STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
E 000	Initial Comments An unannounced recertification survey was conducted on 6/6/21 to 6/14/21. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# ZRE011.	E 000		
F 000	INITIAL COMMENTS A recertification, complaint investigation and COVID-19 Focused Infection Control Survey was conducted on 6/6/21 to 6/14/21. Immediate Jeopardy was identified at: CFR 483.45 at tag F760 at scope and severity (J). The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/22/21 for Residents #64 and 97 and was removed on 6/10/21. An extended survey was conducted. 6 of the 67 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive	F 636		7/9/21

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

Electronically Signed | 07/05/2021

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F 636	Continued From page 1	F 636		

assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes

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F 636	Continued From page 2 prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete an annual comprehensive Minimum Data Set (MDS) assessment within 366 days for 1 of 34 residents (Resident # 71) reviewed for comprehensive assessments. The findings included: Resident # 71 was admitted to the facility on 8/17/19 with diagnoses that included, in part, diabetes and heart failure. The annual MDS comprehensive assessment with an assessment reference date of 5/4/21 was reviewed and signed as completed on 5/24/21. The previous comprehensive MDS assessment was completed 5/15/20. An interview was completed with MDS Nurse #1 on 6/8/21 at 2:14 PM. She said MDS Nurse #3 had completed the assessment late and it should have been signed as completed by 5/18/21. She shared the MDS assessments were three months behind schedule since there had been staff turnover in the MDS office due to illness and retirement. She explained MDS Nurse #3 came	F 636	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 636 COMPREHENSIVE ASSESSMENT & TIMING Corrective Action: Resident #71. Admission Comprehensive Assessment, Assessment Reference Date (ARD) 5/4/2021. Completed, Submitted and Accepted on 6/9/2021 to the State Quality Improvement Evaluation System QIES system Identification of other residents who may be involved with this practice: All current residents with Comprehensive Minimum Data Set (MDS) assessments due have the potential to be affected by	

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F 636	Continued From page 3 from a sister facility two days a week and helped with the MDS assessments in efforts to get caught up on the assessments. During a phone interview with MDS Nurse #3 on 6/8/21 at 2:27 PM she verified she completed Resident #71's comprehensive assessment. She stated she helped at the facility part time so they could get caught up on past due MDS assessments. The Administrator was interviewed on 6/9/21 at 2:53 PM. He said the staff in the MDS office were out on sick leave for a significant amount of time and MDS assessments had fallen behind. The facility had initiated a quality improvement plan, which included a part time MDS nurse, to complete past due assessments and improve the timeliness of current assessments.	F 636	the alleged practice. On 7/3/2021 through 7/5/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted a comprehensive, accurate, standardized reproducible assessment of each residents' functional capacity. Out of the 136 current residents, 8 number of residents did not have their comprehensive assessments completed within 14 calendar days after admission, excluding readmission in which there is no significant change in the residents' physical or mental condition. This assessments were completed by 7/9//2021. Systemic Changes: On 7/5/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Support nurses any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each residents' functional capacity. OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a residents' status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: Admission	

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F 636	Continued From page 4	F 636	Assessment, Annual Assessment, and Significant Change in Status Assessment (SCSA)and Significant Correction to Prior Comprehensive Assessment (SCPA). The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: this is the residents' 'first time in this facility, OR the resident has been admitted to this facility and was discharged return not anticipated, OR the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments□ ARDs and completion dates. Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:(i) Identification and demographic information(ii) Customary routine.(iii) Cognitive patterns.(iv) Communication.(v) Vision.(vi) Mood and behavior patterns.	

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F 636	Continued From page 5	F 636	(vii) Psychological well-being.(viii) Physical functioning and structural problems.(ix) Continence.(x) Disease diagnosis and health conditions.(xi) Dental and nutritional status.(xii) Skin Conditions. (xiii) Activity pursuit.(xiv) Medications. Special treatments and procedures.(xvi) Discharge planning.(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non licensed direct care staff members on all shifts. This in service was completed by 7/5/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Mini Data Set (MDS) Coordinators will review weekly, 5 residents electronic records Mini Data Set(MDS) assessment this could be either one of the following Comprehensive assessments (Admission Assessment,	

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F 636	Continued From page 6	F 636	Annual Assessment, and Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment) to ensure that the comprehensive assessments are completed timely. This will be done on weekly basis to include the weekend for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/9/2021	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date of the	F 638	F 638 QRTLY ASSESSMENT AT LEAST EVERY 3 MONTHS Corrective Action: Resident #56 Quarterly Assessment	7/9/21

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F 638	Continued From page 7	F 638		

previous MDS assessment for 3 of 34 residents (Residents #56, #47 and #13) reviewed for timely completion of MDS assessments.

The findings included:

1. Resident #56 was admitted to the facility on 12/17/20 with diagnoses that included, in part, diabetes mellitus.

The quarterly MDS assessment with an assessment reference date (ARD) of 4/26/21 was reviewed and signed as completed on 6/7/21. The previous MDS assessment was completed on 1/27/21.

An interview was completed with MDS Nurse #2 on 6/9/21 at 2:50 PM. She verified Resident #56's quarterly assessment should have been signed as completed by 5/10/21.

During an interview with MDS Nurse #1 on 6/8/21 at 2:14 PM, she shared the MDS assessments were three months behind schedule since there had been staff turnover in the MDS office due to illness and retirement. She added there was a MDS nurse from a sister facility that came two days a week and helped with the MDS assessments in efforts to get caught up on the assessments.

The Administrator was interviewed on 6/9/21 at 2:53 PM. He said the staff in the MDS office were out on sick leave for a significant amount of time and MDS assessments had fallen behind. The facility had initiated a quality improvement plan, which included a part time MDS nurse, to complete past due assessments and improve the timeliness of current assessments.

Reference Date (ARD) 4/26/2021. Completed, Submitted and Accepted on 6/7/2021 to the State Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
Resident #47 Quarterly Assessment Reference Date (ARD) 4/30/2021. Completed, Submitted and Accepted on 5/21/2021 to the State QIES ASAP system.
Resident #13 Quarterly Assessment Reference Date (ARD) 5/4/2021. Completed, Submitted and Accepted on 5/21/2021 to the State QIES ASAP system.
Identification of other residents who may be involved with this practice:
All current residents with Quarterly Minimum Data Set (MDS) assessments due have the potential to be affected by the alleged practice. On 7/2/2021 through 7/5/2021 an audit was completed by the MDS Nurse consultant to ensure that the facility had conducted Quarterly Review assessment of each residents. Out of the 136 current residents, 0 number of residents did not have their quarterly review assessments completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment. This assessments were completed and submitted by 7/9/2021.
Systemic Changes:
On 7/5/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator, Licensed Practical Nurse (LPN) Support nurses any other Interdisciplinary team

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F 638	Continued From page 8 2. Resident #47 was admitted to the facility on 1/30/20 with diagnoses that included, in part, hypertension and cerebrovascular accident. The quarterly MDS assessment with an assessment reference date (ARD) of 4/30/21 was reviewed and signed as completed on 5/21/21. The previous MDS assessment was completed on 1/30/21. An interview was completed with MDS Nurse #2 on 6/9/21 at 2:50 PM. She verified Resident #47's quarterly assessment should have been signed as completed by 5/13/21. During an interview with MDS Nurse #1 on 6/8/21 at 2:14 PM, she shared the MDS assessments were three months behind schedule since there had been staff turnover in the MDS office due to illness and retirement. She added there was a MDS nurse from a sister facility that came two days a week and helped with the MDS assessments in efforts to get caught up on the assessments. The Administrator was interviewed on 6/9/21 at 2:53 PM. He said the staff in the MDS office were out on sick leave for a significant amount of time and MDS assessments had fallen behind. The facility had initiated a quality improvement plan, which included a part time MDS nurse, to complete past due assessments and improve the timeliness of current assessments. 3. Resident #13 was admitted to the facility on 1/26/21 with diagnoses that included, in part, hypertension and dementia.	F 638	member that participates in the MDS assessment process was in serviced /educated by the MDS nurse consultant. The education focused on: The facility must conduct initially and periodically a Quarterly Review Assessment of each residents functional capacity. OBRA-required quarterly review assessments are to be completed within 92days since the ARD of the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days). The MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This in service was completed by 7/5/2021. Any MDS nurse (full time, part time, and PRN) and member of the interdisciplinary team who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring: To ensure compliance, The Director of Nursing and/or Minimum Data Set(MDS) Nurse Consultant will review weekly, 5 residents electronic records Minimum Data Set(MDS) Quarterly assessments to ensure that the assessments are to be completed within 92days since the ARD of	

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F 638	Continued From page 9 The quarterly MDS assessment with an assessment reference date (ARD) of 5/4/21 was reviewed and signed as completed on 5/21/21. The previous MDS assessment was completed on 2/1/21. An interview was completed with MDS Nurse #2 on 6/9/21 at 2:50 PM. She verified Resident #13's quarterly assessment should have been signed as completed by 5/18/21. During an interview with MDS Nurse #1 on 6/8/21 at 2:14 PM, she shared the MDS assessments were three months behind schedule since there had been staff turnover in the MDS office due to illness and retirement. She added there was a MDS nurse from a sister facility that came two days a week and helped with the MDS assessments in efforts to get caught up on the assessments. The Administrator was interviewed on 6/9/21 at 2:53 PM. He said the staff in the MDS office were out on sick leave for a significant amount of time and MDS assessments had fallen behind. The facility had initiated a quality improvement plan, which included a part time MDS nurse, to complete past due assessments and improve the timeliness of current assessments.	F 638	the previous OBRA Quarterly Review Assessment or ARD of previous comprehensive assessment, or significant Correction to Prior Quarterly Assessment (ARD of any of the mentioned assessments + 92 calendar days) and completed timely : the MDS completion date (item Z0500B must be no later than 14days after the ARD (ARD + 14 calendar days). This will be done on weekly basis to include the weekend for 12 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Wound Nurse. Date of Compliance: 7/9/2021	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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	F 641	F641 Accuracy of Assessments	7/9/21

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F 641	Continued From page 10 interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of catheters (Resident #75), medications (Resident #71) and hospice (Resident #478) for 3 of 32 sampled residents reviewed. (Residents #75, #71 and #478). The findings included: 1. Resident #75 was admitted to the facility on 7/19/17 with diagnosis of cerebral infarction. An observation on 6/7/21 at 9:38 AM revealed Resident #75 had an indwelling catheter in place. A significant change in status MDS dated 5/12/21 revealed Resident #75 was always incontinent of bladder. An interview on 6/10/21 at 10:37 AM with MDS Nurse #1 revealed the significant change in status MDS for Resident #75 should have been coded for the indwelling catheter. She added it was an oversight that always incontinent was checked instead of indwelling catheter. 2. Resident #71 was admitted to the facility on 8/17/19 with diagnoses that included, in part, anxiety disorder. A physician's order dated 3/12/21 read escitalopram (an anti-depressant), 10 milligrams, daily for depression. The medication was discontinued on 5/12/21. The Medication Administration Record (MAR) for May 2021 indicated Resident #71 received	F 641	Corrective Action: Resident # 75 Resident Minimum Data Set (MDS) assessment (Significant Change in Status Comprehensive Assessment) with Assessment /Reference Date (ARD) [5/12/2021] was modified with a Corrective Attestation Date of 6/11/2021. The assessment was submitted to the state QIES system on 6/14/2021 and was accepted on 6/14/2021. Submission ID: 20534957. Resident # 71 Resident Minimum Data Set (MDS) assessment (Annual Comprehensive Assessment) with Assessment /Reference Date (ARD) [5/4/2021] was modified with a Corrective Attestation Date of 6/14/2021. The assessment was submitted to the state QIES system on 6/15/2021 and was accepted on 6/15/2021 Submission ID: 20540515 Resident # 478 Resident Minimum Data Set (MDS) assessment (Quarterly Assessment) with Assessment /Reference Date (ARD) [4/9/2021] was modified with a Corrective Attestation Date of 6/11/2021. The assessment was submitted to the state QIES system on 6/14/2021 and was accepted on 6/14/2021. Submission ID: 20534957. Identification of other residents who may be involved with this practice: All current residents who are on hospice services; who are on antidepressant medication , who are using indwelling catheters during the Mini Data Set (MDS) 7 day look back for quarterly assessment reference date(s), and who have elected hospice care have the potential to be	

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F 641	Continued From page 11 escitalopram daily from 5/1/21-5/12/21. The annual MDS assessment dated 5/4/21 revealed Resident #71 received an anti-anxiety medication seven of seven days during the look back period. The use of an anti-depressant medication was not checked on the MDS assessment. On 6/8/21 at 2:27 PM an interview was completed with MDS Nurse #3. She verified she completed the MDS assessment for Resident #71. She explained when she coded the medication section of the assessment, the medications were coded per drug classification and not how they were used. She said escitalopram was an anti-depressant medication and thought she mistakenly coded it as an anti-anxiety medication on the MDS assessment. During an interview with the Assistant Director of Nursing on 6/10/21 at 8:56 AM she expressed coding should be accurate when staff completed MDS assessments. She said there was corporate support available to the MDS nurses for education on accurately completing MDS assessments. 3. Resident #478 was readmitted to the facility on 8/23/20 with diagnoses that included, in part, Rheumatoid Arthritis, age-related physical debility, and atrial fibrillation. On 6/8/21 at 10:44 AM a record review for hospice revealed that Resident #478 was readmitted to hospice on 4/13/21 and a new hospice care plan was completed.	F 641	affected by the alleged practice. On 7/2/2021 through 7/5/2021 an audit was completed by the MDS Nurse Consultant to review all Quarterly Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who have elected hospice services that section O0100K Hospice Care while a resident is coded accurately. On 7/2/2021 through 7/5/2021 an audit was completed by the MDS Nurse Consultant to review all Annual Comprehensive Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who use antidepressant medication by pharmacological classification, not how it is used during the last 7days or since admission/entry or reentry if less than 7days, is coded accurately. On 7/2/2021 through 7/5/2021 an audit was completed by the MDS Nurse Consultant to review all Significant Change Comprehensive Minimum Data Set (MDS) assessments in the last 6 months to ensure that all residents who used an indwelling catheter during the last 7days of the Assessment reference date, is coded accurately. This was completed on 07/5/2021. Systemic Changes: On 07/05/2021 The Registered Nurse (RN) Minimum Data Set (MDS) Coordinator and MDS Support nurse and any other Interdisciplinary team member that participates in the MDS assessment process was in serviced /educated by the MDS Nurse consultant. The education focused on: The facility must ensure that each assessment	

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F 641	Continued From page 12 The quarterly MDS assessment dated 4/19/21 revealed that hospice was not marked and was left blank under the special treatments and programs section. During an interview with MDS Coordinator #1 on 6/8/21 at 3:35 PM, she stated that the business office was made aware that resident was transitioning to hospice care on 4/13/21 and it was care planned the same day. It was not marked on the MDS by accident and will be corrected. The Administrator was interviewed on 6/8/21 at 3:57 PM. He shared the facility will be working on educating staff to ensure MDS assessments were accurate.	F 641	accurately reflects the residents' status. Section H0100A:Indwelling Catheter(Including suprapubic catheter and nephrostomy tube). Check that it used at any time in the past 7 days. Section N0410C Antidepressant : Record the number of days an antidepressant medication by pharmacological classification, not how it is used ,was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Section O0100K Hospice care while a resident. Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. This in service was completed by 7/5/2021.The Registered Nurse (RN) and or Licensed Practical Nurse (LPN) Support Minimum Data Set (MDS) Coordinators and any other Interdisciplinary team member that participates in the MDS assessment process who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Monitoring:	

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F 641	Continued From page 13	F 641	To ensure compliance, The Director of Nursing and/or Administrator will review 5 resident electronic medical records Minimum Data Set (MDS) assessment this could be either one of the following assessments Admission, Annual or Quarterly Assessment to ensure that section O0100K Hospice Care while a resident, Section H0100A Indwelling Catheter(including suprapubic catheter and nephrostomy tube), and Section N0410N Antidepressant are coded accurately. This will be done on weekly basis for 4 weeks then monthly for 3 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 07/09/2021	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		7/9/21

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F 655	Continued From page 14 §483.21(a) Baseline Care Plans §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- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §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: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.	F 655		

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F 655	Continued From page 15 (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission to the facility for 1 of 5 residents (Resident #176) reviewed for new admissions. The findings included: Resident #176 was admitted to the facility on 5/14/2021 and readmitted on 5/25/2021 with diagnosis that included acute and subacute infective endocarditis, septic arterial embolism, vascular access device and sensorineural hearing loss to the left ear. list dx that would have been care planned - diabetes, hearing loss A review of the Minimum Data Set (MDS) system revealed Resident #176 was admitted on 5/14/2021 and discharged on 5/16/2021. The Resident was readmitted on 5/25/2021 and the admission assessment review date for the MDS assessment was scheduled for 6/1/2021 and was still in progress. A review of the electronic medical record did not reveal a baseline care plan and a progress note was not written that indicated a base line care plan was conducted. Resident #176 was listed as her own responsible party (RP). An interview with Resident #176 was conducted on 6/7/2021 at 11:05 a.m. and the Resident denied being invited to a care plan meeting. The Resident added she had to go ask a nurse on the unit for any information and was not aware a care	F 655	F655 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #176 was discharged from the facility on 06.11.2021, therefore no corrective action was completed. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 06.30.2021, The Director of Nurses (DON) initiated an audit of all current residents admitted during the last 14 days to identify any residents who did not have a base line care plan completed within 48 hours of their admission. The audit was completed on 7.1.2021. Results: 15 of 21 residents did not have base line care plans correctly completed. On 07.02.2021, the DON ensured that all residents who did not have base line care plans completed were immediately corrected and a baseline care plan was completed for them. On 06.30.2021, the DON and Staff Development Nurse began educating all full time, part time, agency staff, and as needed (PRN) Licensed Nurses (Registered Nurses and Licensed Practical Nurses) on the following topics:	

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F 655	Continued From page 16 plan meeting existed in the facility. The Resident stated she was her own legal representative, lived in the community independently prior to being admitted for intravenous antibiotic therapy and would return to her home at discharge. On 6/8/2021 at 9:49 a.m. an interview was conducted with MDS #2 and she revealed the process for baseline care plans had changed due to change of ownership. She added that the current corporate company used the actual orders that a resident is admitted with to print and establish the base line care plan. A printed copy would be provided to the resident, the RP, and the physician. She stated a copy would be signed by each and scanned into the documents section of the electronic medical record. She opened the electronic medical record for Resident #176 and stated she did not see a baseline care plan scanned into the system. On 6/8/2021 at 9:58 a.m. an interview was conducted with the corporate nurse consultant and she revealed her expectation for the baseline care plan process included the following: the admission summary be printed with all of the orders and reviewed with the resident, RP and the Interdisciplinary team (IDT). She stated the IDT team was composed of a nursing representative, dietary department, MDS, social services and therapy if indicated. She revealed the admission summary was scanned into the documents area of the electronic medical record for Resident #176 and was labeled "order summary," signed only by a physician. She added that she did not see a progress note that indicated a baseline care plan was conducted. On 6/8/2021 at 10:14 a.m. an interview was	F 655	" Procedure for Initiating a Base Line Care Plan. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 06.30.2021, the DON and Staff Development Nurse began educating all full time, part time, agency staff, and as needed (PRN) Licensed Nurses (Registered Nurses and Licensed Practical Nurses) on the following topics: Procedure for Initiating a Base Line Care Plan. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 07.09.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F655 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with	

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F 655	Continued From page 17 conducted with the ADON and she revealed her expectation for a baseline care plan was for the base line care plan to occur within the required time frame. She added at the facility, MDS was to complete the baseline care plan.	F 655	initiating base line care plans within the specified time frame and provide the resident and/or their representative with a summary of the baseline care plan. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nurses, Assistant Director of Nurses, Minimum Data Set Nurses, Therapy Manager, RN Unit Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 07/9/2021	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		7/9/21

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F 690	Continued From page 18 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to change a urinary catheter as ordered for a resident (Resident #119) for 1 of 4 sampled residents reviewed for urinary catheters. The findings included: Resident #119 was admitted on 12/16/2020 with medical diagnosis that included neuromuscular dysfunction of the bladder, chronic urinary device, and retention of urine. A review of the most recent Minimum Data Set (MDS) assessment, dated 3/17/2021, coded Resident #119 to have severe cognitive impairment, require one-person total dependance	F 690	F 690 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 06.07.2021, the Staff Nurse changed the catheter for the indwelling catheter of resident #119. The catheter will be changed per MD order. There were no adverse effects observed as a result of the deficient practice. The physician was notified of the above information. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 690	Continued From page 19 in all areas, to include personal hygiene and toileting and to have an indwelling catheter. A review of Resident #119's individualized care plan, dated 4/17/2021 revealed a focused area for an indwelling foley catheter with a goal to remain free from catheter related trauma and show no signs of a urinary infection through the review date. Interventions included to check the tubing everyday and provide catheter care every shift. A review of Resident #119's physician orders included to change the urinary catheter every 30 days on the 17th day of the month. An observation of Resident #119's urinary catheter bag occurred on 6/6/2021 at 10:01 a.m. The urinary catheter bag was observed to have a handwritten date in black marker that read 4/27/2021. The catheter tubing had dark yellow urine with large amounts of sediment. An observation of Resident #119's urinary catheter bag occurred on 6/7/2021 at 2:31 p.m. The catheter bag was observed to continue to have a date written in black marker that read 4/27/2021. An interview was conducted on 6/7/2021 at 2:33 p.m. with Nurse #02, and she reported that she had not assessed the urinary catheter bag for the date changed on that shift. She stated that an order was on the Medication Administration Record (MAR) that read to change the urinary catheter every 30 days or as needed for occlusion, infection, or a compromised drainage system. She added a date was not scheduled on the MAR to provide direction to the hall nurse on	F 690	On 06.07.2021, the Assistant Director of Nurses (ADON), the Registered Nurse (RN) Unit Manager, and the Unit Support Nurse changed the collection bag for indwelling catheters for all current residents who had an indwelling catheter including changing the catheters for those residents who were due for a routine catheter change and those residents that had clinical indications for change of the catheter. The Clinical Nurse Consultant reviewed all orders for all current residents who had an indwelling catheter to identify that each resident had an order in place to change the catheter as needed and if there was an order for a routine change that the date of the order change was indicated on EMAR. Results of the audit indicated that all residents had an order to change the indwelling catheter including the collection bag as needed and any routine indwelling catheter orders had a designated date to change the catheter. On 06.14.2021, the Director of Nurses (DON), Staff Development Coordinator (SDC) Nurse, and the ADON initiated education for all Licensed Nurses, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), full time, part time, PRN staff, and agency staff on catheter education. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur:	

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F 690	Continued From page 20 what day the urinary catheter should be changed. She went to observe Resident #119's bag and stated the urinary catheter was overdue to be changed and that she would change it immediately. An observation occurred on 6/7/2021 at 2:52 p.m. of Resident #119's urinary catheter drainage system with the Assistant Director of Nursing (ADON) and the Corporate Nurse consultant. The urinary catheter drainage system was observed to have a new bag with the date of 6/7/2021 and the trash container had the old urinary drainage system. The ADON placed on a pair of gloves, lifted the bag, and stated the date was 4/27/2021. An interview was conducted on 6/7/2021 at 2:52 p.m. with the ADON during the observation of Resident #119's urinary catheter drainage system and the ADON stated the date was greater than 30 days and this was a concern. She added it was her expectation that all urinary catheters receive care on time as written in the orders.	F 690	Education: On 06.14.2021, the Director of Nurses (DON), Staff Development Coordinator (SDC) Nurse, and the ADON initiated education for all Licensed Nurses, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), full time, part time, PRN staff, and agency staff on catheter education. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 07.09.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will monitor compliance utilizing the F690 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with changing the indwelling catheters including the collection bag for catheters. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program	

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F 690	Continued From page 21	F 690	reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Compliance Date: 07.09.2021	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent a significant medication error when a medication aide failed to identify residents which resulted in 2 residents receiving the other one's medications (Residents #97 and #64) resulting in medication induced shock for Resident #97 requiring hospitalization and intravenous medications and fluids for 2 of 5 sampled residents reviewed for medication administration (Residents #97 and #64). Immediate jeopardy began on 5/22/21 when, during medication administration on the 400 hall, Medication Aide #1 administered Resident #97's medications to Resident #64 and Resident #64's medications to Resident #97 and was removed on 6/10/21 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated potential for actual harm that is not immediate jeopardy) to	F 760	F760 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #97 no longer resides at the facility. He discharged on 05/23/2021, therefore no corrective action was completed for him. Resident # 64 received the incorrect medications on 5/22/2021. Resident # 64 did not have any observed adverse effects as evidenced by no changes in his clinical vital signs. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected.	7/9/21

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F 760	Continued From page 22 ensure monitoring systems in place are effective. The findings included: 1a. Resident #97 was admitted to the facility on 3/31/20 with diagnoses that included, in part, hypertension, cerebrovascular accident, hypothyroidism, and hyperlipidemia. A quarterly Minimum Data Set assessment dated 4/19/21 revealed Resident #97 had severe cognitive impairment. A nurse's note dated 5/22/21 at 10:50 PM revealed Resident #97 was sent out to the hospital for evaluation due to rapid decline in blood pressure. The on-call physician's assistant was notified at 10:10 PM and family was also notified. Resident #97's blood pressure was 68/36 and he was alert and talking prior to leaving the facility with emergency medical services. A medication error report dated 5/22/21 revealed Medication Aide #1 failed to properly identify Resident #97 and gave him Resident #64's evening medications to include depakote 500 milligrams (a mood stabilizer) and the following medications used to treat high blood pressure: hydralazine 50 milligrams, labetalol 200 milligrams, clonidine 0.3 milligrams, lisinopril 40 milligrams and isosorbide dinitrate 20 milligrams. b. Resident #64 was admitted to the facility on 3/1/21 with diagnoses of hypertensive chronic kidney disease and diabetes mellitus type 2. An admission MDS dated 3/8/21 revealed Resident #64 had severely impaired cognition.	F 760	No other residents were impacted by the medication error. On 5/23/2021 the Director of Nurses (DON) audited all current residents door name plates and compared it to the electronic health record to ensure that the name plates matched the current resident and their bed/room assignments. On 5/23/2021, the risk management nurse also reviewed all current residents in the electronic health record ensure that photos were uploaded. On 5/24/2021, the Quality Assurance Committee conducted a root cause analysis and determined that the root cause of the error was that the medication aide did not validate the resident identify prior to administering the medications. The medication aide also had poured two residents' medications at one time. On 05/23/2021, the primary RN staff immediately in-serviced the Agency staff nurse the six rights of medication administration. On 05.23.2021, the DON, Assistant Director of Nurses (ADON), Clinical Nurse Consultant, Staff Development Coordinator (SDC) Nurse, and the Registered Nurse (RN) Unit Manager began education of All Full Time, Part Time, and as needed (PRN) Nurses; RNs, Licensed Practical Nurses (LPNs), and Medication aides on the following by the Director of Nurses, Nurse Managers and	

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F 760	Continued From page 23 The medication error report dated 5/22/21 further revealed Medication Aide #1 failed to properly identify Resident #64 and gave him Resident #97's medications which included Seroquel 25 milligrams (a medication used to treat behaviors), amlodipine 5 milligrams (a medication used to lower blood pressure) and Buspar 5 milligrams (a medication used to treat anxiety). Review of Resident #97's Medication Administration Record (MAR) for May 2021 indicated his evening medication was documented as administered on 5/22/21. Review of Resident #64's MAR for May 2021 indicated his evening medication was documented as administered on 5/22/21. A telephone statement by Medication Aide #1 taken by the Director of Nursing (DON) on 5/24/21 was reviewed. The statement revealed she was administering medications to Residents #64 and #97 and Nurse #1 was the charge nurse. She proceeded to prepare the medications for the residents. Both residents' medications were put in individual cups and crushed. No markings were put on the cups. Medication Aide #1 entered the room with both cups in hand and she noted both residents' door tags were labeled "A". Medication Aide #1 stated she knew which cup belonged to which resident, but she got the cups switched up. Medication Aide #1 stated she went and got Nurse #1 after 5 minutes after she realized she made a mistake. Medication Aide #1 was educated that evening by Nurse #1 on the appropriate identifiers for residents and the 6 rights of medication administration which include identifying the correct resident, drug, route for administration, dose, time, assessing for pain and	F 760	Staff Development Nurse: " Preventing medication errors " Validating identity by using door plates, pictures, and verbal identification if indicated) " 6 rights of medication administration " Following medication safety practices (Including only pouring one residents' medications at a time). On 06/10/2021, the ADON, Clinical Nurse Consultant, RN Unit Manager, and the SDC Nurse initiated observational competency for the education on preventing medication errors to all Full Time, Part Time, and (PRN) Nurses; RNs, LPNs, and Medication Aides. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 05/23/2021, the Assistant Director of Nurses (ADON), Clinical Nurse Consultant, Staff Development Coordinator (SDC) Nurse, and the Registered Nurse (RN) Unit Manager began education of All Full Time, Part Time, and as needed (PRN) Nurses; RNs, Licensed Practical Nurses (LPNs), and Medication Aides on the following by the Director of Nurses, Nurse Managers and Staff Development Nurse: " Preventing medication errors " Validating identity by using door plates, pictures, and verbal identification if indicated)	

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ensuring the documentation is accurate. She verbalized understanding on the night of 5/22/21. During the phone statement, she was remorseful of the mistake she made. The DON educated her on the importance of only administering one person's medications at a time to prevent these kinds of errors. She verbalized she knew that was not the proper way to administer medications.

An interview was conducted on 6/8/21 at 2:28 PM with Medication Aide #1. She stated she worked the 7:00 PM - 7:00 AM shift on 5/22/21 and administered medications to Residents #64 and 97. She stated both residents were in the same room and both had "A" on their door tags, indicating they were both in the "A" bed. She added she never worked the hall before but thought she knew one of the residents. She stated she didn ' t ask either one of their names and should have. When she checked Resident #64's blood sugar and it was normal, she realized her error because his blood sugar was normal, and she did not expect it to be so she immediately notified Nurse #1. Nurse #1 immediately assessed both residents while she obtained vital signs. Resident #97's blood pressure dropped to 74/53. She stayed with Resident #97 until the ambulance arrived and he remained alert. She stated she was immediately educated by Nurse #1 on the 6 medication rights. She was also checking Resident #64's vital signs and they remained normal.

A statement by Nurse #1 dated 5/23/21 revealed on the night of 5/22/21, Medication Aide #1 was working on 400 hall and she was assigned to cover her hall. At approximately 9:45 PM, she came to her and informed her of a medication error that just occurred. She explained that 411 A

" 6 rights of medication administration
" Following medication safety practices (Including only pouring one residents' medications at a time).

On 06/10/2021, the ADON, Clinical Nurse Consultant, RN Unit Manager, and the SDC Nurse initiated observational competency for the education on preventing medication errors to all Full Time, Part Time, and (PRN) Nurses; RNs, LPNs, and Medication Aides.

This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 06.10.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.
4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nursing or designee will monitor compliance utilizing the F760 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with labeling medications with a date when opened and ensuring the cart and the medication room is free of expired medications. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing

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F 760	Continued From page 25 and 411 B were given each other ' s medications as when she pulled the medication for "A" bed and looked at the card on the door it showed "A" bed to be Resident #64's so when she pulled the meds for "B" bed she brought them to the roommate Resident #97. Medication Aide #1 stated when looking at pictures on the computer, they looked similar and did not realize they were not the right residents. Nurse #1 assessed both residents' level of consciousness and while Medication Aide #1 obtained vitals for both residents, she looked over the medications that had been given in error. Nurse #1 assessed Resident #97's heart sounds which were faint, and no radial pulses were palpated. Manual blood pressure on left arm was 78/56 and right arm was 74/53. Nurse #1 checked Resident #97's chart and identified no code status. 911 was called due to blood pressure dropping to 60/30's. Medication Aide #1 stayed at the bedside while she notified the physician and family. The on-call physician's assistant gave an order to hold Resident #64's medications until the next administration and obtain vital signs every hour x 4 hours and then every 2 hours x 8 hours if remained stable. She also notified the DON and Assistant Director of Nursing and educated Medication Aide #1 on the medication rights. The emergency room physician called and stated the resident was stable and would be monitored with the hopes of returning to the facility by morning. At 4:00 AM, Nurse #1 called the hospital to ask when they could expect Resident #97 back and was informed that he would be admitted due to a heart rate in the 20 ' s and he would need to be started on a medication drip. An interview with Nurse #1 was conducted on 6/9/21 at 9:30 AM. She stated she worked the	F 760	program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 07.09.2021	

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7:00 PM - 7:00 AM on 5/22/21. She was assigned to C-100 hall and was the RN for the C-200 medication aide (Med Aide #1). She stated Med Aide #1 came to her and told her that she thought she made a mistake and that she gave the residents in room 411 each other's medications. Med Aide #1 stated she looked at both residents' pictures and they looked similar, but she went by their facial hair which wasn ' t the same as it was in the pictures because they weren't current. Nurse #1 stated she immediately went to Room 411 to assess both residents. She also looked at both residents' medications and noted several blood pressure medications. Med Aide #1 began checking vital signs and Resident #97's blood pressure was in the 70's/40's range. She checked the chart and found Do not resuscitate status, called physician and 911 to send resident to emergency department. Last blood pressure checked was in the 60's over 30's range. She educated Medication Aide #1. She stated that Monday, on 5/24/21, she got a text message from the Assistant Director of Nursing (ADON) regarding medication administration and it included making sure to pull only one resident's medications at a time. Nurse #1 stated Medication Aide #1 did not tell her at that time that she prepared both residents' medications at the same time.

A review of the hospital history and physical for Resident #97 dated 5/22/21 read, "the resident presented from the facility after the resident developed hypotension at the facility after inappropriately receiving wrong medication due to staff error. Upon arrival to Emergency Department, resident ' s blood pressure was in the 90/50 ' s and heart rate as low as 20 ' s".

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A review of the hospital discharge summary dated 5/28/21 read "active hospital problem: diagnosis hypotension due to medication. Hospital course: resolved medication-induced shock. Patient required extended course on levophed infusion (used to treat life threatening low blood pressure) on 5/23/21 due to persistent bradycardia (low heart rate) and hypotension. Resident was discharged in stable condition on 5/28/21 to another skilled nursing facility with no follow up required".

On 6/9/21 at 10:00 AM, the Administrator was interviewed. He stated he was informed of the medication error involving Residents #97 and #64 and that Resident #997 was transferred to the hospital. He recalled Medication Aide #1 reported she thought the residents looked alike. He stated he didn't agree, and Medication Aide #1 should still have followed the 6 rights of medication administration. She was immediately asked not to return to facility.

On 6/9/21 at 10:25 AM, the ADON was interviewed. She stated she got a call from Nurse #1 and was informed Medication Aide #1 made a medication error. Medication Aide #1 administered Resident #64 & 97's medications to each other. Nurse #1 told her she immediately assessed both residents and Resident #97's blood pressure was dropping so she sent him to the emergency department, and he was admitted. They met with the family on 5/24/21 to let them know what they were going to put into place to prevent further errors. She stated she found out after the DON interviewed Med Aide #1 that she poured both residents ' medications at the same time, but she was unaware of that at the time. Education was immediately provided to

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Medication Aide #1. The Director of Nursing provided education to all nurses and medications aides on 5/24/21 on the 6 medication rights and the DON also did an audit of door tags to ensure they were accurate.

The Administrator, Assistant Administrator and Corporate Nurse Consultant were notified of the immediate jeopardy on 6/10/21 at 11:05 AM.

The facility provided the following credible allegation of immediate jeopardy removal:

Resident # 97 received the incorrect medications on 5/22/2021. The resident was sent to the hospital for evaluation and was notified to have a blood pressure of 68/36. The resident was alert and verbal at the time of transfer. Medication Aide #1's failure to properly identify Resident #97 resulted in him being transferred to the hospital emergency department and subsequently admitted for treatment of low blood pressure and low heart rate requiring intravenous medications and fluids.

Resident # 64 received the incorrect medications on 5/22/2021. Resident # 64 did not have any changes in vital signs.

No other residents were impacted by the medication error. On 5/23/2021 the Director of nursing audited all current resident ' door name plates and compared to the electronic health record to ensure that the name plates matched the current resident and their bed/room assignments. On 5/23/21, the risk management nurse also reviewed all current residents in the electronic health record ensure that photos were uploaded.

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On 5/23/2021, the nurse managers conducted a root cause analysis and determined that the root cause of the error was that the medication aide did not validate the resident identify prior to administering the medications. She also had poured two residents' medications at one time.

All Full Time and Part Time and as needed (PRN) Nursing (Registered Nurses, Licensed Practical Nurses) and Medication aides will be educated on the following by the Director of Nursing, Nurse Managers and Staff Development Nurse. Education began on 5/23/2021.

Director of Nursing, and /or Assistant Director of Nursing and/or Unit Managers and /or Nurse Managers will complete a Medication observation of med pass using a Medication observation tool, on 12 staff nurses {Registered nurse and Licensed Practical Nurse} and 3 medication aides). This was completed on 6/10/2021.
In-service topics included preventing medication errors (including validating identity by using door plates, pictures and verbal identification), the 6 rights of medication administration, and following medication safety practices (such as only pouring one resident's medications at a time). Those that did not receive the in-service training by 5/26/2021 will not be allowed to work until the training is complete. This training was incorporated into the general orientation program and provided by the Staff Development Nurse.

The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Mini Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Wound

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F 760	Continued From page 30 Nurse, Pharmacist), were notified of the medication error by 5/23/2021 and were involved in the removal plan. Immediate Jeopardy Removal date: 6/10/21. The credible allegation for immediate jeopardy removal was validated on 6/14/21 which removed the immediate jeopardy on 6/10/21 as evidenced by staff interviews, in-service record reviews and medication audit record reviews. The in-service included information on types of medication errors, preventing medication errors by following the 6 rights of medication administration, preparing medications for only one resident at a time and other safe practices to incorporate into the daily medication pass routine such as: minimizing distractions.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		7/9/21

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F 812	Continued From page 31 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed sanitize dishware for meal service by failing to ensure the wash and final rinse cycles of the dishwashing machine operated at accurate temperatures. Also, the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened food items in the refrigeration/freezing units and dry storage areas were resealed, labeled, and dated; and by failing to ensure the food preparation areas, food storage areas, and food service equipment were maintained clean and free from debris. The facility also failed to ensure the food items stored in the snack/nourishment refrigerators in 2 of 2 residents' nourishment rooms were clean, and food items not provided by the facility were dated and labeled. These practices had the potential to affect food served to residents. Findings included: 1. The facility's "High Temperature Dishwasher Log" located on the wall next to the dishwashing machine in the kitchen read in part: Acceptable Temperatures: wash 160-170 degrees Fahrenheit; final rinse 180-190 degrees Fahrenheit. Report temperatures higher than 190 degrees Fahrenheit or below 180 degrees Fahrenheit for the final rinse to a manager. The wash and final rinse temperatures of the dishwashing machine were to be checked and recorded on the temperature log three times each day. The wash temperatures recorded on the Log from 5/1/21 through 6/7/21 ranged from 140	F 812	F812 1. For dietary services, a corrective action was obtained on 6/6/2021, 6/8/2021, 6/15/2021, 6/16/2021, 6/23/2021, 7/4/2021. During initial walk through of the kitchen on 6/6/2021 build-up was noted around 1 of 2 handwashing sinks, stains/gray film/debris noted on the floor in dry storage, buildup of debris and food stains noted on blade of meat slicer, hood over grill noted with gray/black greasy lint, 8 of 8 opened meal carts noted stained with food debris, and 2 of 2 plate warmers were noted as stained and with debris. These items identified by surveyor were assigned and cleaned by dietary staff 6/6/2021. Further deep cleaning was completed after hours on 6/16/2021. A cleaning list which require staff to sign off as cleaning tasks are completed and for dietary supervisor to review for completion was implemented on 7/4/2021. During initial walk through on 6/6/2021 1 opened bag of clean cloths stored on an uncovered meat slicer was observed. The cloths were removed and sent to environmental services to be cleaned and the meat slicer was covered by the Dietary Service Director. During initial walk through on 6/6/2021 the	

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degrees Fahrenheit to 180 degrees Fahrenheit. The final rinse temperatures recorded on the Log from 5/1/21 through 6/7/21 ranged from 160 degrees Fahrenheit to 190 degrees Fahrenheit.

During three observations of the operation of the high temperature dishwashing machine in the kitchen on 6/8/21 from 10:03 a.m. to 10:17 a.m., the water temperatures during the wash cycle ranged from 138 degrees Fahrenheit to 140 degrees Fahrenheit; and the water temperatures during the rinse cycle were 132 degrees Fahrenheit during each observation. The dietary staff continued to send dishes through the dish machine then stacked the dishware on the storage racks.

During an interview on 6/8/21 at 10:15 a.m., dietary staff #1 stated the wash cycle temperature should read 160 degrees Fahrenheit and the rinse cycle temperature should be 180 degrees Fahrenheit.

During an interview on 6/8/21 at 10:20 a.m., the Dietary Supervisor stated when washing dishware in the dishwashing machine, the temperature gauge machine must read 165 degrees Fahrenheit and the final rinse temperature should read 180 degrees Fahrenheit. She revealed there had been constant problems with the dishwashing machine temperatures for approximately one year. She stated the repairman has had to repair and/or replace the wires in the machine every week. She stated that when the repairman replaced the wires in the dish machine again the prior week, he informed her the dishwashing machine overheated causing the wires to burn out and he recommended the facility replace the dishwashing machine. She

following resealed items were identified to not be dated or labeled in the walk in cooler: 1-2 quart measuring pitcher in unidentified liquid covered in plastic and 1-6 inch deep plastic container of raw porkchops covered in plastic. The reach in cooler was noted to have a steel pan of macaroni noodles without date and label. In the walk freezer 1 opened box of fish patties with an unsealed box, 1 opened paper bag with frozen patties not dated or labeled, 1 opened bag of waffle fries not dated or labeled, 1 opened and improperly closed breaded patties, 1 open bag of potato puffs not dated and labeled with a box of unidentifiable frozen meats pieces. These identified items were removed and discarded by the Dietary Service Director.

During the initial kitchen walk through the dry storage door was improperly propped open with an unopened bottle of cooking oil. The Dietary Service Director removed oil and closed the door to dry storage.

During initial walk through on 6/6/2021 and observation on 6/8/2021 4 of 4 storage ingredient bins remained dirty and with sticky debris, 2 of 4 bins noted to be unlabeled, 1 of 4 bins noted to have scoop devices, and 1 of 4 bins noted with a 2 handle cup within the ingredients. Bins were cleaned, scoops removed, and new scoop holders purchased on 6/16/2021.

During observation of the operation of the high temp dish machine on 6/8/2021 it was noted temperatures were not meeting required temperatures for proper

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F 812	Continued From page 33 stated she informed the maintenance supervisor several months ago the dishwashing machine needed to be replaced. She stated she was unaware of the status of the request. During an interview on 6/9/21 at 11:38 a.m., the Administrator stated he became aware the dish machine was not maintaining temperatures approximately March 10, 2021. He revealed that in March 2021 he requested and received a quote for a new dishwashing machine from a food equipment company and was currently awaiting approval from the facility's corporate office. 2. During the initial tour of the kitchen on 6/6/21 at 6:40 a.m., there was dark gray/black build-up surrounding the base of 1 of 2 handwashing sinks. There were stains, food debris and a dirty gray film on the kitchen floor and a large brown stain on the floor beneath the storage rack in the dry storage room. There was 1-opened plastic bag of clean cloths stored on the uncovered meat-slicer. The door to the dry storage room was propped open with a box containing an unopened bottle of cooking oil. 3a. During the initial tour of the kitchen on 6/6/21 at 6:40 a.m., the following resealed food items were observed not dated or labeled in the walk-in cooler: 1-2 quart plastic measuring pitcher containing an unidentifiable tan colored liquid covered with plastic; and 1-6 inch deep, plastic container of raw porkchops covered with plastic. 3b. The reach-in cooler contained 1-4 inch-deep stainless steel pan of macaroni noodles that was not dated and labeled.	F 812	sanitation; it was also noted temperatures below temperature requirements had be recorded on logs and not reported for maintenance. The facility switched to paper products until the dish machine vendor was able to repair the dish machine on 6/15/2021. A new dish machine was ordered on 6/23/2021. During observation of the A wing nourishment room on 6/8/2021 5 commercial food containers were noted to not be dated or labeled. A-wing fridge noted to have a large, dried, yellow/brown stain. During observation of the C wing nourishment room on 6/8/2021 1 fast food container and 4 commercial containers observed as not dated or labeled. Stains were also noted in the bottom of the fridge on C-wing. All items identified to not be dated or labeled were discarded by the Dietary Service Director. The nourishment fridge/fridges were cleaned by dietary on 6/16/2021 and will be maintained by environmental service. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 6/16/2021, the Dietary Service Director and dietary staff completed a deep clean of the kitchen and nourishment rooms. A cleaning list was implemented on 7/4/2021.	

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F 812	Continued From page 34 3c. There were boxes of food items haphazardly contained in the reach-in freezer: 1-opened box with and an unsealed bag of fish patties; 1-plastic bag with a large hole containing breaded patties which was not dated and labeled; 1-opened paper bag of waffle fries which was not dated and labeled; 2-opened bags of breaded patties; 1-opened bag of potato puffs which was not dated and labeled and this bag was in an opened box containing bags of unidentifiable, frozen meat pieces. 4. During the initial tour on 6/6/21 at 7:30 a.m., dirty food service equipment was observed throughout the food preparation areas in the kitchen. There were 8-open-sided meal delivery carts were stained with food debris. Dietary staff were observed placing the breakfast plated meal trays on the dirty meal carts for delivery to residents' rooms. There were 4-plastic bins (containing loose, grainy substances) that were stained and consisted of particle debris and sticky build-up on the lids and along the sides of the bins. 2 of the 4-bins contained substances which were not labeled. 1-unlabeled bin contained a white powdered substance and had a plastic scoop with the handle flushed in it. The bin labeled as the rice bin contained a 2-handled plastic cup flushed in the rice. The uncovered tabletop meatslicer was dirty with food stains of brown, yellow, and white in color. Also, there was a build-up of brown debris on and beneath the blade of the meatslicer. 2 of 2 plate warmers were stained with brown and black debris on the inside and outside of the warmers. During a kitchen observation on 6/8/21 at 12:11	F 812	On 6/16/2021 bins and scoops for ingredient bins were purchased. On 6/15/2021 the dish machine was repaired and meeting temperature requirements and on 6/23/2021 a new dish machine lease was signed to have a new machine installed. On 6/30/2021 all dietary staff were in-serviced on food storage, food sanitation, and food procurement, dish machine, and nourishment room policies. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: " Cleaning duties and implementation of cleaning schedule. " Food Procurement, Sanitation, and Procedure policies. " Dish room policies and procedures. " Nourishment room policies and procedures. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure.	

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F 812	Continued From page 35 p.m., 4 of 4 bins remained dirty and stained with sticky debris. 1 of 4 bins continued with a plastic scoop lying flat in the bin (not labeled) containing tan colored grain; and the 2-handled cup remained in the bin containing rice. The hood over the grill had a build-up of gray/black greasy lint. During an interview on 6/8/21 at 12:45 p.m., the Dietary Supervisor revealed the hood over the stove was professionally cleaned every six months, but staff had never removed the filters to routinely clean. During an interview on 6/9/21 at 1:00 p.m., the Administrator stated he was informed by the RD/Kitchen Manager that there was a kitchen cleaning schedule. During an interview on 6/9/21 at 3:08 p.m., the Administrator revealed he was informed by the Dietary Supervisor that she and the dietary staff worked together to clean the kitchen, they did not follow an assigned cleaning schedule. He presented for review a copy of the dietary cook's cleaning schedule, and the duty schedules of dietary aide 1 and dietary aide 2 tasks for each. However, there were no completed assignment sheets. 5. During an interview on 6/8/21 at 9:15 a.m., the Registered Dietician revealed the facility's 2-nourishment room's refrigerators were restocked twice each day. She stated whenever residents' families brought food and beverages for residents, the nursing staff were required to label each item with the resident's name, room number and date received before placing the	F 812	The Dietary Service Director will implement a cleaning list which will be completed by dietary staff and reviewed by Dietary Service Director for completion. The Dietary Service Director will complete a Cleaning List Audit to monitor cleaning duties are completed 5 times weekly x 2 weeks, then weekly x 2 months, and then monthly x 3 months. On going monitoring will continue by the Dietary Supervisor reviewing weekly cleaning list per Liberty Healthcare and Rehab policies. The Dietary Service Director will monitor proper food procurement and sanitation procedures by kitchen and nourishment room inspections 5 times weekly x 2 weeks, then weekly x 2 months, and then monthly x 3 months using the Dietary Quality Assurance Audit. On going monitoring will continue with inspections per Liberty Healthcare and Rehab policies. The Dietary Service Director will also monitor proper dish room procedures 5 times weekly x 2 weeks, then weekly x 2 months, and then monthly x 3 months using the Dish Machine Log Audit. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Service Director.	

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F 812	Continued From page 36 item(s) in the refrigerator/freezers in the nourishment rooms. She stated that any food/beverage that was not labeled as required was discarded by herself or the dietary staff assigned to restock the refrigerator/freezers. During observations of the 2 of 2 residents' nourishment rooms on 6/8/21 at 2:57 p.m., there were food items in the refrigerator/freezers which were not provided by the facility that were not dated and not labeled with the residents' names and room numbers. The refrigerator/freezer in the A-wing nourishment room contained 5-boxes of commercial food entrees that were not dated and did not have a resident's name and room number. There was also a large dried, brown/yellow stain in the bottom drawer of the refrigerator. The refrigerator/freezer in the C-wing nourishment room contained 1-box of food (name of fast-food restaurant) and 4-small boxes of commercial food entrees that were not dated and did not have a resident's name and room number. There was also a dried yellow/brown stain on the bottom floor, inside the refrigerator. The Dietary Supervisor acknowledged the observations and discarded the food items that were not labeled. She also indicated she would have dietary staff clean the refrigerator/freezers, immediately.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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.	F 880		7/9/21

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F 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 38 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and review of the facility policy, the facility failed to ensure staff performed hand hygiene prior to entering a Resident's room (Resident #50) and after providing personal assistance to a resident (Resident #50) during meal tray delivery in 2 of 2 observations of one staff member. The findings included: A review of the facility policy, revised 2/5/2021, regarding hand hygiene specified that hand hygiene should be performed before entering a room, upon exiting a room, before and after patient care, before initiating a clean procedure and after glove removal. An observation was conducted on 6/6/2021 at 8:40 a.m. on the 300C hall during meal tray	F 880	F 880 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #50 was not affected by the deficient practice. On 06.06.2021, the Assistant Director of Nurses(ADON) re-educated NA #1 on the facility policy related to hand hygiene practice when entering and exiting resident rooms and when touching her face mask. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 06.18.2021, the Staff Development	

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F 880	Continued From page 39 delivery. Nursing assistant (NA) #1 was observed to enter Resident #50's room without performing hand hygiene. She answered a question to the Resident and then was observed to exit the room carrying an empty meal tray. She then walked to the meal tray cart, placed the tray on the cart, touched a meal ticket and a cup on another tray. She then exited the 300C hall. NA #1 returned to the 300C hall at 8:50 a.m. She placed a tray she was carrying onto the meal cart, touched her face mask, walked to a nursing medication cart, picked up a pen to write something, touched her mask and glasses a second time, returned to the meal tray cart, removed two cereal packages from a tray and entered Resident #50's room a second time without performing hand hygiene. The NA was stopped prior to delivering the items to the Resident and interviewed. An interview was conducted on 6/06/2021 at 8:54 a.m. with NA #1 and she stated she forgot to use hand sanitizer or wash her hands prior to entering Resident #50's room. She stated the facility policy was to wash her hands prior to entering or exiting a resident room. An interview was conducted on 6/10/2021 at 11:21 a.m. with the ADON that serves as the infection control staff member for the facility, and she revealed it was the policy of the facility to conduct hand hygiene prior to entering or exiting a resident room. She provided copies of the policy, "COVID 19 and infection control," and the policy, "Infection control." She stated it was her expectation that an employee follows the infection control policy and perform hand hygiene. A review of the monthly infection control education from April 2021 through May 2021,	F 880	Coordinator (SDC) Nurse began a random audit weekly of resident care areas to observe 15 staff members for compliance with appropriate hand hygiene practice when entering and exiting resident rooms and during resident care. Results revealed no other concerns related to compliance. On 06.14.2021, the Director of Nurses (DON), SDC Nurse, and the ADON who are all Infection Preventionist who have completed a course in Infection Control via NC SPICE initiated education for all full time, part time, PRN staff, and agency staff on the CDC□s Clean Hands: Combat COVID-19 (https://www.youtube.com/watch?v=xmYMUly7qiE) and Hand Hygiene Education. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 06.14.2021, the Director of Nurses (DON), SDC Nurse and ADON initiated education for all full time, part, PRN staff, staff on the CDCs Clean hands: Combat COVID-19 (https://www.youtube.com/watch?v=xmYMUly7qiE) and Hand Hygiene Education. The SDC and ADON are both Infection Preventionist who have completed a course in Infection Control via NC SPICE This information has been integrated into	

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F 880	Continued From page 40 revealed NA #1 had signed the in-service in May 2021, that included hand hygiene.	F 880	the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 07.09.2021, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Root Cause Analysis: A Root Cause Analysis was initiated on 06.28.2021 to discuss the root cause of this event. The team members participating in the Root Cause Analysis included the following staff members: Administrator, Assistant Administrator, DON, ADON, SDC Nurse. A follow-up QA meeting was held on 7/2/2021 to discuss on-going solutions to address the root cause. The QA meeting was attended by the Administrator, Assistant Administrator, DON, ADON, Minimum Data Set Nurse, Business Office Manager, and the Clinical Nurse Consultant and Medical Director of all of who are members of the facility Quality Assurance and Performance Committee. This Root Cause Analysis will be a part of our ongoing Performance Improvement Process. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will	

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F 880	Continued From page 41	F 880	monitor compliance utilizing the F880 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor for compliance with wearing appropriate PPE (to include donning/doffing of PPE) and hand hygiene practices. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Directed Plan of Correction Compliance Date: 07.09.2021 Compliance Date: 07.09.2021	