PRINTED: 01/23/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345228	B. WING _			C 12/21/2017	
	ROVIDER OR SUPPLIER ODD LIVING & REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZII 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F 0	000			
	complaint investigation	re cited as a result of the on. Event ID D5D911 exit enumbers NC00134260 and					
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)	-	F 5	550		1/18/18	
	self-determination, ar access to persons ar	Rights. ght to a dignified existence, nd communication with and nd services inside and ncluding those specified in					
	with respect and digr resident in a manner promotes maintenand						
	access to quality care severity of condition, must establish and m practices regarding to	cility must provide equal e regardless of diagnosis, or payment source. A facility naintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.					
		right to exercise his or her fthe facility and as a citizen					
		cility must ensure that the e his or her rights without					
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/28/2017

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBED: `		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345228	B. WING			C 12/21/2017		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/21/2017			
				1624 HIGHLAND DRIVE				
RIDGEWOOD LIVING & REHAB CENTER			WASHINGTON, NC 27889					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 550	Continued From page	e 1	F 5	50				
	interference, coercior from the facility.	n, discrimination, or reprisal						
	free of interference, or reprisal from the facil rights and to be supp exercise of his or her subpart. This REQUIREMENT by: Based on observation and resident interview maintain dignity by far announce their preser rooms for 3 of 32 resi #91, Resident #321, Findings included: 1. Resident #91 was 10/16/14. His active of failure, hypertension, depression. Review of Resident # data set assessment was assessed as cognitive of the support o	admitted to the facility on diagnoses included heart anxiety disorder, and e91's most recent minimum dated 11/21/17 revealed he		Regarding the alleged deficier of failure to knock on resident #321 and #74 door or announcentry, the Staff Development Coprovided in service education of 2017, for NA #1, regarding Resights: Dignity and Respect, k doors and announcing prior to resident room. Current facility residents are at alleged deficient practice of fail knock on resident door or announce presence before entering the room. The Staff Development Coordinator provided in service for current facility staff beginning -2017, regarding Resident Rigliand Respect. The Staff Development Coordinator provided in service education for provided in service education for provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Development Coordinator provided in service education for the staff Deve	□s # 91, ce prior to coordinator on 12-26- sident knocking on entry into t risk of the lure to bunce their esidents□ ce education ng on 12-26 hts: Dignity inator			
	#91 's room without permission to enter.			facility staff beginning on 12-26 regarding Resident Rights: Dig Respect. In service education	6-2017, gnity and			
	Resident #91 stated knocked before enter staff to knock or anno	n 12/18/17 at 11:05 AM Nurse Aide #1 never ring his room and he wanted bunce their presence before to further stated he was		provided during new hire orient Administrator, DON, ADON, St Development Coordinator, MD Coordinators, and Social Work observe 15 resident rooms wee	tation. The taff S er will			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				c
		345228	B. WING			12/	21/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RIDGEWO	OD LIVING & REHAB	CENTER			624 HIGHLAND DRIVE /ASHINGTON, NC 27889		
040.15	CLIMMADY C	STATEMENT OF DEFICIENCIES	- 15	•			0/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page frustrated that Nurse herself or let him knoroom. During an interview Nurse Aide #1 state and announce their a resident's room. Shave knocked before room and she would During an interview Director of Nursing staff would knock or before entering a reresidents who were further stated Nurse knocked before entering a reresident #321 was 9/22/17. Her active to heart failure, hyperte functional quadriplet. This identifies the reresident was mainimum data set as revealed she was mainimum data set as revealed she was mainimum data without knocking or During an interview	ge 2 e Aide #1 did not announce ow she was entering his on 12/18/17 at 2:22 PM d staff should always knock presence before they entered the further stated she should e entering Resident #91's at from now on. on 12/18/17 at 10:47 AM the stated it was her expectation announce their presence sident rooms including cognitively impaired. She Aide #1 should have ering Resident #91's room. as admitted to the facility on diagnoses included anemia, ension, diabetes mellitus, and gia.		550		for s I thly are	
	before entering the dignity of residents a	resident 's room for the					

Facility ID: 923432

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345228	B. WING		C 12/21/2017	
	ROVIDER OR SUPPLIER	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE NASHINGTON, NC 27889	1221/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 550	Continued From pa		F 550			
	and announce their a resident's room. S	d staff should always knock presence before they entered he further stated she should e entering Resident #321's I from now on.				
	of Nursing stated it would knock or annuentering a resident were cognitively imp	on 12/18/17 at 10:47 Director was her expectation staff bunce their presence before rooms including residents who paired. She further stated ld have knocked before 321 's room.				
	8/26/17. Her active hypertension, diabe	s admitted to the facility on diagnoses included anemia, tes mellitus, hyperlipidemia, on, and anxiety disorder.				
	data set assessmen	#74 's most recent minimum it dated 11/17/17 revealed she everely cognitively impaired.				
	Nurse Aide #1 enter	on 12/18/17 at 11:45 AM red Resident #74 ' s room announcing her presence.				
	Nurse Aide #1 state and announce their a resident's room w impaired residents.	on 12/18/17 at 2:22 PM d staff should always knock presence before they entered hich included cognitively She further stated she should e entering Resident #74's d from now on.				
	Director of Nursing staff would knock or	on 12/18/17 at 10:47 AM the stated it was her expectation announce their presence sident rooms including				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	· '	COMPLETED		
		345228	B. WING _			C 1 2/21/2017	
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD LIVING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	12/21/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 550 F 761	further stated Nurse	cognitively impaired. She Aide #1 should have ring Resident #74 ' s room.	F 5			1/18/18	
SS=D	CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological labeled in accordance professional principle appropriate accesso instructions, and the applicable. §483.45(h) Storage of §483.45(h)(1) In acc Federal laws, the fact biologicals in locked temperature controls personnel to have acc §483.45(h)(2) The fact locked, permanently storage of controlled the Comprehensive of Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN' by: Based on medical re staff and pharmacy in discard expired insul	of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and compartments under proper, and permit only authorized		Regarding the alleged deficient of to discard 1 vial of expired Lantus and 1 vial of expired Novolog instruments was found on Medication cart B2, #1 removed the expired insulins for the state of the s	s insulin ulin that , Nurse	17/10/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345228	B. WING		1	C 2/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		2/21/2017	
				1624 HIGHLAND DRIVE			
RIDGEWO	OOD LIVING & REHAB C	ENTER		WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From pag	e 5	F 70	51			
	Findings included:			medication cart on 12/19/17, a them to the pharmacy for disp Staff Development Coordinato	osal. The or provided		
		n on 12/19/17 at 9:24 AM a		in service education to Nurse			
		served with the open date a vial of Novolog was		12-19-2017 regarding Policy a Procedure for dating and labe			
		en date labeled 11/11/17 and		expiration dates for medicatio	•		
	a vial of Novolog with	n an open date of 11/8/17.		opened.			
	During an interview o	on 12/19/17 at 9:25 AM		Current facility residents are a being affected by the alleged			
		the Lantus and Novolog		practice related to labeling an			
	insulins expired 30 days after they were opened			medications. The DON, Assis			
		had expired over 10 days		Staff Development Coordinate			
	•	observed taking the expired		Coordinators, and unit coordin			
	insulin bottles from th	ne medication cart.		performed and audit of facility			
	The Director of Nursi	ing (DON) on 12/19/17 at		carts, treatment carts and mer			
		nurses should date insulins		medications were dated/labele			
	when they were oper	ned, should look at the insulin		discarded according to facility	policy and		
	open date and check	prior to administration to		procedure. Medications were			
	make sure the insulir	n had not expired. The DON		dated/labeled appropriately, a			
		e medication carts should		medications were observed to			
		on Monday (12/18/17) and		The Staff Development Coord			
	l	ere were expired insulins on		provided in service education			
	the medication cart.			facility licensed nurses beginn 19-2017, regarding	ling on 12-		
	On 12/20/17 at 4:04	PM the Pharmacist stated		Dating/Labeling/Storage of me	edications		
	that she went by the			and recommended expiration			
		both the Lantus and the		medications are opened. Edu			
	Novolog would expire	e 28 days after opening the		be provided for new hires duri			
	insulins and the nurs	es should have discarded		orientation. The DON, ADON	, Staff		
	the insulins when the	ey expired.		Development Coordinators, M			
				Coordinators, and/or the Unit			
				Coordinators will audit medica			
				and medication rooms daily for			
				then 3 times a week for 4 week			
				once weekly ongoing to valida			
				medications are dated/labeled			
				disposed of according to facili	ty policy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345228	B. WING		C 12/21/2017
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 761	Continued From page	e 6	F 76	The DON, ADON, MDS Coordinato and Staff Development Coordinator review audits for patterns/trends an adjust plan to maintain compliance will review plan during the monthly meeting for 6 months or until compl is maintained.	r will d will and QAPI
F 867 SS=D	§483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct identification.	(ii) sessment and assurance. ality assessment and	F 86		1/18/18
	Based on observation interviews, the facility Assurance (QAA) Complemented procedulation interventions previous was related to non-congrouping of 483.45 or recertification surveys medication storage at 483.45 was cited during annual recertification again on the current recertification surveys related to non-compling grouping of 483.10 or recertification surveys dignity at the regulated originally cited during recertification surveys the recertification surveys the regulated originally cited during recertification surveys the received the rece	sly put in place. This failure impliance at the regulatory in two consecutive annual is. A deficiency in the area of it the regulatory grouping of ing the facility's 11/2/16 survey, and was recited 12/21/17 annual		1)Regarding the alleged deficient pof failure to discard 1 vial of expired Lantus insulin and 1 vial of expired Novolog insulin that was found on Medication cart B2, Nurse #1 removexpired insulins from the medication on 12/19/17, and returned them to the pharmacy for disposal. The Staff Delopement Coordinator provided in service education to Nurse #1 on 12-19-2017 regarding Policy and Procedure for dating and labeling a expiration dates for medications on opened. Current facility residents are at risk being affected by the alleged deficie practice related to labeling and stor medications. The DON, Assistant I Staff Development Coordinator, ME Coordinators, and unit coordinators	ved the n cart the Oev nd ce of ent rage of DON, DS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345228	B. WING			С	
		343228	B. WING _		•	2/21/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
RIDGEWO	OD LIVING & REHA	B CENTER		1624 HIGHLAND DRIVE			
				WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 867	Continued From p	page 7	F 8	67			
F 007	The facility's continued recertification survival facility's inability to program. Findings Included 1. This tag is cross 483.45: Labeling on medical record and pharmacy into discard expired in of 5 medications of storage. 483.45 was origin 2016 recertification expired medication. During an intervie Administrator stat storage issues the medication carts of the monthly and for medications that we medications that we medication that we medicat	inued failure during the veys showed a pattern of the or sustain an effective QAA in a susta	F8	performed an audit of facility carts, treatment carts and m rooms on 12-21-2017, to as medications were dated/labediscarded according to facility procedure. Medications were dated/labeled appropriately, medications were observed. The DON and Staff Develop Coordinator provided in sensor for current facility licensed in beginning on 12-19-2017, respectively. Dating/Labeling/Storage of and recommended expiration medications are opened. Experience to be provided for new hires described for new hires described for the Unit will audit medication carts a rooms daily for 4 weeks, the week for 4 weeks then once ongoing to validate medication dated/labeled/stored and disaccording to facility policy. The Regional Director of Cli will provide in service educations.	nedication sure eled and ity policy and re , and no to be expired. oment vice education nurses egarding medications on dates once ducation will uring DN, Staff MDS t Coordinators nd medication en 3 times a e weekly ions are esposed of inical Services ation on ment team		
	2. This tag is cros 483.10: Resident	s referenced to: Rights: Based on observation,		consisting of the Administration Nursing, Assistant Director of MDS coordinators, Social W	of Nursing,		
	record review, and the facility failed to knock on doors of before entering re- residents observer #321, and Reside	d staff and resident interviews or maintain dignity by failing to rannounce their presence sident rooms for 3 of 32 d (Resident #91, Resident		Activities Director and Infect Nurse, regarding QAPI, how plan and implement a qualit improvement and ongoing n assure compliance. The DON will review audits patterns/trends and will adjumaintain compliance and wi	tion Control v to identify, y plan for nonitoring to for ust plan to		

Facility ID: 923432

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		345228	B. WING			1	C 21/2017
	ROVIDER OR SUPPLIER			16	TREET ADDRESS, CITY, STATE, ZIP CODE 824 HIGHLAND DRIVE VASHINGTON, NC 27889	<u> 12/</u>	21/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ID PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 867	dignity for residents i meals on trays. During an interview of Administrator stated deliveries in the dining dignity for the resident performed weekly, expending and no further meal service in the dignate that concerns about lentering resident roo	urvey for failing to provide a n the dining room by serving on 12/21/17 at 10:55 AM the they audited the meal g room in order to ensure	F	867	during the monthly QAPI meeting for 6 months or until compliance is maintaine 2)Regarding the alleged deficient pract of failure to knock on resident □s # 91, #321 and #74 door or announce prior to entry, the Staff Development Coordinat provided in service education on 12-26 2017, for NA #1, regarding Resident Rights: Dignity and Respect, knocking doors and announcing prior to entry int resident room. Current facility residents are at risk of the alleged deficient practice of failure to knock on resident door or announce the presence before entering the residents room. The Staff Development Coordinator provided in service educate for current facility staff beginning on 12-2017, regarding Resident Rights: Dignity and Respect. The Staff Development Coordinator provided in service education for current facility staff beginning on 12-26-2017, regarding Resident Rights: Dignity and Respect. In service education will be provided during new hire orientation. The Administrator, DON, ADON, Staff Development Coordinator, MDS Coordinators, and Social Worker will observe 15 resident rooms weekly for 4 weeks then 15 resident rooms monthly 3 months to validate that staff members are knocking on resident doors prior to entering or announcing their presence prior to entering the residents □ room. The Staff Development Coordinator will review Resident Rights monthly with facility staff as an ongoing training/education. The Activity Directors in the provise of the pr	cice o tor i- on o he eir26 hity nt	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L LIDENTIEICATION NITIMBED:		PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		345228	B. WING	B WING		C	
NAME OF D	ROVIDER OR SUPPLIER	343220	B: WINO_	STREET ADDRESS, CITY, STATE, ZIP CODE		2/21/2017	
NAME OF T	NOVIDER OR OUT FEEL			1624 HIGHLAND DRIVE			
RIDGEWO	OOD LIVING & REHAB CI	ENTER		WASHINGTON, NC 27889			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETION DATE	
F 867	Continued From page	9	F 8	will review Resident Rights during Resident Council meeting. The Administrator and/or the Social Wo will identify resident concerns that related to resident right issues as the voiced or observed and will implement appropriate interventions to prevent deficient practice. The Regional Director of Clinical Swill provide on 1-3-2018 in service education for the Management teal consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing, Activities Director and Infection Converse, regarding QAPI, how to idea plan and implement a quality plan improvement and ongoing monitoriassure compliance. The Administrator, Staff Developme Coordinator and/or the Social Worker audits to identify patterns are trends and will adjust plan to maint compliance and review plan during monthly QAPI meeting for at least months or until compliance is main	rker are ney are ney are nent t ervices m ector of ing, ntrol ntify, or ng to ent ker will nd/or ain the 6		