PRINTED: 11/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345049	B. WING _	B. WING		C 10/14/2018	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	14/2010
				6	16 WADE AVENUE		
RALEIGH	REHABILITATION CENT	ER		R	ALEIGH, NC 27605		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI: TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677 SS=D	ADL Care Provided for CFR(s): 483.24(a)(2)	or Dependent Residents	F	677			10/29/18
SS=D	§483.24(a)(2) A reside out activities of daily is services to maintain opersonal and oral hydrogen and	dent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced on, record review, and staff ailed to assure incontinent for two (Residents # 11 and residents. The findings on 3/15/17 with dementia, cular accident, and epilepsy. In the minimum data set (MDS) (19/18, revealed the resident ance with her toileting was assessed as being ent of bladder and always on the continent of the continen			1. Activities of Daily Living (ADL) care was provided and the bed linens were changed, for Resident #11 by Nurse Aid (NA) #1 during the survey when it was noted that care was needed. NA#1 is r longer employed at the facility so no further follow up could be completed fo this employee. Activities of Daily Living (ADL) care was provided and the bed linens were changed, for Resident #13 Nurse Aide (NA) #2 during the survey when it was noted that care was needed All residents assigned to NA#1 were checked by the administrative nursing team to see if they were in need of ADL assistance and assistance was provide as necessary. The shift supervisor on duty 10/12/18 was in-serviced by the Director of Nursing (DON) on 10/15/18 regarding notifying the DON when there last minute staffing change for further instruction. 2. Any resident requiring assistance with ADLs assigned to NA#1 had the potent to be affected. The Nursing Staff was	no r g by d. d	
	set) assessment coor AM revealed the facil significant change as	dinator on 10/14/18 at 11			in-serviced by the Nursing Administration Team through 10/29/18 regarding the standards for providing timely incontinence care, the expectation of	on	
ADOD/====		fused, totally incontinent, and			notifying a supervisor if a staff member		(VO) DATE
ABURATURY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	:		TITLE		(X6) DATE

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

10/25/2018

Electronically Signed 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345049	B. WING		C 10/14/2018	
	ROVIDER OR SUPPLIER REHABILITATION CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605	1 13:11:120:10	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 677	Continued From pag	e 1	F 677	,		
		sistance with her activities of her return from the hospital		feels they are unable to meet the sta of timely incontinence care, and the responsibility of the supervisors che- to ensure timely care is being provid	cking led	
	AM as Nurse Aide (N	oserved on 10/13/18 at 7:30 IA) # 1 checked the resident		and providing assistance as necessary		
	for incontinence needs. There was a strong odor of urine as the NA prepared to care for the resident. NA # 1 explained she was a night shift			3. The shift supervisor will notify the when there is a last minute staffing change for further instruction. The s		
	NA who was trying to complete her last night rounds after her shift ended. NA # 1 stated she had been assigned 27 residents during her night			supervisor and/or licensed nurse will check with the Certified Nursing Assistants (CNA) throughout the shi		
	shift, and she had last given Resident # 11 incontinence care at 1 AM. According to the NA			ensure the residents are being provi care as needed and provide assistan	ded	
	during her 6 AM rour	le to check on the resident ad because she had too		necessary. Audits will be conducted every shift daily for the next 4 weeks ensure all staff noted on the assignment.	s to	
	# 11, it was observed disposable brief, inco	t 1 provided care to Resident I that the resident's ontinent pad, draw sheet, and eavily soiled with urine. The		sheets are present, and ADL care is provided to the residents.		
	NA removed all of the linens from the bed, and urine was observed to have gone through the 4. The Director of Nursing or design will audit 5 residents per day for 4 village.		4. The Director of Nursing or design will audit 5 residents per day for 4 w then 5 residents per month for 2 month	eeks		
dry the urine from the		e mattress with a towel. NA# A # 1 with a complete linen		to ensure incontinence care is provide timely. The findings of those audits	ded	
		oved the linens, it was eet was also soiled with urine.		reported to the monthly Quality Assu Performance Improvement (QAPI) committee and the quality monitoring		
	7:30 AM care revealed	immediately following the ed she had to assist another t 6 AM on 10/13/18 for an		schedule will be assessed and modi based on findings. The QAPI comm will review the results of the audits		
	early morning appoir	tment, and this had made it her last 6 AM rounds to		monthly for three months and as need thereafter. The administrator will be responsible for implementing the plate correction.		
	10/14/18 at 10:40 AN	ator was interviewed on I and reported the following. ninistrator, prior to 10/12/18,				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED		
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NI CENTED		616 WADE AVENUE			
ON CENTER		RALEIGH, NC 27605			
MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ON SHOULD BE COMPLETE HE APPROPRIATE DATE		
eted an acuity assessment on all of who resided on Resident # 11's ing to the acuity assessment, ads could be met with either two or the 11:00 PM to 7:00 AM shift. The considered three NAs to be optimal ugh two were sufficient according to ent. The administrator reported an a scheduled NA, who had not ork for the night shift which began at 10/12/18. The administrator stated in was supposed to have alerted a staff, but did not do so on according to the administrator, the with two NAs on Resident # 11's an three as planned. The also stated NA # 1's assignment 27 residents on the night shift which if the night shift which began at 12/18. The administrator is assignment showing that she ents for the night shift which began at 12/18. The assignment showing that she ents for the night shift which began at 11:00 and 18. The room numbers for the 22 and 11:00 and 11	F 67				
	IDENTIFICATION NUMBER: 345049 ALIER MARRY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION) The active assessment on all of who resided on Resident # 11's and to the acuity assessment, and the active active and the active active active and the active	IDENTIFICATION NUMBER: 345049 B. WING WINCENTER IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION IDENTIFY INFORMA	LIER 345049 B. WING STREET ADDRESS, CITY, STATE, ZIP C 616 WADE AVENUE RALEIGH, NC 27605 MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION) DOM page 2 eted an acuity assessment on all of who resided on Resident # 11's ng to the acuity assessment, eds could be met with either two or the 11:00 PM to 7:00 AM shift. The considered three NAs to be optimal ugh two were sufficient according to nt. The administrator reported en a scheduled NA, who had not bork for the night shift which began at 10/12/18. The administrator, the with two NAs on Resident # 11's an three as planned. The also stated NA # 1's assignment 27 residents on the night shift which 0 PM on 10/12/18. He was unsure lought she had 27 residents, and not been able to check on the AM rounds. The administrator # 12/18. at 12:55 PM, a follow up interview d with NA # 1 via phone. This haded it had been her understanding been assigned more than the 22 he night shift which began at 11:00 18. The room numbers for the 22 pment, which had been provided by stor, was reviewed with NA # 1. the assigned rooms, the NA had an additional room than noted ment provided by the administrator. the NA that would have been an	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 10/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 16 WADE AVENUE RALLEIGH, N. C. 27665 MARY STATEMENT OF DEPICIENCIES PARADE CORRECTION PREFIX TAG COMPLET CORP. COMPLET COMPLET CORP. COMPLET CORP. COMPLET CORP. COMPLET CORP. COMPLET COMPLET COMPLET CORP. COMPLET COM	

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		345049	B. WING _			C 10/14/2018
NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP 616 WADE AVENUE RALEIGH, NC 27605	CODE	10/14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	
F 677	Continued From page	e 3	F 6	677		
		ealed Resident # 13 was				
	admitted to the facility had a diagnosis of Le	y on 4/22/15. The resident wy Body Dementia.				
	(MDS) assessment, or resident was cognitive extensive assistance total assistance with	at's Minimum Data Set dated 8/23/18, revealed the ely impaired, needed with his hygiene needs, and his bathing needs. The ed to be incontinent of both				
	revealed staff were di	nt's care plan, dated 8/24/18, irected to check the resident is and provide incontinence				
	AM as Nurse Aide (N resident incontinence was a day shift NA, a check was the first sh 13 on her 10/13/18 sl of urine prior to the st the resident was observed incontine draw sheet. The resident was observed to have	served on 10/13/18 at 8:10 A) # 2 prepared to give the care. NA # 2 reported she and the 8:10 AM incontinent the had done for Resident # nift. There was a strong odor cart of care. During the care, the erved to have a urine soiled crine soiled disposable brief, and urine soiled dent was also observed to eveen his buttock folds. NA the to wipe several times in stool, and verified the stool				
	care for Resident # 1	ho had been assigned to 3 on the previous night shift /er Resident # 13's care at 7				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER		B. WIIRE	STREET ADDRESS, CITY, STATE, ZIP 616 WADE AVENUE RALEIGH, NC 27605	CODE	10/14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE
F 677	10/13/18 at 7:29 AM was conducted with PM via phone. NA # had looked in on Res 10/13/18 during her it time to check and proper last 6 AM round. Thought she had 27 ron the shift which we 10/12/18 to 7:00 AM The facility administr 10/14/18 at 10:40 AM According to the administrator who residents' needs couthree NAs on the 11: administrator stated be optimal staffing, at The administrator fur a scheduled NA, who the night shift which 10/12/18. The administrator, the staff, but did not do administrator, the staff, but did not do sadministrator, the staff shift which beg He was unsure why residents, and why scheck on the resident administrator present	a # 1 was interviewed on and a follow up interview NA # 1 on 10/14/18 at 12:55 1 reported the following. She sident # 13 at 6 AM on night shift, but had not had ovide incontinent care during According to the NA, she esidents for whom she cared ent from 11:00 PM on on 10/13/18. ator was interviewed on M and reported the following. Initiatrator, prior to 10/12/18, in acuity assessment on all of sided on Resident # 13's in acuity assessment, acuity assessment, and be met with either two or 100 PM to 7:00 AM shift. The interported there had been on had not reported to work for obegan at 11:00 PM on istrator stated the supervisor and a late of the interported to work for obegan at 11:00 PM on istrator stated the supervisor are alerted administrative in the According to the laft worked with two NAs on a rather than three as strator also stated NA # 1's obeen 27 residents on the lan at 11:00 PM on 10/12/18. NA # 1 thought she had 27 the had not been able to the tat 6 AM rounds. The sted NA # 1's assignment to 122 residents for the night	F	577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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		345049	B. WING _		10	/14/2018	
NAME OF PROVIDER OR SUPPLIER RALEIGH REHABILITATION CENTER		ER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 677	Continued From page During the follow up i 12:55 PM with NA # 1 22 resident assignme by the administrator, Upon hearing the ass reported she had an a on the assignment pr According to the NA t additional two resider there had been 27 res Bowel/Bladder Incont CFR(s): 483.25(e)(1) §483.25(e) Incontiner §483.25(e)(1) The face resident who is continued admission receives some interes and incontinence of condition is or become not possible to maintal §483.25(e)(2)For a resident who entinominence, based of comprehensive assessed ensure that- (i) A resident who entinomined indivelling catheter is resident's clinical con catheterization was in (ii) A resident who entinomined indivelling catheter or is assessed for remove	Interview on 10/14/18 at 11, the room numbers for the ent, which had been provided was reviewed with NA #1. signed rooms, the NA additional room than noted ovided by the administrator. That would have been an ents, and she still thought sidents on her assignment. Sinence, Catheter, UTI (3) Ince. Cility must ensure that the ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. Esident with urinary on the resident's essment, the facility must ers the facility without an not catheterized unless the dition demonstrates that		CROSS-REFERENCED TO THE APPI DEFICIENCY) 77		10/29/18	
	and (iii) A resident who is	theterization is necessary; incontinent of bladder treatment and services to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345049	B. WING		C 10/14/2018
	ROVIDER OR SUPPLIER REHABILITATION CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 616 WADE AVENUE RALEIGH, NC 27605	10/14/2010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 690	S483.25(e)(3) For a rincontinence, based of comprehensive assessmented that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation interview the facility for prevent urinary tract if # 11) of three sample urinary tract infection. The findings included Record review reveal admitted to the facility diabetes, cerebrovas. Review of Resident # set (MDS) assessmenthe resident needed I toileting needs. The ribeing occasionally including always continent of bring Review of the resident resident resident resident resident of the resident of	esident with fecal on the resident's assment, the facility must to who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced in, record review, and staff ailed to provide services to infections for one (Resident dominated residents reviewed for second recident with the second recident with the second recident was assessed as continent of bladder and owel.	F 690	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. Resident #11 is currently without sign or symptoms of a urinary tract infection status post treatment. Activities of Daliving (ADL) care was provided and the bed linens were changed, for Resider #11 by Nurse Aide (NA) #1 during the survey when it was noted that care was needed. NA#1 is no longer employed the facility so no further follow up could	n uily ne ut as
	transferred to the hos	ed Resident # 11 was spital on 8/30/18, secondary troke, and returned to the		completed for this employee. All residents assigned to NA#1 were che by the administrative nursing team to if they were in need of ADL assistance and assistance was provided as	see e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345049	B. WING			C 10/14/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/ 14/2016	
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F 690	Continued From pag	e 7	F 69	90			
	Interview with the fact set) assessment coor AM revealed the fact significant change as According to the MD the resident was conneeded total staff as	cility MDS (minimum data ordinator on 10/14/18 at 11:00 dility was working on a seessment for Resident # 11. S assessment coordinator, of the seed of		10/12/18 was in-serviced by of Nursing (DON) on 10/15/notifying the DON when the minute staffing change for f instruction. 2. Any resident requiring as ADLs assigned to NA#1 har	18 regarding ere is a last further esistance with		
	According to Resider on 9/12/18 revealed bacteria in her urine. pending at that time. receiving antibiotics 9/13/18. A review of result, dated 9/17/18 urine had grown greathe bacteria Klebsiel	for a urinary tract infection on the final urine lab culture is, revealed the resident's ater than 100,000 colonies of la Pneumoniae. A repeat eted on 9/21/18, revealed the in 50,000 colonies of the resident was again		to be affected. The Nursing in-serviced by the Nursing A Team through 10/29/18 reg standards for providing time incontinence care, the important incontinence care, the important incontinence care in of urinary tract infections, the of notifying a supervisor if a feels they are unable to me of timely incontinence care, responsibility of the supervito ensure timely care is being and providing assistance as	g Staff was Administration arding the ely ortance of the prevention a staff member et the standard and the sors checking ng provided s necessary.		
	AM as Nurse Aide (Nor for incontinence need of urine as the NA progressident. As NA#1 progressident. As NA#1 progressident. As noted to brief, incontinent packages were heavily someoved all of the line was observed to have onto the mattress. Nor the urine from the mattered to assist NA change. As they removed needs to assist NA change. As they removed needs to assist NA change.	bserved on 10/13/18 at 7:30 NA) # 1 checked the resident ds. There was a strong odor repared to care for the crovided care to Resident # that the resident's disposable d, draw sheet, and bottom coiled with urine. The NA mens from the bed, and urine re gone through the sheets A # 1 was observed to dry attress with a towel. NA # 2 # 1 with a complete linen moved the linens, it was eet was also soiled with urine.		when there is a last minute change for further instruction supervisor and/or licensed in check with the Certified Nur. Assistants (CNA) throughout ensure the residents are becare as needed and provide necessary. Audits will be devery shift daily for the next ensure all staff noted on the sheets are present, and AD provided to the residents. 4. The Director of Nursing will audit 5 residents per daily	staffing on. The shift nurse will rsing ut the shift to eing provided e assistance as conducted t 4 weeks to e assignment of care is being or designee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345049	B. WING _			10/14/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DΕ		
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F 690	started the care on 1 again directly following the following. She we trying to complete he shift ended. NA # 1 s Resident # 11 inconti # 1 reported she had care, and she had no 6 AM round complete. Interview with the fact 10/14/18 at 10:30 AM expectation that the I make her last 6 AM r incontinent residents preventative measure tract infections for residents.	red directly before she 0/13/18 at 7:30 AM and and the care. NA # 1 reported as a night shift NA who was ar last night rounds after her tated she had last given tinence care at 1:00 AM. NA 27 residents for whom to be been able to make her last ely.	F6	then 5 residents per month for to ensure incontinence care in timely. The findings of those reported to the monthly QAPI and the quality monitoring so assessed and modified based. The QAPI committee will review results of the audits monthly months and as needed there administrator will be responsified implementing the plan of corresponding to the plan of corresp	s provided audits will I committed hedule will d on finding ew the for three after. The ible for	be e be	