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	345363	A. BUILDING _____ B. WING _____	08/04/2016

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THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

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F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, family interview and record reviews, the facility failed to provide medical justification for the use of restraints and failed to develop a systematic approach for restraint reduction for 3 of 3 sampled residents with restraints (Resident #65, #136 and #121). The findings included: 1. Resident #65 was admitted on 10/4/10. The cumulative diagnoses included cerebral vascular accident, dementia, atrial fibrillation and contracture of knees. The annual Minimum Data Set (MDS) dated 4/15/16, indicated that Resident #65 required total assistance with all activities of daily living, transfers and mobility. The quarterly MDS dated 7/15/16 coded Resident #65 with a daily trunk restraint. The physician order dated 12/20/12, documented to apply the lap buddy when resident was out of bed to wheelchair related to resident's inability to stand without falling. Review of the updated care plan dated 8/3/16, identified the problem as: resident had abnormal posture and leans forward. The goal included Resident would have improved posture and will	F 221	DISCLAIMER RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	9/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2016

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F 221	Continued From page 1 not lean forward. The approaches included nursing would apply T-pillow with physician ' s order and family permission, therapy would evaluate quarterly and the RNC (restorative nurse coordinator) would complete and update quarterly restraint form. The T- pillow would be removed at meals. Review of the physical restraint elimination assessment dated 1/23/16, 4/15/16 and 7/15/16, the form was blank. There was no information available to include a specific reason, medical symptom or target behavior, least restrictive measure used or restraint reduction attempts or elimination. The physical restraint elimination assessment indicated average score of 29-33 which indicated Resident #65 was a good candidate for restraint reduction and/or elimination. Review of the falls CAA (care area assessment) dated 4/15/16, indicated falls triggers due to generalized weakness and decreased lower extremities and total dependence on nursing for mobility and transfers in and out of bed. Resident #65 remained on fall precautions per shift with call light frequently used activities of daily living items were kept within reach at all times. The resident used a wheelchair for primary source of mobility on/off unit with nursing assistance. There were no CAA's for restraint. During an observation on 8/3/16 at 9:30AM, Resident #65 was cognitively impaired seated in a standard wheelchair in the bedroom alone with lap buddy (T-pillow) in place. The resident was unable to remove the lap buddy. The resident did not exhibit any repetitive movement in any direction. Resident #65 could reposition self by	F 221	F-221 Presbyterian Home of Hawfields will continue to strive to ensure that all residents are free from any physical restraints, when used, the residents has a medical justification for the use of restraints and the facility will use a systemic approach to ensure there is justification for restraint use. The RNC□s and/or designee will evaluate residents regularly, to assess appropriateness of restraint devices use and assessment. Residents #65, #136 and #121 T-pillows have been removed.	

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F 221	Continued From page 2 pushing feet down on the floor and slide back into the wheelchair. During an observation on 8/3/16 at 10:30AM, Resident #65 remained in the bedroom alone with lap buddy (T-pillow) in place, verbalizing and yelling out. The resident was seated in a standard wheelchair with hands folded across the lap buddy. She sat in an upright position with no physical movements in any direction. Resident was able to reposition herself within the chair. During an observation on 8/3/16 at 12:04PM, Resident #65 remain seated in her room with lap buddy in place alone. Resident #65 seated in an upright position yelling out and no repetitive movements in any direction. During an interview on 8/3/3/16 at 12:08PM, NA#3 stated Resident #65 had the lap buddy in place for several years and was known to throw her legs across the chair and lean forward when she became agitated. She acknowledged that main behaviors were yelling and screaming out and the only time the restraint was to be removed was during meals, activities of daily living care or when resident was put to bed. During an observation on 8/3/16 at 12:15PM to 12:40PM, Resident #65 was observed in the dining room seated in wheelchair at the horseshoe table without lap buddy. Resident #65 sat quietly until verbal cues were given to be fed. The resident rested her elbows on her lap as she waited to be fed. She made no attempt to get up or exit the chair. Resident #65 did not have any repetitive movements or attempt to throw legs over the chair. NA#4 escorted Resident # 65 back to the room without the lap buddy in place. The	F 221	The RN Coordinators have been retrained by the DON regarding the need to have medical justification for restraint use and the step by step approach to ensure restraints are properly used. The RN Coordinator, DON, and/or designee will conduct an audit of in-house residents to make sure that a resident with a restraint has a medical justification for its use. The RN Coordinator or designee will randomly audit in-house residents to ensure that a resident with a restraint has a medical justification. A QA Audit will be utilized. A QA Audit Tool will be used three (3) times per week for one month and reviewed at least weekly by the DON, Administrator, and/or designee. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance.	

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resident was very calm and continue to rest her arms/elbow in her lap until she arrived to the room to be changed by NA#3. NA#4 indicated that she was part time and this was the first time she had fed the resident meal. She stated she was unaware of the resident wearing a lap buddy.

During an interview on 8/3/16 at 2:35PM, Nurse #1 stated Resident #65 had the lap buddy for many years due to resident leaning forward and sliding forward. She was unable to give a medical justification for the use of the lap buddy.

During an interview on 8/3/16 at 2:51PM, the Director of Nursing (DON) indicated any individual with restraint should have a medical justification and reviewed every quarter for restraint reduction. The DON stated for Resident #65 he did not have any information as to the interventions or restraint reduction attempts, last physical therapy evaluation was 8/19/15 and the physical therapy assessment indicated the resident had abnormal posture and that was being used as medical justification and leaning to left. He further indicated the staff did not document the reason for the continuation. The DON reviewed Resident #65 fall history and the last noted fall from the wheelchair was 2014. He confirmed there were no on-going issues that would require the use of the restraint.

During an interview on 8/3/16 at 3:44PM, Nurse #4 indicated the lap buddy was for safety and leaning. Nurse#4 stated Resident #65 did not lean as much as when the lap buddy was initially implemented. She stated that resident was not being treated for any medically related conditions. The resident's current and on-going problem is the yelling and outburst. She reported that

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resident was able to sit independent of the lap buddy without any problems but when she gets agitated she would throw arms, around and may potentially lean. She stated that there was no documentation that she was aware of any behaviors of her leaning for extended period of time. She was unaware of any other type of device used or tried for the resident.

During an interview on 8/3/16 at 3:48PM, NA #5 indicated the lap buddy was placed on daily for the resident's safety and leaning. The NA stated that she only would do more leaning when she was upset or agitated. She could be redirected with soft conversation and singing if necessary. She stated they did not document any of the behaviors anywhere.

During an interview on 8/3/16 at 4:00PM, the Physical Therapist (PT) indicated that therapy had not seen the resident since last year. She stated that therapy had not received any new referral and did not have any other documentation of a restraint reduction. The PT indicated the lap buddy was for abnormal posture and safety of the resident due to leaning to the left side.

Review of the physical therapy discharge summary evaluation dated 8/7/15, revealed Resident #65 was placed in high back wheelchair that was lower to the ground so the feet can be placed down and a wedge cushion placed to improve sitting position. Attempted to remove T-pillow however, assessment reveals t-pillow enables resident to sit up due to frequent leaning to left.

During an observation on 8/4/16 at 9:43AM,

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F 221	Continued From page 5 Resident #65 was seated in the wheelchair in the bedroom with lap buddy in place calm relaxed no repetitive movements. The resident was in and out of sleep. 2. Resident #136 was admitted to the facility on 5/2/16. Her diagnoses included major depression, urinary tract infection (UTI) and chronic obstructive pulmonary disease. The most recent Minimum Data Set (MDS), dated 5/30/16, revealed Resident #136 was severely cognitively impaired. She was totally dependent for activities of daily living. Record review of the physician ' s order dated 6/21/16 and 6/28/16, revealed that Resident #136 may use lap buddy due to poor posture in chair, balance and inability to stand without falling. She did not sit in an upright position. Review of Resident 136 ' s updated plan of care on 6/21/16, revealed that she required assistance with ADLs. The approach was to keep T-pillow/lap buddy (physical restraint device) on when in wheelchair for poor posture, balance and inability to stand without falling. T-pillow should be removed at meal time. During an observation on 8/2/16 at 11:00 AM, Resident #136 was in her room sitting in her wheelchair. The T-pillow was attached to the wheelchair. During an interview on 8/2/16 at 11:05 AM, Resident #136 confirmed that staff applied	F 221		

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T-pillow every time she was in wheelchair. The resident could not remove the restraint.

During an interview on 8/3/16 at 9:00 AM, Nurse #2 stated that Resident #136 had T-pillow attached to her wheelchair every time she was out of bed to prevent her from falling. Resident #136 was confused, agitated and tried to get up from the wheelchair without assistance. After the resident slid out of wheelchair onto the floor, the staff received physician ' s order for T-pillow. The resident was not able to remove it herself but tolerated it well and was treated for UTI.

During an interview on 8/3/16 at 2:45 PM, Nurse #1 stated that Resident #136 was diagnosed with UTI, became more confused and agitated, often attempted to get up without assistance and slid out of wheelchair onto the floor. The staff obtained the physician ' s order for T-pillow to prevent her from sliding out of the wheelchair. The resident was not able to apply or remove the T-pillow herself and received it every time she was in her wheelchair.

During a family interview on 8/3/16 at 3:50 PM, Resident 136 ' s family member indicated that for over a month the resident received T-pillow attached to her wheelchair every time she was out of bed. The staff applied T-pillow to wheelchair and the resident was not able to remove it herself.

During an interview on 8/3/16 at 2:55 PM, Nurse Aide #1 stated that Resident #136 used the T-pillow every time she was in her wheelchair. The staff removed the T-pillow for meal times.

During an interview on 8/4/16 at 9:00 AM, the

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Occupational Therapy Director stated that Resident #136 received occupational therapy due to her attempts to get out of wheelchair on multiple occasions.

During an interview on 8/4/16 at 11:20AM, the Director of Nursing could not provide clear medical justification and clarification in regards to the order for T-pillow/restraint for Resident #136.

Record review revealed the occupational therapy (OT) summary, which indicated that Resident #136 continued to receive OT from 5/3/16 five times a week. The goals included increasing dynamic sitting balance in order to maintain upright posture without loss of balance.

Record review of the nurses ' notes, dated 6/21/16, revealed that Resident #136 was disoriented and anxious during the evening shift. At 2 PM she tried to get up out of wheelchair. The safety was maintained by attaching the T-pillow to the wheelchair for protection. The physician and family members were notified.

Record review of the nurses ' notes, dated 6/21/16, revealed that at 5 AM Resident #136 tried to stand up from her wheelchair without assistance.

Record review of the nurses ' notes, dated 7/2/16, revealed that Resident #136 was agitated, was constantly trying to get out of bed and most of the time and had to be closely monitored by the staff.

Record review of the nurses ' notes, dated 7/4/16, revealed that Resident #136 was agitated and attempted to remove the lap buddy. The

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Ativan (antianxiety medication) was effectively administered.

Record review of the nurses ' notes, dated 7/10/16, revealed that Resident #136 was agitated and tried to get out of bed without assistance. The Ativan was effectively administered.

3. Resident # 121 was admitted to the facility on 12/13/2015 with diagnoses which included right femur fracture, muscle weakness, wheelchair dependence, lack of coordination, Hypertension (HTN) , gout, insomnia, hypothyroidism, constipation, Diabetes Mellitus Type 2, Alzheimer ' s Disease, chronic embolism, history of falling and unsteadiness on feet.
Review of the medical record for Resident # 121 included a quarterly Minimum Data Set (MDS) dated 06/10/2016 which indicated that Resident # 121 had moderate cognitive impairment, had eye glasses and had no mood or behavior concerns coded. Resident # 121 was coded as being wheelchair dependent for mobility and that a chair to prevent rising was used daily during the 7 day review period. Resident # 121 was coded as having no falls during the MDS review period.
The care plan which had been updated on 06/18/2016 indicated that Resident # 121 required assistance with Activities of Daily Living (ADLs) and the goal was to encourage ADL participation. The care plan intervention included to use a T- Pillow (a foam cushion placed across the arms of the front of the wheelchair) when in the wheelchair and to document when the T - Pillow was removed.
Review of the Fall Risk Assessment form which was initiated on 12/23/2015 and updated on

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03/18/2016 and 06/10/2016 indicated that there was no change in fall risk factors for Resident # 121 from the initial assessment or either updated assessment. Resident # 121 was coded as having intermittent confusion, having at least 1-2 falls in the past 3 months, being chair bound and having predisposing diseases which could impair safety. The final fall risk score for each assessment was 15, which indicated a high fall risk potential and required an immediate fall prevention protocol to be put in place immediately.

A Restraint Elimination Assessment dated on 12/23/2015 indicated that no restraints were in place for Resident # 121. The Restraint Elimination Assessment dated 03/18/2016 and 06/10/2016 both indicated that Resident # 121 had a T - Pillow in place for positioning in the wheelchair and that Resident # 121 was a high priority candidate for restraint elimination.

The facility fall incident reports were reviewed and on 01/13/2016 at 2:47 PM, Resident # 121 was leaning forward in her wheelchair and fell. The physician was in the facility as were family members of Resident # 121 and the family requested a T - Pillow to be placed in the wheelchair. After the physician examined Resident # 121 and confirmed that there was no apparent injury, the physician ordered a T - pillow to be used in the wheelchair for positioning of Resident # 121 when she was out of bed in the wheelchair.

Physical Therapy (PT) notes dated 12/24/2015 through 01/21/2016 were reviewed. PT discontinued services for Resident # 121 on 01/21/2016 because maximum potential had been achieved for pivot transfers, bilateral lower extremity strengthening, but that Resident # 121 continued to need verbal cues to stay on task and

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that PT would order and provide a wedge cushion to improve alignment in wheelchair.
An observation on 08/01/2016 at 2:51 PM, revealed Resident # 121 sitting in her wheelchair in her room with a green foam T - Pillow in place across the front of the wheelchair. Resident # 121 stated that she was not able to remove the T-Pillow cushion because she did not have the keys to remove it. Resident # 121 did not respond when asked if she was comfortable and continued to smile.
Resident # 121 was observed at 8:44 AM, on 08/02/2016 sitting in her wheelchair in her room with the green T - Pillow in place. She remained with her eyes closed and did not respond to any questions.
On 08/03/2016 at 2:02 PM, Resident # 121 was observed in her wheelchair with the green T-Pillow in place across the front of her wheelchair and responded that she did not know how to remove " it. "
An interview with NA #2 on 08/03/2016 at 2:03 PM, revealed that Resident # 121 had a T-Pillow to her wheelchair when she was out of bed and that Resident # 121 was able to remove the pillow, but only when she wanted to, not if asked to take it off. NA #2 stated that if the pillow was not used, resident # 121 would try to walk and would lean and fall. NA #2 also revealed that the pillow was removed during meals and during activities with close supervision.
Nurse #1 was interviewed on 08/04/2016 at 8:00 AM, Nurse #1 recalled that the physician and family were present in the facility on 01/13/2016 when Resident # 121 fell from her wheelchair and the physician immediately ordered the T- Pillow to be used for positioning. Nurse #1 could not recall the medical symptom for the use of the T - Pillow use, but was aware that the family members

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present had requested the order from the physician.
A review of the Physical restraint Elimination Assessment on 08/04/2016 at 8:36AM, revealed that the Assessment had been updated on 08/04/2016 and indicated that a Rehab referral had been made on 08/04/2016 to re assess the use of the T - Pillow use.
Resident # 121 was observed on 08/04/2016 at 8:48 AM, sitting still in the wheelchair in the hallway without the T - Pillow in place.
During an interview with the PT conducted on 08/04/2016 at 10: 42 AM, the PT was observed with Resident # 121 in the Rehab gym and without the T - Pillow in place. The PT stated that she was evaluating the need for the T- Pillow and the possibility of trials of other less restrictive devices because Resident # 121 was not able to sit straight and leaned in the chair without support. The PT stated that she could not confirm or deny that a wedge cushion noted by a former PT had ever been tried, but that the current PT thought that since the physician had been present on 01/13/2016 and ordered the T - Pillow use, that the PT could not change the device.
Resident # 121 was observed to be sitting still without leaning during the interview.
Interview with the DON conducted on 08/04/2016 at 10:56 AM revealed that the DON was aware that reassessment of restraints to less restrictive devices was lacking in the facility and that referrals had been made that date for Rehab to evaluate all restraints and the facility would initiate a proactive Quality Assurance monitoring tool and that the facility would review all falls in the morning staff clinical meetings and would immediately update care plans. The DON stated that he was aware that restraint use required a medical symptom for use and could not be used

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F 221	Continued From page 12 only per family request. The DON also stated that he needed to review the current restraint policy and procedure use to update and to make current to follow the regulations.	F 221		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/1/16

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	345363	A. BUILDING _____ B. WING _____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

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F 272	Continued From page 13	F 272		

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to assess for restraint reduction for 1 of 3 sampled residents with restraints (Resident #65).

The findings included:

Resident #65 was admitted on 10/4/10. The cumulative diagnoses included cerebral vascular accident, dementia, atrial fibrillation and contracture of knees. The annual Minimum Data Set (MDS) dated 4/15/16, indicated that Resident #65 required total assistance with all activities of daily living, transfers and mobility. The quarterly MDS dated 7/15/16 coded Resident #65 with a daily trunk restraint.

The physician order dated 12/20/12, documented to apply the lap buddy when resident was out of bed to wheelchair related to resident ' s inability to stand without falling.

Review of the comprehensive MDS dated 4/15/16, the restraint CAA (care area assessment) was not completed. Resident #65 had trunk restraint in place during annual review period.

Review of the physical restraint elimination assessment dated 1/23/16, 4/15/16 and 7/15/16,

F-272

Presbyterian Home of Hawfields will continue to strive to ensure that all residents have a comprehensive assessment to ensure reduction of restraint use.

The RN Coordinators and/or designee have been retrained by the DON regarding the quarterly assessments of restraint elimination.

The RN Coordinator, DON or designee will conduct an audit of in-house residents restraint elimination form to identify if the least restrictive device is being used.

The RN Coordinator or designee will randomly audit in-house residents to see if the least restrictive device is being used. A QA Audit will be utilized.

A QA Audit Tool will be used three (3) times per week for one month and reviewed at least weekly by the DON, Administrator and/or designee.

QA Committee will review the QA Action Plan once a month for three (3)

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F 272	Continued From page 14 the form was blank. There was no information available to include a specific reason, medical symptom or target behavior, least restrictive measure used or restraint reduction attempts or elimination. The physical restraint elimination assessment indicated average score of 29-33 which indicated Resident #65 was a good candidate for restraint reduction and/or elimination. During an interview on 8/3/16 at 2:51PM, the Director of Nursing (DON) indicated any individual with restraint should have a medical justification and reviewed every quarter for restraint reduction. The DON stated for Resident #65 he did not have any information as to the interventions or restraint reduction attempts, last physical therapy evaluation was 8/19/15 and the physical therapy assessment indicated the resident had abnormal posture and that was being used as medical justification and leaning to left. He further indicated the staff did not document the reason for the continuation. During an interview on 8/3/16 at 4:00PM, the Physical Therapist (PT) indicated that therapy had not seen the resident since last year. She stated that therapy had not received any new referral and did not have any other documentation of a restraint reduction. The PT indicated the lap buddy was for abnormal posture and safety of the resident due to leaning to the left side	F 272	months and revise the action plan to ensure continued compliance	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		9/1/16

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F 279	Continued From page 15 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop a care plan for 1 of 3 sampled residents with restraints(Resident #65) and 1 of 2 sampled residents receiving antipsychotic medications (Resident #88). The findings included: 1. Resident #65 was admitted on 10/4/10. The cumulative diagnoses included cerebral vascular accident, dementia, atrial fibrillation and contracture of knees. The annual Minimum Data Set (MDS) dated 4/15/16, indicated that Resident #65 required total assistance with all activities of daily living, transfers and mobility. The quarterly MDS dated 7/15/16 coded Resident #65 with a daily trunk restraint.	F 279	F-279 Presbyterian Home of Hawfields will continue to strive to ensure that all residents have a comprehensive careplan that include antipsychotics, and restraints. Resident #88□s careplan has been reviewed and updated by the MDS Coordinator. Revisions were noted on the careplan. Resident #65□s restraint was D/C□d. The MDS Coordinator was retrained by the DON regarding the updating and revision of residents□ careplans as appropriate.	

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F 279	Continued From page 16 The physician order dated 12/20/12, documented to apply the lap buddy when resident was out of bed to wheelchair related to resident's inability to stand without falling. Review of the updated care plan dated 8/3/16, identified the problem as: resident had abnormal posture and leans forward. The goal included Resident would have improved posture and will not lean forward. The approaches included nursing would apply T-pillow with physician ' s order and family permission, therapy would evaluate quarterly and the RNC (restorative nurse coordinator) would complete and update quarterly restraint form. The T-pillow would be removed at meals. During an interview on 8/4/16 at 10:00AM, Nurse #4 indicated that she had only been the MDS coordinator a few weeks and as of yesterday 8/3/16 she added the care area for restraint to Resident #65's care plan. The care plans and MDS were expected to be reviewed and updated during the care plan meeting. 2. Resident # 88 was admitted to the facility on 4/30/15 with diagnoses bipolar with psychosis, depression, anxiety and sleep apnea. Review of the quarterly Minimum Data Set (MDS) dated 6/10/16 revealed the resident was cogitatively intact and received antipsychotic during the 7 day look back period. Review of the care plan dated 3/18/16 revealed that there was not a care plan for antipsychotic	F 279	The MDS Coordinator or designee conducted an audit of residents on antipsychotic medication and restraints. He/She will update the careplans as needed. The MDS Coordinator or designee will randomly audit in-house residents receiving antipsychotic medications and that have a restraint to ensure the careplan is updated. A QA Audit Tool will be used three (3) times per week of for once a month and reviewed at least weekly by DON, Administrator and/or designee. QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure continue compliance.	

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F 279	Continued From page 17 mediations for resident #88. In an interview with the Director of Nursing (DON) on 8/4/16 at 10:06 AM, the DON stated that he would expect any resident using antipsychotics should be care planned.	F 279		