STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	09/21/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews the facility failed to clean the floors to prevent the buildup of dirt and grime in the resident rooms, bathrooms and the common areas of 4 of 5 halls (A, B, C, D). Findings included: On 09/18/2017 at 11:34 AM, an observation of the facility floors in resident rooms, bathroom, dining rooms and activity rooms were observed to have dark accumulated residue along the edges of the walls, in all doorways along halls A, B, C and D. Room concerns for this observation included: on Hall A: Room #'s 2,4,5,11,12,13,15, and 20; on Hall B: Room #'s 2,5,8,7; on Hall C: Room #'s 1,3,4,7, 8, 9, and 15 and on Hall D: Room #10. On 09/18/2017 at 1:07 PM during an interview with Resident #125, the resident indicated the dining room floor needed to be cleaned and the halls and resident rooms had dirty floors and black marks. On 09/21/17 at 9:00 am during an interview with Resident #31, the resident revealed the floors were dirty looking and needed to be stripped and waxed and the bathroom was very black. On 09/21/2017 at 9:59 AM, an interview was conducted with Housekeeper (HK) #1. HK #1 indicated the floors were no longer being waxed	F 253	F-253 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 provision 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, forma appeal, and/or other administrative or legal procedures.	11/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/11/2017

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F 253	Continued From page 1	F 253		

or stripped. HK #1 reported they needed to be waxed. She further added, they were mopped every day, but they still looked dirty. HK #1 indicated she scrubbed the floors with the mop, but the black marks did not come out. She stated that the housekeeping supervisor was aware.

On 09/21/2017 at 10:00 AM, an interview was conducted with HK #2 and she revealed the floors were swept and mopped daily. HK #2 reported she had been employed for a year and the floors had never been waxed, but they needed to be stripped and waxed. HK #2 stated there was a discussion with the Housekeeping Supervisor, but there was no plan to strip or wax floors.

On 09/21/2017 at 10:11 AM, an interview was conducted with HK #3. HK #3 stated she cleaned in all areas of the facility and indicated the floors were swept and mopped daily, but they did not look like it. She stated the grime was built up dirt and the floors needed to be stripped and waxed. HK #3 stated the supervisors were aware of the black floors.

On 09/21/17 at 10: 20 AM, an interview was conducted with HK #4 and she indicated that she swept and mopped floor daily, but was not sure why the floors were black. HK #4 stated she was not aware if the supervisors were aware of the condition of the floors, but she stated "The floors do not look clean."

On 09/21/2017 at 10:33 AM, an interview was conducted with the Housekeeping Supervisor and revealed she had acknowledged the common areas, resident rooms and bathrooms, and halls needed to be stripped and waxed. The Housekeeping Supervisor was unable to recall

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F 253	Continued From page 2 the last time it was done and there were no plans to do it soon. On 09/21/2017 at 10:40 AM, an interview with the Administrator revealed that he acknowledged the floors needed to be stripped and waxed. The Administrator indicated that the facility had stopped buffing the floors because it made them shiny and the residents thought the floor was wet. The Administrator further stated it was discussed and needed to be put into the budget. The Administrator confirmed "The floors needed attention."	F 253	F-253 Presbyterian Home of Hawfields will continue to strive to ensure that the floors are free of dirt and grime in resident□s rooms, bathrooms and common areas. The Housekeeping Supervisor and/or designee will inspect the floors on a regular basis to assure the cleanliness of the floor. A company has been contacted to clean and wax the floors and the housekeeping staff has been retrained on how to clean the floors and report any issues. The housekeeping supervisor and/or designee will conduct an audit of all floors (resident□s rooms, bathrooms, and common areas) to make sure that the maintain a sanitary, orderly and comfortable interior.	

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F 253	Continued From page 3	F 253	The Housekeeping Supervisor and/or designee will randomly audit floors. A QA Audit will be utilized. A QA Audit tool will be used three (3) times per week for one (1) month and reviewed at least weekly by the Housekeeping Supervisor, Administrator, and/or designee. QA committee will review the QA Action plan once (1) pre month for three (3) months and revise the action plan to ensure continued compliance.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		10/19/17

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F 278	Continued From page 4 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessment for two of 15 sampled residents in the area of hospice services (Resident #94) and ability to eat (Resident #31). Findings included: 1. Resident #94 was admitted 11/21/15 with diagnoses that included dementia, renal insufficiency, fracture of the left lower radius, and osteoporosis. The MDS dated 08/02/17 indicated that cognitive status could not be assessed. She was totally dependent for all activities of daily living. The resident ' s care plan included an entry dated 08/02/17 for an end-stage disease process with a poor prognosis of six months or fewer to live. A hospice referral was signed by the physician on 07/22/17. The resident was accepted for hospice	F 278	-278 10/19/2017 Presbyterian Home of Hawfields will continue to strive to ensure that the MDS is accurately coded resident□s # 94 and # 31 MDS□s have been updated. The CNA□s were retrained in the importance of proper ADL documentation in the kiosh. The MDS coordinator and/or designee will randomly audit in-house residents MDS to ensure accuracy. A QA Audit Tool will be used three (3) times per week for one(1) month and reviewed at	

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F 278	Continued From page 5 services. The Hospice Certification and Plan of Care form listed the Start of Care date as 07/26/17 and was signed by the facility's Director of Nursing (DON). An MDS dated 08/02/17 was completed for a significant change. "Hospice care" was not checked for Special Treatments, Procedures and Programs (Section O) the resident was receiving. In an interview on 09/21/17 at 3:10 p.m., the MDS Coordinator confirmed that Resident #94 had started hospice services and that a new MDS was completed 08/02/17 for a significant change in her status. She did not offer a reason why the MDS item "Hospice care" was not checked. In an interview on 09/21/17 at 3:40 p.m., the DON acknowledged the lack of MDS coding for hospice services. He shared his expectation that the MDS accurately reflected the resident ' s status. 2. Resident #31 was admitted on 11/16/16 with diagnosis in part of diabetes mellitus and depression. The most recent quarterly Minimum Data Set (MDS) dated 8/18/18 revealed she was cognitively intact and required assistance with activities of daily living (ADL) and supervision with eating. Review of the previous MDS dated 05/26/17 revealed independence while eating. Review of the ADL look back period 08/12/17 through 08/18/17 documentation revealed on 08/16/17 Resident#31 required assistance with eating. Review of the nursing documentation revealed that there was no documented change in Resident #31 need for supervision. On 09/21/17 at 8:30 AM Resident #31 was	F 278	least weekly by the DON, Administrator and/or designee. QA Committee will review the QA Action Plan once (1) a month for three (3) months and revise the action plan to ensure continued compliance.	

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observed eating unsupervised in her room. During interview she indicated that she had always ate independently.

On 09/21/2017 at 12:43 PM the administrative nurse reviewed the look back documentation and indicated that Resident #31's change in the MDS was due to an error made by an Aide in the kiosk on 08/16/17. She had missed the correction.

On 09/21/2017 at 2:28 PM Aide #1 said that Resident #31 was independent with eating. She received her tray and she sets it up and eats independently. Documentation of how much assistance was required was entered into the kiosk.

On 09/21/17 at 3:28 PM the Director of Nursing indicated the expectation was the MDS was coded accurately.
Resident # 31 was admitted on 11/16/16 with diagnosis in part of diabetes mellitus and depression. The most recent quarterly minimum data set (MDS) dated 8/18/18 revealed she was cognitively intact and required assistance with activities of daily living (ADL) and supervision with eating. Review of the previous MDS dated 5/26/17 revealed independence while eating.

Review of the ADL look back period 8/12/-18 thru 8/18/7 documentation revealed on 08/16/17 Resident#31 required assistance with eating. Review of the nursing documentation revealed that there was no documented change in Resident #31 need for supervision.

On 09/21/17 at 8:30 AM Resident #31 was observed eating unsupervised in her room. During interview she indicated that she had

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F 278	Continued From page 7 always ate independently. On 09/21/2017 at 12:43 PM administrative nurse reviewed the look back documentation and indicated that Resident # 31's change in the MDS was due to an error made by an Aide in the kiosk on 08/16/17. She had missed the correction. On 09/21/2017 at 2:28 PM Aide # 1 said that Resident #31 was independent with eating. She received her tray and she sets it up and eats independently. Documentation of how much assistance was required was entered into the kiosk. On 09/21/17 at 3:28 PM the Director of Nursing indicated the expectation was the MDS was coded accurately.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279		10/19/17

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includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified 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

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including 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 PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care

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F 279	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for one of 15 sampled residents (Resident #94). Findings included: Resident #94 was admitted 11/21/15 with diagnoses that included dementia, renal insufficiency, fracture of the left lower radius, and osteoporosis. The Minimum Data Set (MDS) dated 08/02/17 indicated that cognitive status could not be assessed. She was totally dependent for all activities of daily living. A hospice referral was signed by the physician on 07/22/17. The resident was accepted for hospice services and started care on 07/26/17. The care plan for Resident #94 included an entry dated 08/02/17 for an end-stage disease process with a poor prognosis of six months or fewer to live. It included interventions for pain assessment, medication and monitoring; mental health; protection of bony prominences; and ambulation as tolerated. The facility care plan did not include the provision of hospice services or measures to facilitate communication between the facility and the hospice agency. In an interview on 09/21/17 at 3:10 p.m., the MDS Coordinator acknowledged that the care plan for Resident #94 had been updated to include end-of-life interventions but did not include a	F 279	F-279 10/19/2017 Presbyterian Home of Hawfields will continue to strive to ensure that all residents have a comprehensive core plan that includes Hospice Services and Measures to facilitate communication between the facility and the Hospice Agency. resident # 94□s care plan has been updated. The MDS Coordinator was retained by the DON regarding the updating and revision of resident□s care plans as appropriate. The MDS Coordinator and/or designee continued an audit of residents on Hospice Services. The MDS coordinator will update the care plans as needed. The MDS Coordinator and/or designee will randomly audit in house residents receiving hospice services to ensure the care plan is updated. A QA Audit Tool will be used three (3) times per week for one (1) month and reviewed at least	

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F 279	Continued From page 10 specific reference to the resident receiving care by hospice. In an interview on 09/21/17 at 3:40 p.m., the DON reviewed the care plan for end-of-life interventions. He shared his expectation that a comprehensive care plan to include the provision of hospice services and coordination between the facility and agency be completed.	F 279	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	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	F 371		10/19/17

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F 371	Continued From page 11 Based on observation and staff interviews, the facility failed to cover, label and date foods in one of one sampled walk-in freezer, one of one sampled walk-in refrigerator and one of three sampled nourishment room refrigerators. Findings included: 1a. An observation of the walk-in freezer on 09/18/17 at 10:30 a.m. revealed an uncovered tray with 15 small plastic bowls filled with a pudding-like substance. The tray was not labeled to identify the food, the preparation date or the use-by date. Individual bowls on the tray were also uncovered. The tray was placed on a shelf opposite freezer fans, with air blowing directly on the tray. The second-shift Kitchen Supervisor identified the food as pureed pears. He acknowledged that air was blowing on the uncovered food and indicated that the food would not be served to residents. 1b. An observation of the walk-in freezer on 09/18/17 at 10:30 a.m. revealed two oblong metal pans covered with foil which were unlabeled and undated. The second-shift Kitchen Supervisor indicated that the facility does batch cooking and the food in the pans was cooked vegetables. In an interview on 09/18/17 at 10:35 a.m., the Administrator acknowledged the lack of appropriate labeling of food items for the observations during survey. He shared his expectation that staff follow accepted guidelines to cover, label and date stored foods. 2a. An observation of the walk-in refrigerator on 09/18/17 at 10:40 a.m. revealed a foil-covered tray labeled "lunch" was present. It was undated.	F 371	F-371 10/19/2017 Presbyterian Home of Hawfields will continue to strive to ensure that all food is covered, labeled and dated in the walk-in freezer and refrigerators. The Dietary Staff was retrained by the Dietician and Dietary Manager regarding all items in refrigerators/freezers are covered, labeled and dated properly with use by dates honored. Unlabeled, uncovered, or outdated items discarded. All items in the nourishment room refrigerators/freezer are labeled/ dated and stored proper with no personal items in the refrigerator/ freezer. Items not labeled, dated, stored properly and/or any personal items will be discarded. The Dietician, Dietary Manager and/or designee conducted an audit of all freezer and refrigerators to ensure that they meet the required regulations. The Dietician, Dietary Manager and/or designee will randomly audit the freezers and refrigerators to ensure they meet the required regulations. A QA Audit will be utilized. A QA Audit Tool will be used three (3) times per week for one (1) month And reviewed at least weekly by the	

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F 371	Continued From page 12 Among other items on the tray, there were three small bowls covered with plastic and two small plastic glasses covered with plastic lids not labeled with resident names. The five items were not labeled to identify the food, the preparation date or the use-by date. The second-shift Kitchen Supervisor identified the liquid in the cups as "smoothies" and the material in the bowls as egg salad to be served at lunch. In an interview on 09/18/17 at 10:35 a.m., the Administrator acknowledged the lack of appropriate labeling of food items for the observations during survey. He shared his expectation that staff follow accepted guidelines to cover, label and date stored foods. 3a. An observation of the nourishment room refrigerator on the A/B Hall on 09/21/17 at 2:50 p.m. revealed one unopened ready-to-eat frozen dinner in the freezer with no label on the box. In the refrigerator was on store-bought clear plastic container with a pre-printed label of "pineapple chunks, best by 09/23/17." There was no name on the container to identify whose food it was. In an interview on 09/21/17 at 3:40 p.m., the Dietician identified the brand of frozen dinner found in the freezer as that provided by the facility to third-shift staff. A frozen meal is provided each night to staff members not present during the work day to take advantage of the free meal offered to those working. He could not explain why the dinner was present in the nourishment room refrigerator instead of the staff break-room refrigerator. He stated that he removed the frozen dinner from the freezer. He also indicated that he discarded the container of unlabeled pineapple chunks because there was no way to know	F 371	Dietician, Dietary Manager, Administrator and/or designee.	

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	345363	A. BUILDING _____ B. WING _____	09/21/2017

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F 371	Continued From page 13 whether the item belonged to a staff member or was brought in for a resident by a family member. In an interview on 09/18/17 at 10:35 a.m., the Administrator acknowledged the lack of appropriate labeling of food items for the observations during survey. He shared his expectation that staff follow accepted guidelines to cover, label and date stored foods.	F 371	QA Committee will review the QA Action Plan once a month for three (3) months and revise the action plan to ensure compliance.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514		10/19/17

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F 514	Continued From page 14 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to maintain complete and accurate documentation of wound treatment administration for 1 of 2 sampled residents (Resident # 43). Findings included: Resident #43 was admitted on 4/21/17. Review of the admission Minimum Data Set assessment dated 7/14/17, revealed resident ' s cognition was moderately impaired. Her diagnoses included pressure ulcer, dementia, psychosis, anxiety and depression. 1.a. Record review of Resident 43 ' s physician ' s orders for September 2017 revealed: wound rinse with H-Chlor (Sodium Solution) 0.125% (percent), prior to wound dressing daily at 8 AM. Review of Resident 43 ' s Treatment Administration Record (TAR) for September 2017 revealed that wound rinse with H-Chlor was not marked as complete on 9/2/17 - 9/5/17, 9/8/17 and 9/15/17.	F 514	F-514 10/19/2017 Presbyterian Home of Hawfields will continue to strive to ensure that all wound treatment administration records are complete and accurate. The nurses have been retrained on accurate and complete documentation by the DON. The Supervisor, DON and/or designee will randomly audit in-house residents to see if the treatment administration records are complete and accurate. A QA Audit Tool will be used three (3) times per week for one (1) month and reviewed at least weekly by the DON, Administrator and/or designee. QA Committee will review the QA	

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F 514	Continued From page 15 1.b. Record review of Resident 43 ' s physician ' s orders for September 2017 revealed: apply Santyl (topical medication) ointment to ankle wound daily at 8 AM. Review of Resident 43 ' s TAR for September 2017 revealed that application of Santyl ointment was not marked as complete on 9/2/17 - 9/5/17 and 9/15/17. 1.c. Record review of Resident 43 ' s physician ' s orders for September 2017 revealed: apply Solosite (topical medication) ointment to ankle wound daily at 8 AM. Review of Resident 43 ' s TAR for September 2017 revealed that application of Santyl ointment was not marked as complete on 9/2/17 - 9/7/17, 9/9/17 - 9/10/17 and 9/15/17. 1.d. Record review of Resident 43 ' s physician ' s orders for September 2017 revealed: Cover right ankle with foam dressing daily 7AM to 3 PM. Review of Resident 43 ' s TAR for September 2017 revealed that covering of ankle with foam dressing was not marked as complete on 9/2/17 - 9/5/17 and 9/15/17. On 9/21/17 at 11:15 AM, during an interview, Nurse # 2 indicated she provided daily wound treatment, according to the physician ' s order, but forgot to document it in the TAR. On 9/21/17 at 11:45 AM, during an interview, the Director of Nursing indicated that his expectation the nurses to provide the wound treatment as ordered by physician and document it in the TAR.	F 514	Action Plan once a month for three (3) months and revise the action plan to ensure continued compliance	

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F 520	Continued From page 16	F 520		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		10/19/17

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F 520	Continued From page 17 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and residents interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place in August of 2016. The deficiency was in the area of plan of care development (F279). The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Finings included: This tag is cross-referred to: F279: Development of plan of care: Based on staff interview and record review, the facility failed to develop a comprehensive care plan for 1 of 15 sampled residents, received hospice service (Resident #94). On 9/21/17 at 2:30 PM, during an interview, the Administrator indicated that the Quality Assessment and Assurance Committee meetings occurred monthly and based on the results of the several previous surveys the facility created and implemented the plan of correction. The Administrator confirmed that the facility constantly worked on quality improvement projects and conducted multiple audit in different areas of care.	F 520	F-520 10/19/2017 The QA Committee has been retained regarding sustaining an effective quality assurance program. The MDS Coordinator, Supervisor, DON and/or designee will conduct an audit of all residences on hospice to ensure they have a comprehensive care plan and all deficient areas will be monitored on a monthly basis after the initial review. The MDS Coordinator and/or designee will randomly audit in-house residents on hospice to ensure they have a comprehensive care plan and all deficient areas remain compliant. A QA Audit will be utilized. A QA Audit Tool will be used three (3) time per week for one (1) month and reviewed by the DON, Administrator, and/or designee. QA Committee will review the QA Care Plan once a month for	

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F 520	Continued From page 18	F 520	three (3) months and review the action plan to ensure continued compliance. Presbyterian Home of Hawfields will continue to strive to ensure that the facility has an effective Quality Assurance Program.	