| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345113 | A. BUILDING _____ B. WING _____ | 06/01/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WILLOW CREEK NURSING AND REHABILITATION CENTER | 2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534 |

| (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 |
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| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the | F 550 | | 6/29/18 |

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

Electronically Signed | 06/22/2018

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| F 550 | Continued From page 1<br>exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and resident and staff interviews, the facility failed to provide care in a dignified manner by dressing a resident in a hospital gown instead of her clothes which resulted in feelings of embarrassment for 1 of 4 residents reviewed for dignity (Resident #101).<br><br>Findings included:<br><br>Record review revealed Resident #101 was admitted to the facility on 4/3/2018 with diagnoses which included Myocardial Infarction (heart attack) and Hypertension. The Admission Minimum Data Set (MDS) dated 4/10/2018 indicated the resident was cognitively intact and required extensive to total assistance of 1 staff member for all activities of daily living. The MDS further indicated it was very important to the resident to choose what clothes to wear.<br><br>An observation was made of Resident #101 on 5/29/2018 at 2:30 PM. The resident was observed in her room in bed. The resident was sleeping and was dressed in a hospital gown.<br><br>An interview was conducted with Resident #101 on 5/30/2018 at 10:46 AM. The resident stated she had clothes in the closet in the room. The resident indicated the staff dressed her in a hospital gown most of the time. The resident reported she thought it was easier for the staff to dress her in a hospital gown instead of dressing her in clothes. The resident stated she told the staff several times that she preferred to be | F 550 | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>The process that lead to the deficiency was based on record review, observation and resident and staff interviews, the facility failed to provide care in a dignified manner by dressing a resident in a hospital gown instead of her clothes which resulted in feelings of embarrassment for 1 of 4 residents reviewed for dignity (Resident #101).<br><br>100% interviews were completed with all alert and oriented residents, to include resident #101, on 6.25.18 by the Social Workers (SW). The SW asked the resident the preference regarding daily clothing choices. The Minimum Data Set nurses (MDS) updated the resident care guides on 6.26.18 to reflect the resident□s daily clothing choices. All non-alert and oriented residents representative were asked the resident preference regarding the resident□s daily clothing choices. 100% audit was completed on 6.26.18 by the Director of Nursing (DON), the Assistant Director of Nursing, the RN supervisor, the Quality Improvement (QI) nurses, and Staff Facilitator for all alert and oriented residents to ensure each resident is being treated with dignity and respect by being given a choice of clothing for the day and all non- alert and oriented residents is | |

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| F 550 | Continued From page 2<br>dressed in her clothes rather than a hospital gown and there were clothes in the closet. The resident indicated she felt embarrassed at times to be dressed in a hospital gown when she had visitors.<br><br>An observation and interview was conducted with Resident #101 on 5/31/2018 at 2:09 PM. The resident stated she had a bath earlier and Nursing Assistant (NA) #5 dressed her in a hospital gown. The resident stated NA #5 did not ask if she wanted to wear clothes.<br><br>An interview was conducted with Nursing Assistant (NA) #5 on 5/31/2018 at 2:29 PM. NA #5 confirmed she was the NA assigned to Resident #101 and worked with her almost every day on the 7AM to 3 PM shift. NA # 5 reported she gave the resident a bath earlier in the shift and dressed her in a hospital gown. NA #5 reported she did not ask the resident about wearing clothes and did not know why. NA #5 stated it was just easier to put a hospital gown on the resident. NA #5 indicated she was aware the resident had clothes in the closet but never dressed her in clothes unless the resident was going out for an appointment.<br><br>An interview was conducted with the Director of Nursing (DON) on 5/31/208 at 3:35 PM. The DON stated the expectation was for residents to be dressed in clothes during the day to maintain their dignity. | F 550 | being treated with dignity and respect by following the resident preference regarding the resident□s daily clothing choices, on the resident care guides. All identified issues were addressed immediately by the DON on 6.27.18 to ensure each resident is being treated with dignity and respect by being given a choice of clothing for the day.<br>100% in-service of licensed nurses, to include agency nurses, and nursing assistants, to include Nursing assistant (NA) #5, was initiated by the Staff Facilitator on 6.18.18 regarding the residents right to choose their clothes for the day, and to make choices about aspects of his or her life in the facility that are significant to the resident including their bathing preferences. The in-service will be completed by 6.26.18. All new staff will be in serviced by the Staff Facilitator during orientation regarding the resident□s right to choose their clothes for the day, and to make choices about aspects of his or her life in the facility that are significant to the resident including their bathing preference.<br>10% of all residents, to include resident #101, will be reviewed by the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and Staff Facilitator to ensure residents are being treated with dignity and respect by being given a choice of clothing 3 times week for 4 weeks, then weekly for 4 weeks then monthly for 1 month using a Clothing Audit Tool. The Director of Nursing will review and initial the Resident Care Audit Tool weekly for 8 | |

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| F 550 | Continued From page 3 | F 550 | weeks then monthly for 1 month for completion and to ensure all identified areas of concern were addressed.<br>The Executive QI committee will meet to review the Resident Care Audit tool monthly for 3 months to determine issues and trend to include continued monitoring frequency.<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. | F 561 | | 6/29/18 |

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| F 561 | Continued From page 4<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and resident and staff interviews, the facility failed to honor resident's choice by dressing a resident in a hospital gown instead of her clothes and failed to provide a resident with showers as scheduled for 2 of 5 residents reviewed for choices (Resident #101and Resident # 21).<br><br>Findings included:<br><br>1-Record review revealed Resident #101 was admitted to the facility on 4/3/2018 with diagnoses which included Myocardial Infarction (heart attack) and Hypertension. The Admission Minimum Data Set (MDS) dated 4/10/2018 indicated the resident was cognitively intact and required extensive to total assistance of 1 staff member for all activities of daily living. The MDS further indicated it was very important to the resident to choose what clothes to wear.<br><br>An observation was made of Resident #101 on 5/29/2018 at 2:30 PM. The resident was observed in her room in bed. The resident was sleeping and was dressed in a hospital gown.<br><br>An interview was conducted with Resident #101 on 5/30/2018 at 10:46 AM. The resident stated she had clothes in the closet in the room. The resident indicated the staff dressed her in a hospital gown most of the time. The resident | F 561 | F561<br>Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>The process that lead to the deficiency was based on record review, observation and resident and staff interviews, the facility failed to honor residents choice by dressing a resident in a hospital gown instead of her own clothes and failed to provide a resident with showers as scheduled for 2 of 5 residents (Resident #101 and Resident #21).<br><br>100% interviews were completed with all alert and oriented residents, to include resident #101, on 6.21.18 by the Social Workers (SW). The SW asked the resident the preference regarding daily clothing choices. The Minimum Data Set nurses (MDS) updated the resident care guides on 6.26.18 to reflect the resident□s daily clothing choices. All non-alert and oriented residents representative were asked the resident preference regarding the resident□s daily clothing choices. 100% interviews were completed with all alert and oriented residents, to include resident #21, on 6.25.18 by the Social Workers (SW) regarding preferences for bathing. The | |

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| F 561 | Continued From page 5<br>reported she thought it was easier for the staff to dress her in a hospital gown instead of dressing her in clothes. The resident stated she told the staff several times there were clothes in the closet. The resident indicated she preferred to wear clothes instead of a gown but the staff only dressed her in clothes when she went out for an appointment.<br><br>An observation and interview was conducted with Resident #101 on 5/31/2018 at 2:09 PM. The resident stated she had a bath earlier and Nursing Assistant (NA) #5 dressed her in a hospital gown. The resident stated NA #5 did not ask if she wanted to wear clothes.<br><br>An interview was conducted with Nursing Assistant (NA) #5 on 5/31/2018 at 2:29 PM. NA #5 confirmed she was the NA assigned to Resident #101 and worked with her almost every day on the 7AM to 3 PM shift. NA # 5 reported she gave the resident a bath earlier in the shift and dressed her in a hospital gown. NA #5 reported she did not ask the resident about wearing clothes and did not know why. NA #5 stated it was just easier to put a hospital gown on the resident. NA #5 indicated she was aware the resident had clothes in the closet but never dressed her in clothes unless the resident was going out for an appointment.<br><br>An interview was conducted with the Director of Nursing (DON) on 5/31/208 at 3:35 PM. The DON stated the expectation was for residents' choices to be honored and for residents to be dressed in clothes during the day if that was their preference.<br><br>2-Record review revealed Resident #21 was | F 561 | Minimum Data Set nurses (MDS) updated the resident care plans and the resident care guides on 6.27.18 to reflect the residents bathing preferences. All non-alert and oriented residents will be given a shower per policy as medically indicated.<br>100% audit was completed on 6.27.18 by the Director of Nursing (DON), the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and Staff Facilitator for all residents to ensure each resident is being treated with dignity and respect by following the resident preference regarding the resident□s daily clothing choices and to ensure each resident is given the choice of a shower or bath per their preference, on the resident care guides. All identified issues were addressed immediately by the DON on 6.27.18 to ensure each resident is given the choice of a shower or bath per their preference. All identified issues were addressed immediately by the DON on 6.27.18 to ensure each resident is being treated with dignity and respect by being given a choice of clothing for the day and to ensure each resident is given the choice of a shower or bath per their preference, on the resident care guides.<br>100% in-service of licensed nurses, to include agency nurses, and nursing assistants, to include Nurse #4, Nursing assistants (NA) #5 and #6, was initiated by the Staff Facilitator on 6.1.18 regarding the resident right to choose their clothes for the day, and to make choices about aspects of his or her life in the facility that | |

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| F 561 | Continued From page 6<br>admitted to the facility on 8/27/2017 with diagnoses which included Urinary Tract Infection and Hypertension. Review of the Quarterly Minimum Data Set (MDS) dated 2/22/2018 indicated the resident was cognitively intact and required extensive assistance of 1 staff member for bathing. The MDS further indicated it was very important for the resident to choose between a bath and a shower. The MDS revealed the resident displayed no rejection of care.<br><br>An interview was conducted with Resident #21 on 5/29/2018 at 10:16 AM. The resident stated she required assistance with bathing. The resident further stated she preferred to take a shower but could not remember the last time she was given one. The resident stated the staff did not ask her if she wanted a shower.<br><br>Review of the shower schedule posted at the nurses' station revealed Resident #21 was scheduled for showers on the 7AM to 3PM shift on Wednesdays and Saturdays.<br><br>An interview was conducted with Resident #21 on 5/31/2018 at 9:39 AM. The resident stated she did not receive a shower the day before (Wednesday 5/30/2018) and was not offered a shower.<br><br>An interview was conducted with Nurse #4 on 5/31/2018 at 10:17 AM. Nurse #4 confirmed she was the nurse responsible for Resident #21. Nurse #4 reported she was the nurse responsible for the resident on Wednesday, May 30, 2018. The nurse stated the resident did not get a shower the day before and did not know why. Nurse #4 confirmed Wednesdays and Saturdays were the resident's scheduled shower days. | F 561 | are significant to the resident including their bathing preferences. The in-service will be completed by 6.26.18. All new staff will be in serviced by the Staff Facilitator during orientation regarding the resident□s right to choose their clothes for the day, and to make choices about aspects of his or her life in the facility that are significant to the resident including their bathing preference.<br>10% of all residents, to include resident #101and resident #21, will be reviewed by the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and Staff Facilitator to ensure residents are being treated with dignity and respect by being given a choice of clothing and that each resident is given the choice of a shower or bath per their preference, on the resident care guides 3 times week for 4 weeks, then weekly for 4 weeks then monthly for 1 month using a Resident Care Audit Tool. The Director of Nursing will review and initial the Resident Care Audit Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all identified areas of concern were addressed.<br>The Executive QI committee will meet to review the Resident Care Audit tool monthly for 3 months to determine issues and trend to include continued monitoring frequency<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |

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| F 561 | Continued From page 7<br>Nurse #4 indicated the resident did not consistently get showers and she did not know why. Nurse #4 indicated there was adequate staff on the hall but they did not complete the showers.<br><br>An interview was conducted with Nursing Assistant (NA) # 6 on 5/31/2018 at 10:23 AM. NA #6 confirmed she was the NA assigned to Resident #21 the day before and worked with the resident regularly. NA #6 indicated she did not know it was the resident's scheduled shower day and did not check the schedule. NA #6 stated she did not give the resident a shower the day before and had not given the resident a shower in a long time. NA #6 stated she did not know why she had not given the resident a shower.<br><br>An interview was conducted with the Administrator on 10/31/2018 at 10:30 AM. The Administrator stated the expectation was showers would be offered not only on the scheduled shower days but daily. | F 561 | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when | F 582 | | 6/29/18 |

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| F 582 | Continued From page 8<br>changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by: | F 582 | | |

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| F 582 | Continued From page 9<br>Based on record review and staff interviews the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for 1 of 3 residents reviewed for beneficiary protection notification. (Resident #429).<br><br>The findings included:<br><br>Resident #429 was admitted to the facility on 01/25/18 with diagnoses including acute respiratory failure with hypercapnia, diabetes mellitus, hypertension, chronic obstructive pulmonary disease, muscle weakness, fibromyalgia, acute kidney failure, and unsteadiness on feet.<br><br>Resident #429 Medicare Part A skilled services ended on 02/06/18. Resident was discharged to home on 02/07/18.<br><br>Record review revealed that Resident #429 was not given the Notice of Medicare Non-Coverage letter.<br><br>During an interview with the Business Office Manager (BOM) on 06/01/18 at 10:53 AM, she stated that she had just started back to work on 01/30/18 and it was an oversight that the Notice of Non-Coverage letter was not send out.<br><br>During an interview with the Administrator on 06/01/18 at 11:10 AM, he stated that it was his expectation that Business Office Manager would send the Notice of Medicare Non-Coverage letter within 48 hours of Medicare Part A skilled services ending. | F 582 | F582<br>Medicaid/Medicare Coverage/Liability Notice<br>CFR(S): 483.10(g)(17)(18)(i)-(v)<br><br>The process that lead to the deficiency was based on record review and staff interviews the facility failed to provide the Notice of Medicare Non-Coverage letter indicating the resident was notified prior to Medicare coverage ending for 1 of 3 residents reviewed for beneficiary protection notification. (Resident #429).<br>All current residents receiving coverage under Medicare have been reviewed for anticipated discharge on 6/21/2018, Medicare non-coverage letters have been issued as indicated by the Accounts Receivables Department utilizing the Daily Medicare Worksheet<br>Accounts Receivable Bookkeeper and the back-up Accounts Receivable Bookkeeper have been retrained on the process of administering Medicare non-coverage letters at least two days prior to Medicare coverage ending on 6/4/18 by the Field Accountant.<br>The Administrator will monitor residents receiving Medicare coverage weekly for 8 weeks then monthly for 1 month utilizing the Daily Medicare Worksheet. Accounts Receivable Bookkeeper will provide copy of Medicare non-coverage letter issued to the beneficiary to the Administrator weekly for 8 weeks then monthly for 1 month to ensure timely provision of notice. The Administrator will check dates of letters to projected day of cessation of coverage weekly for 8 weeks then monthly for 1 | |

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| F 582 | Continued From page 10 | F 582 | month utilizing the Daily Medicare Worksheet.<br>The Executive QI committee will meet monthly and review audits of the Daily Medicare Worksheet for the provision of Medicare non-coverage letters and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (#106) with side rails as a restraint and accurately code 1 of 1 resident (#50) to reflect Level II Preadmission Screening and Resident Review (PASRR) identified as a Level II PASRR.<br><br>The findings included:<br><br>1-Record review revealed Resident #106 was admitted to the facility on 10/10/2017 with diagnoses which included Dementia with Behavioral Disturbance, Cognitive | F 641 | F641<br>Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>The process that lead to the deficiency was based on observations, record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (#106) with side rails as a restraint and accurately code 1 of 1 resident (#50) to reflect Level II Preadmission Screening and Resident Review (PASRR) identified as a level II PASSR. | 6/29/18 |

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| F 641 | Continued From page 11<br>Communication Deficit and Osteoarthritis.<br><br>Review of the Quarterly Minimum Data Set (MDS) dated 4/17/2018 indicated Resident #106 was severely cognitively impaired and required extensive to total assistance with all activities of daily living. The MDS further revealed bed rails were not used for the resident.<br><br>Review of Resident #106's Care Plan updated/revised 1/21/18 revealed the following:<br>Use of bed rails for maintaining current bed mobility or transfer ability<br>-Will continue to use bed rails safely for facilitating bed mobility and transfers through the next review<br>-Assess res for risk of entrapment from bed rails periodically and as necessary<br>-check bed rails periodically for proper functioning<br>-Provide and review with resident and or residents representative the risks and benefits of the use of bed rails<br><br>Review of a Bed Rail Evaluation for resident #106 dated 4/17/2018 revealed the following:<br>Cognitive ability: oriented to person<br>Resident has a safety awareness deficit<br>Resident has impaired short term and long-term memory<br>Resident has moderate impaired decision making<br>Benefits of Side Rail use:<br>Enables resident to position self in bed<br>Enables resident to rise from a supine to a sitting or standing position<br>Uses side rails for care with staff with cueing<br>Provides feeling of safety and/or comfort for resident<br>Risks of Side Rail use:<br>May increase potential for injuries (skin tears, | F 641 | The Minimum Data Set (MDS) for resident #106 was modified on 6.22.18 for the correct coding of the use of the side rail as a restraint by the MDS nurses.<br>Resident #50 with Level II PASSR number had Minimum Data Set (MDS) modifications completed on 6.8.18 for the information needed for the Level II PASSAR by the MDS nurses.<br>100% audit of all current resident most current MDS, were reviewed by the Director of Nursing (DON), the Assistant Director of nursing (ADON), the RN supervisor and the Quality Improvement (QI) nurses to ensure all MDS□s completed are accurate to include all diagnosis, restraints and correct PASSAR levels II and are coded correctly, was completed on 6.21.18 using a MDS Accuracy QI tool. Any issues will be addressed and documented at that time.<br><br>100% in-service of the MDS nurses to ensure all MDS assessments are completed accurately to include all diagnosis, restraints and correct PASSAR levels II are coded correctly on the MDS was completed on 6.18.2018 by the MDS consultant.<br>10% of completed MDS□s, will be reviewed to ensure MDS accuracy for all diagnosis, restraints and PASSAR levels II by the ADON and/or the RN supervisor 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 1 month utilizing a MDS Accuracy QI tool. All identified areas of concern will be addressed immediately by the ADON and/or RN supervisor, by retraining | |

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| F 641 | Continued From page 12<br>bruising, etc.)<br>May increase potential for falls and associated injuries (laceration fractures, head injuries)<br>May contribute to wedging of extremity or part of body in SR or between SRs<br>Alternatives/Interventions/Recommendations-none listed<br>Recommendations:<br>Left and right side rails<br>The resident has requested to have Side Rails while in bed<br>Side rails indicated and serve as an enabler to promote independence<br><br>An observation of Resident #106 was conducted on 05/29/18 at 3:14 PM. The resident was observed in bed with the head of the bed raised approximately 45 degrees. The bed was in the low position and bed rails were observed on both sides of the bed. The bed rails were raised and positioned between the head of the bed and the footboard.<br><br>An observation was made of Resident #106 on 05/30/18 at 10:14 AM. The resident was observed in bed with the head of the bed raised approximately 45 degrees. The bed was in the low position and bed rails were observed on both sides of the bed. The bed rails were raised and positioned between the head of the bed and the footboard.<br><br>An observation and interview was completed with Resident #106 on 05/31/18 at 8:31 AM. The resident was observed in bed with the head of the bed raised approximately 45 degrees. The bed was in the low position and bed rails were observed on both sides of the bed. The bed rails | F 641 | appropriate staff making the coding error and the MDS nurse will make modifications to the MDS. The DON will review and initial the MDS Accuracy QI tool weekly for 8 weeks and then monthly for 1 month to ensure any areas of concerns have been addressed.<br>The Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |

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| F 641 | Continued From page 13 | F 641 | | |

were raised and positioned between the head of the bed and the footboard. The resident was confused and unable to state her name. When the resident was asked to hold touch the side rail, she appeared unable to understand the request.

An interview was conducted with Minimum Data Set (MDS) nurse #1 on 5/31/2018 at 8:45 AM. MDS nurse#1 reported she completed Resident #106's assessments. MDS nurse #1 indicated the rails were not coded on the MDS as she did not think they should be coded as restraints and there was no other area in the MDS to code them. MDS nurse #1 indicated the resident was not able to request the rails and that was an error on the assessment form. MDS #1 indicated the resident usually was in bed with the head of the bed raised and the side rails were at the head of the bed.

An observation of Resident #106 was conducted on 5/31/2018 at 9:37 AM. The Director of Nursing (DON), the Administrator (ADM) and MDS nurse #1 were present during the observation. The resident was observed with the head of the bed approximately raised approximately 45 degrees. The ½ side rails were observed to be raised and on both sides of the bed. The rails were observed to be positioned approximately ½ way between the head of the bed and the foot board. MDS nurse #1 asked the resident if she could lower the head of the bed and the resident stated she did not care. The MDS nurse #1 used the control for the electric bed to lower the head of the bed and the resident became agitated and told the nurse to stop before the head of the bed was lowered to approximately 30 degrees. When the bed was lowered the side rails automatically began to move towards the head of the bed. MDS nurse

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| F 641 | Continued From page 14 | F 641 | | |

#1 raised the bed back to the prior position per the resident's request.

An interview was conducted with the Administrator (ADM) on 5/31/2018 at 9:44 AM. The ADM stated the side rails for resident #106 were coded incorrectly and his expectation was for the assessments to be coded accurately.

2. Resident #50 was admitted to the facility on 11/18/15 with diagnoses of major depressive disorder and disorganized schizophrenia.

Review of the Annual Minimum Data Set (MDS) dated on 03/21/18 indicated the resident was not considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness and/or intellectual disability. The results of this screening and review are used for formulating a determination of need, determination of an appropriate care setting and a set of recommendations for services to help develop an individual's plan of care.

Review of Resident's #50 PASRR Level II Determination Notification dated on 05/14/12 revealed that the resident had a permanent number.

During an interview with the Social Worker (SW) on 05/31/18 at 1:25 PM, she stated that she was not responsible for completing section A1500 of the MDS.

During an interview with the MDS Coordinator on

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| F 641 | Continued From page 15<br>05/31/18 at 4:28 PM, she stated that this resident was not on the list of residents that were PASRR level II. The MDS Coordinator further stated the SW provides the list of Level II PASRR residents.<br><br>During an interview with the Administrator on 06/01/18 at 4:37 PM, he stated it was his expectation that the facility staff accurately code the MDS. | F 641 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission. | F 655 | | 6/29/18 |

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| F 655 | Continued From page 16<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to provide a care plan for a feeding tube within forty-eight hours of admission for one of one residents reviewed with a feeding tube (Resident #299).<br><br>Findings included:<br><br>A review of the medical record revealed Resident #299 was admitted 5/21/2018 with a diagnosis of non-traumatic stroke. The medical record noted placement of a feeding tube on 5/15/2018.<br><br>The Admission Minimum Data Set (MDS) dated 5/28/2018 noted Resident #299 to be cognitively intact, and needed extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. The MDS noted the feeding tube provided more that 51% of total calories to Resident #299. The Care Area Assessment (CAA) noted a focus of tube feeding | F 655 | F655<br>Baseline Care Plans<br>CFR(s): 483.21(a)(1)-(3)<br><br>The process that lead to the deficiency was based on observation, staff interview and record review, the facility failed to provide a care plan for a feeding tube within forty-eight hours of admission for one of one residents reviewed with a feeding tube (Resident #299).<br><br>100% audit of baseline care plans for residents, to include resident #299, that were admitted to the facility in the last 30 days were reviewed by the Director of Nursing (DON), the Assistant Director of nursing (ADON), the RN supervisor and the Quality Improvement (QI) nurses to ensure all areas of care, to include feeding tubes, were care planned on the | |

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| F 655 | Continued From page 17<br>and this area would go to care plan.<br><br>A review of Resident #299's care plan revealed no care plan for a feeding tube.<br><br>On 6/1/2018 at 2:39 PM, in an interview, an MDS nurse assigned to Resident #299 stated the tube feeding was left off of the forty-eight hour care plan, but would be included in the twenty-one day care plan due 6/3/2018.<br><br>On 6/1/2018 at 3:30 PM, the Director of Nursing stated her expectation was if a resident was admitted with a feeding tube, it would be care planned on the initial care plan. | F 655 | initial care plan and will be completed by 6.18.2018. Any baseline care plan that needed to be revised will be updated by the Minimum Data Set (MDS) nurse and an updated care plan would be given to the resident and/or the resident representative (RR) by the MDS nurse.<br><br>100% in-service for all the MDS nurse on creating and implementing the resident baseline care plan will be conducted by the facilities MDS consultant and will be completed by 6.19.2018.<br><br>10% of completed baseline care plans will be reviewed by the Assistant Director of nursing (ADON), the RN supervisor and the Quality Improvement (QI) nurses to ensure all areas of care, to include feeding tubes, were care planned on the initial care plan 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 1 month utilizing Baseline Care Plan Audit tool. The DON will review and initial the Baseline Care Plan Audit tool weekly for 8 weeks and then monthly for 1 month to ensure any areas of concerns have been addressed.<br>The Executive QI committee will meet monthly and review audits of Baseline Care Plan Audit tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly for 3 months.<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related | |

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| F 655 | Continued From page 18 | F 655 | to the plan of correction. | |
| F 698 SS=D | Dialysis<br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations and facility staff and resident interviews, the facility failed to monitor a dialysis residents access/shunt site, failed to provide nursing assessments for a resident after dialysis treatments and failed to provide ongoing communication documentation with the hemodialysis center for 1 of 1 residents reviewed for dialysis (Resident #72).<br><br>Findings included:<br><br>Record review revealed Resident #72 was admitted to the facility on 12/28/2017 with diagnoses which included End Stage Renal Disease with Hemodialysis three times a week.<br><br>Review of the most recent Minimum Data Set (MDS) dated 4/6/2018 revealed Resident #72 was severely cognitively impaired and required extensive assistance with all her activities of daily living. The MDS indicated the resident required hemodialysis three times a week for End Stage Renal Disease.<br><br>Review of Resident #72's care Plan initiated revised 4/6/2018 revealed the resident had End | F 698 | F698<br>Dialysis<br>CFR(s): 483.25(l)<br><br>The process that lead to the deficiency was based on record review, observations and facility staff and resident interviews, the facility failed to monitor a dialysis residents access/shut site, failed to provide nursing assessments for a resident after dialysis treatments and failed to provide ongoing communication documentation with hemodialysis center for 1 of 1 residents reviewed for dialysis (Resident #72).<br><br>100% audit was completed on 6.4.18 by the Director of Nursing (DON), the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and Staff Facilitator for all residents, to include resident #72, receiving dialysis treatment to ensure that the shunt site is being checked daily for the bruit and thrill per documentation on the Medication Administration Record | 6/29/18 |

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| F 698 | Continued From page 19<br>Stage Renal Disease and was at risk for complications due to dialysis. The Care Plan interventions included dialysis treatments Mondays, Wednesdays and Fridays, assessment of the resident upon return from dialysis treatments, communication with dialysis center for any adjustments in care or treatment plan and to monitor dialysis site.<br><br>An observation of Resident #72 was conducted on 5/29/2018 at 11:18 AM. The resident was observed to be seated in a wheelchair beside the bed in her room. The resident reported she went to dialysis three times a week. The resident also reported the dialysis treatments were completed through a "thing" in her right arm. The resident raised her sleeve and there what appeared to be a dialysis shunt (a dialysis shunt is a connection of an artery to a vein to allow a high blood flow for dialysis).<br><br>Review of the Medication Administration Records and the Treatment Administration Records for Resident #72 for the month of May 2018 revealed no entry for checking the shunt site. There was no documentation in the electronic medical records/nursing notes/assessments for the shunt site.<br><br>An interview was conducted with Nurse #3 on 5/31/18 2:21 PM. Nurse #3 confirmed she was the nurse who worked with resident #72 during the day shift. Nurse #3 indicated she checked the resident's blood pressure and would send the Medication Administration Record and the resident's face sheet to the dialysis center on the days the resident was transported to dialysis. Nurse #3 indicated the other residents who received dialysis had a communication book that | F 698 | (MAR) and if not on the MAR it will be placed on the MAR for the hall nurses to check the shunt site for the bruit and thrill every shift daily and to ensure that there is an assessment prior to the resident leaving the facility for dialysis treatment and that the Dialysis progress note in the residents electronic record is being completed on the residents return from receiving dialysis treatment utilizing an Initial Dialysis Review Tool. Any issues will be addressed at that time by the Director of Nursing (DON), the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and/or Staff Facilitator.<br><br>100% in-service was initiated on 6.4.18 by the Staff Facilitator for all licensed nurses, to include nurse #4 and nurse #5, to include agency nurses, regarding: checking the bruit and thrill every shift daily and documenting on the MAR the results. That the resident□s assigned nurse will complete an assessment of the resident, to include checking the shunt site, to include the bruit and thrill, with documentation of the assessment in the resident□s electronic chart. When the resident returns to the facility after the dialysis treatment that the residents assigned nurse will complete the Dialysis progress note in the resident electronic record that includes; the time the resident returned from dialysis, Condition of the shunt site (dressing intact, bleeding, drainage, etc.), Bruit & thill: =/- Site:, Condition & Mental status on return (alert, oriented, confusion, lethargy, other | |

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| F 698 | Continued From page 20<br>was sent with them but Resident #72 did not. Nurse #3 stated she did not know why the resident did not have a communication book. Nurse #3 indicated she was not sure if the resident had a shunt because the resident usually returned after her shift was completed. Nurse #3 stated she did not check a shunt site on Resident #72's non-dialysis days.<br><br>An interview was conducted with the Quality Improvement (QI) nurse on 5/31/18 2:56 PM. The QI nurse indicated she was familiar with resident #72. The QI nurse stated each dialysis resident was supposed to have a dialysis communication book that was to be sent to the dialysis center with them each treatment. The QI nurse revealed the book contained information regarding the resident's condition at the facility before the treatment and documentation from the dialysis staff of the resident's condition after treatment. The QI nurse stated she did not know why resident #72 did not have a communication book. The QI nurse also indicated she was the one responsible for making sure the dialysis residents had the books available. The QI nurse also stated there should be an assessment in the nurses' documentation of Resident #72's condition before and after dialysis and documentation in the Medication Administration Record of the dialysis shunt site assessments every shift. The QI nurse stated she did not know why the information was not in the medical record.<br><br>An interview was conducted with Nurse #5 on 5/31/18 4:43 PM. Nurse #5 reported she worked with Resident #72 on the 3PM to 11PM shift and was familiar with her needs. Nurse #5 indicated the resident returned from dialysis treatments | F 698 | symptoms, etc.), Instructions &/or communication from dialysis ctr (pre/post wts, lab results, etc.), and additional comments (time dressing removed, MD notification and orders changes/verified, etc.). The inservice will be completed by 6.26.18.<br><br>All residents receiving dialysis treatment, to include resident #72, will be reviewed by the Assistant Director of Nursing, the Quality Improvement (QI) nurses, the RN supervisor, and Staff Facilitator to ensure that the residents shunt is being checked for the bruit and thrill every shift daily and that it is documented on the resident MAR, that there is an assessment prior to the resident leaving the facility for dialysis treatment and that the Dialysis progress note in the residents electronic record is being completed on the residents return from receiving dialysis treatment utilizing a Follow Up Dialysis Review Tool, 3 times a week for 4 weeks, then weekly for 4 weeks and then monthly for 1 month. The Director of Nursing will review and initial the Follow up Dialysis Review Tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all identified areas of concern were addressed.<br>The Executive QI committee will meet monthly and review audits of the Follow up Dialysis Review tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly for 3 months.<br>The Administrator and the DON will be responsible for the implementation of | |

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| F 698 | Continued From page 21<br>during the 3PM to 11PM shift. Nurse #5 stated she thought she checked the resident's shunt site when the resident returned from dialysis. Nurse #5 stated if she checked the site she would document the assessment in the nurses' notes. Nurse #5 indicated if there was no documentation in the notes she may have forgotten to assess the site. Nurse #5 reported all dialysis residents were supposed to have a dialysis communication book but was unsure if she remembered looking at Resident #72's book.<br><br>An interview was conducted with the Director of Nursing (DON) on 5/31/18 4:57 PM. The DON stated the facility expectation was for all dialysis residents to be assessed prior to dialysis, to be assessed post dialysis and the shunt site to be assessed every shift. The DON stated the assessments should be documented. The DON stated the facility expectation also included all dialysis residents to have a dialysis communication book to ensure there was communication for any issues documented from the dialysis center staff. | F 698 | corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |
| F 880 SS=C | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | F 880 | | 6/29/18 |

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| F 880 | Continued From page 22<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and | F 880 | | |

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| F 880 | Continued From page 23<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to wear gloves during the administration of insulin and the removal and application of a patch for one of one resident (Resident #169) resulting in a possible staff member exposure to a bloodborne pathogen and reception of the medication through skin absorption.<br><br>Findings included:<br>A review of a facility in-service entitled "Infection Control Policy Safe Medication Administration, Handwashing, Use of PPE" dated 05/02/18 was conducted. It stated gloves were to be worn when staff performed procedures that they may encounter bodily fluids. This included performing ADLs (activities of daily living) such as mouth care, bathing and perineal (genital area). Also, it stated gloves were to be worn during medication administration if administering injections, eye drops, nasal sprays, inhalers and removing or applying patches. | F 880 | F880<br>Infection Prevention and Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>The process that lead to the deficiency was based on observations, record reviews, and staff interviews, the facility failed to wear gloves during the administration of insulin and the removal and application of a patch for one of one resident (Resident #169) resulting in a possible staff member exposure to a blood borne pathogen and reception of the medication through the skin.<br>100% medication pass audit was initiated on 6.1.18 with all license nurse, to include agency nurses, and medication aides by the Director of nursing (DON), the Assistant Director of nursing (ADON), the RN supervisor, the Staff Facilitator, and the Quality Improvement (QI) nurses on | |

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| F 880 | Continued From page 24<br><br>On 05/30/18 at 5:15 p.m. an LPN (Licensed Practical Nurse) was observed preparing medications for Resident #169. She withdrew 5 units of Humulin R Insulin from the insulin bottle into an insulin syringe and dated a 25 mcg Duragesic Patch. She entered the resident's room and proceeded to cleanse the back of the resident's left arm with an alcohol wipe. She administered the insulin without donning gloves. The nurse did not wash her hands upon completion of the insulin injection. The nurse then removed an old Duragesic Patch from the resident's left upper chest. No gloves were worn to remove the old patch. Subsequently, the nurse removed the protective application paper from the new patch and applied the patch to Resident #169's right upper chest. No gloves were worn to apply the new patch. When asked what, if any, medication administration procedures require the use of gloves the nurse replied, "eye drops, insulin and patches. Oh, my goodness, I forgot to put my gloves on, I usually do but I'm nervous."<br><br>On 05/30/18 at 5:37 p.m. an interview was conducted with the DON (Director of Nursing). She stated her expectation was staff would wear gloves during the administration of medications that there may be a possibility of exposure to bodily fluids. She further added the expectation of hand washing and cleaning equipment to aid in infection control.<br><br>At 5:46 p.m. on 05/30/18 an interview was conducted with the administrator. He stated he expected "all staff to be trained in infection control and infection control practices to be maintained throughout the facility and with all staff." | F 880 | proper medication administration to include wearing gloves when administering injections and applying medication patches to ensure proper medication administration utilizing a Medication Pass audit form. Any issues identified during the medication pass audit was immediately corrected with retraining of the license nurse, to include agency nurses, and/or medication aide by the DON, ADON, RN supervisor, Staff Facilitator, and the QI nurses and will be completed by 6.26.18.<br>100% in-service was initiated on 6.1.18 for all licensed nurses, to include agency nurses, and medication aides by the Staff Facilitator regarding appropriate medication administration to include wearing gloves when applying medication patches and giving injections and will be completed by 6.26.18. All newly hired nurses, to include agency nurses, and medication aides will be in-serviced by Staff Facilitator on appropriate medication administration to include the wearing of gloves when applying medication patches and injections.<br>The Medication Pass Audit Tool will be utilized by the ADON, RN supervisor, Staff Facilitator, and the QI nurses 2 times per week for 4 weeks; then weekly for 4 weeks; then monthly for 1 month to ensure each hall nurse to include agency nurses, and medication aides is in compliance with medication administration to residents, to include resident #169, and the five rights, to include the application of medication patches and insulin injections. Immediate retraining will be conducted for | |

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| F 880 | Continued From page 25<br>On 05/31/18 at 8:39 a.m. an interview was conducted with the SDC (Staff Development Coordinator) who also oversaw the facility's Infection Control Program. She stated she began working at the facility on March 1, 2018. She stated Infection Control was taught in her new hire classes. The SDC stated although the LPN was an agency (temporary help) nurse, she attended a training on Infection Control on 05/02/18. She stated in addition to other infection control measures, she taught the importance of using proper PPE (Personal Protective Equipment) during medication administration for things such as injections, eye drops, and patch removal/application. | F 880 | the licensed nurse or medication aide for any identified issues observed during the medication pass audits by the ADON, RN supervisor, Staff Facilitator, and the QI nurses. The DON will review and initial the Medication Pass Audit Tool for appropriate medication administration to residents to include resident #169 for compliance and to ensure all identified areas of concern were addressed weekly for 8 weeks, then monthly X1 month.<br>The Executive QI committee will meet monthly and review audits of the Medication Pass Audit Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.<br>The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction. | |