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	345313	A. BUILDING _____ B. WING _____	C 10/28/2021

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NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/25/21 through 10/28/21. The facility was found in compliance with the requirement CFR483.73, Emergency Prepardeness. Event ID # EBNR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 10/25/21 through 10/28/21. Event ID # EBNR11. 14 of 14 complaint allegations were not substantiated.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		11/25/21

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

Electronically Signed | 11/19/2021

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to provide showers according to the resident ' s preference for 1 of 18 residents reviewed for choices (Resident #33). The findings included: Resident #33 was admitted to the facility on 3/11/21 with a diagnosis of spinal cord injury and atrial fibrillation. The admission Minimum Data Set (MDS) dated 3/18/21 revealed it was very important for Resident #33 to choose between a bed bath and a shower. The quarterly MDS dated 9/13/21 revealed Resident #33 was cognitively intact and required assistance with all activities of daily living. He required total dependance for bathing. A review of the resident care guide for Resident #33 dated 9/16/21 showed the following: Baths/Showers as requested. There were no scheduled days for showers. On 10/25/21 at 11:23 AM an interview was conducted with Resident #33 and he stated he had not been offered a shower since admission and he would like to get one. Resident #33 was unable to recall if he ever asked for a shower.	F 561	Northampton Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Northampton Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Northampton Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F561 Self Determination On 11/16/21, resident #33 was provided a shower per resident preference. On 10/28/21, the Facility Consultant	

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F 561	Continued From page 2 Nurse Aide (NA) #1 was interviewed on 10/27/21 at 9:03 AM and she stated showers were not often offered and she couldn ' t remember if she had ever offered Resident #33 a shower. She stated she was unaware if there was a shower schedule. On 10/27/21 at 9:05 AM an interview was conducted with Nurse #1 and she stated she wasn ' t sure if Resident #33 had ever had a shower. The resident care tracking sheet for bathing was reviewed for Resident #33 from 9/29/21 through 10/27/21. It was documented he received full bed baths and revealed no shower had been documented as being given during the time reviewed. An interview was conducted with the interim Director of Nursing on 10/27/21 at 9:15 AM. She stated it had not been documented Resident #33 had a shower from 9/29/21 through 10/27/21. She also stated it was not documented Resident #33 refused a shower. On 10/28/21 at 4:00 PM the administrator was interviewed. She stated there was not a shower schedule for the residents. She stated residents should be getting showers and they should be offered. She was unaware why Resident #33 was never offered a shower.	F 561	initiated an audit of showers for all residents to include resident #33 from 10/13/21-10/28/21. This audit is to identify any resident who was not offered a shower per facility protocol during review period or who is not documented as refusing a shower. All areas of concern will be addressed by the assigned hall nurses and nursing assistants to include offering and providing resident with a shower or documenting resident refusal of shower with notification of RR of refusal if indicated. Audit will be completed by 11/25/21. On 11/15/21, the Social Worker initiated a Resident Preference Questionnaire with all alert and oriented residents to include resident #33 in regards to preference for showers. The assigned nurse, Unit Mangers and/or Minimum Data Set (MDS) nurse will address all concerns identified during the audit to include providing shower/bath care per resident preference and updating all care plans to reflect resident preference for shower/bed bath. Audit will be completed by 11/25/21. On 11/18/21, the Director of Nursing initiated an updated shower schedule to reflect resident preferences to include resident #33. Shower schedule will be posted at the nurses station and a copy provided to all alert and oriented residents by the Social Worker. Updated shower schedule will be completed by 11/25/21. On 11/19/21, the Staff Development Coordinator initiated an in-service with all	

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F 561	Continued From page 3	F 561	nurses and nursing assistants in regards to (1) Resident Preferences with emphasis on resident right to make choices about aspects of life to include but not limited to shower preference. (2) Resident ADL/Showers with emphasis on offering resident a shower per resident preference, documentation of resident refusal and notification of resident representative for resident refusals when indicated. In-service will be completed by 11/25/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regard to Resident Preferences and Resident Showers. 10% of assigned resident showers will be reviewed weekly x 4 weeks then monthly x 1 month, by the Charge Nurse and/or Staff Facilitator. This audit is to ensure all residents, to include resident #33, are offered/provided a shower per resident preference and/or facility protocol, utilizing the Showers Audit Tool. The assigned hall nurse and nursing assistant will address all areas of concern identified during the audit to include providing resident care per preference, updating care plan/care guide of resident preference, notification of the resident representative of care refusals and/or additional staff training. The DON will initial the Showers Audit Tool weekly x 4 weeks, then monthly for one month to ensure all areas of concern were addressed. The Administrator will forward the results of the Showers Audit Tool to the Executive Quality Performance Improvement	

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F 561	Continued From page 4	F 561	Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Showers Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may	F 563		11/25/21

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F 563	Continued From page 5 need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews and record review, the facility imposed a restricted visitation schedule which limited resident visitations for 2 of 2 residents reviewed for visitation. (Resident #25 and Resident #5). This practice had the potential to affect all residents. The findings included: 1. Resident #25 was admitted to the facility on 6/9/21. The quarterly Minimum Data Set revealed Resident #25 was cognitively impaired. On 10/27/21 at 2:30 PM an interview was conducted with Resident #25's family member. She stated she could visit her mother from 1:00 PM to 5:00 PM daily. She stated she has not been made aware if visiting hours were different. She stated she has asked to visit after 5:00 PM and the facility said no. On 10/28/21 at 3:22 PM an interview was conducted with the Administrator. She stated visiting hours, both indoor and outdoor, were from 1:00 PM to 5:00 PM. She stated she thought if the facility was in a high positivity area, visiting hours could be limited. 2. Resident #5 was admitted to the facility on 1/16/20. The admission Minimum Data Set revealed Resident #5 was cognitively impaired.	F 563	F563 Right to Receive or Deny Visitors Resident #25 no longer resides in the facility. On 11/18/21, the Social Worker updated the resident representative for resident #5 on the visitation guidance to include visitation without restrictions. On 11/15/21, the Social Worker initiated questionnaires with all alert and oriented residents in regards to visitation to include: Are you able to receive visitors of your choosing at the time of your choosing? The Social Worker will address all concerns identified during the audit. Audit will be completed by 11/25/21. On 11/19/21, the Payroll Bookkeeper mailed a letter to all resident representatives to include resident #5 in regards to updated facility Visitation Guidelines without restrictions. This includes removing restrictions in regards to frequency or length of visits, number of visitors or required advanced scheduling of visits. Letters will be mailed by 11/25/21. On 11/15/21, the Administrator initiated an in-service with all screeners, social workers, nurses, business office manager, accounts receivable, activity staff, admission staff and supply clerk in	

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F 563	Continued From page 6 On 10/26/21 at 3:22 PM an interview was conducted with Residents #5's family member. She stated she could visit her Aunt from 1:00 PM to 5:00 PM daily. She stated it would be more convenient if some of the time, she could visit in the morning. On 10/28/21 at 3:22 PM an interview was conducted with the Administrator. She stated visiting hours, both indoor and outdoor, were from 1:00 PM to 5:00 PM. She stated she thought if the facility was in a high positivity area, visiting hours could be limited.	F 563	regards to Visitation Guidelines. Emphasis is on updated facility guidelines on visitation without restrictions to include removing restrictions in regards to frequency or length of visits, number of visitors or required advanced scheduling of visits. In-service will be completed by 11/25/21. All newly hired screeners, social workers, nurses, business office manager, accounts receivable, activity staff, admission staff and supply clerk will be in-serviced during orientation in regards to Visitation Guidelines. The Social Worker will interview 10 residents and/or resident visitors weekly x 4 weeks then monthly x 1 month utilizing the Visitation Audit Tool. This audit is to ensure residents are able to receive visitors at their choosing and at times of their choosing. The Social Worker and Director of Nursing will address all concerns identified during the audit. The Administrator will review and initial the Visitation Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Visitation Audit Tool to the Executive Quality Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Visitation Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 656		11/25/21

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F 656	Continued From page 8 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 develop a comprehensive individualized care plan for a resident receiving anticoagulant medication for 1 of 18 residents reviewed for care plans (Resident #33). The findings included: Resident #33 was admitted to the facility on 3/11/21 with a diagnosis of spinal cord injury and atrial fibrillation. Review of a physician order dated 6/12/21 indicated Resident #33 was receiving Eliquis 5 milligrams 2 times a day for atrial fibrillation. The quarterly Minimum Data Set (MDS) dated 9/13/21 revealed Resident #33 was cognitively intact and required assistance with all activities of daily living. The MDS indicated Resident #33 received an anticoagulant medication 7 of 7 days during the look back period. A review of the comprehensive care plan for Resident #33 last updated on 9/16/21 revealed no care plan had been developed for use of anticoagulation medication. On 10/27/21 at 8:33 AM and interview was conducted with the MDS nurse. She stated she would initiate a care plan for a resident receiving anticoagulation medication. She stated Resident #33 was on Eliquis and should have been care planned for the medication. She stated it was an	F 656	F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) On 10/27/21, the Minimum Data Set (MDS) nurse updated care plan for resident #33 for use of anticoagulant therapy. On 11/17/21, the Director of Nursing initiated an audit of all care plans for residents to include resident #33 receiving anticoagulant medication. This audit is to ensure that all residents to include resident #33 are care planned for use of anticoagulant medications. The assigned nurse and/or Minimum Data Set (MDS) nurse will address all concerns identified during the audit to include updating care plan as indicated. Audit to be completed by 11/25/21. On 11/19/21, the Staff Facilitator initiated an in-service with all nurses in regards Care Plan for Medications with emphasis on ensuring resident care plan is updated for use of medications to include but not limited to anticoagulants. The in-service also include the responsibility of the Minimum Data Set nurse (MDS) to ensure care plan reflects use of medications to include but not limited to anticoagulants when completing assessments. In-service to be completed by 11/25/21. All newly hired nurses and nursing assistants will	

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F 656	Continued From page 9 oversight and the care plan should have been initiated.	F 656	be in-serviced by the Staff Facilitator during orientation in regards to Care Plan for Medications. 10% of care plans for residents receiving anticoagulants to include resident #33 will be completed by the Minimum Data Set Nurse (MDS) weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure care plans reflect use of anticoagulant therapy. The MDS nurse and assigned hall nurse will address all areas of concern identified during the audit to include updating care plan as indicated. The Director of Nursing (DON) will review and initial the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and that all areas of concerns were addressed. The DON will forward the results of the Care Plan Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		11/25/21

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F 658	Continued From page 10 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to obtain a physician's order for 1 of 1 sampled resident reviewed receiving dialysis (Resident #66). And failed to obtain a physician's order for the use of an indwelling urinary catheter for 1 of 1 sampled resident reviewed for urinary catheter use (Resident #32). The findings included: Resident #66 was admitted to the facility on 12/23/20 and had diagnoses of end stage renal disease, gout related to renal impairment, congestive heart failure, anemia, arthropathy and stroke. The annual Minimum Data Set dated 10/01/21 revealed the resident as cognitively intact and able to make her needs known. The MDS noted the resident required supervision with activities of daily living and was coded for receiving dialysis three times a week. The residents care plan dated 5/31/21 noted she was at risk for complications due to end stage renal disease. Staff were to send to dialysis on tues, thurs, sat and to provide gloves for dialysis visits. Staff were to communicate with Dialysis Treatment Center as indicated for adjustments in resident's care or treatment plan, assess resident upon return from dialysis treatment and notify physician of any significant changes. There was a physician's order dated 12/23/20 to send to dialysis for treatment on tues, thurs. and sat. On 10/27/21 at 11:08 AM the traveling nurse	F 658	F658 Services Provided to Meet Professional Standards On 11/198/21, the Staff Facilitator contacted the physician and obtained an order for Dialysis for resident #66. On 11/18/21, the Foley catheter was discontinued for resident #32 per physician order. On 11/17/21, the Treatment Nurse initiated an audit of residents receiving dialysis to include resident #66 to ensure residents receiving dialysis have an order indicating place and days receiving dialysis. The assigned nurse will address all concerns identified during the audit to include obtaining an order for dialysis when indicated. Audit will be completed by 11/25/21. On 11/17/21, the Treatment Nurse initiated an audit of residents with catheters to include resident #32 to ensure residents with catheters have an order indicating size of catheter with supporting diagnosis for use and parameters for changing. The assigned nurse will address all concerns identified during the audit to include obtaining an order for use of Foley when indicated. Audit will be completed by 11/25/21. On 11/19/21, the Staff Facilitator initiated an in-service with all nurses in regards to	

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F 658	Continued From page 11 indicted it looked like Resident #11's dialysis order was discontinued when she was sent out to the emergency room on 7/03/21 and was never reactivated when she returned. On 10/28/21 at 9:35 AM the traveling nurse revealed the physician was not aware he needed to reorder Resident #3's order for dialysis on readmission. On 10/28/21 at 3:30 PM the Administrator revealed Resident #3 was a long-time dialysis patient and should have had an order for dialysis. 2. Resident #32 was re-admitted to the facility on 8/30/21 with a diagnosis of heart failure and end stage renal disease. The 5-day Minimum Data Set dated 9/5/21 revealed Resident #32 had severe cognitive impairment. He required assistance with all activities of daily living and had a urinary catheter. A review of the physician orders revealed there were no orders for urinary catheter care. On 10/27/21 at 1:45 PM an interview was conducted with the interim Director of Nursing (DON). She reviewed the physician orders and stated there were no orders for catheter care. A second interview was conducted with the interim DON on 10/27/21 at 3:50 PM and she stated she called the physician and orders were placed for catheter care. A telephone interview was conducted with the	F 658	Physician Orders. Emphasis is on ensuring a physician order is obtained for all treatments (including but not limited to dialysis and Foley catheters). In-service will be completed by 11/25/21. All newly hired nurses will be in-serviced during orientation in regards to Physician Orders. The Treatment nurse and/or Staff Facilitator will review 10% of orders for all residents receiving dialysis weekly x 4 weeks then monthly x 1 month utilizing the IDT Dialysis Tool. This audit is to ensure residents receiving dialysis have an order for dialysis to include place and days of the week to receive dialysis. The assigned nurse will address all concerns identified during the audit to include obtaining an order when indicated. The DON will review the IDT Dialysis Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Treatment nurse and/or Staff Facilitator will review 10% of orders for all residents with Foley catheters weekly x 4 weeks then monthly x 1 month utilizing the IDT Foley Catheter Tool. This audit is to ensure residents with Foley catheters have an order for use of Foley catheter to include size, supporting diagnosis and parameters for changing in place. The assigned nurse will address all concerns identified during the audit to include obtaining an order for Foley use when indicated. The DON will review the IDT Foley Catheter Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 12 physician on 10/28/21 at 2:45 PM. He stated he believed the facility had standing orders for catheter care. The Administrator was interviewed on 10/28/21 at 4:00 PM. She stated the facility did not have standing orders for catheter care and orders for catheter care should have been placed for Resident #32.	F 658	The DON will forward the results of the IDT Dialysis Audit Tool and the IDT Foley Catheter Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the IDT Dialysis Audit Tool and the IDT Foley Catheter Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a call light was functioning properly for 1 of 6 residents who was dependent on staff assistance for activities of daily living (Resident #11). The findings included: Resident #11 was admitted to the facility on 5/31/17 with diagnoses that included hemiplegia, vascular dementia, anxiety, schizophrenia, insomnia and hypertension.	F 919	F919 Resident Call System On 10/26/21, the Maintenance Director repaired call system for resident #11. On 10/26/2021, the Assistant Director of Nursing (ADON) initiated an audit of all resident call lights to include resident #11 to ensure all call lights are functional. Any identified resident without a properly functioning call light will receive a manual tap bell by the Assistant Director of	11/25/21

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F 919	Continued From page 13 The Minimum Data Set (MDS) dated 4/09/21 revealed Resident #11 was cognitively impaired. The MDS noted Resident #11 required extensive assistance with toilet use and total assistance with personal hygiene. An observation on 10/26/21 at 1:28 PM, Resident #11 was sitting up in bed with his call light beside him. Resident #11 was able to follow the instructions to activate his call light. The resident's call light did not activate the light panel on his wall, nor did it activate the light above his door in the hallway. In an interview on 10/26/21 at 10:03 AM nurse aide # Monica Williams stated Resident #11 was able to ring the call light but usually would yell out when he needed staff. On 10/26/21 at 1:45 PM the social worker stated if a resident's call light did not work, she would tell the maintenance man it needed repair. On 10/26/21 at 1:49 PM the Director of Nursing revealed if a call light was not working, they would get the maintenance man to look at the call light and repair as needed. An interview with the Maintenance Director on 10/27/21 at 9:21 AM, he indicated he was not aware Resident #11's call light did not function and when staff reported it, he replaced the call light cord immediately. He indicated if staff reported any call light was not working, he would repair/replace it immediately.	F 919	Nursing. The Maintenance Director will address all concerns identified during the audit. Audit will be completed by 11/25/21. On 11/15/2021, the Administrator initiated an in-service with all nurses, nursing assistants, therapy department, housekeeping department, and Department Managers (Social Worker, Activities, Bookkeeper, Payroll) regarding Call Lights. This in-service is to ensure that all call lights are functioning properly. If a call light is identified as not working properly, the staff must provide resident with a manual tap bell to ensure they can call for assistance. Staff will place a work order in TELS so maintenance can repair the nonfunctioning call light. The in-service will be completed by 11/25/21. All newly hired nurses, nursing assistants, therapy department, housekeeping department, and Department Managers (Social Worker, Activities, Bookkeeper, Payroll) will be in-serviced during orientation in regards to Call Lights. The Maintenance Director and/or Maintenance Assistant will audit 10% of all call bells to ensure the call bells are functional and to ensure work orders have been completed for any identified areas of concern weekly x 4 weeks then monthly x 1 month utilizing a Call Light Audit Tool. The nurses, nursing assistants, therapy department, housekeeping department, and Department Managers (Social Worker, Activities, Bookkeeper, Payroll) will be reeducated by the Staff Development Coordinator for any	

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F 919	Continued From page 14	F 919	identified areas of concern during the audit. The Administrator will review and initial the Call Light Audit Tool weekly x 4 weeks for completion and to ensure all areas of concern have been addressed. The DON will forward the results of the Call Light Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months to review the Call Light Audit Tool Catheter Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	