses, certified nursing assistants and medication aides. The in-service topics included: " Staff will be educated on providing timely incontinence care and meeting resident request timely " Staff will be educated on commuciating concerns with assignments or resident needs for care planning 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 08-04-17 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 clinical employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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F 353	Continued From page 16	F 353	Quality Assurance The Administrator will monitor this issue using the Staffing QA Tool for monitoring staffing is adequate to meet resident needs. 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, Therapy Manager, Health Information Manager, Dietary Manager, Admissions Coordinator, Activity Coordinator and the Administrator. Compliance date: 08-04-2017	