STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345342	A. BUILDING _____ B. WING _____	C 03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG ELM RETIREMENT AND NURSING CENTERS	**1285 WEST A STREET KANNAPOLIS, NC 28081**

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 3/10/19 to 3/13/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2PX811.	E 000		
F 000	INITIAL COMMENTS A staggered survey was completed for a recertification/complaint investigation with a Sunday entrance on 3/10/19. The survey exit date was 3/13/19. Event ID # 2PX811.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		4/10/19

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

Electronically Signed | 04/05/2019

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to provide 1 of 3 residents, (Resident #39) privacy during a shower. Findings included: Resident #39 was admitted to the facility on 3/19/16 with diagnoses of stroke, hypertension, and dementia with communication deficit. A Quarterly Minimum Data Set Assessment dated 2/15/19 revealed Resident #39 had memory problems and was moderately impaired for cognitive skills for daily decision making. During an interview with Nurse Aide #1 on 3/13/19 at 5:30 pm he stated on 7/10/18 he took Resident #39 and her roommate into the shower, placed them side by side in the same shower stall, and showered them together. He also	F 550	F550 483.10(a) 1. An in-service was held on April 3, 2019 with the Certified Nursing Assistant (CNA) identified in the CMS-2567 to re-educate him on resident rights in regards to privacy and dignity while giving showers and that showers provided should be done on an individual basis. In addition, the nursing staff, to include registered nurses, licensed practical nurses, CNAs, medication aides (RN, LPN, CNA, and MA) have been in-serviced and re-educated on resident rights in regards to privacy and dignity while giving showers and that showers provided should be done on an individual basis. The staff aforementioned has been in-serviced by April 10, 2019.	

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F 550	Continued From page 2 indicated both Resident #39 and her roommate were naked and could see each other. On 3/13/19 at 10:34 am, during an observation with Nurse Aide #1 of the shower room, he indicated he had placed both Resident #39 and her roommate into a large shower stall side by side. He demonstrated how he had placed both residents side by side in the shower stall facing him with no curtain or barrier between the two residents. On 3/13/19 at 5:54 pm an interview with the Administrator revealed his expectation of staff was they would protect all resident's privacy and treat all residents with dignity and respect. He stated Resident #39 should not have been showered with another resident. An interview with the Director of Nursing on 3/13/19 at 6:09 pm revealed her expectation of staff is all resident's dignity should be protected. She stated she had already begun the education with Nurse Aide #1 and all staff on the importance of protecting resident's privacy and treating residents with dignity and respect.	F 550	2. An in-service was held on April 3, 2019 with the Certified Nursing Assistant (CNA) identified in the CMS-2567 to re-educate him on resident rights in regards to privacy and dignity while giving showers and that showers provided should be done on an individual basis. In addition, the nursing staff, to include registered nurses, licensed practical nurses, CNAs, medication aides (RN, LPN, CNA, and MA) have been in-serviced and re-educated on resident rights in regards to privacy and dignity while giving showers and that showers provided should be done on an individual basis. The staff aforementioned has been in-serviced by April 10, 2019. 3. There were no systemic changes that needed to be addressed. The allegation identified in the 2567L had occurred a few months prior and was identified during an investigation unbeknownst to facility management. Staff training and quality assurance rounding will be used to ensure compliance. 4. In order to ensure corrective actions are sustained the facility will complete random audits by the unit manager and the Director of Nursing for both 100 and 200 halls through various days of the workweek. Audits will be conducted on at least four (4) residents weekly for four (4) weeks, monthly for (3 months), and quarterly thereafter. Negative trends and findings will be presented monthly at the facility QAPI meetings and corrective	

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F 550	Continued From page 3	F 550	actions taken as necessary. The administrator is responsible for overall compliance.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		4/10/19

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F 640	Continued From page 4 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a Discharge Tracking Minimum Data Set (MDS) assessment to the Centers for Medicare & Medicaid Services (CMS) system within the required time frame for 1 of 1 resident (Resident #1) selected to be reviewed for Resident Assessments. Findings included: Resident #1 was originally admitted to the facility on 7/3/18 and was most recently readmitted to the facility on 10/11/18. The resident's diagnoses included: Congestive Heart Failure (CHF), shortness of breath, generalized weakness, and pressure ulcers to the left and right heels. Review of Resident #1's most recent Minimum Data Set (MDS) assessments revealed an admission assessment with an Assessment	F 640	F640 483.20(f)(1)-(4) 1. Resident #1 had his discharge summary completed and transmitted on March 12, 2019 by the facility MDS Coordinator. The Minimum Data Set (MDS)Coordinator has been re-educated by the director of nursing on April 3, 2019 on completion of the discharge assessment and verifying that these assessments are transmitted timely. 2. The facility has conducted MDS audits for residents requiring a discharge assessment from 12/1/2018-03/15/2019 by the director of nursing to identify residents who needed to have a discharge assessment completed and submitted. The results of the audits did not identify other errors and thus did not have a need to have another assessment completed	

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F 640	Continued From page 5 Reference Date (ARD) of 7/10/18 and a quarterly assessment with an ARD of 9/29/18. Further review of the resident's MDS assessments revealed an open, incomplete, and not transmitted Discharge Return Not Anticipated (DCRNA) assessment with an ARD of 10/12/18. A review was completed of the Final Validation Report for the facility of the transmission of MDS information which took place on 3/13/19. Review of the report revealed the DCRNA assessment for Resident #1 with an ARD of 10/12/18 was transmitted on 3/12/19. Further review of the report revealed a warning for the submission which stated, Assessment Completed Late: The assessment completed date is more than 14 days after the ARD. A review of Resident #1's Electronic Medical Record (EMR) revealed a progress note dated 10/15/18, timed 3:42 PM, completed by the Social Services Director (SSD), which documented the resident was discharged to an Assisted Living Facility (ALF) on 10/12/18 via facility transport. During an interview conducted with the SSD on 3/12/19 at 9:40 AM she stated Resident #1 had been discharged to an ALF in October 2018. An interview was conducted with the MDS Coordinator on 3/12/19 at 9:47 AM. The MDS Coordinator stated she transmitted MDS assessments within 14 days or less from the time the assessment was completed. The MDS Coordinator stated there had been some confusion because the resident was scheduled to discharge to an ALF on a certain date in October, he did not discharge on the certain date in October, and then the resident discharged on a	F 640	and transmitted by April 10, 2019. 3. No systemic changes are necessary. In this instance the MDS coordinator did not complete an assessment and failed to transmit the information. The alleged deficiency is isolated where education and quality assurance will achieve compliance. 4. The director of nursing will be responsible to complete audits of discharge assessments and Final Validation Report (transmittal log) that shows complete and timely filing of facility assessments. Audits will be completed weekly for four (4) weeks, monthly for three (3) months, and quarterly thereafter. Results will be reviewed through monthly Quality Assessment and Performance Improvement (QAPI) and corrective actions taken as necessary. The administrator is responsible for overall compliance.	

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F 640	Continued From page 6 later date. During an interview conducted with the Administrator on 3/13/19 at 6:25 PM he stated it was his expectation for MDS assessments to be completed timely.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for tobacco use for 2 of 3 residents reviewed for smoking (Resident #11 and #25). Findings included: 1. Resident #11 was admitted to the facility on 12/29/2016 with diagnoses to include osteoarthritis, dementia and insomnia. A safe smoking assessment dated 4/21/2018 evaluated Resident #11 to be an unsafe smoker and interventions included Resident #11 ' s family would take her outside to smoke. The most recent comprehensive annual MDS dated 7/6/2018 assessed Resident #11 to be cognitively intact and answered question J1300 Current Tobacco Use "0-no". A care plan was in place dated 1/14/2019 that addressed Resident #11 ' s smoking status and interventions included supervised smoking by her family members.	F 641	F 641 483.20(g) 1. The annual comprehensive assessments for Resident□s #11 and #25 have been re-assessed for smoking and their annual comprehensive assessments updated to indicate that these residents do smoke tobacco. The Minimum Data Set (MDS) coordinator has been in-serviced and re-educated by the director of nursing on April 3, 2019 on importance of accuracy of her comprehensive assessments on section J1300 (tobacco use). Failure to complete accurate assessments related to tobacco use by the MDS coordinator will result in further re-education and also may result in disciplinary action up to and including termination of employment through the facility progressive disciplinary policy. 2. Residents of the facility who do use tobacco have been reviewed for section J1300 to ensure accurate assessment.	4/10/19

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F 641	Continued From page 7 An interview was conducted with Resident #11 on 3/13/2019 at 11:30 AM and she reported her family comes to visit her and they will take her out to the patio to smoke. An interview was conducted with the MDS nurse on 3/13/2019 at 3:11 PM, and she reported Resident #11 smoked only when her family visited. The MDS nurse further reported she was the only nurse who completed the MDS assessment and she was not certain why she coded Resident #11 as not using tobacco products. The Director of Nursing (DON) was interviewed on 3/13/20019 at 3:58 PM. The DON reported it was her expectation the MDS were coded correctly for all residents. The Administrator was interviewed on 3/13/2019 at 4:13 PM and he reported it was his expectation the MDS was coded correctly. 2. Resident #25 was admitted to the facility on 2/11/2016 with diagnoses to include high blood pressure, anxiety and chronic pain. A safe smoking assessment dated 11/21/2018 assessed Resident #25 to be a safe and independent smoker. The most recent comprehensive MDS dated 1/31/2019 assessed Resident #25 to be cognitively intact and answered question J1300 Current Tobacco Use "0-no". A care plan was in place dated 1/31/2019 that addressed Resident #25 ' s smoking status and	F 641	Those identified as not having an accurate tobacco comprehensive annual assessment will be updated. The audit was conducted on April 8, 2019 by the director of nursing and the J1300 was coded accurately. 3. No systemic changes are necessary. The facility will take steps through training and quality assurance to ensure compliance. 4. The facility will review comprehensive assessments of residents who use tobacco to ensure accurate coding of J1300. Reviews will be conducted by the director of nursing weekly for four (4) weeks and monthly thereafter to ensure accuracy of smoking comprehensive assessments. Negative findings will be presented through the facility Quality Assessment and Performance Improvement (QAPI) program and corrective actions taken as necessary to ensure compliance. The administrator is responsible for overall compliance.	

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F 641	Continued From page 8 interventions included to reassess smoking status every 90 days. Resident #25 was observed smoking on 3/10/2019 at 12:28 PM. Resident #25 was interviewed on 3/10/2019 at 12:28 PM and she reported she had smoked for many years. An interview was conducted with the MDS nurse on 3/13/2019 at 3:11 PM, and she reported Resident #25 was an independent smoker and could take herself outside to smoke. The MDS nurse further reported she was the only nurse who completed the MDS assessment and she was not certain why she coded Resident #25 as not using tobacco products. The Director of Nursing (DON) was interviewed on 3/13/20019 at 3:58 PM. The DON reported it was her expectation the MDS were coded correctly for all residents. The Administrator was interviewed on 3/13/2019 at 4:13 PM and he reported it was his expectation the MDS was coded correctly.	F 641		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 693		4/10/19

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F 693	Continued From page 9 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, physician interview, and observation the facility failed to provide nutrition in a safe manner through a gastrostomy tube for 1 of 1 resident, Resident #23, for enteral feedings. Findings included: Resident #23 admitted to the facility on 5/24/17 with diagnoses of stroke with right side weakness, gastrostomy tube placement, hypertension, and anxiety. The most recent Minimum Data Set Assessment, a quarterly, was dated 1/30/19 and indicated Resident #23 was moderately impaired for daily decision making and he required total assistance for meals. The assessment further revealed all of Resident #23's fluid and nutrition was provided by his gastrostomy tube. A review of Resident #23's Care Plan dated 1/30/19 revealed he received bolus feedings and	F 693	F693 483.25 (g)(4)(5) 1. The facility in-serviced and re-educated the Licensed Practical Nurse (LPN) identified in the CMS-2567 on proper tube feeding procedures for Resident #23 on March 12, 2019 by the director of nursing. In addition the nurse will be responsible for demonstrating competency for tube feeding of resident #23. 2. The facility in-serviced registered nurses, licensed practical nurses, medication aides, and certified nursing assistants (RNs, LPNs, MAs, and CNAs) on tube feeding procedures and nursing personnel were required to demonstrate competency in administering tube feedings. In the event staff are unable to demonstrate competency they will be required to receive additional training until they demonstrate being able to administer	

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F 693	Continued From page 10 water flushes to his gastrostomy tube and he had behaviors of chewing and pulling out his gastrostomy tube. The Care Plan further revealed he was at risk for aspiration and alteration in nutrition. The physician orders for Resident #23 indicated an order for bolus feedings of 237 milliliters every 4 hours by gastrostomy tube and water flushes before (50 milliliters) and after (100 milliliters) each feeding written on 2/15/19. A review of the Dietician's Note dated 2/21/19 indicated Resident #23 was receiving bolus feedings every 4 hours via gastrostomy tube and he had no significant weight change in one month. During an interview with Nurse #1 on 3/12/19 at 10:05 am she indicated Resident #23 has bolus gastrostomy tube feedings every 4 hours and his next feeding is at 1:00 pm. She stated he sometimes gags and coughs after his feeding. Nurse #1 noted Resident #23 resisted feeding at times and would fight when you attempted to administer a feeding. She stated he also had behaviors of chewing his gastrostomy tube and pulling it out. During an observation of Nurse #1 on 3/12/19 at 1:11 pm administering a bolus feeding she checked for residual in the stomach. She then attached a syringe with 50 milliliters of water and pushed it through Resident #23's gastrostomy tube and proceeded to fill the syringe with tube feeding formula and attach it to the gastrostomy tube to push the feeding. Nurse #1 stated she had been nervous and should not have pushed the water flush or formula into the gastrostomy	F 693	tube feedings according to facility procedure. Staff will be trained by April 10, 2019. 3. No systemic changes are necessary. In the allegation provided in the CMS-2567 the nurse failed to demonstrate proper bolus tube feeding. The incident was isolated and compliance will be achieved by staff education, competency demonstrations, and direct quality assurance observations. 4. The facility will conduct direct observations quality assurance rounds by either the Director of Nursing, Staff Development, Unit Manager, or Weekend Supervisor of staff administering tube feedings. Direct observations will be conducted on the first and second shifts (schedule for our residents requiring parental feedings) weekly for four (4) weeks, monthly for three (3) months, and quarterly thereafter. Findings will be reviewed during monthly quality assurance meetings and corrective actions taken as needed to ensure compliance. The administrator is responsible for overall compliance. 5. Date of Compliance: April 10, 2019	

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F 693	Continued From page 11 tube. She further stated she should allow the feeding to run into the gastrostomy tube using gravity. An interview with the Director of Nursing (DON) on 3/13/19 at 11:51 am revealed she was aware Nurse #1 had pushed the water flush and attempted to push the formula during the observed administration of the gastrotomy feeding. The DON stated Nurse #1 had just completed her annual skills checklist and knew she should administer the formula by gravity and not push the formula through the gastrostomy tube. The DON stated Resident #23 had nausea and vomiting when he was on continuous feedings and she did not think Nurse #1 routinely pushed the water flushes and formula through the gastrostomy tube. The Physician was interviewed on 3/13/19 at 12:30 pm and indicated if a large amount of formula was pushed quickly through Resident #23's gastrostomy tube it could cause nausea and vomiting. She stated she had never witnessed any of the Nurses pushing Resident #23's formula through his gastrostomy tube. On 3/13/19 at 5:52 pm during an interview with the Administrator he stated his expectation of the nursing staff was Resident #23 would receive his gastrostomy feedings appropriately and safely.	F 693		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		4/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345342	A. BUILDING _____ B. WING _____	C 03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 12 (i) Facility name. (ii) The current date. (iii) 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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. 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. §483.35(g)(4) Facility data retention requirements. 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: The facility failed to update the daily posted nurse staffing form to reflect nurse staff changes or facility census to reflect the current status in the facility.	F 732	F732 483.35 (g)(1)-(4) 1. The daily staffing form was amended on March 13, 2019 to meet the current requirements to ensure the posting is	

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F 732	Continued From page 13 Findings included: A review of the daily posted nursing staff forms dated from 02/10/2019 through 03/13/2019 was conducted on 03/13/2019. The posted staffing forms indicated that the facility did not update the forms to reflect any changes in facility census or nurse staffing on those days. On 03/13/2019 at 5:34 PM with the staffing coordinator revealed that she was responsible to update the posted form for the day and that she did that every morning each morning that she worked. The staff coordinator revealed that the facility census was obtained from the business office every morning and that nurse staff were recorded for each shift for the day from the master schedule and then the form was posted in the display case. The staff coordinator revealed that the posted form was not updated during the day to reflect any changes of the facility census or nurse staffing changes. The staff coordinator revealed that she updated the form the next morning with the current facility census and nurse staff scheduled for the day. An interview with the Director of nurses (DON) on 03/19/2019 at 6:03 PM revealed that the posted staff and census form was updated each morning by the staff coordinator or the DON and that the facility did not update the posted form throughout the day to reflect any changes in the facility census or nurse staffing. The DON revealed that the expectation was that the posted census and nurse staff form be a working tool and that the form was to be adjusted or updated with any changes of the facility census or nursing staff changes through the day.	F 732	updated in accordance with facility census. No specific resident is affected by the deficient practice so the plan of correction for this deficiency will be identified below. 2. The daily staffing form was amended on March 13, 2019 to meet the current requirements to ensure the posting is updated in accordance with facility census. In addition the staffing coordinator, weekend supervisor, and facility charge nurses have been in-serviced on April 5, 2019 on the new staffing form and procedures to update during the day as changes occur. 3. The facility did make systemic changes to its posting of staff procedures. The facility amended its staff posting form to address the requirements in 483.35 (g) (1)-(4). In addition the facility delegated the charge nurse to be responsible after hours staff posting requirements to ensure changes can be made on atypical times during the day. 4. The facility will conduct direct observation quality assurance rounds by the Director of Nursing, Staff Development, Unit Manager, and Weekend Supervisor of posted nurse staffing information. Direct observations will be conducted weekly at least three days during the week and one day on weekends for four (4) weeks, monthly for three (3) months, and quarterly thereafter.	

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F 732	Continued From page 14	F 732	Findings will be reviewed during monthly quality assurance meetings and corrective actions taken as needed to ensure compliance. The administrator is responsible for overall compliance. 5. April 10, 2019	