

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/20/2018
NAME OF PROVIDER OR SUPPLIER HARBORVIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 812 SHEPARD STREET MOREHEAD CITY, NC 28557		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 636 SS=D	<p>Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)</p> <p>§483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>§483.20(b) Comprehensive Assessments §483.20(b)(1) 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:</p> <ul style="list-style-type: none"> (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 	F 636		5/11/18	

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

TITLE

(X6) DATE

Electronically Signed

05/03/2018

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

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F 636	<p>Continued From page 1</p> <p>with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§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 prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(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.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days after admission for 1 of 3 sampled residents (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on 3/22/18 from a hospital. His cumulative diagnoses included a history of involvement in a motor vehicle accident.</p> <p>Resident #3 's admission Minimum Data Set (MDS) assessment was dated with an Assessment Reference Date (ARD) of 3/29/18. A review of this admission MDS assessment</p>	F 636	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F636</p> <p>1) On May 2, 2018 a comprehensive assessment was completed for resident #3 by the MDS/Care Plan Coordinator.</p> <p>2) In order to identify others that may be affected by the similar practice, an</p>		

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F 636	<p>Continued From page 2</p> <p>revealed the following sections were not completed as of 4/19/18: Sections H, I, M, N, and O. Section Z of the MDS was not signed or dated to indicate the assessment was completed.</p> <p>An interview was conducted on 4/19/18 at 3:35 PM with the facility ' s MDS nurse. During the interview, the MDS nurse was asked when Resident #3 ' s MDS admission assessment was due to be completed. The MDS nurse reported the admission MDS assessment was due 14 days after his admission to the facility. She stated his admission MDS was due on 4/5/18 and acknowledged the assessment was late. The MDS nurse stated, "I ' m a one-man show."</p> <p>An interview was conducted on 4/20/18 at 10:57 AM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked what her expectation was in regards to when an admission MDS assessment should be completed for a new resident. In response, the DON stated, "That they be completed within the time frame mandated by CMS."</p>	F 636	<p>audit of 100% of the patient charts was completed on April 26, 2018. Those residents identified as not having an assessment completed will have one completed by the date of compliance noted below. Staff responsible for completing those assessments identified as needing completion will include the current MDS/Care Plan Coordinator, a newly hired MDS/Care Plan Coordinator, and/or contracted consultants if needed.</p> <p>3) In review of the facility systems, the facility had identified prior to the survey that the assessments had gotten behind and was in the process of getting a new MDS/Care Plan Coordinator in place. Systemic changes were not necessary as the reason for being out of compliance was due to staffing vacancies, not systems. A new MDS/Care Plan back up plan is being established to ensure that in the event of a vacancy, the facility will be able to maintain its compliance with its assessments. This plan involves cross-training of an administrative nurse and the Weekend RN Supervisor on completing assessments, MDSs, and Care Plans. In addition, the facility will take measures to ensure that the problem does not recur including:</p> <ul style="list-style-type: none"> The MDS/Care Plan Coordinator Supervisor will be responsible for providing the administrator with a weekly update on assessments and in the event they are getting behind on assessments. In the event the MDS/Care Plan 		

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F 636	Continued From page 3	F 636	Coordinators are identified as being behind, the facility will implement its back up measures to ensure timely completion of the assessments. • The DON will audit the MDS/Care Plan Assessments weekly for 2 months on new admissions for completion for the comprehensive assessments and then monthly thereafter for a period of 1 year. The results of the audits will be provided to the facility QAPI program's coordinator (administrator) where corrective actions, to include additional staffing, will be implemented as necessary. 4) The person responsible for implementing the acceptable plan of correction is the DON, ADON and/or other delegated administrative nurse. 5) Date of Compliance: May 18, 2018		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		5/11/18	

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F 657	<p>Continued From page 4</p> <p>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to develop a comprehensive care plan within 7 days after completion of a resident ' s comprehensive assessment for 1 of 3 sampled residents (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on 3/12/18 from a hospital. Her cumulative diagnoses included hypertension, chronic obstructive pulmonary disease, prediabetes, and a recent history of abdominal surgery.</p> <p>Resident #2 ' s admission Minimum Data Set (MDS) assessment was dated with an Assessment Reference Date (ARD) of 3/19/18. A review of the MDS assessment revealed Resident #2 had cognitively intact skills for daily decision making. She required extensive assistance from staff for all of her Activities of Daily Living (ADLs), with the exception of requiring supervision only for eating. Section M of the MDS indicated the resident required surgical wound care and Section O revealed she</p>	F 657	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F657</p> <p>1) April 30, 2018 a care plan was completed for resident #2 by the MDS/Care Plan Coordinator.</p> <p>2) In order to identify others that may be affected by the similar practice, an audit of 100% of the patient charts was completed on April 26, 2018. Those residents identified as not having a care plan completed will have one completed by the date of compliance noted below. Staff responsible for completing those care plans identified as needing completion will include the current</p>		

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F 657	<p>Continued From page 5 received supplemental oxygen.</p> <p>A review of Resident #2 ' s medical record revealed a baseline care plan was available for this resident. However, a comprehensive care plan was not available as of 4/19/18.</p> <p>An interview was conducted on 4/19/18 at 3:35 PM with the facility ' s MDS nurse. During the interview, the MDS nurse was asked when Resident #2 ' s comprehensive care plan was due to be completed. She reported a comprehensive care plan was due 21 days after Resident #2 ' s admission to the facility, which would have meant the due date was 4/1/18. The MDS nurse stated the comprehensive care plan for this resident had not yet been completed and she acknowledged it was late. The MDS nurse stated, "I ' m a one-man show."</p> <p>An interview was conducted on 4/20/18 at 10:57 AM with the facility ' s Director of Nursing (DON). During the interview, the DON was asked what her expectation was in regards to when a comprehensive care plan should be completed for a new resident. In response, the DON stated, "That it should be completed within the time line mandated by CMS." Upon further inquiry, the DON confirmed the baseline care plan completed for Resident #2 was not considered to be a comprehensive care plan.</p>	F 657	<p>MDS/Care Plan Coordinator, a newly hired MDS/Care Plan Coordinator, and/or contracted consultants if needed.</p> <p>3) In review of the facility systems, the facility had identified prior to the survey that the care plans had gotten behind and was in the process of getting a new MDS/Care Plan Coordinator in place. Systemic changes were not necessary as the reason for being out of compliance was due to staffing vacancies, not systems. A new MDS/Care Plan back up plan is being established to ensure that in the event of a vacancy, the facility will be able to maintain its compliance with its care plans. This plan involves cross-training of an administrative nurse and the Weekend RN Supervisor on completing care plans, MDSs, and Care Plans.</p> <p>In addition, the facility will take measures to ensure that the problem does not recur including:</p> <ul style="list-style-type: none"> The MDS/Care Plan Coordinator Supervisor will be responsible for providing the administrator with a weekly update on care plans and in the event they are getting behind on care plans. In the event the MDS/Care Plan Coordinators are identified as being behind, the facility will implement its back up measures to ensure timely completion of the care plans. The DON will audit the MDS/Care Plans weekly for 2 months on new admissions for completion for the care plans and then monthly thereafter for a period of 1 year. The results of the audits 		

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F 657	Continued From page 6	F 657	will be provided to the facility QAPI program's coordinator (administrator) where corrective actions, to include additional staffing, will be implemented as necessary. 4) The person responsible for implementing the acceptable plan of correction is the DON, ADON and/or other delegated administrative nurse. 5) Date of Compliance: May 18, 2018		
F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to follow physician ' s orders for the treatment of a non-pressure wound for 1 of 3 sampled residents (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on 3/22/18 from a hospital. His cumulative diagnoses included a history of involvement in a motor vehicle accident with a puncture wound to his left lateral malleolus (a bony projection on the outer side of the ankle).</p> <p>A review of the resident ' s admission orders included 3/22/18 wound treatment orders. These orders were clarified on 3/23/18 as follows: Zinc</p>	F 658	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F658 1) On April 23, 2018 the treatment nurse was educated on following physicians orders by the DON. On May 8, 2018 the treatment nurse received further educated on failure to document & outcomes and documentation by the administrator. The</p>	5/11/18	

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F 658	<p>Continued From page 7</p> <p>Oxide 20% ointment (a topical skin protectant) Apply to periwound (the area surrounding a wound) of wounds to the left extremity; and, Santyl Ointment (a sterile enzymatic topical debriding ointment that has the ability to digest collagen in necrotic tissue) Apply to left lower extremity open wounds after cleansing with wound cleanser, cover with ABD pad (a sterile, highly absorbent dressing) and secure with kerlex (woven gauze that provides a wicking action, aeration, and absorbency), then ACE wrap (an elastic wrap). Change daily.</p> <p>A review of Resident #3 ' s medical record included a Wound Assessment Report dated 3/23/18. The Wound Assessment Report indicated the resident had a puncture wound on his left lateral malleolus. The puncture wound was identified upon admission (3/22/18) and noted to be caused by an accident. The wound measured 5.0 centimeters (cm) length, 1.8 cm width, and 0 cm depth. A notation made on the Wound Assessment Report read as follows: "Admitted with hx (history) of MVA (motor vehicle accident), puncture wound is noted to lateral Malleolus. Wound bed is 100% firmly attached slough with small amount of drainage. Periwound is macerated and large amount of peeling moist skin is noted. Dressing changes done to this site with assessment and new dressing orders are began for wound healing and reduction of wound bed maceration. Santyl oint (ointment) is applied to wound bed, zinc oxide oint applied to periwound to aid in protection and enzymatic debridement of slough. Edema is noted and will be monitored with daily dressing changes. He currently has a walking boot in place and is able to participate in therapy."</p>	F 658	<p>content of the education covered the facility expectations of following physician's orders, failure to document appropriately and potential outcomes. It was discussed with the nurse that failing to following physician orders may be subject to disciplinary action up to and including termination of employment.</p> <p>2) The facility already has procedures to ensure that treatment orders are being completed as ordered. Procedures on ensuring completion of treatments are initiated by the nurse receiving the treatment orders, the orders are then placed in the EMR system and a notice is sent to the treatment nurse alerting her that a new treatment has been ordered. The DON or designee reviews all new orders on a daily basis for accuracy. The treatment nurse reviews the orders and then sets them into action. The treatment nurse monitors progress and notifies the physician, the physician then adjusts the orders or discontinues the orders based on his findings on his assessment. The DON currently reviews the E-TAR records for completion and accuracy addresses with the nurses as needed.</p> <p>The facility will in-service its licensed nurses (LPNs and RNs) on following treatment orders and the use of the TAR to verify and ensure treatments have been completed. The process on discontinuing physician treatment orders will also be reviewed and those found to not comply may face disciplinary action up to and including termination. Following</p>		

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F 658	<p>Continued From page 8</p> <p>A review of Resident #3 ' s admission Minimum Data Set (MDS) assessment dated 3/29/18 was not yet completed. However, Section C of the MDS assessment revealed the resident had intact cognitive skills for daily decision making. A comprehensive care plan was not yet completed for this resident.</p> <p>Further review of Resident #3 ' s medical record included a Wound Assessment Report dated 4/17/18 and electronically signed by the facility ' s Wound Care Nurse. The puncture wound on the resident ' s left lateral malleolus measured 3.00 centimeters (cm) length, 1.00 cm width, and 0 cm depth. A notation made on the Wound Assessment Report read, in part: " ...Santyl oint (ointment) is applied to wound bed. Zinc oxide oint applied to periwound to aid in protection and enzymatic debridement of slough ...Wound has decreased in size without any signs of infection. Slough is still firmly attached in 20% of wound bed."</p> <p>An observation was conducted on 4/19/18 at 12:27 PM as the Wound Care Nurse collected and prepared supplies to provide wound care treatment for Resident #3. The nurse sprayed a wound cleanser on a gauze square and squeezed Santyl ointment from the tube into a med cup. She collected an ABD pad, kerlix, and a dry gauze square. The Wound Care Nurse was accompanied as she entered Resident #3 ' s room with the wound care supplies. The Wound Care Nurse was observed as she removed the existing wound dressing from the resident ' s left ankle, wiped the wound with the wet gauze pad, and then wiped it with the dry gauze. She applied a dime-sized amount of Santyl on the wound, placed the ABD pad on the wound, and wrapped</p>	F 658	<p>in-servicing the facility will take quality assurance initiatives to ensure that orders are being followed as outlined in step 3 of our plan of correction.</p> <p>3) The facility's director of nursing and/or assistant director of nursing will review each business day (Mon-Fri standard) for four weeks and then weekly thereafter direct observations of the TAR to ensure that treatments have been completed and signed in accordance with the physician's treatment orders.</p> <p>In addition, the director of nursing, assistant director of nursing and/or weekend RN supervisor will directly observe the treatment nurse in completing a treatment, at least once per week for four weeks and then monthly thereafter for a period of 6 months to ensure the treatment nurse is following orders.</p> <p>In addition, the director of nursing, the assistant director of nursing and/or weekend RN supervisor will directly observe treatments done by other personnel to ensure that treatments are being completed as ordered by other personnel. These additional observations will be performed at minimum, one weekend observation during the first four weeks and then monthly thereafter for a period of 6 months.</p> <p>Results of compliance will be presented in the facility QAPI program for a period of 6 months and corrective actions taken as</p>		

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F 658	<p>Continued From page 9</p> <p>it with kerlix. The ankle and foot were then wrapped with the ACE wrap.</p> <p>A review of the resident ' s physician orders and April 2018 Treatment Administration Record (TAR) revealed there had been no changes made to the initial wound care treatment orders received upon Resident #3 ' s admission. The current orders on Resident #3 ' s April 2018 TAR to date included:</p> <p>--Santyl ointment; Apply to left lower extremity open wounds, after cleansing with wound cleanser, cover with ABD pad and secure with kerlix, then ACE wrap. Change daily. (Order date 3/23/18)</p> <p>--Zinc Oxide 20% ointment; Apply to periwound of wounds to the left extremity. (Order date 3/23/18)</p> <p>An interview was conducted on 4/19/18 at 5:10 PM with Nurse #1. Nurse #1 was assigned as the Hall nurse for Resident #3. During the interview, inquiry was made in regards to the wound treatment for this resident. The nurse stated from what she recalled, Santyl was applied on the wound with zinc oxide applied around the wound bed (as indicated on the TAR). The nurse reported she did not think there had been a change in these treatment orders. The nurse stated that with the exception of weekends, the Wound Care Nurse typically provided the wound care for Resident #3.</p> <p>A telephone interview was conducted on 4/20/18 at 9:00 AM with the Wound Care Nurse. A review of the current wound care treatment orders for Resident #3 was discussed, along with the observation of the wound care provided to the resident on 4/19/18. Upon inquiry, the Wound Care Nurse acknowledged she did not apply the</p>	F 658	<p>needed to ensure compliance.</p> <p>4) The person responsible for implementing the acceptable plan of correction is the DON, ADON and/or other delegated administrative nurse.</p> <p>5) Date of Compliance: May 18, 2018</p>		

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F 658	Continued From page 10 zinc oxide to the periwound during the observation of Resident #3 ' s wound care. When asked why she failed to do so, the nurse stated she was planning to talk with the nurse practitioner to discontinue the zinc oxide because she thought the periwound area had improved. Upon further inquiry, the nurse reported the current order for the use of zinc oxide to the periwound area was still in place. The nurse reported zinc oxide was available on the treatment cart for Resident #3. An interview was conducted on 4/20/18 at 9:12 AM with the Nurse Practitioner (NP) who helped to care for Resident #3. During the interview, the observation of the resident ' s wound care on 4/19/18 was discussed. When the NP was asked if he would expect zinc oxide to be applied to the periwound, he stated he would. The NP reported the zinc oxide would act as a protectant for the area surrounding the wound. He further stated the use of zinc oxide ointment was still a current order for the resident ' s wound care and it should have been used accordingly. An interview was conducted on 4/20/18 at 10:30 AM with the facility ' s Director of Nursing (DON). During the interview, the DON stated, "My expectation would be the current order would be carried out if not discussed with the physician at that time."	F 658			
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		5/11/18	

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F 867	<p>Continued From page 11</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee in November of 2017 in order to achieve and sustain compliance. This was for one recited deficiency which was originally cited in October 2017 on a recertification survey and again on the current complaint investigation survey of 4/20/18. The deficiency was in the area of Comprehensive Care Plans. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.</p> <p>The findings included:</p> <p>This tag is cross referenced to: 483.21(b): Comprehensive Care Plans (F657). Based on record review and staff interviews, the facility failed to develop a comprehensive care plan within 7 days after completion of a resident's comprehensive assessment for 1 of 3 sampled residents (Resident #2).</p> <p>Comprehensive Care Plans (formerly F279) were originally cited during the recertification survey of 10/26/17 for failing to develop a comprehensive care plan for 1 of 1 sampled resident with a contracture (Resident #63).</p> <p>An interview was conducted with the Administrator on 4/20/18 at 11:10 AM. During the interview, the Administrator stated the facility was</p>	F 867	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F867</p> <p>1) The facility's QAA committee has reviewed the root cause for being cited under F867. The root cause was due to a positional vacancy of specially trained nursing specifically for the MDS/Care Plan Coordinator. Originally the facility was to have two MDS/Care Plan coordinators however due to an unexpected employee emergency the facility was left with a vacancy in the position and this is where the facility got behind. The facility had identified that it was getting behind on the care plans with only one MDS/Care Plan Coordinator and it had hired a new employee who was working a notice. In addition, the backup MDS nurse was needed at this time for direct patient care and thus the facility fell behind.</p> <p>In order to ensure compliance, the facility needs to ensure that they have back-up staff available to allow timely completion of assessments and comprehensive care plans when needed. The facility will cross train a facility</p>		

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F 867	Continued From page 12 aware of the problem with care plans being overdue. She reported the facility 's Director of Nursing (DON) sent her a report at least once a week to indicate how far behind they were in completing care plans. The Administrator reported the process of addressing the care plan problem was "more internal" between herself and DON. When asked how the QAA Committee has been involved in the process, the Administrator reported that although the whole team was aware of the issue, their involvement in fixing the problem was very limited.	F 867	administrative nurse and weekend duty RN supervisor as back up in the event of an extended or unforeseen vacancy in the MDS/Care Plan position. The administrative nurse and weekend RN supervisor will be trained by the facility's MDS coordinator and by the facility's MDS consultant. The facility will begin cross-training the administrative nurse and weekend RN supervisor during the month of May on assessments and comprehensive care plans. 2) In order to identify others that may be affected by the similar practice, an audit of 100% of the patient charts was completed on April 26, 2018. To ensure continued compliance a second MDS RN coordinator was hired on April 24, 2018 to ensure adequate staffing within the MDS department. With the addition of a second MDS nurse and the cross training of other administrative nurses the facility will have staff trained to do MDS's when necessary to keep MDS's current. 3) The QAA committee will monitor its performance to assure solutions are sustained monthly for 3 months then quarterly thereafter for a period of one year. The administrator will monitor using monthly reports received for QA from the DON and MDS. The administrator will monitor for compliance with assessments and comprehensive care plans.		

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

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F 867	Continued From page 13	F 867	<p>4) The person responsible for implementing the acceptable plan of correction is the Administrator</p> <p>5) Date of Compliance: May 18, 2018</p>		