STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING _____ B. WING _____	C 03/21/2019

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CAPITAL NURSING AND REHABILITATION CENTER	3000 HOLSTON LANE RALEIGH, NC 27610

(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
E 000	Initial Comments An unannounced Recertification and Complaint survey was conducted on 03/18/19 through 03/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Complaint Intake#'s NC00149641, NC00149581 and NC00149266. Event ID #MFW011.	E 000		
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 document review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) for Discharge Status for 1 of 4 residents reviewed. (Resident #94). The findings included: Resident #94 was originally admitted to the facility on 11/29/18, with diagnoses including Hypertensive Heart Disease with Heart Failure, Chronic Systolic Congestive Heart Failure and Cardiomyopathy. According to the most recent Discharge, return not anticipated MDS (Minimum Data Set) dated 12/19/18, Resident #94's cognition was intact and required extensive assistance in most areas of activities of daily living. Review of Section A of the MDS dated 12/19/18, revealed the MDS was coded for discharge to Acute Hospital.	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for Resident #94 involved modifying the Minimum Data Set assessment with an ARD of 12/19/18 and correcting the answer for question A2100 (Discharge Status) in order to accurately reflect the setting that the resident was discharged to. This was completed by the facility Minimum Data Set Nurse.	4/18/19

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

Electronically Signed | 04/11/2019

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F 641	Continued From page 1 Review of a Nursing note dated 12/19/18 revealed Resident #94 was discharged home. During an interview on 3/21/19 at 10:56 AM, the MDS Nurse revealed Section A, Discharge Status, which was coded for Acute Hospital was an oversight. She said usually the way she found out a resident was being discharged home or discharged to the hospital was that she normally talked about it in PPS meeting which was an assessment that was required for managed Medicare/Medicaid. She stated she also got information from reading notes from the Social Worker. During an interview on 3/21/19 at 1:25 PM, the Administrator revealed her expectation was that the assessment and documentation was accurate.	F 641	Corrected Minimum Data Set assessment was re-submitted to State Database in Batch #1236 and accepted on 03/22/19. All residents have the potential to be affected by the alleged deficient practice. All residents who have been discharged from the facility during the past 60 days (02/09/19 04/09/19) will be audited to ensure that Question A2100 (Discharge Status) is accurately coded on their Discharge Minimum Data Set assessment. Any assessment that is noted to have been inaccurately coded for A2100 will be modified and corrected in order to ensure that the accurate discharge setting is reflected. This audit will be conducted by the Minimum Data Set Nurse and will be completed no later than 04/18/19. Systemic Changes: The Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Nurse that included the importance of obtaining accurate information regarding the disposition of discharged residents, and that this information may be obtained by thoroughly reviewing the medical record prior to completion of question A2100 of the Discharge Minimum Data Set assessment. This education was provided to the Minimum Data Set Nurse on 04/10/19. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.	

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F 641	Continued From page 2	F 641	Monitoring Procedure: The Minimum Data Set Nurse or other designated nurse representative will begin auditing for accurate coding of question A2100 (Discharge Status of the Discharge Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate Coding of Section A2100 (Discharge Status) Audit Tool to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and in compliance with the regulatory requirements. Audits will be done weekly x 4 weeks, monthly x 2 months, and then quarterly. Audit reports will be presented to the Quality Assurance Performance Improvement Committee by the Minimum Data Set Nurse per the audit schedule (weekly, monthly, quarterly) to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The Quality Assurance Performance Improvement meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Assistant Director of Nursing, Therapy Director, Health Information Manager, Dietary Manager, Social Worker and the Activity Director. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 04/18/19	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		4/18/19

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F 656	Continued From page 3 §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	F 656		

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F 656	Continued From page 4 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 observation, record review and staff interview the facility failed to develop a comprehensive care plan for pain and a colostomy for 2 of 24 residents whose care plans were reviewed (Resident #76 and #27). The findings included: 1. Resident #76 was admitted to the facility on 2/26/19 and had a diagnosis of an intertrochanteric fracture of the left femur (fractured hip). Review of the Comprehensive Care Plan initiated 2/26/19 did not include a care plan for pain. The Admission Minimum Data Set (MDS) Assessment dated 3/5/19 revealed the resident was cognitively intact and required extensive assistance with bed mobility, transfers, ambulation, dressing, toileting, personal hygiene and bathing and independent with eating after tray set-up. Functional limitation in range of motion noted impairment of the lower extremities on one side. The MDS showed a pain interview with the resident revealed the resident had occasional pain at 8 out of 10 and received scheduled pain medication along with pain medication on an as needed basis. The MDS revealed the resident received an opioid (pain medication) for 6 of the 7 day assessment period. The Care Area Assessment (CAA) for Pain dated 3/6/19 noted the following: The resident was at risk for pain due to a femur fracture and received	F 656	The care plan for Resident #27 was corrected on 03/19/19. The Minimum Data Set Nurse revised the resident's care plan in order that it accurately reflects the presence of a colostomy. This was completed on 03/19/19. Resident #76 was discharged (return not anticipated) from the facility on 03/14/19 which was prior to the date that the specific deficiency was identified during annual survey so the care plan was not corrected to include interventions for pain. All residents have the potential to be affected by the alleged deficient practice. An audit of all current residents who have reported occasional, frequent or almost constant pain during the past 90 days, or who currently receive routinely scheduled pain medication will be completed by the Minimum Data Set Nurse and/or designated nurse representative. This audit will include a review of each of the identified residents care plans to validate whether or not pain is accurately addressed on the care plan. Any of the above identified residents who do not have a care plan for pain, will immediately have a care plan revision completed so that pain may be added. This audit and any associated necessary care plan revisions will be completed no later than 04/18/19.	

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F 656	Continued From page 5 Oxycodone (narcotic pain medication) as needed and scheduled Tylenol. Staff to assess pain every shift. Will care plan. The resident ' s care plan was updated on 3/6/19 but did not include a care plan for pain. Review of the Medication Administration Record revealed the resident received Tylenol on a scheduled basis and received Oxycodone as needed for pain. On 3/20/19 at 2:15 PM an interview was conducted with the MDS Director who stated she did the MDS for Resident #76. The MDS Director was observed to review the resident ' s Care Plan and stated there was not a care plan for pain and she must have missed it. On 3/21/19 at 11:34 AM the Director of Nursing stated in an interview that a Care Plan was needed for the items triggered in the MDS. 2. Resident #27 was admitted to the facility on 9/28/18 and had a diagnosis of hip fracture, anemia and Parkinson ' s disease. The list of diagnoses did not include an ostomy. (an ostomy is an artificial opening in an organ of the body, created during an operation such as a colostomy). The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/10/19 revealed the resident was cognitively intact and required extensive assistance with most activities of daily living. The MDS noted the resident had an ostomy. There was no information in the Care Area Assessments regarding an ostomy.	F 656	An additional audit will be conducted to review all current residents who have a colostomy. All residents identified as having a colostomy will have a review of their care plan in order to validate whether or not it accurately reflects the presence of a colostomy. Any current resident who has a colostomy and whose care plan is identified as not reflecting the presence of colostomy, will immediately have a care plan revision so that colostomy may be added. This audit and any associated care plan revisions will be completed by the facility Minimum Data Set Nurse and will be completed no later than 04/18/19. Systemic Changes: On 04/10/19 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on Comprehensive Care Plans. This education included the importance of ensuring that each resident□s care plan addressed actual problems, risk factors, resident strengths and preferences. The education emphasized that the care plan must communicate the resident□s current condition, needs, and preferences to the staff. Therefore, the care plan must have ongoing revisions and updates as the residents condition changes. The education also included the importance of ensuring that the presence of special medical devices such as colostomies is addressed on the care plan as well as ensuring that residents who have pain have a care plan that addresses their pain. The educational material included the fact that the care plan is a tool used to	

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F 656	Continued From page 6 Review of the Care Plan for Resident #27 did not include information about an ostomy. On 3/19/19 at 12:50 PM Resident #27 was observed to receive care and an ostomy bag was observed on the left side of the abdomen. On 3/19/19 at 12:55 PM an interview was conducted with the nurse assigned to Resident #27. Nurse #1 stated the resident had a colostomy and the staff took care of the colostomy. On 3/19/19 at 1:08 PM an interview was conducted with the MDS Director. The MDS Director confirmed the resident did have a colostomy on admission to the facility and stated it should have been care planned but could not explain why a care plan was not done for the colostomy. On 3/21/19 at 11:33 AM the Director of Nursing stated in an interview that if a resident had an ostomy they should have a care plan for it.	F 656	communicate resident□s condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and that to ensure residents□ needs are met that the care plans must be person-centered and an accurate and current reflection of resident. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. Monitoring Procedure: The Minimum Data Set Nurse and/or designated nurse representative will conduct audits to ensure that residents who have chronic pain or those who report occasional, frequent or almost constant pain or those who have a colostomy have care plans that reflect these items. This Quality Assurance tool entitled Comprehensive Care Plans QA Tool will be completed weekly for 4 weeks then monthly for 6 months and then quarterly until sustained compliance has been achieved. Audit reports will be presented to the Quality Assurance Performance Improvement Committee per the audit schedule (weekly, monthly, quarterly) by the Minimum Data Set Nurse to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the Quality Assurance Performance Improvement Meeting per the audit schedule. The Quality Assurance Performance Improvement Meeting is attended by the Administrator, Director of	

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F 656	Continued From page 7	F 656	Nursing, Minimum Data Set Nurse, Therapy Director, Assistant Director of Nursing, Health Information Manager, Social Worker and the Dietary Manager. The Administrator is responsible for implementation and completion of the accepted plan of correction. Completion date: 04/18/2019	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and pharmacist interview, the facility failed to have a medication error rate of less than 5 percent as evidenced by 2 out of 29 opportunities resulting in a medication error rate of 6.9 percent for 2 of 2 residents observed during a medication pass (Resident #198 and #67). The findings included: Resident #198 was admitted to the facility from the hospital on 3/15/19 and had a diagnosis of pneumonia. The manufacturer ' s package insert for Breo Ellipta read as follows: "After inhalation the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis" (oral thrush).	F 759	The facility failed to have a medication error rate of less than five percent. For resident # 198, the nurse will be educated by the Director of Nursing by 4/18/19 on the correct procedure for administering inhalers to include reading the manufacture package insert prior to administering an inhaler. The nurse will be observed by 4/18/19 by the Director of Nursing for compliance with facility policy and the manufacture□s guidelines for administration of the Breo Ellipta inhaler. For resident # 67, the Director of Nursing will audit the Medication Administration Record by 4/18/19 for the last 30 days to assure that the resident had not received a medication that did not comply with ordered parameters. The Director of Nursing will educate the nurse on facility	4/18/19

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F 759	Continued From page 8 The hospital discharge orders included an order for Fluticasone Furoate-Vilanterol (Breo Ellipta) 200-25 micrograms/dose inhaler. Inhale 1 puff daily. Breo Ellipta is a bronchodilator and corticosteroid medication that reduces inflammation in the lungs, helps open the airways and improves breathing. The Medication Administration Record (MAR) for Resident #198 noted Fluticasone Furoate-Vilanterol 200-25 micrograms/inhalation 1 puff daily was scheduled for 9:00 AM daily. There were no instructions on the MAR regarding the administration of the inhaled medication. On 3/18/19 at 8:29 AM, Nurse #3 was observed to prepare medications for Resident #198. The nurse was observed to hand the resident the Breo-Ellipta Inhaler and the resident took one puff. The nurse then handed the resident a small cup of water and the resident drank and swallowed the water. On 3/18/19 at 3:09 PM Nurse #3 was asked if she had the resident rinse his mouth and spit out the water after using a steroid inhaler and she stated no that she usually just had them drink something so they did not get thrush. On 3/21/19 at 11:36 AM the Director of Nursing stated in an interview the nurses followed the directions on the MAR when administering medications. On 3/21/19 at 11:43 AM the facility ' s Consulting Pharmacist stated in an interview the patient should rinse the mouth and spit the water out after using a steroid inhaler.	F 759	policy with administration of medications and ordered parameters by 4/18/19. Corrective action for residents with the potential to be affected by the alleged deficient practice: The Director of Nursing/Assistant Director of Nursing will observe administration of Breo Ellipta Inhalers for compliance with the manufacturer□s package insert and facility policy during administration by the nurse for all other residents receiving an ordered Breo Ellipta Inhaler by 4/18/19. The Director of Nursing/Assistant Director of Nursing will audit all resident orders with parameters for compliance with the administration of the medication following the ordered parameters by 4/18/19. Systemic changes: The Director of Nursing/Assistant Director of Nursing began education of all full time, part time and as needed nurses on the prevention of medication errors and medication safety to include facility policy on the use of inhalers and compliance with medication orders that contain parameters for administration. The in-service will be completed by 4/18/19 at which time all nurses must be in-serviced prior to working. Monitoring Procedure: The Director of Nursing/Assistant Director of Nursing will monitor for compliance with facility policy on the administration of inhalers and the administration of medications with ordered parameters by randomly observing two medication passes to include all shifts and	

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F 759	Continued From page 9 Example 3: Resident #67 was admitted to the facility on 10/30/2011 with diagnoses to include hypertensive heart disease, history of myocardial infarction and stroke. A Physician order for Resident #67's medication dated 2/27/2019 read metoprolol tartrate (an antihypertensive medication) 25 milligrams (MG) tablet. Take 1 tablet by mouth twice daily. Hold if systolic blood pressure (SBP) less than 100 or diastolic blood pressure (DBP) less than 66. A Physician order for Resident #67's medication dated 3/15/2019 read isosorbide mononitrate tablet 30 MG extended release (ER) take 1 tablet by mouth once daily. Hold if SBP less than 100 or DBP less than 66. During a medication pass observation conducted on 3/18/2019 at 7:13 AM, Nurse #1 stated he had checked Resident #67's blood pressure and the result was 113/54. Nurse #1 proceeded to prepare the medications for Resident #67 and included metoprolol (Lopressor- brand name) 25 MG and isosorbide (Imdur- brand name) 30 MG. Directions for both medications included parameters which read "Hold if SBP less than 100 or DBP less than 66." These parameters were written on the pill packet and on the electronic Medication Administration Record (MAR). Nurse #1 crushed the medications and mixed them in applesauce, and rechecked the MAR. The Nurse stated, Lopressor should not be given since the blood press is low, so I will have to get the medications ready again. Nurse #1 disposed of the medications and pulled resident #67's medications again, without the Lopressor	F 759	weekends, weekly x 2 and monthly x 3. Reports will be presented to the monthly Quality Assurance Performance Approval committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Performance Improvement Meeting. The Quality Assurance Performance Improvement Meeting is attended by the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Date Set Nurse, Therapy Director, Social Worker, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/18/19	

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F 759	Continued From page 10 but did include the Imdur. Nurse #1 crushed the medications and mixed them in applesauce. Nurse #1 locked his medication cart and closed his electronic MAR, and stated he was ready to give the medications. As Nurse #1 was ready to proceed to resident #67's room he was asked if there were any blood pressure parameters for the Imdur. The Nurse stated there were no parameters for it. The nurse was asked to check the MAR and when the nurse looked at the MAR again, he stated yes, there were parameters for the Imdur and he would have to get the medications ready again without the Imdur. On 3/18/2019 at 10:35 AM an interview was conducted with Nurse #1 who stated he normally looked at the MAR on the computer to see what the parameters were for the medications, but he did not see them this time. On 3/21/2019 at 8:48 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected staff to know the correct parameters when giving medications for blood pressure.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/18/19

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F 761	Continued From page 11 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to lock an unattended medication cart for 1 of 2 medication carts observed (100 Hall medication cart) during a medication pass. The findings included: On 3/18/19 at 8:59 AM Nurse #3 was observed to pass medications on the 100 Hall. During the medication pass, Nurse #3 stated there was a medication she needed that was not on the cart and she would need to go to the medication room to obtain the medication. The Nurse was observed to walk down the hall and enter the medication room closing the door behind her. The medication cart was observed to be unlocked during this time. At 9:03 AM the Nurse returned to the medication cart and stated: "I thought I locked the cart." On 3/18/19 at 9:12 AM Nurse #3 stated in an interview she thought she had locked the medication cart when she went to the medication	F 761	Nurse came back from the medication dispensary room and realized that her medication cart had not been locked. She immediately locked her medication cart. This nurse will be educated on locking her medication cart when not in use or when she is not at her cart by 4/18/19. No other carts were found unlocked. All licensed nurses will be re-educated by the Director of Nursing and/or her designee on remembering to lock their medication cart when not in use or when they are not at their cart by 4/18/19. Nurses who have not received this education by 4/18/19 will not be allowed to work until they do. The Director of Nursing and/or her designee will conduct three random medication cart audits weekly to include 3	

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	345202	A. BUILDING _____ B. WING _____	C 03/21/2019

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F 761	Continued From page 12 room. On 3/21/19 at 11:36 AM the Director of Nursing stated in an interview the nurses were supposed to lock the medication cart when away from the cart.	F 761	shifts, 7 days a week to ensure that medication carts are locked when not in use and the licensed nurse is not at his/her cart. Medication cart audits will be conducted 3 times weekly for 2 weeks, then monthly for 3 months. Results of the audits will be presented weekly by the Director of Nursing for 2 weeks, then monthly for 3 months to the Quality Assurance and Performance Improvement Committee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. Quarterly audits will be conducted to ensure that this area remains in compliance. The Nursing Home Administrator is responsible for implementing and ensuring this plan of correction. Date of Compliance: 4/18/19	
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 staff interview and record review, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the	F 867	The facility was unable to sustain continued quality assessment and assurance implemented procedures and monitoring of interventions for F656 Develop/Implement Comprehensive Care	4/18/19

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F 867	Continued From page 13 recertification survey of 3/2/18. This was for one deficiency which were recited during the recertification survey of 3/21/19 in Develop/implement Comprehensive Care Plan at F-656. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This citation is cross referenced to: F-656 Based on record review and staff interviews the facility failed to develop a comprehensive care plan for pain and a colostomy for two of 24 residents whose care plans were reviewed. (Res. #27 and Res.#76) F-656 was originally cited on 3/2/18 for failing to include a hand roll for a contracture in a resident's comprehensive care plan for 1 of 2 residents reviewed for contractures. (Resident #35). During an interview with the Administrator and the MDS Nurse on 3/21/19 at 1:25 PM, the Administrator revealed the plan of correction from last year revealed care plans were updated when information was missing. She stated the MDS Nurse and the Rehabilitation Director were inserviced. She stated in September, the MDS Nurse was sent to MDS training. She stated audits were completed for 4 weeks and then monthly and routine monitoring. The MDS Nurse stated a work sheet was done for everything that was care planned. She stated they made sure the care plan identified any problem and they would bring the problem up in Quality Assurance	F 867	Plan after the cited deficiency and plan of correction from the recertification survey of 3/2/18 resulting in a repeat deficiency. An audit of all current residents who have reported occasional, frequent or almost constant pain during the past 90 days, or who currently receive routinely scheduled pain medication will be completed by the Minimum Data Set Nurse. and/or designated Nurse representative. This audit will include a review of each of the identified residents care plans to validate whether or not pain is accurately addressed on the care plan. Any of the above identified residents who do not have a care plan for pain, will immediately have a care plan revision completed so that pain may be added. In addition to completion of this audit of all current residents for pain for compliance as of April 18, 2019 this audit will be repeated quarterly. An additional audit will be conducted to review all current residents who have a colostomy. All residents identified as having a colostomy will have a review of their care plan in order to validate whether or not it accurately reflects the presence of a colostomy. Any current resident who has a colostomy and whose care plan is identified as not reflecting the presence of colostomy, will immediately have a care plan revision so that colostomy may be added. In addition to completion of this audit of all	

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F 867	Continued From page 14 meeting and they put a PIP (Performance Improvement Plan) in place and they would monitor improvement with it. The Administrator stated her expectation was that after they come in compliance, that they routinely check to make sure they remain in compliance. Based on record review and interviews the facility failed to maintain Quality Assurance for Care Plans.	F 867	current residents who have a colostomy for compliance as of April 18, 2019 this audit will be conducted for 4 weeks and then monthly for 6 months, and then repeated quarterly. Audit reports and findings will be presented to the Quality Assurance Performance Improvement Committee weekly for 4 weeks, then monthly for 6 months, and then quarterly by the Minimum Data Set Nurse and/or other Nurse Managers to ensure corrective action is sustained. Compliance to the ongoing auditing program will be monitored by the Administrator and Corporate Nurse Consultant. The weekly, monthly, and quarterly Quality Assurance and Performance Improvement Committee Meetings are attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Assistant Director of Nursing, Therapy Director, Health Information Manager, Dietary Manager, Social Worker and the Activity Director. The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 4/18/19	