AVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG         B3 CAVALIER DRIVE WILMINGTON, NC 28405           (X4) ID TAG         SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)         ID REFIX REGULATORY OR LSC IDENTIFYING INFORMATION)         PROVIDER'S FLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE PROVIDER'S FLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)           E 000         Initial Comments         E 000           An unannounced Recertification investigation survey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID MM/T6411.         F 641           SS=D         CFR(s): 483.20(g)         F 641           S483.20(g)         S483.20(g)         F 641           SB=D         CFR(s): 483.20(g)         F 641           SB=D         CFR(s): 483.20(g)         F 641           S483.20(g)         S483.20(g)         F 641           SB=D         CFR(s): 483.20(g)         F 641           SB=D         CFR(s): 483.20(g)         F 641           S483.20(g)         S483.20(g)         F 641           SCEND         F 641         Correction constitutes a written allegation of compliance.           This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately medications. Resident #8 was admitted to the facil	MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
BAYE         SUMMARY STATEMENT OF DEFICIENCIES (MULINGTON, NC 22405         D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FILL RESULATORY OR LS: DENTIFYING INFORMATION)         D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FILL RESULATORY OR LS: DENTIFYING INFORMATION)         D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FILL RESULATORY OR LS: DENTIFYING INFORMATION)         D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)           E 000         Initial Comments         E 000         Preprint An unannounced Recertification investigation survey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M/76411. SS=D CFR(s): 483.20(g)         F 641           F 641         SS=D CFR(s): 483.20(g)         F 641         This plan of correction constitutes a written allegation of compliance. Preparation ad submission of this plan correction des not constitute an admission or agreement by the provider the truth of the facts alleged or the correction sessent residents reviewed for unnecessary medications. Resident #8 demonstrated behaviors of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:         The facts alleged or the correction is prepared and submitted of ourections is prepared and submitted solely because of requirement under sta and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each reside of ourection is prepared and submitted solely because of requirement under sta and federal law, and to demonstrate the good faith attempts by the provider to improve the q		345568	B. WING		06/06/2019
Preferx TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CREAH CORRECTIVE ACTION SHOULD BE (RECH CORRECTIVE ACTION SHOULD			8	3 CAVALIER DRIVE	1 00002010
An unannounced Recertification investigation survey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M76411.F 641Accuracy of Assessments SS=DF 641SS=DCFR(s): 483.20(g)F 641Å483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately complete the comprehensive assessment for 1 of 5 residents reviewed for unnecessary medications. Resident #8 demonstrated behaviors of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The pla of correction is prepared and submitted solely because of requirement under sta and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each reside of acre for resisting care was in place. AllA review of the care plans revealed on 04/04/19 a plan of care for resisting care was in place. AllImmediate Action: On 6/26/2019, the MDS assessment for	EFIX (EACH DEF	CIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETI
survey was conducted on 06/03/19 through 06/06/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M76411.F 641 SS=DAccuracy of Assessments CFR(s): 483.20(g)F 641SS=DCFR(s): 483.20(g)F 641SS=D\$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately complete the comprehensive assessment for 1 of 5 residents reviewed for unnecessary medications. Resident #8 demonstrated behaviors of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider the corrections of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan corrections of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:This plan difference of correction is prepared and submitted of deficiencies. The pla of correction is prepared and submitted solely because of requirement under sta and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each reside fourment under sta and federal law, and to demonstrate the good faith attempts by the p	000 Initial Comment		E 000		
The assessment must accurately reflect the resident's status.This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to accurately complete the comprehensive assessment for 1 of 5 residents reviewed for unnecessary medications. Resident #8 demonstrated behaviors of refusal of care. The comprehensive assessment revealed there were no behaviors coded as it related to refusal of care. Findings included:This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan correction does not constitute an admission or agreement by the provider the truth of the facts alleged or the correction is prepared and submitted solely because of requirement under sta and federal law, and to demonstrate the good faith attempts by the provider to improve the quality of life of each resider 04/01/19 revealed no behaviors).A review of the care plans revealed on 04/04/19 a plan of care for resisting care was in place. AllImmediate Action: On 6/26/2019, the MDS assessment for	survey was con 06/06/19. The f with the required Preparedness. 641 Accuracy of Ass	ucted on 06/03/19 through icility was found in compliance ient CFR 483.73, Emergency Event ID #M76411. essments	F 641		6/27/19
measurable. A review of a nursing note written on 03/25/19 at 11:06 PM revealed, in part, Resident #8 refused a laxative (a medication to help with bowel modified and transmitted by MDS #1, to reflect displaying behaviors on the look back period per RAI guidelines in Sectio E of the MDS.	The assessment resident's status This REQUIRED by: Based on obset interviews, the find complete the con- 5 residents review medications. Re- behaviors of refind assessment review coded as it related included: Resident # 8 wat 03/25/19. Resident The Minimum Di- 04/01/19 revealed documented union A review of the of plan of care for interventions we measurable. A review of a nu- 11:06 PM revealed	must accurately reflect the ENT is not met as evidenced vations, record review and staff cility failed to accurately nprehensive assessment for 1 of wed for unnecessary sident #8 demonstrated sal of care. The comprehensive aled there were no behaviors ed to refusal of care. Findings admitted to the facility on ent #8 was cognitively aware. Ita Set (MDS) completed on d no behaviors were er section E (behaviors). are plans revealed on 04/04/19 a esisting care was in place. All re appropriate and goals were sing note written on 03/25/19 at ed, in part, Resident #8 refused a		<ul> <li>written allegation of compliance.</li> <li>Preparation and submission of this correction does not constitute an admission or agreement by the provident the truth of the facts alleged or the correctness of the conclusions set for the statement of deficiencies. The of correction is prepared and submissiolely because of requirement under and federal law, and to demonstrate good faith attempts by the provider improve the quality of life of each restrict and the Action:</li> <li>On 6/26/2019, the MDS assessment resident #8 ARD 04/01/2019, was modified and transmitted by MDS # reflect displaying behaviors on the liback period per RAI guidelines in S</li> </ul>	plan of vider of orth te plan tted er state to to esident. at for 1, to ook

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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		MEDICAID SERVICES				NO. 0938-03 ATE SURVEY	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345568	B. WING			06/06/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
DAVIS HE	ALTH & WELLNESS CTF	R AT CAMBRIDGE VILLAG		83 CAVALIER DRIVE WILMINGTON, NC 28405			
(X4) ID	SUMMARY ST		ID	-		(¥5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG			D BE COMPLET	
F 641	Continued From page	e 1	F 64	1			
	movements).		_	Identification of Others:			
				On 6/19/2019, a 100% a	udit for current		
	A review of a nursing	note written on 03/26/19 at		residents most recent M	DS assessment		
		n part, Resident #8 refused		was completed by the A			
		nedication to relax the		determine if any other re			
	resident).			physical behaviors in the			
	A roviow of a pursing	note written on 03/26/19 at		and it was coded correct guidelines of Section E i			
		n part, Resident #8 refused		The results of the audit i			
		medication to alleviate pain).		residents were coded ina			
	, , , ,	, , , , , , , , , , , , , , , , , , , ,		guidelines in Section E.	• •		
	A review of a nursing	note written on 03/27/19, at		audit is documented on	Section E Coding		
		n part, Resident #8 refused		Audit located in the facili	ty compliance		
	his morning medication	ons.		binder.			
	A review of a nursing	note written on 03/27/19 at		Systematic Changes:			
		s late entry on 03/29/18 at		Effective 6/26/2019, resi	dents who display		
		part, per therapy, Resident		refusal of care behaviors			
	#8 refused evaluation			accordingly in the MDS	3.0 per RAI		
				guidelines.			
	•	note written on 04/01/19 at		On 6/25/2019, the Admir			
		part, Resident #8 refused to		conducted a re-educatio			
		blood draw for lab work to ia (low potassium in the		nurse #1 and the case m accurately coding Section			
	blood).	a (low potassium in the		3.0 per the RAI guideline			
				will also be provided anr			
	An interview was con	ducted with Resident #8 on		nurses, and case manag	•		
	06/03/19 12:10 PM.	Resident #8 was alert and					
		nt refused to conduct an		Monitoring Process:			
		to have a pressure ulcer		Effective 6/26/2019, prio			
	observation conducte	ed.		MDS nurse #1 will review			
	An intonvious unas	ducted with Nurses #1 as		MDS 3.0 to ensure that of displayed refusal of care			
		ducted with Nurse #1 on Nurse #1 stated she was		displayed refusal of care coded accurately per RA			
		t #8 and he was known to		These reviews will take			
		ncontinent care, taking		Monday-Friday, prior to			
		ing blood draws. Nurse #1		weeks, then 25% of all c			
		fused care, the process was		assessments monthly fo			
		ucate the resident regarding		until a pattern of complia			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		345568	B. WING		06/06/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
DAVIS HE	ALTH & WELLNESS CTI	R AT CAMBRIDGE VILLAG		3 CAVALIER DRIVE VILMINGTON, NC 28405	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIO
F 641	Continued From page	e 2	F 641		
	<ul> <li>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 2</li> <li>the care, document the refusal of care and notify the physician of the refusal.</li> <li>An interview was conducted with Nursing Assistant (NA) #1 on 06/05/19 at 11:20 AM. NA #1 reported Resident #8 had been known to refuse care and refused incontinent care on 06/05/19. NA #1 stated she notified the nurse of the refusal of care.</li> <li>An interview was conducted with the MDS nurse on 06/06/19 at 12:45 PM. The MDS nurse revealed when she completed the comprehensive assessments she would obtain her information regarding the resident by assessing the resident, reviewing the hospital records and admission orders, reading the physician orders, reviewing the physician orders, reviewing the progress notes, therapy notes, and the physician notes. The MDS nurse reviewed the progress notes for Resident #8 from 03/25/19 through 04/01/19 and confirmed there was documentation to support the resident had been refusing care. The MDS nurse stated the behavior of this type occurred 4-6 days but less than daily and should have been recorded under E0800 rejection of care.</li> <li>An interview was conducted with the acting Director of Nursing (DON) on 06/06/19 at 1:00 PM. The DON revealed her expectation would</li> </ul>			Any inaccurate coding identified will noted and corrected before submissi Findings of this monitoring process w documented on the MDS monitoring located in the facility compliance bind Effective 6/25/2019, the Administrator report findings of this monitoring pro- to the facility Quality Assurance and Performance Improvement Committe any additional monitoring or modifica of this plan monthly for 3 months, or a pattern of compliance is achieved. QAPI committee can modify this plan ensure the facility remains in substatic compliance. Responsible Party: Effective 6/26/2019, the Administrator MDS nurse #1 will be responsible to ensure implementation of the plan of correction for this alleged noncompli to ensure the facility remains in substantial compliance. Compliance Date: 06/27/2019	ion. vill be tool der. pr will cess ee for ation until The n to ntial pr and f
F 656 SS=D	Director of Nursing (I PM. The DON revea have been for the MI the assessment.	DON) on 06/06/19 at 1:00 led her expectation would DS nurse to accurately code Comprehensive Care Plan	F 656		6/27/19

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TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-03 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		345568	B. WING		06	6/06/2019
NAME OF PR	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIS HE	ALTH & WELLNESS CTF	R AT CAMBRIDGE VILLAG		83 CAVALIER DRIVE WILMINGTON, NC 28405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		SHOULD BE COMPLETI	
F 656	Continued From page	23	F 656	3		
		sident, consistent with the	1 000			
		th at §483.10(c)(2) and				
	§483.10(c)(3), that in					
		ames to meet a resident's				
	÷	l mental and psychosocial				
		ied in the comprehensive				
	assessment. The comprehensive care plan must					
	describe the following - (i) The services that are to be furnished to attain					
	or maintain the resident's highest practicable					
	physical, mental, and psychosocial well-being as					
	required under §483.24, §483.25 or §483.40; and					
		would otherwise be required				
		.25 or §483.40 but are not				
	•	esident's exercise of rights				
		ling the right to refuse				
	treatment under §483.10(c)(6).					
	(iii) Any specialized services or specialized rehabilitative services the nursing facility will					
	provide as a result of					
		a facility disagrees with the				
		RR, it must indicate its				
	rationale in the reside					
	(iv)In consultation wit	h the resident and the				
	resident's representation					
	(A) The resident's go	als for admission and				
	desired outcomes.	e				
	(B) The resident's pre- future discharge. Fac	eference and potential for				
		s desire to return to the				
		ssed and any referrals to				
	-	s and/or other appropriate				
	entities, for this purpo					
	(C) Discharge plans i	n the comprehensive care				
		in accordance with the				
		n in paragraph (c) of this				
	section.	is not met as evidenced				
		in pot mot on ovidenced				1

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u> 0938-03</u>
IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345568	B. WING			06	/06/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DAVIS HE	ALTH & WELLNESS CTF	R AT CAMBRIDGE VILLAG			3 CAVALIER DRIVE VILMINGTON, NC 28405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIO IEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETIC DATE		
F 656	Continued From page	e 4	F 6	656			
	Based on record review and staff interviews, the				F656 Develop/Implement Comprehens	sive	
		e a care plan based on the			Care Plan	-	
	Care Area Assessme						
	-	or 1 of 5 residents (Resident			Immediate Action:		
	#4) reviewed for unne	ecessary medications.			On 6/25/2019, MDS nurse #1 and the Social Worker updated Resident #4's of	ara	
	Findings included:				plan to reflect the CAA from 3/17/2019		
	i mango moladea.				and its recommendation to have a care		
	Resident #4 was adm	nitted to the facility on			plan associated with cognitive		
	03/10/19. Diagnoses			loss/dementia.			
	Alzheimer's disease.				Identification of Othera		
	The Minimum Data S	et (MDS) admission (to long			Identification of Others: On 6/25/2019, MDS nurse #1 and the		
		nt on 03/17/19 revealed the			Social Worker completed a 100% audi	t of	
	resident was cognitiv				current residents most recent MDS		
					assessment and CAA's to ensure that a		
		dated 03/17/19 admission			other resident CAA's were reflected on		
		d the following areas should			their care plan. The results of the audit indicated all oth	hor	
	have a care plan: cog activities of daily livin				residents had active CAA's reflected in		
		ng catheter, falls, pressure			their care plans. Findings of this audit a		
	ulcers and psychotro				documented on the Comprehensive Ca		
					Plan/CAA Audit tool, located in the faci	lity	
		plans revealed the resident			compliance binder.		
		place with measurable goals			Systematic Changes		
		ventions for falls, pressure drug use, ADLs, nutrition,			Systematic Changes: On 6/26/2019, the Administrator educa	Ited	
		g term care. There was no			MDS nurse #1 and the Social Worker of		
	care plan for cognitio				Chapter 4 of the RAI manual regarding		
					Care Area Assessments Process and		
		ducted with the MDS Nurse			Care Planning.		
		PM. The MDS Nurse stated			Effective 6/26/2019, MDS nurse #1 and		
		ments were done upon ally. The CAA ' s would			the Social Worker will accurately updat every resident care plan according the		
		hould be care planned			RAI manuals guidelines pertaining to		
		tion that was entered from			CAA's and Care Planning. When a CA	A is	
		MDS Nurse reported she			triggered from the MDS 3.0, the care p		
	obtained her informat	tion regarding Resident #4			will be updated to reflect the triggered		
	by reviewing hospital	records, admitting orders,			areas from the CAA.		

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345568 B. WING 06/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **83 CAVALIER DRIVE** DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG WILMINGTON, NC 28405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 656 Continued From page 5 F 656 nursing notes, physician notes, ADL notes and therapy notes. The MDS Nurse stated the Social Monitoring Process: Worker was responsible for completing the Effective 6/25/2019, MDS nurse #1, Social assessment for cognition on each resident. The worker, and Administrator will utilize the CAA/Care Plan Tool for 100% of MDS 3.0 MDS Nurse stated she would have expected a care plan to be created since cognitive assessment for two weeks loss/dementia triggered on the CAAs. (Monday-Friday), then 50% of MDS 3.0 assessments for three weeks The Social Worker was unavailable for an (Monday-Friday) or until a pattern of interview after multiple attempts to reach her by compliance is achieved. phone on 06/06/19. The acting Director of Effective 6/25/2019, the Administrator will Nursing (DON) reported she was on vacation. report findings of this monitoring process to the facility Quality Assurance and An interview was conducted with the DON on Performance Improvement Committee for 06/06/19 at 1:00 PM. The DON stated her any additional monitoring or modification expectation of the MDS Nurse would have been of this plan monthly for 3 months, or until to ensure each care area that was triggered in the a pattern of compliance is achieved. The Care Area Assessment was carried over to create QAPI committee can modify this plan to a care plan. ensure the facility remains in substantial compliance. Responsible Party: Effective 6/26/2019, the Administrator and MDS nurse #1 will be responsible to ensure implementation of the plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. Compliance Date: 06/27/2019

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 130545

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