

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/28/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>VILLAGE CARE OF KING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 INGRAM ROAD</b> <b>KING, NC 27021</b>	
(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 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 1 (Resident #54) sampled for tube feedings. Findings included:</p> <p>Resident #54 was admitted to the facility on 2/12/18 with diagnosis, in part, of Dysphagia and Use of Gastrostomy tube.</p> <p>On 2/26/18 at 12:35 AM, during the initial pool selection, an observation was made of Resident # lying in bed with Isosource 1.5 at 50 milliliters per hour infusing into a gastrostomy tube.</p> <p>On 2/26/18 at 3:08 PM at record review revealed a physician's order for Isosource 1.5 at 50 milliliters per hour continuous tube feedings.</p> <p>On 2/26/18 at 3:10 PM a record review revealed a significant change MDS dated 2/19/18 that reflected the resident required extensive assistance with 2 persons for eating.</p> <p>On 2/27/18 at 3:30 PM revealed a physician's order for nothing by mouth (NPO).</p> <p>On 2/27/18 at 2:15 PM an interview with nursing assistant #1 revealed the resident is NPO and they do not give him anything by mouth.</p> <p>On 2/27/18 at 2:25 PM an interview with nursing</p>	F 641	<p>F 641 For resident #54, the MDS Assessment that had the coding error had not been submitted prior to surveyor identifying the error. The assessment was submitted correctly. The traveling MDS nurse who completed the assessment is no longer in the facility.</p> <p>The latest MDS Assessments will be checked for residents who are ordered to be fed via gastrostomy tube and takes nothing by mouth to ensure that the assessment had been coded appropriately.</p> <p>The MDS nurses have been reeducated by the Regional Reimbursement Specialist concerning the appropriate coding for a resident who is fed via a gastrostomy tube and takes nothing by mouth. The reeducation also included that when evaluating a resident with this situation, CNA documentation cannot be the only resource included. The resident must be personally assessed and the orders must be reviewed.</p> <p>CNA's have been reeducated concerning the appropriate coding for a resident who is fed via a gastrostomy tube and takes nothing by mouth.</p>	3/30/18

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

TITLE

(X6) DATE

Electronically Signed

03/22/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641	Continued From page 1 assistant # revealed the resident doesn't get a tray because he is a tube feeder. She revealed she would have to ask the nurse before giving him anything by mouth.  On 2/28/18 at 9:37 AM, an interview with the MDS nurse revealed that a significant change in assessment should not have been done and the coding for eating should have been 4/2 because the resident is fed via a gastrostomy tube and takes nothing by mouth. She further revealed she got the information from the nursing assistants documentation, which was coded incorrectly. The corporate MDS nurse was present in the interview and stated the MDS nurse was new and re-education would have to be completed with the nursing staff.  On 2/28/18 at approximately 4:30 PM, an interview with the Director of Nursing (DON) revealed the nursing assistant coded the assistance needed for feeding section wrong and would need further education. She revealed her expectation was that the MDS be coded accurately.	F 641	The MDS coordinator will review all MDS assessments for residents who are fed via gastrostomy tube and takes nothing by mouth prior to submission to ensure it is accurately coded. This review will be documented weekly for 12 weeks. The MDS coordinator will report the findings to the Administrator each week.  The Administrator will report the findings of the monitoring to the monthly QA committee for review and recommendations concerning the plan for the duration of the monitoring time frame.  The Administrator is the person responsible for implementing the acceptable plan of correction.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		3/30/18	

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F 657	<p>Continued From page 2</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interviews and record review, the facility failed to update the care plan for a resident newly diagnosed with diabetes mellitus (DM) (Resident #51) and failed to update the care plan for a resident with resolved infections that required isolation precautions (Resident #59) for 2 of 6 sampled residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>1. Resident #51 was admitted to the facility on 4/4/17 with diagnoses that included, in part, of hypertension, hyperlipidemia and non-Alzheimer's dementia. Resident #51's Admission Minimum Data Set (MDS) assessment dated 4/10/17 revealed resident was cognitively intact and had no diagnosis of diabetes. A review of the Quarterly MDS assessment dated 2/15/18</p>	F 657	<p>F 657</p> <p>Resident #51 did not have a diagnosis of diabetes mellitus added to the care plan. This was due to an oversight by the MDS coordinator. The process of care planning a new diagnosis is that it be care planned as soon as the diagnosis is on a physician order and is coded into the resident chart. Resident #51 now has a care plan for the diagnosis of diabetes mellitus.</p> <p>Resident #59 now has a care plan updated to show that the infections have been resolved.</p> <p>Care plans will be reviewed to ensure that current residents with a diagnosis of diabetes mellitus have this issue included in their care plans.</p> <p>Care plans will be reviewed to identify</p>		

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F 657	<p>Continued From page 3</p> <p>revealed the resident had a diagnosis of diabetes and received insulin.</p> <p>A review of the current care plan revealed there was no care plan that addressed Resident #51's diagnosis of diabetes or that she received insulin.</p> <p>A review of a Provider note dated 12/15/17 revealed, "Patient with basic metabolic panel that returned with critical blood sugars. Patient has no history of DM. Has had some complaints of dizziness. Did get twelve units of insulin last night for blood sugars greater than 500. Diagnosis: Type 2 DM with hyperglycemia."</p> <p>A review of physician's order dated 12/25/17 revealed an order for Humalog sliding scale insulin four times a day.</p> <p>A review of physician's order dated 1/3/18 revealed an order for Lantus (insulin) 18 units at night.</p> <p>An interview was completed with Resident #51 on 2/28/18 at 2:45 PM. She acknowledged she was recently diagnosed with diabetes and reported staff checked her blood sugars daily and gave her insulin.</p> <p>An interview was completed with Nurse #1 on 2/28/17 at 2:47 PM. She stated Resident #51 was newly diagnosed with diabetes a couple of months ago. She said the residents' blood sugars were checked four times a day and she received insulin.</p> <p>An interview was completed with the Director of Nursing on 2/28/18 at 4:08 PM. She said she was unsure why a care plan for diabetes was not</p>	F 657	<p>residents who have infections in the last 30 days that have resolved and verify that the care plan is updated as appropriate.</p> <p>The nurses completing MDS assessments will be reeducated by the Regional Reimbursement Specialist concerning the expectation that any new diagnosis be care planned at the time of the order and the coding of the diagnosis in the resident chart. They will also be reeducated to include the expectation that any infections that have resolved will be resolved on the care plan.</p> <p>The orders will be reviewed with each morning clinical meeting and any diagnosis on the order will be verified as being addressed on the resident care plan. There will also be a review of residents receiving antibiotics and noting when the antibiotic therapy is completed and the symptoms are resolved to resolve the infection on the care plan as well. This will be documented at each morning clinical meeting by the Director of Nursing or designee for 4 weeks and then weekly for 8 weeks.</p> <p>The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.</p> <p>The Director of Nursing is the person responsible for implementing the acceptable plan of correction.</p>		

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F 657	<p>Continued From page 4</p> <p>completed once Resident #51 was diagnosed with DM. She stated the MDS nurse who was on staff at the time of the diagnosis no longer worked at the facility. The DON further stated she expected a care plan that addressed diabetes would have been developed at the time of the diagnosis.</p> <p>2. Resident #59 was admitted to the facility on 9/1/17 with a diagnosis that included advanced Alzheimer ' s disease.</p> <p>Review of the care plan dated 1/10/18 indicated Resident #59 had problems of infections that included urinary tract infection and C. Difficile (bowel infection). The interventions included for nursing to assess for signs and symptoms of infection, report findings to the physician, obtain physician ordered lab work and report abnormal results to the physician, and isolation as ordered.</p> <p>The Minimum Data Set (MDS) dated 1/30/18, a significant change MDS indicated Resident #59 had severe impairment with short and long- term memory problems, was incontinent of bowel and bladder, and required extensive to total assistance with all activities of daily living. This MDS did not indicate Resident #56 had infections.</p> <p>Record review revealed the C. Difficile was resolved on 1/29/18 per a nurse ' s note.</p> <p>Observations on 2/25/18 at 4:00 PM revealed Resident #59 had no signage posted at the doorway to indicate she was on isolation.</p> <p>Interview with the corporate MDS nurse</p>	F 657			

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F 657	Continued From page 5 consultant on 2/27/18 at 11:00 AM revealed the facility had a contract MDS nurse completing MDS assessments until two weeks ago. The system that was in place to update care plans included using the electronic chart to "flag" when an update would need to be completed. The contract MDS nurse did the assessments, but did not update the care plan. She explained it was missed.	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to provide an intervention for fall prevention for one of four sampled residents with falls. Resident #15.  The findings included:  Resident #15 was admitted to the facility on 9/16/15 with diagnoses of dementia, history of falling, poor vision, and congestive heart failure.  The most recent Minimum Data Set (MDS) dated	F 689	F 689  Resident #15 now has the scoop mattress as is listed on her care plan for a fall intervention.  Residents who have a fall intervention of a scoop mattress listed will have the presence of the scoop mattress validated by the Director of Nursing or designee.  A resident care guide has been created	3/30/18	

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F 689	<p>Continued From page 6</p> <p>12/6/17 was a quarterly. This MDS indicated Resident #15 had severe impairment with short and long-term memory. She required extensive assistance of two persons for bed mobility and transfers, she did not walk and had not had falls in past 90 days.</p> <p>Review of the care plan dated 12/12/17 included a problem of falls due to history of falls. The interventions included the use of a scoop mattress (the edges of the mattress were raised to prevent rolling out of bed) that was initiated on 4/19/16.</p> <p>Review of a nurse's note dated 2/18/18 at 5:00 AM revealed Resident #15 was observed sitting in the floor next to her bed, no signs or symptoms of injury or pain. The resident 's roommate stated she was trying to get up and sat in the floor. The doctor was informed, as was the responsible party.</p> <p>Record review revealed a fall assessment dated 2/18/18 assessed Resident #15 with a score of 18 (high risk for falls).</p> <p>Interview with unit manager #1 on 2/27/18 at 11:00 AM revealed the investigation of the fall indicated the resident was on floor next to bed, the time was 5:00 AM. It was determined the fall occurred while she was attempting to get out of bed. The new intervention included floor mats to both sides of bed to prevent injury from a fall. During the interview, the unit manager #1 was asked what type of mattress was the resident supposed to have on the bed. She replied a scoop mattress. The unit manager #1 was asked to check the mattress on the bed during the interview. Continued interview at Resident #15 's</p>	F 689	<p>for each resident to communicate with staff concerning care planned interventions that should be in place, including a scoop mattress as a fall intervention if indicated.</p> <p>Nursing staff have been reeducated to validate that a scoop mattress is in place if it is indicated on the resident care guide for their assigned residents.</p> <p>The interdisciplinary team will be reeducated to validate that a scoop mattress is in place if it is indicated on the resident care guide for their assigned rooms.</p> <p>The Administrator, Director of Nursing, and/or designee will verify that the residents who have a scoop mattress used as fall interventions as documented on their care guide are present on their beds. This monitoring will be documented daily for 7 days, 5 days per week, and then weekly for 8 weeks.</p> <p>The Administrator will report the results of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.</p> <p>The Administrator is the person responsible for implementing the acceptable plan of correction.</p>		

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F 689	<p>Continued From page 7</p> <p>bedside revealed the unit manager explained it was an alternating air mattress on the bed. She further explained the treatment nurse would decide if the air mattress should be used for Resident #15.</p> <p>Interview with the treatment nurse on 2/27/18 at 3:54 PM revealed she did not remember the resident having a scoop mattress. She explained the air mattress was already on the bed when she became the treatment nurse. The treatment nurse explained the ankle wound had healed on 2/2/18. During the interview she indicated she was not aware she needed to remove the pressure mattress and put the scoop mattress on the bed.</p> <p>Interview with the Director of Nursing (DON) on 2/28/18 at 4:00 PM revealed Resident #15 had a scoop mattress at one time. (a date could not be provided). At the time a pressure ulcer occurred on the left ankle, the scoop mattress was removed and the air mattress was applied. There was a physician 's order for the scoop mattress, and it was not discontinued. According to the orders and the care plan she explained Resident #15 should have had the scoop mattress on the bed. During the interview, the DON explained the treatment nurse would have been responsible to replace the scoop mattress on the bed once the wound was healed. The DON explained the process of reviewing falls and interventions occurred each morning in the administrative morning meeting. The treatment nurse should have been informed during that meeting. Further interview revealed a device list was updated during the review of falls. When asked how the scoop mattress did not get back on the bed after the wound healed, she explained it was missed.</p>	F 689			

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F 757 SS=D	<p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and nurse practitioner interviews the facility failed to prevent an unnecessary antibiotic from being administered for one (Resident #36) of six sampled residents for unnecessary medications.</p> <p>The findings included:</p> <p>Resident #36 was admitted to the facility on 6/12/17 with diagnoses including dementia and Parkinson's disease.</p> <p>The quarterly Minimum Data Set (MDS) dated</p>	F 757	<p>F 757</p> <p>Resident #36 did not have any identifiable negative outcome from the medication administration that has been deemed unnecessary with review.</p> <p>Licensed nursing staff have been reeducated concerning the definition of urinary tract infection according to A Synopsis of McGeer's Definitions of Infection. This includes: A. For residents without an indwelling</p>	3/30/18	

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F 757	<p>Continued From page 9</p> <p>1/11/18 indicated Resident #36 had mild long-term memory problems and no impairment with short term memory. This MDS indicated she needed extensive assistance for toileting, and was occasionally incontinent of urine.</p> <p>Review of the care plan dated 1/11/18 included a problem of history of urinary tract infections. The approaches included to assess for signs and symptoms of an infection and report findings to the physician, obtain lab work as ordered and report abnormal lab results to the physician.</p> <p>Review of a nurse's note dated 2/13/18 revealed Resident #36 had burning with urination. The unit manager received a physician's order to obtain a urinalysis.</p> <p>Further review of the medical record revealed no other symptoms were documented regarding a urinary tract infection.</p> <p>Review of a urine culture and sensitivity dated 2/15/18 indicated the urine culture had bacteria that grew 35,000 colonies of gram negative rods (bacteria present in the urine) per milliliter of urine.</p> <p>Review of a nurse's note dated 2/17/18 revealed the nurse reported the urine culture was "positive for a UTI" (Urinary Tract Infection) to the Nurse Practitioner.</p> <p>Review of the physician order dated 2/17/18 indicated an antibiotic (Levofloxacin) 750 milligrams was ordered to be given every day for seven days.</p> <p>The Medication Administration Record (MAR) documented Levofloxacin 750 mg was administered</p>	F 757	<p>catheter (both criteria 1 and 2 must be present)</p> <p>1. At least 1 of the following sign or symptom sub criteria</p> <p>a. Acute dysuria or acute pain, swelling, or tenderness of the testes epididymis or prostate.</p> <p>b. Fever or leukocytosis (see Constitutional Criteria in Residents of Long Term Care Facilities) and at least 1 of the following urinary tract sub criteria</p> <p>-Acute costovertebral angle pain or tenderness</p> <p>-Suprapubic pain</p> <p>-Gross hematuria</p> <p>-New or marked increase in incontinence</p> <p>-New or marked increase in urgency</p> <p>-New or marked increase in frequency</p> <p>c. In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract sub criteria</p> <p>-Suprapubic pain</p> <p>-Gross hematuria</p> <p>-New or marked increase in incontinence</p> <p>-New or marked increase in urgency</p> <p>-New or marked increase in frequency</p> <p>2 One of the following microbiologic sub criteria</p> <p>a. At least 10 to the 5th power cfu/mL of no more than 2 species of microorganisms in a voided urine sample.</p> <p>b. At least 10 to the 2nd power cfu/mL of any number of organisms in a specimen collected by in -and-out catheter.</p> <p>B For residents with an indwelling catheter (both criteria 1 and 2 must be present)</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>VILLAGE CARE OF KING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 INGRAM ROAD</b> <b>KING, NC 27021</b>		
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F 757	<p>Continued From page 10 to Resident #36 on 2/18/18 through 2/25/18.</p> <p>An interview with the floor nurse who contacted the Nurse Practitioner was not conducted. The floor nurse was not available for interview.</p> <p>Interview with the Nurse Practitioner on 2/28/18 at 11:00 AM revealed the resident was prone to UTI's and she would start her on an antibiotic due to her history and the information provided by the floor nurse.</p> <p>Interview with the Director of Nursing on 2/28/18 at 3:00 PM revealed the unit manager would be responsible to review the labs for cultures and sensitivity. The unit manager for Resident #36 was new and must have missed checking the culture report. Further interview revealed the floor nurse should not have reported to the nurse practitioner it was positive for infection. During the interview she explained the urinalysis and culture report did not meet the criteria for an infection due to the bacteria present in the urine was not greater than 100,00 colonies of bacteria per milliliter of urine.</p>	F 757	<p>1 At least 1 of the following sign and symptom sub criteria</p> <ul style="list-style-type: none"> <li>a. Fever, rigors, or new-onset hypotension, with no alternate site of infection</li> <li>b. Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis</li> <li>c. New-onset suprapubic pain or costovertebral angle pain or tenderness</li> <li>d. Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate</li> </ul> <p>2 Urinary catheter specimen culture with at least 10 to the 5th power cfu/mL of any organism(s)</p> <p>This criteria will be posted at each nurses station for future reference as needed by the licensed nursing staff. The licensed nurses have also been reeducated to question any medical provider who is ordering an antibiotic when these criteria are not met.</p> <p>During morning clinical meeting, the orders will be reviewed. All orders for antibiotics ordered for urinary tract infections will be identified. The documentation related to the diagnosis will be reviewed and the medical provider will be contacted if the criteria is not met as defined by McGeer's. The review will be documented for each morning clinical meeting for 4 weeks and weekly for 8 weeks.</p> <p>The results of the monitoring will be</p>		

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F 757	Continued From page 11	F 757	reported to the monthly QA committee meeting for review and recommendation for the duration of the monitoring period.		
F 867 SS=D	<p>QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee must:</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, record review and staff interviews the facility's Quality Assurance and Assessment Committee failed to maintain implemented procedures and monitor the interventions put in place following the recertification survey of 3/3/17. One deficiency in the area of drug regimen was free from unnecessary medications was recited on the recent recertification/complaint survey of 2/28/18. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance and Assessment program.</p> <p>The findings included:</p> <p>This tag is cross referenced to: F757. Drug regimen free from unnecessary medications. Based on record review, staff and nurse practitioner interviews the facility failed to prevent an unnecessary antibiotic from being</p>	F 867	<p>The Director of Nursing is the person responsible for implementing the acceptable plan of correction.</p> <p>F 867</p> <p>A new plan of correction has put into place for the citation of unnecessary meds.</p> <p>The Administrator has been reeducated by the Regional Vice President of Operations concerning the Quality Assurance and Performance Improvement process. The reeducation included the need to review past issues and investigate to ensure that those issues were still compliant.</p> <p>The Quality Assurance meeting will review the plan of correction for unnecessary meds for the duration of the monitoring periods set. Upon completion of the planned monitoring timeframe, the issue will be placed on the monthly agenda with</p>	3/30/18	

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F 867	<p>Continued From page 12 administered for one (Resident #36) of six sampled residents for unnecessary medications.</p> <p>During the recertification survey of 3/3/17 the facility was cited at F329 for failure to provide an antianxiety medication according to the physician's order for the correct dose and frequency for 1 of 4 sampled residents for unnecessary medications.</p> <p>Interview with the Administrator on 2/28/18 at 3:28 PM revealed the antibiotic use was reviewed in the morning meetings. The Administrator explained the antibiotic for Resident #36 was missed in their reviews. He further explained the unit manager #1 needs more training to check for usage of the antibiotic. The nurse who called the NP no longer works at the facility.</p> <p>Interview on 2/28/18 at 4:00 PM with the Director of Nursing revealed the nurse who called the Nurse Practitioner did not follow the protocols for antibiotic use. The new unit manager #1 needs further training on notifying the physician regarding the reviews of the labs.</p>	F 867	<p>the expectation that the issue is resolved during the month to maintain compliance. This would involve a once a month documentation of the monitoring process from the plan. If there is any non-compliance the committee would initiate a new plan of correction to ensure ongoing compliance. This process will be maintained thru the next annual survey.</p> <p>The Administrator is the person responsible for implementing the acceptable plan od correction.</p>		