STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	**3992 EAST US HWY 64 ALT MURPHY, NC 28906**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# O4QS11. The statement of deficiencies was amended on 04/10/18 following the Informal Dispute Resolution. The scope and severity for F 640 was reduced from a "E" to a "B" and F 658 was deleted.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		3/16/18

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

Electronically Signed | 03/12/2018

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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to notify the physician after an assumed appointment for a Thoracentesis procedure was rescheduled. This resulted in a 5 day continuous holding of an anticoagulant for 1 of 2 sampled residents reviewed for notification (Resident #82). Findings included: Resident #82 was admitted to the facility on 12/15/17 with diagnoses including heart failure, pleural effusion, atrial-fibrillation (A-Fib), and muscle weakness. Review of the admission Minimum Data Set	F 580	" The process that led to the failure to notify the physician of a change was that an assumption was made that a procedure ordered on a Friday would be performed on the following Monday without confirming and MD was not notified the appointment was not able to be scheduled on Monday. " The procedure for implementing the acceptable plan of correction for failure to notify physician of changes will be, that orders related to scheduled procedures will not be implemented until the procedure date can be confirmed. Any changes to the scheduled procedure date	

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F 580	Continued From page 2 (MDS) dated 01/31/18 revealed Resident #82 was cognitively impaired with no history of rejection of care. The MDS indicated Resident #82 demonstrated behavioral symptoms not directed toward others and received 5 days of anticoagulant medications during the assessment. Review of the care plan dated 08/03/17 indicated Resident #82 was at risk for alteration in cardiopulmonary status due to recent right pleural effusion and A-Fib. She was at risk for abnormal bleeding/bruising due to the use of an anticoagulant. The goal was for Resident #82 to be free from abnormal bleeding or bruising over the next 3 months. Interventions included administer anticoagulant as ordered, observe its effectiveness as well as adverse effects and report to physician. Review of Medication Administration Record (MAR) for February 2018 revealed Resident #82 had an order of Pradaxa 150 milligram (mg) twice a day for A-Fib since 01/03/18. Further review of MAR indicated Pradaxa had been held from 02/10/18 evening through 02/15/18 morning. Pradaxa restarted on 02/15/18 evening after the Thoracentesis procedure was completed. Review of the physician order dated 02/10/18 revealed an order to discontinue Pradaxa 48 hours prior to Thoracentesis and restart following the procedure was written and signed by the physician. No other physician orders to hold Pradaxa were found after 02/10/18 through 02/16/18. According to the order, Pradaxa was being held without physician orders for the doses on 02/12/18 in the evening and 02/13/18 in the morning.	F 580	will be communicated to the MD. This process will be in place by 3/16/18. " The monitoring procedure to ensure the plan of correction is effective will be, all scheduled procedures will be added to the nursing 24hr report sheet by the nurse noting off the order. Charge nurses will review the 24hr report sheet daily and notify MD of any delay in scheduled procedures. Physician orders and 24hr nursing report sheets will be brought to the morning administration meeting to verify the process has been followed. The Director of Nursing Services (DNS) or in the event of her absence, the Assistant Director of Nursing (ADON) will be bringing the results of the monitoring to the monthly QAPI meeting to report results and assess for any necessary changes to the plan, for at least 3 months or until substantial compliance is achieved. " The person responsible for implementing the acceptable plan of care is the DNS or in her absence, the ADON.	

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During an observation on 02/15/18 at 09:41 AM, Resident #82's had a few spots of faded bruises on both hands. However, she showed no signs and symptoms of bleeding, shortness of breath, or acute distresses. Attempts to interview Resident #82 unsuccessful as she was unable to engage in the conversation.

In an interview conducted on 02/15/18 at 11:10 AM, Help Unit Coordinator (HUC) stated she was responsible to make Thoracentesis appointment for Resident #82's with the outside provider. The order was written on 02/10/18 weekend. When she called for the appointment on the following Monday, she was told by the provider that the appointment would not be available until Thursday. She informed the Charge nurse (Nurse #4) about the availability of Resident #82's appointment immediately.

In an interview conducted on 02/15/18 at 01:09 PM, the physician revealed he was in the facility on 02/14/18. He was not notified for the delay of Resident #82's Thoracentesis procedure that was supposed to be on 02/12/18. The physician considered the holding of Resident #82's Pradaxa continuously for 5 days as a low risk as he did it frequently for Thoracentesis procedure. He would not reinitiate Pradaxa therapy for one day (02/12/18 evening dose and 02/13/18 morning dose) if he was notified by the nursing staff on that Monday as it had no clinical basis to do that. However, he expected the nursing staff to notify him on Monday when the appointment was not available until Thursday and follow his order.

In a phone interview conducted on 02/15/18 at 02:06 PM, Nurse #4 confirmed she was the

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F 580	Continued From page 4	F 580		

Charge nurse on 02/12/18 morning. She stated that the order for Resident #82's Thoracentesis was written by an on-call Nurse Practitioner (NP) in the weekend of 02/10/18 with the assumption the procedure would be completed on the upcoming Monday. When the HUC informed her that the procedure could only be done by Thursday, she was aware that Resident #82's Pradaxa had been on hold since Saturday evening. Normally she would notify the physician about the changes. However, she could not recall whether she had made the notification. She went ahead to rewrite the order and crossed off the Pradaxa orders for the remaining shifts until the scheduled procedure on Thursday noon. She added the following to the order: "Hold for 48 hours prior to procedure, restart afterward".

In an interview conducted on 02/15/18 at 04:25 PM, Nurse #5, who was the Charge Nurse for the shift stated that if she were the Charge Nurse handling the above incident on 02/12/18 morning, she would have notified the physician and asked for further directions.

In a phone interview conducted on 02/16/18 at 08:39 AM, Nurse #6 confirmed she was working at Resident #82's hall on the morning of 02/13/18.. She recalled when she started the shift on Tuesday morning, the order for Pradaxa had been rewritten and crossed off all the way until the dose on Thursday morning with an additional message "Hold for 48 hours prior to the procedure, restart afterward". Nurse #6 added she interpreted the rewritten order as it was and went ahead to hold the medication without doing any calculation to find out when exactly the holding of Pradaxa should be started.

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F 580	Continued From page 5 In an interview conducted on 02/16/18 at 02:49 PM, the Director of Nursing (DON) stated it was her expectation for the Charge Nurse on duty to notify the Physician if there was any change in Thoracentesis appointment that required the holding of Pradaxa 48 hours prior to the procedure. She expected all the nursing staff to follow physician's order to administer medication as ordered in a timely manner.	F 580		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640		3/16/18

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F 640	Continued From page 6 assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit completed Minimum Data Set (MDS) assessments to the National Data Base (NDB) within the required 92 days for 4 of 30 reviewed MDS assessments (Residents #2, #3, #4, and #5). The findings included: A review of the following residents' MDS assessment logs in Aspen Central Office (ACO) revealed the following MDS assessments had been transmitted to the NDB: a. Resident #2 was admitted to the facility 09/27/12. MDS assessments were noted transmitted to the NDB less than every 92 days	F 640	" The process that led to the failure to transmit assessments was that the facility was transitioning from one owner to another with multiple people involved in the transmission of MDS assessments. Transmissions were not monitored effectively resulting in failure to transmit MDS assessments within the required 92 days. " The procedure for implementing the acceptable plan of correction for the failure to transmit resident assessments is that this facility will designate The MDS Coordinator to be solely responsible for transmitting MDS assessments. This	

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F 640	Continued From page 7 until 09/18/17 which was the date of an annual MDS assessment. No further assessments were listed as transmitted in the ACO log. b. Resident #3 was readmitted to the facility 03/21/17. MDS assessments were noted transmitted to the NDB less than every 92 days until 09/19/17 which was the date of a quarterly MDS assessment. No further assessments were listed as transmitted in the ACO log. c. Resident #4 was readmitted to the facility 11/14/16. MDS assessments were noted transmitted to the NDB less than every 92 days until 09/20/17 which was the date of a quarterly MDS assessment. No further assessments were listed as transmitted in the ACO log. d. Resident #5 was admitted to the facility 11/29/16. MDS assessments were noted transmitted less than every 92 days until 09/20/17 which was the date of an annual MDS assessment. No further assessments were listed as transmitted in the ACO log. During an interview on 02/14/18 at 8:38 AM, MDS Coordinator #1 produced evidence MDS assessments for each of the named residents had been completed by the facility in December of 2017. All the completed assessments were well within the 92 day requirement. MDS Coordinator #1 stated the facility had been sold to another company. At the time the new company took over, the facility also was transitioning to a new computer system in which MDSs were completed. She further explained during the transition of ownership, the cooperate office for the new company took over the responsibility of transmitting MDS assessments to the NDB. MDS Coordinator #1 stated the facility realized they had a problem with transmitting December assessments and had a plan in place to correct	F 640	process will be in place 3/16/18. " The monitoring procedure to ensure the plan of correction is effective will be a weekly comparison made by the MDS Assistant, or in the event of her absence, by the Executive Director of the transmission results report, submission validation report and the missing assessment report to identify if any of the MDS assessments did not get submitted. the Assistant MDS nurse will be bringing the results of the monitoring to the monthly QAPI meeting to report results and assess for any necessary changes to the plan, for at least 3 months or until substantial compliance is achieved. " The person responsible for implementing the acceptable plan of care is the Assistant MDS Nurse, or in the event of her absence, by the Executive Director.	

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this. MDS Coordinator #1 added on 02/16/18 she had received a report from a state auditing company that no MDS assessments had been transmitted for, Resident #2 since 09/18/17, Resident #3 since 09/19/17, Resident #4 since 09/20/17, and Resident #5 since 09/20/17. Until she received this report, the facility thought all MDS assessments had been transmitted.

An interview with the Director of Clinical Reimbursement Services (DCRS) was conducted via phone on 02/14/18 at 1:57 PM. The DCRS stated some issues occurred when changing the information from the old company to the new company and it took longer than expected to get this accomplished. During this period, the DCRS stated the facility was asked to not transmit MDS assessment, but to send them to her corporate office to be transmitted. The DCRS explained she realized some assessments were overlooked and not transmitted timely but was unaware the 4 named residents still did not have their December MDS assessments transmitted. The DCRS stated clerical corporate staff was used to key the MDS assessments but errors were made and were not corrected appropriately. She added the 4 MDSs for the named residents were overlooked.

An interview with the Administrator was conducted 02/14/18 at 2:55 PM. The Administrator explained the facility had problems getting the numbers correct so the facility could transmit MDSs from their new computer system. The facility did a plan of correction which was dated 01/09/18. The facility's MDS Coordinators were doing audits regularly and the MDSs were completed within required time frames. It was not realized the 4 named residents' MDS

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F 640	Continued From page 9 assessments had not been transmitted until review of the state audit report received 02/16/18.	F 640		
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. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update a care plan following an accident to ensure safety from future injury for 1 of 26 reviewed residents' care plans (Resident	F 657	" The process that led to the deficient practice of failure to update a care plan was that interventions identified on the final accident investigation were not being	3/16/18

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F 657	Continued From page 10 #56). The findings included: Resident #56 was admitted to the facility 11/01/15 with diagnoses which included dementia with behaviors, generalized muscle weakness, and history of falls. A review of Resident #56's medical record revealed a nurse's note written 08/21/17. The note described an incident involving Resident #56 that occurred on this date. The nurse described the incident as Resident #56 was attempting to stand from sitting in her wheelchair and received a laceration to her lower left shin that required stitches received in the emergency room. The note specified it was believed the bracket attached to the wheelchair that held the footrest, which were not in place, caused the laceration. A review of the facility's investigation of the incident dated 08/25/17 revealed unable to determine cause of injury no sharp edges were noted but hinges for foot rest was padded to prevent bumping leg against these. A review of a care plan dated 11/16/17 Identified Resident #20 was at risk for skin alterations due to fragile skin. The care plan goal specified the resident would have no skin alterations with signs and symptoms of infection requiring hospitalization over the next 3 months. Interventions included be cautious with care and transfers, nursing to treat skin alterations as ordered and report problems to the physician as needed. An added intervention dated 02/14/18 specified wheelchair padded with nursing noted as responsible of this intervention. No	F 657	added to the care plan. " The procedure for implementing the acceptable plan of correction for updating the care plan will be that all initial accident reports will be reviewed during morning meeting and resident□s care plan will be updated by the MDS nurses during the meeting when indicated. When investigations are complete, they will be reviewed again, in AM meeting, and any additional interventions that have been identified will be added to the care plan by the MDS Nurses if indicated. This process will be in place 3/16/18 " The monitoring procedure to ensure the plan of correction is effective will be, The Director of Nursing Services (DNS) or in the event of her absence, the Assistant Director of Nursing (ADON) will be bringing the results of the monitoring to the monthly QAPI meeting to report results and assess for any necessary changes to the plan, for at least 3 months or until substantial compliance is achieved. " The person responsible for implementing the acceptable plan of care is the DNS or in her absence, the ADON.	

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F 657	Continued From page 11	F 657		

intervention was noted to keep wheelchair hinges for footrest padded.

A quarterly Minimum Data Set (MDS) dated 01/15/18 indicated Resident #20's cognition was severely impaired. The MDS coded the resident required extensive staff assistance for transfers, dressing, toileting, and personal hygiene and staff supervision for locomotion and eating. The MDS specified Resident #20 experienced 2 falls without injury and 1 fall with major injury since the last 90 day assessment.

An interview with the Therapy Manager (TM) 02/14/17 at 4:32 PM revealed she was asked by a family member to pad the wheelchair footrest hinges on Resident #20's wheelchair. The TM stated she did pad the wheelchair hinges that had no padding at that time. The TM was unable to recall the exact date she padded the hinges but thought it was approximately 2 to 3 weeks ago.

An interview with Nurse Aide (NA) #3 was conducted 02/14/17 at 4:47 PM. NA #3 stated she was assigned to Resident #20 most of time she worked. She did recall the wheelchair hinges being padded at one time. NA #3 described washcloths were used. She did not recall when the wheelchair hinges were no longer padded or who was responsible for padding them.

An interview with Nurse #2 on 02/14/17 at 6:43 PM revealed she was assigned to Resident #20's hall on 02/07/18. The nurse stated there were no wraps on the wheelchair footrest hinges on that date.

An interview was conducted via phone with the facility's Medical Director (MD) on 02/15/18 at 1:10 PM. The MD described Resident #20 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURPHY REHABILITATION & NURSING	3992 EAST US HWY 64 ALT MURPHY, NC 28906

(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 657	Continued From page 12	F 657		

decreased blood flow and edema (fluid accumulation) in the lower legs. Both made Resident #20's skin more fragile in the lower extremities and skin openings more difficult to heal. The MD recommended the wheelchair footrest hinges be padded or removed if possible.

An interview was conducted with Nurse #1 on 02/15/18 at 10:21 AM. Nurse #1 stated the wheelchair footrest hinges on Resident #20's wheelchair were padded in August of 2017. Nurse #1 stated the wheelchair footrest hinges stopped being padded but should still be padded. Nurse #1 explained Resident #20 had swelling in her legs to the point of "weeping". This put the resident at increased risk for cellulitis.

An interview was conducted with MDS Coordinators #1 and #2 on 02/15/18 at 3:04 PM. The MDS Coordinators explained they were responsible for updating residents' care plans. They took care plans books to the facility's morning meeting every morning. From discussion of residents and incidences with all the department heads the best plan of care for residents was decided. The MDS Coordinators stated they updated the care plans but did not communicate the changes or additions of care to the staff. MDS Coordinator #1 confirmed no intervention regarding padding of wheelchair footrest hinges was recorded on Resident #20's care plan.

An interview was conducted with the Director of Nursing (DON) on 02/15/18 at 5:19 PM. The DON explained care plan books should be updated during morning meeting with the management staff and staff responsible for carrying out care plan interventions should be

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F 657	Continued From page 13 notified.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews, the facility failed to trim fingernails for 1 of 4 dependent residents reviewed for activities of daily living (ADL) (Resident #20). The findings included: Resident #20 was readmitted to the facility 11/30/18 with diagnoses which included heart failure and dependence on supplemental oxygen. A quarterly Minimum Data Set (MDS) dated 12/05/17 indicated Resident #20's cognition was intact. The MDS coded the resident required extensive staff assistance with bed mobility, dressing, toileting, and personal hygiene. A care plan updated 12/12/17 identified Resident #20 required total assistance with most ADLs. The care plan goal specified ADL assistance would be provided as needed as evidenced by clean, well-groomed appearance over the next three months. Interventions included staff to assist with ADLs as needed. An observation 02/12/18 at 3:09 PM revealed Resident #20's fingernails extended 1/8 to 1/4 of an inch beyond the resident's fingertips. At this	F 677	" The process that led to the deficiency cited was staff did not offer to trim fingernails to the resident□s desired length. " The procedure for implementing the acceptable plan of correction for ADL care for dependent residents will be that during bathing, nursing assistants performing the bathing will ask residents, who are able to make decisions regarding care, if they would like to have fingernails trimmed. For residents who are unable to make their needs known, nursing assistants who are performing the bathing, during bathing, will evaluate nails. Nail care will be provided as indicated. The process will be in place by 3/16/18. " The monitoring procedure to ensure that plan of correction is effective will be, the Bath team supervisor (who is also staff development nurse), or in the event of her absence, the DNS will spot check dependent residents after baths to inspect nails for appropriate or desired length. (5 residents per day Mondays- Fridays). The bath team supervisor will bring the results	3/16/18

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F 677	Continued From page 14 time Resident #20 stated she liked her fingernails to be a moderate length, not long like they were now. The nails were not polished at the time of this observation. An additional observation on 02/14/18 at 1:01 PM revealed Resident #20's fingernails were unchanged in length. The fingernails on the middle 3 fingers of her right hand contained debris which appeared to be food. The nails were not polished at the time of this observation. An interview was conducted with Nurse Aide (NA) #1 on 02/14/18 at 2:41 PM. NA #1 stated she had provided a tub bath for Resident #20 on 02/09/18 and a bed bath on 02/12/18. She added on 02/09/18 the resident's nails were polished and were long. The NA stated she thought they were pretty and she did clean under them but did not trim them. NA #1 was unaware the nails were no longer polished on 02/12/18. NA #1 stated Resident #20 did not ask to have her nails trimmed and the NA did not ask the resident if she would like them trimmed. An interview was conducted with the Director of Nursing (DON) on 02/14/18 at 5:28 PM. At this time, the DON observed Resident #20's fingernails. The DON was observed asking the resident if she liked her nails long. The resident was observed replying the nails were a little long and she would like them trimmed. The DON agreed Resident #20's fingernails were too long and should be trimmed. She added the NAs providing bathing should ask residents if they wanted their nails trimmed.	F 677	of her monitoring to the monthly QAPI meeting to report results and assess for any necessary changes to the plan of correction for at least 3 months or until substantial compliance is achieved. " The person responsible for implementing the acceptable plan of care is the Staff Development Nurse, who is also the bath team supervisor, or in the event of her absence, the DNS	