POC ACCEPTABLE YES NO
Reviewed By: Name
Fax
Original

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

PRINTED: 03/11/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056288 | A. BUILDING _____ B. WING _____ Facility Notified Name: Date: Time: Notified By: | C 02/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HANFORD NURSING & REHABILITATION CENTER | 1007 WEST LACEY BLVD HANFORD, CA 93230 |

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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health-Licensing and Certification during a RECERTIFICATION survey.<br><br>Representing the California Department of Public Health: 31506 HFEN, 20362 HFEN, 36067 HFEN, 36244 HFEN, and 36578 HFEN.<br><br>Capacity: 124<br>Census: 85<br>Sample: 17<br>Random: 5<br><br>Entity Reported Incident (ERI) Regulatory Grouping investigated for the following ERI during the Recertification Survey:<br><br>CA00477100: No deficiency was issued.<br><br>Complaint investigated during the Recertification Survey:<br><br>CA00453847: Substantiated with one deficiency issued - F 314. | F 000 | F 000<br><br>This Plan of Correction is prepared in compliance with state and federal regulations, and is not intended to be an admission to or agreement of the allegations in the survey document. | |
| F 221 SS=D | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical | F 221 | F 221<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>The IDT completed a Physical Restraint/Enabler Assessment for resident 10 on 2/24/16, reviewed and revised the residents' plan of care to reflect her current status. Resident's 10's MDS was revised by MDS coordinator to reflect the resident use of physical restraint devices.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>The IDT completed a review of all residents who utilize full bilateral side rails on 2/24/16. All residents' current Physical Restraint/Enabler Assessment were reviewed to ensure that they reflect residents current status. The IDT was in-serviced on physical restraint use and reduction 2/29/16 by the regional director of clinical services.<br><br>Amended 4/7/16 | 2/24/16 |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Meneles RN | TITLE: RN, DNS | (X6) DATE: 3/25/16 4/5/16

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.

Revised

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| F 221 | Continued From page 1<br>and administrative document review, the facility failed to ensure one of two sampled residents (Resident 10) was free from physical restraints used for purposes of convenience, when Resident 10 was restrained with full bilateral siderails without intervention to reduce or minimize their usage.<br><br>This failure violated Resident 10's right to be free of a physical restraint.<br><br>Findings:<br><br>Resident 10's clinical record indicated she was readmitted to the facility on 3/26/13, with diagnoses of Alzheimer's dementia, hypertension, heart failure, and dysphagia (difficulty swallowing).<br><br>Review of Resident 10's Order Summary Sheet dated 2/14/16, indicated the following physician order:<br><br>"SIDE RAILS UP X 2 FOR BED MOBILITY R/T [related to] MUSCLE WEAKNESS SECONDARY TO ALZHEIMER'S every day and night shift related to ALZHEIMER'S DISEASE MUSCLE WEAKNESS GENERALIZED." The order was dated 3/27/13, and started on 12/3/14.<br><br>Review of Resident 10's clinical record titled, "MDS" [Minimum Data Set] assessment (a tool used to assess periodically a resident cognitive and physical function] dated 9/4/15, indicated Resident 10 had no physical restraint devices in use.<br><br>Review of Resident 10's clinical record titled, "MDS [Minimum Data Set] 3.0 Assessment dated | F 221 | **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>IDT will follow Hanford Nursing and Rehabilitation's policy and procedure regarding physical restraint use and reduction. All residents utilizing physical restraints will be reassessed quarterly by the IDT and as needed to assure they are free from the use of physical restraints for purpose of convenience. The physical restraint audit will be completed by Medical Records Director on admission, quarterly, and as needed.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br><br>Any findings identified in the medical records audit of the Physical Restraint Audit will be brought to the Quality Assurance Committee meeting quarterly for three quarters. If concerns are identified by the Quality Assurance Committee they will develop and implement an action plan for compliance as needed. | |

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| F 221 | Continued From page 2<br>11/30/15, indicated Resident 10 had no physical restraint devices in use.<br><br>On 2/23/16 at 1:50 p.m., during an observation, Resident 10 was observed lying in her bed with full bilateral siderails in place.<br><br>On 2/23/16 at 3 p.m., during an interview, Certified Nurse Assistant (CNA) 1 stated he cared for Resident 10 on a regular basis. When asked whether Resident 10 utilized her siderails for turning, he stated, "Not really."<br><br>On 2/23/16 at 4 p.m., during an interview, Charge Nurse (CN) 1 stated she did not know whether Resident 10 utilized her siderails to turn. She further stated she would have to ask the CNA staff.<br><br>On 2/24/16 at 7:40 a.m., during an observation, Resident 10 was observed lying in her bed, watching television, both full siderails up on her bed.<br><br>Resident 10's Care Plan dated 2/23/16, indicated under Focus, "The resident uses physical restraints full side rails x 2 (SRX2) for Bed Mobility r/t Muscle Weakness." Under Interventions it indicated, "Evaluate resident's restraint use per policy. Evaluate/record continuing risks/benefits of restraint, alternatives to restraint, need for ongoing use, reason for restraint use.....Observe for/document/report to MD as needed changes regarding effectiveness of restraint, less restrictive device, if appropriate,..."<br><br>On 2/24/16 at 10 a.m., during a concurrent observation and interview, CNA 2 stated Resident | F 221 | **Responsible persons for monitoring:** DNS, IDT team, Medical Records Director and Administrator. | |

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| F 221 | Continued From page 3<br>10 required turning every two hours. CNA 2 and a second staff person entered Resident 10's room and physically turned her. Resident 10 did not assist the staff and made no effort to use her siderails. CNA 2 made no attempt to prompt Resident 10 to use her siderails.<br><br>On 2/24/16 at 4 p.m., during an interview, the Director of Nursing (DON) stated Resident 10's bilateral side rails were in place for safety measures. On inquiry regarding safety, she stated Resident 10 had no history of falls, no history of accidents, and no safety issues had been identified for Resident 10 necessitating a physical restraint. On further inquiry, she stated Resident 10's siderails were in place because her bed is an older model, and sat higher from the ground. When asked about interventions taken toward restraint reduction measures, she stated the facility had no documentation of reduction or reevalution measures.<br><br>On 2/24/16 at 4:30 p.m., during an interview, the MDS Coordinator (MDSC) stated the facility used an enabler assessment to evaluate quarterly the need for continued restraints. The assessments were requested.<br><br>Review of a facility document titled, "Physical Restraint/Enabler Review" dated 11/30/15, indicated under Recommendations, "1. Continue with use of restraint/enabler to prevent injuries/falls that could cause decline in function, fracture and psychological problems..." Under Summary it indicated, "Resident has order for SRX2 [Siderails x 2] for muscle weakness, continue with Restraints, attempted to reduce during assessment and not indicated at this time. Reduction not appropriate this quarter, monitor | F 221 | | |

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| F 221 | Continued From page 4<br>for changes PRN [as needed] and quarterly."<br><br>On 2/24/16 at 4:45 p.m., during an interview, the DON stated no documentation was available on the attempts referenced in the above document.<br><br>The facility document titled, "Physical Restraints" reviewed 9-21-12, indicated under Policy, "Facility will honor the Elder's right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the Elder's medical symptoms...Physical restraints shall be used as a last resort measure...The least restrictive alternative will be used for the least amount of time and only under the most controlled circumstances." Under 13. it indicated, "...Consideration will be given to elimination of the restraint or reduction of the use of the restraint to a less restrictive device or less frequent use of the device whenever possible." | F 221 | | |
| F 278 SS=E | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who | F 278 | F 278<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident 5,7,8,10 and 19's most current MDS were immediately updated to reflected the current use of restraint devices by the MDS coordinator. DNS and MDS coordinator were in serviced immediately by RCDNS 2/26/2016 on accuracy of assessments. | |

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| F 278 | Continued From page 5<br>willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and clinical and administrative document review, the facility failed to accurately reflect the status for four of 17 sampled residents (Resident 5, Resident 7, Resident 8, Resident 10), and one of five sampled random residents (Resident 19), when side rails used as a physical restraint device were not recorded on the following Minimum Date Set (MDS) assessment (a periodic assessment of resident's cognitive and physical function):<br><br>1. Resident 5's MDS assessment dated 1/18/16<br>2. Resident 7's MDS assessment dated 2/1/16<br>3. Resident 8's MDS assessment dated 3/28/15, and 12/9/15<br>4. Resident 10's MDS assessments dated 9/4/15, and 11/30/15<br>5. Random Resident 19's MDS assessment dated 9/10/15 and 11/23/15<br><br>These failures placed residents at risk for inaccurate assessment and unidentified care planning needs secondary to the use of side rails | F 278 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents who utilize full bilateral side rails as restraints have the potential to be affected by the deficient practice. On 2/26/2016 the MDS coordinator reviewed and revised section "p" of all MDS's of all residents utilizing full bilateral side rails to reflect current use of restraint devices.<br><br>**What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>MDS coordinator's employment was [redacted] [redacted] Outside consulting company will complete Medicare utilization audit annually to verify accurate coding of the MDS. The DNS will complete an audit of section "P" during resident's quarterly restraint review to assure accurate coding of physical restraints.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** | |

2/26/16 LW

3/11/16 LW

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| F 278 | Continued From page 6<br>as a physical restraint.<br><br>Findings:<br><br>1. Resident 5's clinical record indicated she was admitted to the facility on [redacted], with a diagnosis of anoxic brain damage, contractures (deformity and stiffness of joints), unspecified lack of coordination, aphasia (loss of ability to understand or express speech), and dysphagia (difficulty swallowing).<br><br>On 2/23/16 at 10:50 a.m., during an observation in Resident's 5's room, the resident was laying in bed with two full side rails up.<br><br>On 2/23/16 at 4 p.m., during an interview, Resident 5 stated she felt safer and could move more easily with both side rails up.<br><br>On 2/24/16 at 11:30 a.m., during a concurrent interview and document review, Resident 5's MDS Annual assessment dated 1/18/16 was reviewed, the MDS Coordinator (MDSC) stated section "P, Physical Restraints" did not indicate bilateral side rail use as a physical restraint. The MDSC stated the side rails should have been coded as a physical restraint, this was her mistake. She further stated, "I didn't realize...I thought if they [the resident] couldn't get out [of the restraint] it wasn't a restraint...I had the wrong definition..they [the MDS assessments] are probably all wrong."<br><br>On 2/26/16 at 2:45 p.m., during an interview, the Director of Nurses (DON) stated Resident 5's side rails were considered a restraint because the resident was not able to lower them herself. The DON stated the MDS should have had side | F 278 | Any findings identified in the DNS audit will be brought to the Quality Assurance Committee meeting quarterly for three quarters. If concerns are identified by the Quality Assurance Committee they will develop and implement an action plan for compliance as needed.<br><br>**Responsible persons for monitoring:** DNS and Administrator. | |

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| F 278 | Continued From page 7<br>rails coded as restraints.<br><br>Resident 5's physician orders dated 12/15/14, indicated, "Side rails up x 2 [bilateral side rails] for mobility R/T [related to] muscle weakness secondary to osteoporosis every day and night shift order date 12/15/14."<br><br>2. On 2/23/16 at 8:15 a.m., during an observation, Resident 7 was observed in bed with bilateral 3/4 side rails up times two. He gripped the side rail to assist moving himself.<br><br>On 2/15/16 at 10 a.m., during an observation, Resident 7 slept in his bed with bilateral 3/4 side rails up times two.<br><br>Resident 7's clinical record indicated he was admitted to the facility on 9/8/14, with a diagnosis of dementia, pressure ulcers, above the knee amputation, and history of falling.<br><br>Resident 7's consent titled "Resident Information For The Use Of Restraints", dated 1/29/16, under Type Of Restraint: [3/4 side rails up times 2 for bed mobility related to muscle weakness secondary to dementia]."<br><br>Resident 7's Physical Restraint/Enabler review dated 2/1/16, indicated "Yes" "Restraints currently in use".<br><br>Resident 7's Weekly Summary dated 2/3/16, and 2/11/16,<br>Device/Restraints were used in the last 7 days - No."<br><br>Resident 7's Order Summary Report, dated 2/3/2016, indicated there was no physician order | F 278 | | |

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| F 278 | Continued From page 8<br>for side rails.<br><br>Resident 7's Care Conference Review dated 2/8/16, indicated "current interventions", and the Care Conference Review dated 4/9/15, indicated "current intervention" SRX2 (Side Rails Times 2).<br><br>Resident 7's MDS dated 2/1/16 under Physical Restraints indicated "no restraint".<br><br>On 2/25/16 at 4:15 p.m., the MDS coordinator stated the side rails should have been coded as a physical restraint on the MDS assessment.<br><br>On 2/25/16 at 4:20 p.m.. during an interview, the Assistant Administrator stated there were inaccuracies between Resident 7's MDS, Physical restraint Enabler, Care Conference Reviews, and Resident Weekly Summaries.<br><br>Review of the RAI (Resident Assessment Instrument - an assessment of care needs and abilities) Version 3.0 Manual indicated under Section P: Restraints, "The intent of this section is to record the frequency over the 7 day look back period that the resident was restrained by any of the listed devices at any time during the day or night." Under Planning For Care it indicated, "When the use of restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary, to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues."<br><br>3. Resident 8's clinical record indicated he was admitted to the facility on 4/10/14, with a diagnosis of dementia without behaviors, retention of urine, history of falls, osteoporosis, | F 278 | | |

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| F 278 | Continued From page 9<br>and femur fracture.<br><br>On 2/24/16 at 8:15 a.m., during an observation, Resident 8 moved himself in bed and used the bilateral, side rails to prepare for breakfast.<br><br>On 2/24/16 at 12:30 p.m., during an interview, Resident 8 stated, "I need them [side rails] so I can help myself as much as possible."<br><br>Resident 8's consent titled "Resident Information For The use of Restraints," dated 1/26/16, under (Type of Restraint: 1/4 Side rails up times 2 for bed mobility related to muscles weakness secondary to osteoporosis.)<br><br>Resident 8's Order Summary report, dated 2/3/16, indicated no physician order for bilateral side rails.<br><br>Resident 8's Care Conference Reviews dated 3/25/15, and 6/17/15, indicated under Physical Restraint Review "Side rails 2X (were used for) for bed mobility".<br><br>Resident 8's Weekly Summary Report under Device/Restraints 3/24/15 and 6/17/15 indicated devices/restraints were not used.<br><br>Resident 8's MDS's dated 3/28/15 and 12/9/15 indicated no restraints were used.<br><br>On 2/25/16 at 4:15 p.m., the MDSC stated the side rails should have been coded as a physical restraint on the MDS assessments dated 3/28/15 and 12/9/15<br><br>On 2/25/16 at 4:20 p.m., during an interview, the DON stated there were inaccuracies between | F 278 | | |

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| F 278 | Continued From page 10<br>Resident 8's MDS's and Physical Restraint Enabler, Care Conference Reviews, and Resident Weekly Summaries.<br><br>Review of the RAI Version 3.0 Manual indicated under Section P: Restraints, "The intent of this section is to record the frequency over the 7 day look back period that the resident was restrained by any of the listed devices at any time during the day or night." Under Planning For Care it indicated, "When the use of restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary, to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues."<br><br>4. Resident 10's clinical record indicated she was readmitted to the facility on 3/26/13, with diagnoses of Alzheimer's dementia, hypertension, heart failure, and dysphagia.<br><br>Review of Resident 10's Order Summary Sheet dated 2/14/16, indicated the following physician order:<br><br>"SIDE RAILS UP X 2 FOR BED MOBILITY R/T [related to] MUSCLE WEAKNESS SECONDARY TO ALZHEIMER'S every day and night shift related to ALZHEIMER'S DISEASE MUSCLE WEAKNESS GENERALIZED." The order was dated 3/27/13, and started on 12/3/14.<br><br>On 2/23/16 at 1:50 p.m., during an observation, Resident 10 laid in her bed with full bilateral side rails in place.<br><br>On 2/23/16 at 3 p.m., during an interview, CNA (Certified Nurse Assistant) 1 stated he cared for | F 278 | | |

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| F 278 | Continued From page 11<br>Resident 10 on a regular basis. When asked whether Resident 10 utilized her side rails for turning, he stated, "Not really."<br><br>On 2/23/16 at 4 p.m., during an interview, Charge Nurse (CN) 1 stated she did not know whether Resident 10 utilized her side rails to turn. She further stated she would have to ask the CNA staff to find out.<br><br>Review of Resident 10's clinical record titled, "MDS 3.0 Assessment dated 9/4/15, indicated Resident 18 had no physical restraint devices in use.<br><br>Review of Resident 10's clinical record titled, "MDS 3.0 Assessment dated 11/30/15, indicated Resident 10 had no physical restraint devices in use.<br><br>On 2/24/16 at 4:30 p.m., during an interview, the MDSC stated she gathered information for the resident MDS assessment from observation and clinical record review. She further stated, "I didn't realize...I thought if they [the resident] couldn't get out [of the restraint] it wasn't a restraint...I had the wrong definition..they [the MDS assessments] are probably all wrong."<br><br>Review of the RAI Version 3.0 Manual indicated under Section P: Restraints, "The intent of this section is to record the frequency over the 7 day look back period that the resident was restrained by any of the listed devices at any time during the day or night." Under Planning For Care it indicated, "When the use of restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary, to determine reversible causes and contributing | F 278 | | |

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| F 278 | Continued From page 12<br>factors and to identify alternative methods of treating non-reversible issues."<br><br>5. Random Resident 19's clinical record indicated she was readmitted to the facility on [redacted], with diagnoses of dementia with behavioral disturbances, hypertension, cognitive communication deficit, and dysphagia.<br><br>On 2/26/16 at 2:45 p.m., during a concurrent interview and record review of Resident 10's MDS Initial assessment dated 11/23/15 and the Quarterly assessment dated 9/10/15, the DON stated the "P Physical Restraints" section of Resident 10's MDS, dated 11/23/15 and 9/10/15 did not indicate bed rails were used as a physical restraint. The DON stated the bed rails should have been coded as a physical restraint on the MDS assessment. DON stated Resident 19 had side rails up and could not release those side rails himself, therefore was a restraint.<br><br>Resident 19's physician orders dated 11/13/15 and 1/29/15, indicated "Side rails up x 2 for bed mobility R/T muscle weakness order dates 11/13/15 and 1/29/16."<br><br>On 2/26/16 at 9:30 a.m., during an interview, Licensed Nurse (LN) 1 stated Resident 19 uses the side rails for mobility. LN 1 stated the resident has had side rails since his first admission. | F 278 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality. | F 281 | | |

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| F 281 | Continued From page 13<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, clinical record and administrative document review, the facility failed to meet professional standards of medication safety for one of five random residents (Resident 22) when licensed nurse (LN) 2 prepared medications and did not review the Medication Administration Record (MAR) to ensure accuracy of the medications for Resident 22.<br><br>This failure had the potential to result in lack of receipt of prescribed medication for Resident 22.<br><br>Findings:<br><br>On 2/25/16 at 8:27 a.m., during a concurrent observation and interview, LN 2 prepared medications for Resident 22. LN 2 prepared ten oral medications for administration and placed them in a plastic medication cup. LN 2 stated she counted nine oral (by mouth) pills in the cup. LN 2 entered Resident 22's room. Resident 22 was seated at the bedside. LN 2 was asked to exit the room. LN 2 reviewed the MAR, opened the controlled medications cabinet of her medication cart, and retrieved one oral pill, Alprazolam (Xanax- an antianxiety medication) .25 milligrams (unit of measure) from the bottom of the controlled medications storage cabinet. LN 2 stated, "I didn't double check [the MAR]." LN 2 walked to another LN on the same wing, and stated to an LN, "I need to waste this [the Alprazolam tablet]." LN 2 prepared a second dose of the same medication, and administered ten medications to Resident 22. | F 281 | F 281<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident 22's medication was immediately administered to resident after omission accrued. LN 2 was provided immediate one on one in-service on 2/25/2016 by DNS on medication administration and safety of residents to ensure accuracy of medications administration to future residents.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents receiving medications form LN 2 have the potential to be effected. On 3/7/2016 pharmacy nurse consultant completed a medication administration observation on LN 2, with a zero percent medication error rate. All licensed nursing staff were in-serviced on 3/7/2016 by pharmacy nurse consultant on medication administration.<br><br>**What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>DNS or designee to complete a random medication administration observation monthly on all licensed nurses for the next three quarters of licensed nursing staff to ensure accuracy of medications given to residents and meet professional standards of medication safety. | 3/7/16 |

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| F 281 | Continued From page 14<br>The facility policy and procedure titled, "Medication Administration" dated 9/20/12, indicated, "To accurately administer medication to Elders... "1. Medication and biological orders shall be reviewed by a Licensed Nurse prior to administration." | F 281 | **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br><br>The DNS will present the findings from the medication administration observations to the Quality Assurance Committee meeting for three quarters. Negative findings will be addressed by the quality assurance committee to develop and implement an action plan for compliance as needed.<br><br>**Responsible Persons:** DNS/Designee. | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff and resident interview, and clinical record and administrative document review, the facility failed to ensure residents received the services necessary to prevent the development of a pressure ulcer for one of five random sampled residents (Resident 18) when she developed an open area on her back which progressed to a Stage III wound (destruction of full layer of skin, extending into subcutaneous layer) and required daily medical treatment.<br><br>This failure resulted in harm for Resident 18.<br><br>Findings: | F 314 | F 314<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident 18's stage three pressure ulcer healed as of 1/20/2016. The IDT completed a review of resident 18's current plan of care related to pressure ulcer prevention and management on 2/27/2016. A new pressure ulcer assessment was completed on 2/27/2016 which identified the potential for pressure ulcer development to be high, with a score of 21. Resident 18's care plan was immediately reviewed and revised on 2/27/2016 by IDT to reflect current appropriate preventive measures. | |

2/27/16

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| F 314 | Continued From page 15<br>Resident 18's clinical record indicated she was admitted to the facility on 11/13/14, with diagnoses of dementia, and Kyphosis (an abnormal curvature of the spine).<br><br>Resident 18's Nurses Notes (NN) dated 7/18/15 at 10:06 p.m., indicated, "This writer called into residents room by CNA (Certified Nurse Assistant) that resident has an opening on her back. Resident assessed by this writer to have a 1 inch in diameter opening in the middle of her back in the spinal area. Resident states it is tender. This writer assessed area, measured 1 inch in diameter. Notified MD [Medical Doctor] and received a new order to cleanse area..."<br><br>Resident 18's NN dated 8/3/15 at 4:53 p.m., indicated, "...Treatment orders renewed on 8/3/15. Cleanse Stage III to thoracic spine with wound spray, pat dry, apply silvadene [a treatment creme] topically to wound bed. Apply moist 2 x [by] 2 gauze and cover with foam dressing Q [every] daily x 14 days. One time a day related to KYPHOSIS ACQUIRED POSTURAL... for 14 days."<br><br>Resident 18's Care Plan dated 2/26/16, indicated under Focus, "Resident has a Stage III pressure ulcer to her thoracic spine. Resolved as of 8/24/15. ..." Under Interventions it indicated, "...Monitor stage III to thoracic spine for signs and symptoms of reopening Q shift x 30 days. Date initiated 8/24/15."<br><br>Resident 18's MDS (Minimum Data Set) assessment (an assessment tool to determine resident cognitive and physical abilities) dated 5/28/15, indicated "Totally dependent" on staff for transferring, and required two persons to assist | F 314 | **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents scoring "high" on Pressure Ulcer Assessment have the potential to be affected. The IDT completed a review of all residents scoring high on their Pressure Ulcer Assessments. The plan of care for each resident scoring high on their Pressure Ulcer Assessments' was reviewed and revised by IDT on 2/28/2016 to ensure appropriate pressure ulcer prevention measures are in place. Licensed nursing staff was in serviced 2/27/16 on pressure ulcer prevention and management.<br><br>**What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>Upon admission, quarterly, and as needed residents will be assessed for potential risks for developing pressure ulcers by MDS coordinator or a licensed nurse. The IDT in conjunction with the PMD will develop a plan of care that is individualized to each resident unique diagnosis to assure the residents plan of care reflects the appropriate interventions required. Residents identified with clinical conditions that make the development of new pressure ulcers unavoidable will be reflected in their plan of care. The Medical Records Director will complete the pressure ulcer audit weekly and as needed to assure the residents care plan is accurate and reflects interventions for pressure ulcer prevention and maintenance. | |

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| F 314 | Continued From page 16<br>her. Resident 18 required extensive assistance and physical help for her hygiene and bathing.<br><br>On 2/26/16 at 1:50 p.m., during an interview, the Director of Nursing (DON) stated she was aware Resident 18 developed a pressure ulcer in July 2015. She further stated, "It's [the pressure ulcer development] is on us...She has Kyphosis...It turned red, and we started to monitor it, but it progressed to Stage 3...it was not because of her [recent] hospitalization."<br><br>On 2/26/16 at 2:30 p.m., during a concurrent observation and interview, Resident 18 watched TV. Resident 18 stated she was having pain in her back, and waited for the nursing staff to come and turn her. Resident 18 stated sometimes she was turned, and sometimes not (turned). Resident 18 stated she is not turned regularly on the night shift.<br><br>On 2/26/16 at 2:45 p.m., during a concurrent observation and interview, Charge Nurse (CN) 2 stated she was going to turn Resident 18 to check her back, due to her complaint of pain. CN 2 stated Resident 18 had a history of skin breakdown.<br><br>The facility document titled, "Wound and Skin Management" revised 9/25/12, indicated, "It is the policy of this facility that any Elder who enters the facility without pressure sores will have the appropriate preventative measures taken to insure that the Elder does not develop pressure ulcers unless the elder's clinical condition makes the development unavoidable... Prevention... 1. The IDT [interdisciplinary team], Licensed Nurses and CNA's [Certified Nurse Assistants] will assure the following preventative measures for Elders at | F 314 | **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br><br>Any findings identified in the medical records audit of the Pressure Ulcer Audit will be brought to the Quality Assurance Committee meeting quarterly for three quarters. If concerns are identified by the Quality Assurance Committee they will develop and implement an action plan for compliance as needed.<br><br>**Responsible persons for monitoring:** DNS, IDT team, Medical Records Director and Administrator. | |

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| F 314 | Continued From page 17<br>risk for skin breakdown:...c. Assure Elders are turned and repositioned in bed or chair if the Elder can't do so independently. Frequency should be based on individual Elder's risk factors..." | F 314 | F 431<br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** | |
| F 431 SS=E | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can | F 431 | No residents were found to be affected by deficient practice. All medications were removed by DNS from the affected refrigerator; influenza vaccine and pneumococcal vaccine were immediately destroyed on 2/25/2016 by DNS and Pharmacist. Insulin pens were moved to medication cart and utilized until expiration date. The refrigerator that temped above acceptable range was immediately taken out of service. A new refrigerator was immediately installed on 2/25/2016 and remained un-used until DNS verified appropriate temperature range had been met on 2/25/2016, normal operations were then reinstated.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>Two medication refrigerators had the potential to be affected. After a review of the temperature logs and current thermometers readings on 2/25/2016 by DNS, it was determined that the appropriate range, 36 degrees to 46 degrees, for all other medication refrigerator was maintained. Temperature will continue to be checked at beginning of each shift by charge nurse, twice a day. An audit will be completed by the medical records director daily to assure temperatures are within normal limits. | |

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| F 431 | Continued From page 18<br>be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and administrative document review, the facility failed to store refrigerated medications and biologicals under appropriate temperatures (36-46 degrees Fahrenheit), when the medication refrigerator internal temperature measured 50 degrees F (Fahrenheit).<br><br>This placed residents at risk for receiving ineffective medications secondary to excessive temperature storage.<br><br>Findings:<br><br>On 2/25/16 at 10:45 a.m., during a concurrent observation and interview in the medication storage room, the Director of Nursing (DON) opened the medication refrigerator, retrieved the internal thermometer, and stated, "It says 50 degrees." She sealed the refrigerator for 15 minutes.<br><br>On 2/25/16 at 11 a.m., during an observation, the DON rechecked the internal thermometer of the refrigerator and stated, "It looks like 48 degrees." A second thermometer was placed in the refrigerator to rule out the first as a faulty thermometer. The refrigerator was sealed.<br><br>On 2/25/16 at 11:30 a.m., during a concurrent observation and interview, both thermometers were checked by the DON, who stated, "48-50 degrees [both thermometers]...We can't use them | F 431 | **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>A daily audit will be completed by the medical record director to assure all refrigerators are within normal temperature range. The Medication Refrigerator Temperature Log form was reviewed and revised by the Regional Director of Clinical Services on 2/25/2016 to reflect the process for the LVN/Charge Nurse reporting out of range temperatures to the Maintenance Department and the DNS for immediate corrective action. The DNS will review the audit findings. All licensed nursing staff were in-serviced on 2/26/2015 or 2/27/2015 on medication administration and storage, including appropriate refrigerator temperature range and procedure for out of range temperatures. Pharmacy Consultant will continue to complete an audit of medication refrigerators quarterly.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** | 2/26/16 & 2/27/16 |

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| F 431 | Continued From page 19<br>[the refrigerated medications]...It all has to come out."<br><br>On 2/25/16 at 11:35 a.m., during an observation, the DON listed the contents of the refrigerator, which consisted of influenza vaccine, a dose of pneumococcal vaccine, and several types of injectable insulin.<br><br>The facility policy and procedure titled, "Medication Storage In The Facility" revised 9/25/12, indicated under Procedure, "9. Medications requiring 'refrigeration' are kept at temperatures ranging from 36 degrees to 46 degrees F. [Fahrenheit] in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage 'in a cool place' are refrigerated unless otherwise directed on the label." | F 431 | Findings of the audit completed by Medical Records and Pharmacy Consultant will be brought to Quality Assurance Committee quarterly for two quarters. Negative findings will be addressed by the quality assurance committee.<br><br>**Responsible persons for monitoring:** DNS, Medical Records Director, Pharmacy Consultant, and Administrator. | |
| F 458 SS=B | 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT<br><br>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation during the survey period of 2/23/16 through 2/26/16, the facility failed to provide the minimum square footage in 8 of 32 resident rooms. This placed the residents at potential risk of unmet needs including privacy, storage and care.<br><br>Findings: | F 458 | F 458<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>There is sufficient room space and residents' health and safety were not affected.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>There is sufficient room space and residents' health and safety were not affected. | |

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| F 458 | Continued From page 20<br><br>During observation throughout the survey from 2/23/16 to 2/26/16, the residents had a reasonable amount of privacy and there was enough closet and storage space for each resident. There was sufficient room for the provision of nursing care to the residents. The health and safety of the residents would not be adversely affected by the continuance of the waiver.<br><br>Room / Square Footage / No. of Beds.<br>106 — 318.88 sq. ft. — 4<br>108 — 294.37 sq. ft. — 4<br>119 — 317.43 sq. ft. — 4<br>208 — 298.81 sq. ft. — 4<br>209 — 293.91 sq. ft. — 4<br>212 — 299.61 sq. ft. — 4<br>213 — 296.90 sq. ft. — 4<br>217 — 312.95 sq. ft. — 4<br><br>Recommend waiver continue in effect for 8 of 32 rooms.<br><br>[redacted] MSN, HFES<br>3/11/16<br>Health Facilities Evaluator Nurse — Date<br><br>Request Waiver for above identified resident rooms. | F 458 | **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>There is sufficient room space and residents' health and safety were not affected.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br><br>The facility has requested a waiver and will review and submit the waiver and then annually thereafter. This will be monitored by the facility Quality Assessment and Assurance Committee for compliance. | |

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| F 458 | Continued From page 21 | F 458 | | |
| | Facility Administrator Date | | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, clinical record and administrative document review, the facility failed to maintain accurate clinical records for two of five random sampled residents (Residents 20 and 21) when controlled medications administered were not documented in the Medication Administration Record (MAR) for Residents 20 and 21.<br><br>These failures placed residents at risk for adverse events secondary to an inaccurate MAR for Residents 20 and 21. | F 514 | F 514<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident number 20's Medication Administration Records were immediately updated on 2/25/2016 by LVN two, to reflect the administration of the controlled substance.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents who have physician orders for controlled medications under the care of LVN number 2 have the potential to be affected. Licensed nurse two was in serviced 2/25/2016 by DNS on medication documentation and medical records. LVN two and all other licensed nurses were in serviced 2/29/2016 by the DNS on medication documentation and medical records. | |

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| F 458 | Continued From page 21 | F 458 | | |
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| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, clinical record and administrative document review, the facility failed to maintain accurate clinical records for two of five random sampled residents (Residents 20 and 21) when controlled medications administered were not documented in the Medication Administration Record (MAR) for Residents 20 and 21.<br><br>These failures placed residents at risk for adverse events secondary to an inaccurate MAR for Residents 20 and 21. | F 514 | F 514<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>Resident number 20's Medication Administration Records were immediately updated on 2/25/2016 by LVN two, to reflect the administration of the controlled substance.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents who have physician orders for controlled medications under the care of LVN number 2 have the potential to be affected. Licensed nurse two was in serviced 2/25/2016 by DNS on medication documentation and medical records. LVN two and all other licensed nurses were in serviced 2/29/2016 by the DNS on medication documentation and medical records. | 2/29/16 |

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| F 514 | Continued From page 22<br><br>Findings:<br><br>Resident 20 was admitted to the facility on 5/7/15. Current physician orders included the following medication order:<br><br>"Norco Tablet 5-325 MG [milligrams] (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as need for moderate Pain 4-6 [pain level scale] related to OTHER CHRONIC PAIN..."<br><br>On 2/25/16 at 10:30 a.m., during a concurrent observation and interview with Licensed Nurse (LN) 2 and the Director of Nursing (DON), Resident 20's Controlled Drug Record [a form to record medication that can be habit forming] was reviewed. The record indicated one Norco tablet had been signed out by LN 2 on 2/25/16 at 8:30 a.m. Resident 20's MAR under the section to document PRN [as needed] medications for 2/25/16 was blank, which indicated no documentation of medication administered. When LN 2 saw the blank MAR, she stated, "I forgot to sign the PRN sheet." LN 2 then documented the administration of the Norco tablet on Resident 20's MAR in the presence of the DON and the surveyor.<br><br>Resident 21 was admitted to the facility on 9/10/13. Current physician orders included the following medication order:<br><br>"Lorazepam [Ativan-an antianxiety medication] Tablet 1 MG Give one tablet by mouth every 12 hours as needed for Anxiety M/B [manifested by] repetitive anxious movements." | F 514 | **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>The licensed nursing staff will be responsible for completing a self-audit directly following each medication pass to verify accuracy of documentation. Medical Record Director will complete a Medication Administration Record audit daily. During orientation and annually the license staff will be instructed on the pour, pass, chart method and the five rights of medication administration by the DNS or designee.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br><br>Any negative findings identified in the medical records audit of the Medication Administration Record will be brought to the Quality Assurance Committee meeting quarterly for three quarters. If concerns are identified by the Quality Assurance Committee they will develop and implement an action plan for compliance as needed.<br><br>Responsible persons for monitoring: DNS, Medical Records Director and Administrator. | |

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| F 514 | Continued From page 23<br>On 2/25/16 at 10:40 a.m., during a concurrent observation and interview with LN 2 and the DON, Resident 21's Controlled Drug Record was reviewed. It indicated one Lorazepam tablet signed out by LN 2 on 2/24/16 at 5:45 p.m. Resident 21's MAR in the section for documentation of PRN medications, dated 2/24/16, was blank. The DON stated a blank space indicated the medication had not been given. When LN 2 was asked when medications should be documented in the MAR as administered, she stated, "When I give it to them [the residents]."<br><br>The facility policy and procedure titled, "HA7 Controlled Medications" dated 2007, indicated under Procedures, "D. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR):<br><br>1. Date and time of administration<br>2. Amount administered.<br>3. Signature of the nurse administering the dose, completed after the medication is actually administered." | F 514 | | |
| F 518 SS=D | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. | F 518 | | |

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| F 518 | Continued From page 24<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and administrative document review, the facility failed to provide effective emergency procedures training to employees when one of eight employees [Licensed Nurse (LN) 3] failed to locate the key that provides access to the emergency utility.<br><br>These failures put all residents in the facility at risk in the event of an emergency related to electricity.<br><br>Findings:<br><br>On 2/24/16 at 8:36 a.m., during a concurrent observation and interview in the maintenance hallway, LN 3 failed to locate a key which provided access to the emergency electrical shut-off. LN 3 stated that she was not trained on the key location or how to obtain the key.<br><br>On 2/24/16 at 9 a.m., during an interview, the DON stated the Administrator (Admin), Maintenance Supervisor (MS), and she (DON) had a key to the utility. The DON did not know what the staff would do if they could not get reach her, the Admin, or the MS in an emergency.<br><br>On 2/24/16 at 3:40 p.m., during a concurrent interview and record review, the Director of Staff Development (DSD) did not provide written evidence of demonstrating LN 3's ability to turn off the electrical shut-off. The DSD stated that she believes it states in the orientation packet of where the key is located. The facilities orientation quiz indicated the location of the emergency electrical shut-off, but had no questions about | F 518 | F 518<br><br>**How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.**<br><br>On 2/24/16 an Electrical Room key was added to all Charge Nurses keysets. All staff were in-serviced on 2/24/16, 2/25/16, and 2/26/2016 on keysets by DNS and ESD. The in-service addressed the addition of the electrical room key to the charge nurse key set as a well a demonstration on how to access the electrical shut off switch.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br><br>All residents had the potential to be affected by deficient practice in the event of an emergency related to electricity. All staff were in-serviced on 2/24/16, 2/25/16, and 2/26/2016 by DNS the in-service addressed emergency procedures, location of emergency shut offs, and proper technique to disable electrical services. | 2/24 2/26 |

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| F 518 | Continued From page 25<br>how to access the electrical shut-off.<br><br>On 2/24/16 at 4:20 p.m., during an interview, the DSD stated that she did not find a written explanation of how to obtain the key to gain access to the electrical shut-off.<br><br>The facility policy and procedure titled, "Emergency Fire Procedures" dated 12/11/15, indicated, "Emergency Controls and Shut-Off: SOUTH/WEST BACK OF BUILDING NEAR MAINTENANCE SHOP." No documentation of key location was indicated in the document. | F 518 | **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?**<br><br>DSD or designee will provide emergency procedure in-service to new hires, periodically to existing staff, and perform unannounced disaster drills which include the process of how to disconnect electrical services. The new hire Orientation Quiz was reviewed and revised by DNS on 2/29/2016 to include: where emergency shut offs are located, how to shut them off and where electrical room key is located.<br><br>**How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.**<br>Negative findings on Orientation Quiz and unannounced disaster drills will be immediately corrected and findings will be brought to quality assurance committee meetings for two quarters to develop and implement on action plan for compliance as needed.<br><br>**Responsible Persons:** DNS, Administrator, and DSD. | |

2/29/16