STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to attempt a gradual dose reduction (GDR) of an antidepressant medication since admission for (resident #51) 1 of 5 residents reviewed for unnecessary medications. Findings included: Resident #51 was admitted on 9/3/13 with a diagnosis of depression. The annual Minimum	F 329	Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents.	10/30/14

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

Electronically Signed | 10/16/2014

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F 329	Continued From page 1 Data Set (MDS) dated 8/13/14 indicated resident #51 was cognitively intact and required extensive assistance with his activities of daily living except for supervision only for eating. His mood was coded as occasionally feeling down and insomnia with no observed behaviors. A review of resident #51's mood history as coded on the MDS indicated the following: 9/10/13- admission MDS-no reported feeling down or insomnia 9/29/14- 30 day MDS-no reported feeling down or insomnia 11/23/13- quarterly MDS- reported feeling down never to 1 day 2/12/14- quarterly MDS reported feeling down and insomnia never to 1 day 5/5/14- quarterly MDS reported feeling down and insomnia never to 1 day 6/26/14- quarterly MDS reported feeling down and insomnia never to 1 day A review of resident #51's care plan included the following interventions related to his use of an antidepressant medication: -Monitor his mood and encourage him to discuss his feelings -Monthly pharmacy consult -Monitor for adverse side effects to include falls, drowsiness or increased confusion. A review of resident #51's care plan included the follow interventions related to his use of a hypnotic: -Create a sleep environment conducive to rest, darken room and minimize noise -Monitor for effects and side effects of the medication	F 329	The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Scottish Pines Rehabilitation and Nursing. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. F 329 1) On 10/8/14, resident #51 was evaluated by Psychiatric Mental Health Nurse Practitioner (PMHNP). PMHNP initiated new orders for the following: reduce Restoril to 7.5mg by mouth every night as needed for insomnia, reduce Lexapro to 15mg by mouth daily, add Trazodone 25mg by mouth every night. 2) On 10/14/14, facility Executive Director and facility Director of Operations phoned Psychiatric Mental Health Nurse Practitioner (PMHNP) to review psychiatric progress notes of 10/8/14. In conversation, PMHNP reports that the Restoril was continued, although the dosage was reduced and it remained as an as needed medication. PMHNP indicated that it would be contraindicated to discontinue the Restoril without tapering it down due to the fact the resident had received several times. PMHNP also indicated that the Trazadone would take approximately seven to ten days before it would likely be effective. Once this period has passed and the as needed Restoril is not being used, the Restoril can be discontinued.	

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F 329	Continued From page 2 A review of resident #51's medication administration record (MAR) since admission revealed that resident #51 had taking Lexapro (antidepressant) 20 milligrams (mg) by mouth everyday since admission. A review of the chart revealed a physician order dated 8/7/14 for Restoril (hypnotic) 15 mg by mouth every evening as needed for insomnia. A review of the MAR for August 2014 revealed resident #51 received Restoril on 9 occasions, in September he received Restoril on 19 occasions and as of October 2nd, he received Restoril once. A review of the facility policy regarding the tapering of medications and gradual drug reductions was dated as revised April 2007 read in part the following: Within the first year after a resident is admitted on a psychotropic medication other than and antipsychotic or an sedative/hypnotic, the facility will attempt to taper the medication during at least two separate quarters with a least one month between attempts unless clinically contraindicated. Annually thereafter the first years unless contraindicated. A review of the pharmacy consult sheet revealed no recommended GDR attempt until 9/9/14. There was no mention of the addition of the Restoril noted since it was added to resident #51 on 8/7/14. The rationale documented for the recommended GDR attempt of the Lexapro read Centers of Medicare & Medicaid Services (CMS) requirement. In an interview with resident #51 on 9/29/14 at 3:20 PM he stated no concerns except he was having trouble resting at night. He indicated the problem was more related to his roommate's	F 329	3) Nursing administrative staff will monitor the as needed Restoril five times per week to determine if the medication is being used. Facility Director of Nursing Services, or appropriate designee, will notify psychiatric services of frequency of usage weekly being on 10/15/14. If Restoril has not been used after 10/20/14, then an order will be requested to discontinue the as needed Restoril. 4) Facility pharmacy will continue to monitor resident #51 use of antidepressants for opportunity to initiate the next gradual dose reduction if indicated. 5) Facility Psychiatric Mental Health Nurse Practitioner (PMHNP) will continue to monitor resident #51 use of antidepressants for the opportunity to initiate gradual dose reduction if indicated. 6) On 10/15/14, facility Medical Director was notified by facility Administrator of facility Psychiatric Mental Health Nurse Practitioner (PMHNP) recommendations for gradual dose reduction. Resident #51 will be seen and evaluated by facility Medical Director on or before 10/24/14. 7) On 10/14/14, facility Administrator met with resident (#51) responsible party and informed of recommendation for attempt in gradual dose reduction of medication. Responsible party also made aware that facility licensed nursing staff will monitor for any changes in mood or behavior and will notify Psychiatric Mental Health Nurse Practitioner (PMHNP) and facility Medical Director as needed. 8) Upon facility Medical Director request, facility Director of Medical Records or	

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F 329	Continued From page 3 preference to keep the door open at night. His mood and affect appeared appropriate. He was alert and engaged. He reported no sadness or feeling down. In an interview on 10/2/14 at 930 AM the director of nursing (DON) stated the medical director deferred any GDR's related to a resident receiving psychiatric services to them to address pharmacy recommendations. The DON reviewed the medical record and verified there had been no attempt to reduce the Lexapro since his admission on 9/3/13. She stated the recommendation for a GDR completed by the pharmacist on 9/9/14 was placed in the folder for psychiatric services to address. In a telephone interview on 10/2/14 at 10:46 AM, the pharmacist stated he allowed psychiatric services determine if a resident would decompensate if GDR was attempted. The pharmacist verified he was aware of the CMS regulation of 2 attempts at a GDR in the first year of admission unless there was documented evidence of a previous attempt that resulted in a decompensation in the resident's status. He stated another pharmacist did the review of resident #51's MAR in August and he was unaware that resident #51 was taking the Restoril regularly to sleep since 8/7/14. A review of the progress notes from each visit made by psychiatric mental health nurse practitioner (PMHNP) indicated the following: 2/18/14- Initial evaluation for depression-resident did not appear sad or anxious but stated difficulty with sleep but stated it was due to his roommate talking in his sleep. There was no noted behaviors, no problems with appetite, and	F 329	designee will ensure that all monthly pharmacy recommendations for possible gradual dose reductions on antidepressant medications will be forwarded directly to facility Psychiatric Mental Health Nurse Practitioner (PMHNP) for review. This is to ensure timely completion of any new recommendations for medication reductions. 9) On 10/8/14, facility Administrator met with facility Psychiatric Mental Health Nurse Practitioner (PMHNP) and provided re-education on regulation of facility policy that within the first year of admission, facility will attempt taper of medication at least two separate quarters with at least one month between attempts unless clinically contraindicated. 10) Pharmacy recommendations written by facility pharmacist on 9/9/14, were reviewed by Psychiatric Mental Health Nurse Practitioner (PMHNP) on 10/8/14 (including resident #51) and completion of all recommendations and assessment of these residents for possible reductions will be completed on or before 10/30/14. 11) On 10/14/14, facility Director of Operations, requested most recent copy of facility residents currently receiving antidepressants from facility pharmacy. 12) On 10/14/14, facility Director of Operations and facility Administrator met with facility pharmacy to discuss plan to review all residents currently on antidepressants and facility policy to recommend attempts to be made for possible dose reductions. Facility Director of Operations and facility Administrator	

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F 329	Continued From page 4 psychosis, no mania, no social or homicidal ideations. He appeared stable and well adjusted to the facility. His medications were reviewed and she noted the Lexapro at 20 mg daily by mouth. Her recommendation stated resident #51 was stable and his current dose but more time was needed to see beneficial effects. A dose reduction will cause decompensation of resident #51. The PMHNP did a follow up visit on 4/9/14 with resident #51. The note indicated the following: He denies feelings of sadness or anxiety. He stated difficulty at times with sleep interruptions but he could normally return to sleep. No problems with appetite, no indications of psychosis, no suicidal or homicidal ideations, no mania were noted. He was currently taking Lexapro 20 mg by mouth daily and his mood appeared stable and he had adjusted well to the facility. No side effects noted on current regimen. Her recommendation stated resident #51 was stable at his current dose and more time was needed to see beneficial effects. A dose reduction will cause decompensation of resident #51. The PMHNP did a follow up visit on 5/14/14 with resident #51. The note indicated the following: He denies feelings of sadness or anxiety. He denied difficulty sleeping and no problems with his appetite. No psychosis, no mania and no social or homicidal ideations. Currently taking Lexapro 20 mg by mouth daily and his mood appeared stable and well adjusted to the facility. There were no side effects noted on the current regimen. Her recommendation stated resident #51 was stable at his current dose and more time was needed to see beneficial effects. A dose reduction will cause decompensation of resident #51.	F 329	reviewed list of current residents receiving antidepressants with facility pharmacist and reviewed audit form to be used to evaluate status of gradual dose reduction for all residents listed. 13) On 10/14/14, all residents on antidepressants were reviewed by facility pharmacist for status of gradual dose reductions. During audit, facility pharmacist noted if gradual dose reduction had been recommended, attempted, declined or indication of date due (if not due at this time). This audit was documented on Pharmacy Review Objective, GDR Attempted on R with antidepressants form by facility pharmacist. 14) Upon facility Medical Director request, facility Director of Medical Records or designee will ensure that all monthly pharmacy recommendations for possible gradual dose reductions on antidepressant medications will be forwarded directly to facility Psychiatric Mental Health Nurse Practitioner (PMHNP) for review. This is to ensure timely completion of any new recommendations for medication reductions. 15) On 10/8/14, facility Administrator met with facility Psychiatric Mental Health Nurse Practitioner (PMHNP) and provided re-education on regulation of facility policy that within the first year of admission, facility will attempt taper of medication at least two separate quarters with at least one month between attempts unless clinically contraindicated. 16) Pharmacy recommendations written	

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F 329	Continued From page 5 The PMHNP did a follow up visit on 6/18/14 with resident #51. The note indicated the following: He was noted to be pleasant and confused today. He was being treated for an infection at this time. He denied sadness or anxiety. No indication of difficultly with sleep, no problems with appetite and overall, he was cooperative with treatment. No indicated of psychosis, no suicidal or homicidal ideations and no mania. He was currently taking Lexapro 20 mg by mouth daily. At this time, his mood appeared stable and no side effects were noted with current regimen. Her recommendation stated resident #51 was stable at his current dose and more time was needed to see beneficial effects. A dose reduction will cause decompensation of resident #51. The PMHNP did a follow up visit with resident #51 on 8/27/14. The note indicated the following: He was pleasantly confused today. He denied sadness and anxiety today. Denied difficulty with sleep since Restoril added to his regimen. No problems with appetite and overall was cooperative with treatment. No indication of psychosis, mania and no suicidal or homicidal ideations. Currently taking Lexapro 20 mg by mouth daily and no side effects were noted with current regimen. Her recommendation stated resident #51 was stable at his current dose and more time was needed to see beneficial effects. A dose reduction will cause decompensation of resident #51. In a telephone interview on 10/2/14 at 11:50 AM, the PMHNP stated she did not feel a dose reduction was indicated because he was having some issues and trouble sleeping. The PMHNP verified she did not know and had not treated resident #51 prior to her initial evaluation on	F 329	by facility pharmacist on 9/9/14, were reviewed by Psychiatric Mental Health Nurse Practitioner (PMHNP) on 10/8/14 (including resident #51) and completion of all recommendations and assessment of these residents for possible reductions will be completed on or before 10/30/14. 17) On 10/14/14, facility Director of Operations, requested most recent copy of facility residents currently receiving antidepressants from facility pharmacy for review. 18) On 10/14/14, facility Director of Operations and facility Administrator met with facility pharmacy to discuss plan to review all residents currently on antidepressants and facility policy to recommend attempts to be made for possible dose reductions. Facility Director of Operations and facility Administrator reviewed list of current residents receiving antidepressants with facility pharmacist and reviewed audit form to be used to evaluate status of gradual dose reduction for all residents listed. 19) On 10/14/14, all residents on antidepressants were reviewed by facility pharmacist for status of gradual dose reductions. During audit, facility pharmacist noted if gradual dose reduction had been recommended, attempted, declined or indication of date due (if not due at this time). This audit was documented on Pharmacy Review Objective, GDR Attempted on R with antidepressants form by facility pharmacist. 20) Results of plan and audits will be discussed during morning administrative	

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F 329	Continued From page 6 2/18/14. The PMHNP stated she could not verify a GDR had resulted in a decompensation in resident #51's condition because there had been no attempt tried to her knowledge. In a telephone interview on 10/2/14 at 12:10 PM, the physician stated he did defer to psychiatric services for GDR's on resident receiving psychiatric services. He stated he assumed the PMHNP was consulting with her supervisor about the pharmacy recommendations. The physician stated he would have expected an attempted dose reduction of the Lexapro twice in the first year of resident #51's admission to determine lowest practicable dose.	F 329	meeting weekly x 4 weeks with adjustments to plan made as needed followed by: 21) Results of audits and compliance with plan will be discussed and minutes recorded x 4 months during the facility□s monthly QA meeting, with adjustments to plan made as needed, followed by: 22) Results of audits and compliance with plan will be discussed and minutes recorded quarterly x 3 quarters during the facility□s quarterly QA committee meeting, with adjustments to plan made as needed followed by: 23) Should revisions be necessary, appropriate staff will be re-in-serviced by DON or appropriate designee. 24) Any revisions to plan will require monitoring steps to begin again at step 20.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		10/30/14

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F 431	Continued From page 7 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to destroy expired medication on 3 of 5 medication carts and to properly store insulin pens on 2 of 5 medication carts. Findings included: 1 On 10/2/14 at 11:40 am an inspection of the medication cart used for the 300 hall was completed. A Novolog insulin pen was being stored open in a drawer on the medication cart. The pen had no date on it indicating when it was opened; this pen had a pharmacy label on it stating it had been filled on 8/14/14. There was another novolog insulin pen being stored in a drawer on the medication cart with the pharmacy label stating it was filled on 8/20/14. The	F 431	Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Scottish Pines Rehabilitation and Nursing. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	

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F 431	Continued From page 8 manufactures guidelines indicate if the novolog pens expire in 28 days when stored at room temperature. Nurse #1 was present during the inspection of the medication cart. Nurse #1 stated "I just went through the cart about a week ago and it was all ok. Who ever administrates the medication is responsible to ensure the medication has not expired. 2. On 10/2/14 at 12:40 pm an inspection of the medication cart used on the 500 hall was completed. One bottle containing metoprolol 25mg/ml liquid had a pharmacy label on it that read do not use after 8/8/14. Nurse #2 stated "most of the time I check for expiration dates. I do not always look at the date before I give the medication." 3. On 10/2/2014 at 12:15 pm an inspection of the medication cart used on the 400 hall was completed. One bottle of a facility stock medication of Oyster Shell Calcium with an expiration date of 5/14. The medication aide #1 who was present during the inspection removed the medication and stated she would destroy it. The medication aide #1 also stated that all the nurses are responsible for checking dates and labeling medication. On 10/02/2014 at 12:45:24 pm an interview with the director of nursing (DON) stated all the staff assigned to a medication cart are responsible for checking the expiration dates on the medication prior to administering them to a resident. Further discussion revealed that when ever staff pull a medication out of the refrigerator and place them in the medication cart they are suppose to date	F 431	F431 1) All expired or undated medications identified during the time of survey were discarded by appropriate means. 2) All medication carts will be checked by the RN unit coordinators on/before 10/17/14 for any additional expired medications. Should any medications be found to be past usage date or not dated as to date opened, the medication will be discarded immediately by appropriate means. 3) All licensed nursing staff and medication aides will be re-in serviced by the RN Unit Coordinator on/before 10/17/14 with regards to checking applicable medications for expiration date and/or dating of medication once opened and awareness of Medications with Special Expiration Date or Dating Requirements provided by facility contracted pharmacy. 4) Laminated postings of Medications with Special Expiration Date or Dating Requirements will be located in all medication rooms on/before 10/17/14. 5) Nursing staff once per day assigned the duty of checking medication carts for any expired medications or opened medications not dated, beginning on/before 10/17/14. Any expired or medication requiring to be dated and not found to be dated will be discarded immediately by appropriate means. 6) Documentation of such checks will be completed daily x 4 weeks by the applicable nurse/medication aide on the	

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F 431	Continued From page 9 them. "I did an in-service on 9/24/14 for all the nurses about putting the dates on medication when they open them for use." The pharmacy goes through the medication rooms and the medication carts. The last time the pharmacist went through the carts and med room was on 9/15/14. A reviewed the report from the pharmacist dated 9/15/14 revealed that on the medication cart for the 100/200 hall expired medication was removed from the cart. On the 400 hall medication cart four insulin pens were identified as having no date on them. Also one expired medication was removed from the medication cart. 1. On 10/2/14 at 11:40 am an inspection of the medication cart used on the 300 hall was completed. Two levemir insulin pens were stored in a plastic bag in a drawer on the medication cart. Neither of the pens had a date as to when they were opened. The manufacturer states the pens expire in 42 days without refrigeration. Nurse #1 was present during the inspection of the medication cart. Nurse #1 stated "I just went through the cart about a week ago and it was all ok. Who ever administrates the medication is responsible to ensure the medication has not expired." Further discussion revealed that their is no facility system in place for any staff to check the carts. Nurse #1 stated "the pens should have had a open date and the initials of the nurse who opened the pen". 2. On 10/2/14 at 12:40 am an inspection of the medication cart used on the 500 hall was completed. 1 novolog flex pen was stored in a	F 431	Daily Medication Cart Check 7) The two RN Unit Coordinators will be responsible for checking Stock Medication located in the medication rooms 2x per month for any expired medications and discard any expired medications by appropriate means. 8) The two RN Unit Coordinators will do random monitoring of medication carts 2 times per week x 2 weeks, weekly x 2 weeks, monthly x 2 months, quarterly 3 quarters and as needed. 9) Director of Nursing Services or appropriate designee will complete random checks on stock medications in medication rooms monthly X 3 months, then quarterly x 3 quarters and as needed. 10) Outcomes of compliance with the daily medication cart checks and stock medication audits will be reviewed at morning administration meeting weekly x 4 weeks, and as needed. Any discrepancies/corrections will be addressed immediately by the Director of Nursing Services, or appropriate designee. 11) Following this, the Director of Nursing Services, or appropriate designee, will bring results of compliance with plan to the facility monthly QA meeting x 2months for review by all committee members. Discussion of compliance/non-compliance will be entered into the committee meeting minutes. 12) This will be followed by results of compliance with plan being brought to the facility quarterly QA meeting by the Director of Nursing Services, or	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 10 drawer, there was no pharmacy label on it. Hand written on manufactures label was a residents name. No date indicating when the pen was placed on the medication cart for use was written on it. Nurse #2 was present during the inspection of the medication cart stated "most of the time I check for expiration dates. I do not always look at the date before I give the medication. I used the pen yesterday it came out of the emergency backup supply from the pharmacy." Nurse #2 looked at pen and confirmed their was no open date on the pen. Nurse #2 stated "normally I put a date on them when I pull them out. I missed this one." On 10/02/2014 at 12:45:24 pm an interview with the director of nursing (DON) stated all the staff assigned to a medication cart are responsible for checking the expiration dates on the medication prior to administering them to a resident. Further discussion revealed that whenever staff pull a medication out of the refrigerator and place them in the medication cart they are suppose to date them. "I did an in-service on 9/24/14 for all the nurses about putting the dates on medication when they open them for use." The pharmacy goes through the medication rooms and the medication carts. The last time the pharmacist went through the carts and med room was on 9/15/14. A reviewed the report from the pharmacist dated 9/15/14 revealed that on the medication cart for the 100/200 hall expired medication was removed from the cart. On the 400 hall medication cart four insulin pens were identified as having no date on them. Also one expired medication was removed from the medication cart.	F 431	appropriate designee, quarterly X 3 quarters. Discussion of compliance/non-compliance will be entered into the committee meeting minutes. 13) Any non-compliance with the medication cart checks or stock medication checks will require QA committee members to review plan and develop modifications as needed. 14) Any modification to the plan will require re-in servicing of applicable nursing personnel by the Director of Nursing Services, or appropriate designee. 15) Any modifications to the plan will require monitoring of such revisions and subsequent outcomes to begin again with Step 9.	

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