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	345282	A. BUILDING _____ B. WING _____	C 12/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to accurately code a discharge destination and range of motion and cognition assessments correctly for 3 of 30 residents' Minimum Data Sets reviewed (Residents #122, #17, and #100). The findings included: 1. Resident #122 was admitted to the facility on 08/21/17 with diagnoses including dementia and a left hip fracture. The admission assessment of Minimum Data Set (MDS) dated 08/28/17 indicated severe cognitive impairment with no behaviors. The MDS also indicated extensive assistance was needed for bed mobility and transfers and impaired range of motion on 1 side of the lower extremities. A review of the discharge summary dated 09/21/17 revealed Resident #122 was discharged to home with family. A recapitulation of the notes explained Resident #122 was admitted from the hospital after a left femur fracture repair. The nursing staff provided assistance with activities of daily living and medication administration while in the facility. Resident #122 had received therapy and achieved max potential and was discharged home with home health to follow. A review of section A1800 of the discharge MDS dated 09/21/17, indicated Resident #122 was	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. During the annual survey ending 12/22/17, the surveyor reviewed Residents #122, #17, and #100 Minimum Data Set (MDS) Assessments for accuracy. It was determined that the MDS Coordinators did not review the sections for discharge destination, range of motion, and cognition, which led to the inaccurate MDS coding. On 12/22/17, the MDS Coordinators reviewed and submitted MDS assessment corrections for Residents #122, #17, and #100. All members of the Interdisciplinary Team (IDT) will be educated by the Director of Nursing (DON) regarding Federal and State regulations to ensure discharge destination, range of motion, and cognition are coded correctly in each resident's MDS. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be	1/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/17/2018

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F 641	Continued From page 1 sent to an acute hospital upon discharge from the facility. During an interview on 12/22/17 at 12:51 PM, MDS Coordinator #1 explained Resident #122 was not discharged to an acute hospital anytime during the stay at the facility, but was discharged home. The MDS Coordinator also revealed the Social Worker had entered the incorrect information, but no longer worked at the facility. MDS Coordinator #1 confirmed section A1800 of the discharge MDS dated 09/21/17 should have been coded as discharged home and a modification would be done to correctly represent Resident #122. During an interview on 12/22/17 at 3:38 PM, the Director of Nursing revealed it was her expectation for the MDS to reflect the residents' and section A1800 should have been correctly coded as discharged to home for Resident #122. 2. Resident #17 was admitted to the facility 09/21/15 with diagnoses which included unspecified dementia with behavioral disturbance, non-Alzheimer's dementia, depression, and kidney disease. Minimum Data Set (MDS) assessments dated 06/27/17 and 04/04/17 indicated impaired range of motion of bilateral upper and lower extremities. Review of Resident #17's medical record revealed an abductor bolster was ordered on 08/17/17, to be placed between the resident's lower extremities for up to six hours on the 1st shift daily, to prevent worsening of lower extremity contractures.	F 641	required to complete training prior to working a scheduled shift. Director of Nursing or designee will conduct weekly 100% audit of MDS Assessments ready for submission, for discharge destination, range of motion, and cognition, to ensure accuracy. Any identified issue will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. MDS Coordinators will be responsible for ensuring accuracy of each resident's MDS assessments.	

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F 641	Continued From page 2	F 641		

Further record review revealed question G0400 under Section G of the MDS dated 09/19/17 indicated Resident #17 had no limitation in range of motion of upper or lower extremities.

On 12/20/17 at 8:43 AM Resident #17 was observed to have bilateral contractures of her legs and hands. She was sitting up in a specialty chair with both knees bent at a forty-five degree angle and her hands were bent. An abductor bolster was noted in place between her knees.

On 12/20/17 at 10:40 AM during an interview Nurse #2 stated Resident #17 used an abductor bolster between her legs to prevent worsening of her lower extremity contractures per Occupational Therapy recommendation.

On 12/20/17 at 4:30 PM during a discussion with MDS Coordinator #2 she stated she was aware Resident #17 had contractures. She explained she must have accidentally marked question G0400 wrong when she completed the MDS assessment for 09/19/17. MDS Coordinator #2 stated a correction would be made. She added she was aware that Resident had abductor bolster to prevent worsening of the Resident's lower extremity contractures.

On 12/22/17 at 3:38 PM during an interview the Director of Nursing (DON) stated her expectation was that MDS assessments would be completed accurately. The DON stated the MDS assessment from 09/19/17 would be corrected.

3. Resident #100 was admitted to the facility 03/02/17 with diagnoses which included dementia with behavioral disturbance, anxiety, agitation,

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F 641	Continued From page 3 and depression. Review of a quarterly Minimum Data Set (MDS) dated 11/26/17 revealed sections C0700 short term memory and C0800 long term were coded as no memory problem. Section C0900 was coded the resident was unable to recall the current season, location of her own room, staff names and faces, and that the resident was in a nursing home. An interview on 12/20/17 at 3:52 PM with MDS Coordinator #2 revealed she was unable to explain why the MDS assessment of 11/26/17 was coded as no impairment of short and long term memory and no memory recall. She was unable to explain why Resident #100 could have intact short and long term memory and no memory recall. She stated the Social Worker (SW) completed that section of the MDS. An interview on 12/21/17 at 10:15 AM with the SW assistant revealed Resident #100 has had a "fluctuating" cognitive status. The SW assistant explained the resident could have good memory one day but not the next. The SW that completed the assessment was unavailable for interview. An interview on 12/22/17 at 3:38 PM with the Director of Nursing revealed her expectation was the MDS assessments be completed accurately. She stated she would make sure the 11/26/17 assessment would be corrected.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		1/19/18

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F 656	Continued From page 4 §483.21(b) Comprehensive Care Plans §483.21(b)(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 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 plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 5 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to develop a comprehensive care plan with measurable goals and implement identified care plan interventions for 2 of 30 residents reviewed for comprehensive care plans (Residents #114 and #41). The findings included: 1. Resident #114 was admitted to the facility 10/17/17. The resident's diagnoses included history of stroke and carbapenem-resistant Enterobacteriacea (a multi-drug resistant organism that can be contagious to long term care residents and is most commonly referred to as CRE infections) urinary tract infection. A significant change Minimum Data Set (MDS) dated 11/28/17 indicated the resident's cognition was severely impaired. The MDS coded the resident required extensive staff assistance for activities of daily living except eating, was frequently incontinent of bowel and bladder, and had received 2 days of antibiotics during the 7 day look back period. An observation conducted 12/18/17 at 12:16 PM revealed a sign on the door of Resident #114's room noting contact precautions were in place. Personal protective supplies were observed provided in containers on the room door. A review of Resident #114's care plans revealed an undated hand-written care plan that specified the resident had CRE in the urine. The care plan contained no goals and no timeframes in which	F 656	During the annual survey ending 12/22/17, the surveyor reviewed Resident #114 and #41 Comprehensive Care Plans. It was determined the nurse did not verify the orders addressed as care plan interventions, for Resident #41. Resident #41 was reassessed by the MDS Coordinator and determined that the bed cradle and heal protectors were appropriate interventions. The MDS Coordinator contacted the physician and obtained orders for implementation. For Resident #114, it was determined the MDS Coordinator did not include measurable goals for contact precautions, during the most recent care plan update. On 12/22/17, the MDS Coordinator updated the care plan which included measurable goals for contact precautions. Nurses will obtain orders for bed cradles, air mattresses, and heal protectors. MDS Coordinators will review updated orders and communicate changes to the IDT team, for care plan updates. Education will be provided by Staff Development Coordinator or designee to nursing staff and IDT, regarding verification of orders and including measurable goals in each resident's care plan. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift.	

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F 656	Continued From page 6 goals should be met or reviewed. Interventions included instructions for care prior to the resident going outside of her room and use of "isolation" items which included a gait belt with transfers. An interview was conducted with the Director of Nursing (DON) on 12/21/17 at 6:05 PM. The DON confirmed the undated care plan for Resident #114's CRE requiring contact precautions contained no measurable goals. An interview was conducted with MDS Coordinator #2 on 12/22/17 at 11:13 AM. She explained a hand written undated care plan was in the care plan book kept at the nurses' station and was available at all times. MDS Coordinator #2 stated a typed care plan that was dated was kept in the computer. A review of a copy of the typed care plan dated 11/06/17 revealed the care plan goal specified the resident and staff would maintain isolation precautions therapy preventing the spread of infection per facility policy and procedures. No measurable timeframes were provided to meet the resident's needs. MDS Coordinator #2 stated the dated care plan did not contain measurable goals. She explained she was unsure of when the contact precautions would end. 2. Resident #41 was admitted to the facility on 01/08/14 with diagnoses including diabetes mellitus and lower extremity edema (excess fluid in the tissues). A review of the quarterly Minimum Data Set (MDS) dated 10/18/17 indicated Resident #41 had moderately impaired cognition and needed extensive assistance with bed mobility, dressing, and personal hygiene, and total assistance for transfers using a mechanical lift. The MDS also	F 656	Director of Nursing or designee will conduct weekly 10% audit of care plans, to ensure interventions are implemented and include measurable goals. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. MDS Coordinator will be responsible for ensuring care plans include measurable goals and interventions.	

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F 656	Continued From page 7	F 656		

indicated no unhealed pressure ulcers were present during the assessment look back period, but Resident #41 was at risk for developing pressure ulcers.

A review of the revised care plan dated 11/01/17 included the risk for poor skin integrity due to decreased mobility with a goal to keep comfortable and remain free of skin breakdown until next review. The nursing interventions were to use a bed cradle (used to keep bed covers from touching the feet to prevent pressure ulcers while in bed) and place pressure reducing boots on the feet.

During an interview on 12/20/17 at 9:27 AM, Nurse Aide (NA) #2 explained she had provided the morning care for Resident #41 and confirmed she had not placed the pressure reducing boots on the feet or the bed cradle at the foot of the bed.

During an observation on 12/20/17 at 12:21 PM, Resident #41 was in bed with no bed cradle in place and was not wearing the pressure reducing boots.

During an observation on 12/20/17 at 03:12 PM, Resident #41 was in bed with no bed cradle in place and was not wearing the pressure reducing boots.

During an observation on 12/21/17 at 7:41 AM, Resident #41 was in bed with no bed cradle in place and was not wearing the pressure reducing boots.

During an interview on 12/21/17 at 3:20 PM, Nurse #4 confirmed Resident #41 was not

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F 656	Continued From page 8 wearing pressure reducing boots and the bed cradle was not in place to keep the covers of the feet. Nurse #4 also explained it was the nurses' responsibility to check and ensure the care plan interventions were in place, but she had forgotten to check. During an interview on 12/22/17 at 8:42 AM, the Director of Nursing revealed it was her expectation for the direct care staff and nurses to follow resident care plans and to ensure the interventions were in place.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide adequate supervision to prevent an avoidable skin tear for 1 of 5 residents (Resident #48) reviewed for accidents. The findings included: Resident #48 was admitted to the facility on 03/28/17 and readmitted on 05/12/17. His diagnoses included advanced dementia, type 2 diabetes mellitus and chronic kidney disease.	F 689	During the annual survey ending 12/22/17, the surveyor observed NA #3 cause Resident #48 to sustain a skin tear. It was determined that NA #3 was rushed at the time of the accident and was unaware of the injury to Resident #48. Nurse #2 completed the incident reporting process and Resident #48's skin tear was treated appropriately per protocol at time of injury. NA #3 was immediately re-educated on safe resident handling and received counseling, in accordance with the progressive discipline process.	1/19/18

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F 689	Continued From page 9 Resident #48's most recent quarterly Minimum Data Set (MDS) dated 10/19/17 revealed severely impaired cognition with no behaviors. Review of Resident #48's admission Care Area Assessment (CAA) summary dated 05/12/17 revealed he was at risk for impaired skin integrity. Review of Resident #48's care plan dated 11/10/17 revealed he was at risk for skin integrity related to episodes of bowel and bladder incontinence, impaired mobility and episodes of agitated behaviors. The goal was for the resident to remain free from pressure related skin breakdown and skin tears through the next 90 days. The interventions included in part: 1. Check skin with daily care and as needed (prn) - observe for redness, edema, purulent drainage or other negative signs and symptoms, 2. Document each incident of bruising or skin tear and tailor interventions to prevent further occurrence, 3. Dress in protective clothing as tolerated and apply lotion to dry skin daily, and 4. When resident is agitated, re-approach at a later time to prevent skin tears, bruising and notify nurse when unable to provide care. Observation of Resident #48 on 12/18/17 at 4:46 pm revealed him lying in bed with matching and fitting clothing on and a bandaged skin tear on his right forearm. Observation of Resident #48 on 12/19/17 at 11:21 am revealed him up in his wheelchair and dressed neatly, moving along the hallway propelling himself in his wheelchair. The skin tear to his right forearm remained bandaged. Observation of Resident #48 on 12/21/17 at 11:25	F 689	Facility-wide education will be provided by Staff Development Coordinator or designee regarding safe resident handling. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Director of Nursing or designee will conduct weekly 10% audit of safe resident handling during locomotion on and off the unit, to ensure safe resident handling. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Staff Development Coordinator will be responsible for implementing safe resident handling practices.	

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F 689	Continued From page 10	F 689		

am revealed him up in his wheelchair outside his room moving back and forth in his wheelchair and stopped his chair in front of his room next to a medication cart that was parked outside his room. Nurse Aide (NA) #3 came out of the room and moved Resident #48's chair back out of the doorway so he could assist the roommate out to the dining room. Resident #48 moved his wheelchair back in front of the doorway next to the medication cart by rolling the wheels with his hands. NA #3 came out of the room and again pulled the resident's wheelchair back out of the doorway and the resident started yelling "oh, oh." NA #3 was asked to stop because the resident's left hand was caught in the wheel of the chair. NA #3 stopped, picked up the residents left arm and let it drop on the arm rest. NA #3 then walked away from Resident #48 and proceeded to push the roommate in his wheelchair down to the dining room for lunch. Resident #48 put his hand up on the handrail beside his chair and his hand was bleeding and there was blood on the handrail beside his chair. Nurse #2 was informed that the resident's left hand was bleeding and she immediately went over to Resident #48 and assessed his hand and pulled him in his chair into his room to provide care for him. As she was pulling him into his room she asked another nurse to clean the blood off the hand railing. Nurse #2 used a clean cold cloth and removed the blood from the resident's left hand and revealed a dime sized skin tear to the left forefinger. She cleaned the area and applied steri-strips and a bandage over the wound to prevent the resident from picking at the strips and the wound.

An interview with Nurse #2 on 12/21/17 at 11:45 am revealed she would complete an incident

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report describing the events of the injury and notify the family and physician of the injury to the resident. She stated she would have expected NA #3 to have assured Resident #48's hands were inside the wheelchair or on the arm rests before he moved his wheelchair. She also stated she would have expected NA #3 to have notified her of the resident's injury as soon as it happened.

An interview with NA #3 on 12/21/17 at 12:17 pm revealed he had worked at the facility for 4 months. Stated he had taken care of Resident #48 often and he required extensive assistance of 1-2 persons with all activities of daily living (ADL). NA #3 stated he usually tried to assure that Resident #48's legs were on his foot rest and arms were on the arm rest or inside the chair but stated he was in a hurry to get the roommate to the dining room for lunch and did not check before he moved the resident's wheelchair. Stated he had not expected Resident #48 to have his hand down in the wheel. He added typically he would have reported the incident to the nurse right away but he had not done that today because he was in a hurry to get the roommate to the dining room. NA #3 stated he should have checked Resident #48's hand before taking the roommate to the dining room.

An interview with the Clinical Coordinator (CC) on 12/21/17 at 12:23 pm revealed that she was aware of the incident with Resident #48. The CC stated she would have expected anyone moving a resident to make sure they did not bump the resident on anything or on another resident. If a resident got hurt she would have expected the NA to notify the nurse immediately and for the nurse to have taken the appropriate actions to take care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	C 12/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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 689	Continued From page 12	F 689		

of the resident's injury and have reported the incident to the physician and family or responsible party.

An interview with the Environmental Services Manager on 12/21/17 at 2:54 pm revealed she had worked at the facility for almost 2 years. She stated that she was standing and talking with a resident when she saw NA #3 roll Resident #48 back in his wheelchair and the resident yelled "oh, oh" and heard the surveyor say "stop, his hand is caught in the wheel." The Manager stated she then saw NA #3 pull Resident #48's arm up and "let it drop onto the arm rest of the wheelchair." She stated NA #3 then pushed the roommate on down to the dining room without looking at Resident #48's hand. The Manager stated she then saw Resident #48 put his hand up on the hand rail and it was bloody and there was blood on the hand rail. The manager stated she then saw the nurse come and look at the resident's hand and stated it was cut and took him into his room and closed the door.

Review of a Care Event Notification dated 12/21/17 at 3:23 pm revealed Nurse #2 had completed an incident report regarding Resident #48's skin tear. The description stated "staff was moving resident from in front of doorway and resident's left hand was caught in the wheel of the wheelchair, staff states he was unaware and moved resident. Causing skin tear to left index finger. Treatment started per protocol." The document further specified the date the event occurred was 12/21/17 and time of Event was 11:30 am. The severity of the injury was described as mild harm.

An interview with the Director of Nursing (DON)

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F 689	Continued From page 13 on 12/22/17 at 3:31 pm revealed it was her expectation the NA be sure that resident's arms were within the chair prior to moving them in their wheelchairs. The DON also stated that it was her expectation if an injury does occur, the NA acknowledge the injury prior to walking away from the resident and notify the nurse immediately of the incident.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assurance Performance Improvement Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in November of 2016. This was a recited deficiency which was originally cited in October of 2016 on a recertification survey and subsequently recited on the current recertification survey. The deficiency was in the area of accuracy of Minimum Data Set (MDS) assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. This tag is cross referred to: 483.20 (g) Accuracy of MDS Assessment: Based on observations, record review, and staff	F 867	During the survey ending 10/27/16, the facility received a citation related to accuracy of Minimum Data Set (MDS) Assessments. During the annual survey ending 12/22/17, the surveyor reviewed Residents #122, #17, and #100 Minimum Data Set (MDS) Assessments for accuracy. It was determined that the MDS Coordinators did not review the sections for discharge destination, range of motion, and cognition, which led to the inaccurate MDS coding. On 12/22/17, the MDS Coordinators reviewed and submitted MDS assessment corrections for Residents #122, #17, and #100. The QAPI committee□s plan of correction for monitoring MDS Assessments from the previous citation was very narrowly	1/19/18

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F 867	Continued From page 14 interviews the facility failed to accurately code a discharge destination and range of motion and cognition assessments for 3 of 30 residents' Minimum Data Sets reviewed (Residents #122, #17, and #100). The facility was recited for 483.20 (g) for inaccuracy of MDS assessments in the areas of discharge destination, range of motion, and cognition. The 483.20 (g) was, also, cited on the recertification survey of October 2016 for inaccuracy of MDS assessments in the areas of cognition, vision, dental, and falls. An interview was conducted with the Administrator on 12/22/17 at 3:56 PM. The Administrator stated the facility had plans for 2018 to have monitoring systems in place to monitor deficiencies.	F 867	focused on cognition, vision, dental, and falls, and was not comprehensive to include discharge destination, range of motion, and cognition. All members of the Interdisciplinary Team (IDT) will be educated by the Director of Nursing (DON) regarding Federal and State regulations to ensure discharge destination, range of motion, and cognition are coded correctly in each resident□s MDS. Any staff members who do not receive the training by the specified date (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. Director of Nursing or designee will conduct weekly 100% audit of MDS Assessments ready for submission, for discharge destination, range of motion, and cognition, to ensure accuracy. Any identified issue will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly. QAPI committee will only consider discontinuing monitoring if subsequent surveys through the annual recertification survey results in no repeat citations. Administrator will be responsible for ensuring ongoing compliance with accuracy of MDS Assessments.	