STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 11/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF DUNN	711 SUSAN TART ROAD DUNN, NC 28335

(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 000	INITIAL COMMENTS A complaint ivestigation survey was conducted from 11/08/22 through 11/09/22. Event ID:#RZWE11. The following intakes were investigated: NC00192316; NC00193642; NC00194304; NC00194377; NC00194567; NC00194649; and NC00194683. Three (3) of the 21 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		12/7/22

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

Electronically Signed | 12/02/2022

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide privacy during care for 1 of 4 residents (Resident #2) reviewed for residents' rights when Nurse #1 performed tracheostomy care to Resident #2 with the room door completely open to the hallway leaving the resident visible from the hall. The reasonable person concept was applied to this deficiency as individuals have the expectation of privacy within their home environment. Findings included: Resident #2 was admitted to the facility on 8/24/2022 with respiratory failure. The admission Minimum Data Set (MDS) assessment dated 8/24/2022 indicated Resident #2 was comatose, a state of deep unconsciousness for a prolonged period) and received tracheostomy care. On 11/7/2022 at 1:55 p.m. Resident #2 was observed in a private room lying in the bed with no privacy curtains in the room. Nurse #1 was observed standing on the right side of Resident #2's bed providing tracheostomy care with the door located behind Nurse #1 left shoulder completely open to the hallway. The head of	F 583	F583 Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Immediate action(s) taken for the resident(s) found to have been affected include: 1. Nurse #1 was counseled on 11/7/2022 regarding leaving the door open during	

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F 583	Continued From page 2 Resident #2's bed was elevated close to 90 degrees, and she was visible to staff and residents passing the doorway. On 11/7/2022 at 2:06 p.m. in an interview with Nurse #1, she stated privacy during Resident #2's care was provided by closing the door. When asked why Resident #2's door was not closed during tracheostomy care, she stated she did not think about closing the door. On 11/7/2022 at 2:20 p.m. in an interview with Director of Nursing (DON) with the Administrator present, the DON stated residents with tracheostomy resided in private rooms, and privacy was provided by closing the door. She stated Resident #2's door should had been closed while Nurse #1 was performing tracheostomy care.	F 583	tracheostomy care. Formal re-education will be conducted with nurse #1 regarding resident privacy on 11/29/22. 2. Administrative staff members were in□serviced during a staff meeting on 11/10/22 regarding resident privacy for all residents, including resident #2. Action taken/systems put into place to reduce the risk of future occurrence include: 1. Mandatory in-services for 100% of all licensed nurses to include Nurse #1 will be conducted 11/14/22 through 12/7/22. In-services included: " Resident Privacy and Confidentiality " Providing privacy during care to include tracheostomy care 2. Direct observation of all residents receiving tracheostomy care including Resident #2 will be performed by administrative nurses to ensure the licensed nurse is providing privacy during tracheostomy care including closing the room door and pulling the privacy curtain. 3. Licensed nurses all shifts will be	

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F 583	Continued From page 3	F 583	monitored using the Resident Privacy Monitoring tool from 11/28/22 through 12/7/2022. Any areas of concern identified during the monitoring will be immediately addressed and nurses will be providing additional training. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. All residents to include Resident #2 requiring tracheostomy care will be monitored by administrative nurses using the Resident Privacy Monitoring tool to ensure all tracheostomy care is provided in a private environment with room doors closed and privacy curtains pulled in semi□private rooms. 2. Monitoring will continue 3 times weekly for 4 weeks, then once weekly for 4 weeks. Any areas of concern identified during the monitoring process will be addressed immediately and additional staff training will be conducted as needed. The DON will review and initial the Resident Privacy Monitoring tool weekly during the monitoring process.	

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F 583	Continued From page 4	F 583	3. The Administrator and/or designee will present the findings of the Resident Privacy Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. 4. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		12/7/22

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F 655	Continued From page 5 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a resident centered baseline care plan to address tracheostomy care (Resident #1) and risk for falls (Resident #3) on admission for 2 of 2 residents reviewed for baseline care plans. Findings included:	F 655	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a	

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F 655	Continued From page 6 1. Resident #1 was admitted on 10/7/2022 with diagnoses including respiratory failure and a tracheostomy. The baseline care plan for Resident #1 initiated on 10/7/2022 revealed no focus for tracheostomy care. The admission Minimum Data Set (MDS) assessment dated 10/14/2022 indicated Resident #1 was cognitively intact and received tracheostomy care and suctioning. On 11/7/2022 at 11:54 a.m. in an interview with the Regional Nurse Consultant, she stated the MDS nurse initiated the baseline plan within forty-eight hours of admission, and tracheostomy care should had been included on the baseline care plan. On 11/8/2022 at 10:04 a.m. in an interview with the MDS Nurse, she stated the baseline care plan was initiated by the Director of Nursing (DON) on 10/7/2022 and did not include tracheostomy care. She stated baseline care plans were not completed due to MDS staff were being pulled from the office to work nursing assignments weekly. On 11/8/2022 at 11:48 p.m. in an interview with the DON, she stated baseline care plans could only be initiated by a registered nurse, and she initiate the care plan for Resident #1. She stated the MDS nurse was responsible for completing the baseline care plan based on the items triggered in the admission assessment. Due to MDS staff frequently covering nursing assignments, she stated the MDS staff were	F 655	written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F655 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident # 1 discharged from the facility on 10/28/2022. 2. Resident #3□s care plan was updated on 11/7/2022 by the Minimum Data Set (MDS) nurse to reflect fall precautions. Action taken/systems put into place to reduce the risk of future occurrence include: 1. Mandatory in-services for 100% of all licensed nurses to include Nurse #1 will be conducted 11/14/22 through 12/7/22. In-services included: " Resident Privacy and Confidentiality " Providing privacy during care to include	

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F 655	Continued From page 7 unable to complete care plans. 2. Resident #3 was admitted to the facility on 10/19/22 with diagnoses that included dementia and muscle weakness. Review of Resident #3's baseline care plan dated 10/20/22 revealed no focus for high fall risk. Record review revealed a document labelled "Communication to Nursing" dated 10/20/22 completed by therapy which stated Resident #3 was a fall risk. Resident #3's admission Minimum Data Set (MDS) assessment dated 10/26/22 revealed he was assessed as having a moderate cognitive impairment. He did not have a history of falls. During an interview with the Regional Nurse Consultant on 11/7/22 at 3:06 PM, she stated the baseline care plan should have reflected the assessment completed by therapy regarding Resident #3's fall risk. An interview was conducted with the MDS Nurse on 11/8/22 at 11:30 AM she reported she did not complete the baseline care plan for Resident #3. Attempts to contact the nurse who initiated Resident #3's baseline care plan were unsuccessful. During an interview with the Director of Nursing on 11/8/22 at 11:48 am she stated Resident #3's baseline care plan should have reflected his fall risk. She stated the MDS nurse was responsible for completing the baseline care plan based on items triggered on the admission assessment. Due to the MDS staff frequently covering nursing assignments, she stated the MDS staff were	F 655	tracheostomy care. 2. The interdisciplinary care plan team members (MDS Coordinator, MDS Nurse, Social Worker (SW), Dietary Manager, Activity Director, DON, and Administrator) and licensed nurses were in-serviced on 11/14/2022 by the Facility Nurse Consultant in regards the base line care plans requirements and the Carrolton Baseline Care Plan Policy. 3. All newly hired MDS Coordinators, MDS Nurses, Social Workers (SW), Dietary Managers, Activity Directors, and licensed nurses will be in-serviced during orientation by the ADON/DON regarding base line care plan requirements and the Carrolton Baseline Care Plan Policy to include care planning residents for tracheostomy care and/or fall precautions as applicable. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. 10 % of all new admits will be reviewed by the administrative nurses to ensure	

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F 655	Continued From page 8 unable to complete care plans.	F 655	accuracy and timely completion of base line care plans, including addressing tracheostomy care, weekly X 4 weeks and monthly X 1 month utilizing the Care Plan Accuracy Monitoring tool. Areas of concern identified during the monitoring will be immediately addressed by the DON to include staff retraining and/or baseline care plan revision. The MDS coordinator or MDS nurse will update the care plan during the audit for any identified areas of concerns. 2. The DON will review and initial the Care Plan Accuracy Monitoring tool weekly X 4 weeks and monthly X 1 month to ensure completion and that all areas of concerns have been addressed. 3. The Administrator and/or designee will present the findings of the Care Plan Accuracy Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months.	

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F 655	Continued From page 9	F 655	Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. 4. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(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).	F 656		12/7/22

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F 656	Continued From page 10 (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 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an individualized care person centered care plan for a resident receiving tracheostomy care (Resident #1) and a resident at risk for falls (Resident #3) for 2 of 10 residents reviewed for comprehensive care plans. Findings included: 1. Resident #1 was admitted on 10/7/2022 with diagnoses including respiratory failure and a tracheostomy.	F 656	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of	

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F 656	Continued From page 11 The admission Minimum Data Set (MDS) assessment dated 10/14/2022 indicated Resident #1 was cognitively intact and received tracheostomy care and suctioning. The comprehensive care plan dated 10/21/2022 for Resident #1 revealed no focus for tracheostomy care. On 11/7/2022 at 11:54 a.m. in an interview with the Regional Nurse Consultant, she stated tracheostomy care should had been included on the comprehensive care plan. On 11/8/2022 at 10:04 a.m. in an interview with the MDS Nurse, she stated Resident's #1's comprehensive care plan was completed on 10/21/2022 and did not include tracheostomy care. She stated due to MDS staff working nursing assignments weekly, comprehensive care plans were not completed. On 11/8/2022 at 11:48 p.m. in an interview with the DON, she stated the MDS nurse was responsible for completing the comprehensive care plans. Due to MDS staff frequently covering nursing assignments, she stated the MDS staff were unable to complete care plans. 2. Resident #3 was admitted to the facility on 10/19/22 with diagnoses that included dementia and muscle weakness. Review of Resident #3's care plan dated 10/20/22 revealed no focus for fall risk. Record review revealed a document labelled "Communication to Nursing" dated 10/20/22 completed by therapy which stated Resident #3 was a fall risk.	F 656	Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F656 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident #1 was discharged from the facility on 10/28/2022. 2. Resident #3 comprehensive care plan was revised to reflect fall precautions on 11/7/2022 by the Minimum Data Set (MDS) nurse. Action taken/systems put into place to reduce the risk of future occurrence include: 1. A 100% audit of all comprehensive care plans was initiated on 11/11/2022 by the corporate nurse consultant, to ensure accuracy of comprehensive care plans, including addressing tracheostomy care and fall precautions as applicable will be completed by 12/7/2022. Any deficient care plans will be immediately addressed by the Director of Nursing (DON) and/ or the Assistant Director of Nursing	

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F 656	Continued From page 12 Resident #3's admission Minimum Data Set (MDS) assessment dated 10/26/22 revealed he was assessed as having a moderate cognitive impairment. He did not have a history of falls. During an interview with the Regional Nurse Consultant on 11/7/22 at 3:06 PM, she stated the care plan should have reflected the assessment completed by therapy regarding Resident #3's fall risk. An interview was conducted with the MDS Nurse on 11/8/22 at 11:30 AM she reported Resident #3's care plan should have included his fall risk. She reported she added his fall risk to his care plan on 11/8/22. The MDS Nurse stated she was unable to complete comprehensive care plans due to MDS staff being pulled to the floor to complete nursing tasks weekly. On 11/8/2022 at 11:48 p.m. in an interview with the DON, she stated the MDS nurse was responsible for completing the comprehensive care plans. Due to MDS staff frequently covering nursing assignments, she stated the MDS staff were unable to complete care plans.	F 656	(ADON) to include additional staff training regarding accurate completion of comprehensive care plans and the Carrolton Comprehensive Care Plan Policy and/or revision of the comprehensive care plan to reflect tracheostomy care and/or fall precautions. 2. An in-service for the interdisciplinary care plan team members (Dietary manager, MDS Nurse, Social Services Director, Activities Director, Director of Nursing (DON) and Administrator) and all licensed nurses will be initiated by the Facility Nurse Consultant on 11/14/2022 regarding requirements for accurately and timely completion of a comprehensive care plan for each resident to include tracheostomy care, to be completed by 12/7/2022. Any licensed nurses not receiving the in-service during this time will be educated on the in-service prior to working their next scheduled shift by the DON. All newly hired IDT care plan team members and licensed nurses will receive the in-service during	

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F 656	Continued From page 13	F 656	orientation by the Facility Nurse Consultant and/ or the DON. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. 10% of all residents□ care plans will be audited weekly x 4 weeks then monthly x 1 month by the administrative nurses and/or the ADON to ensure that the care plans accurately reflect the resident to include tracheostomy care and timely completion utilizing the Care Plan Accuracy Monitoring tool. The interdisciplinary care plan team members will be immediately re-trained and the care plan will be revised immediately by the DON for any identified areas of concern noted during the monitoring. 2. The DON will review and initial the Care Plan Accuracy Monitoring tool weekly x 4 weeks then monthly x 1 month for compliance with timely and accurate completion. 3. The Administrator and/or designee will present the findings of the Care Plan	

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F 656	Continued From page 14	F 656	Accuracy Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. 4. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide tracheostomy care as prescribed by the physician for 1 of 2 residents	F 695	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the	12/7/22

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F 695	Continued From page 15 reviewed for tracheostomy care. (Resident #1) Findings included: Resident #1 was admitted to the facility on 10/7/2022 with diagnoses including respiratory failure and tracheostomy. Physician orders dated 10/7/2022 stated to suction and change the inner cannula of the tracheostomy tube every shift and as needed for occlusion and to change the tracheostomy dressing every shift. The admission Minimum Data Set (MDS) dated 10/14/2022 revealed Resident #1 was cognitively intact and was receiving oxygen, suctioning and tracheostomy care. There was not a focus for tracheostomy care included on the care plan for Resident #1. The October 2022 Medication Administration Record (MAR) revealed tracheostomy care was not documented as performed on 10/11/2022. On 11/8/2022 at 9:19 a.m. in a phone interview with Nurse #3, she stated she did not have enough time to perform tracheostomy care to Resident #1 on 10/11/2022 during the 7:00 p.m. to 7:00 a.m. shift. She stated she suctioned Resident #1 once and did not change the inner cannula of the tracheostomy tube or the tracheostomy dressing as ordered by the physician. On 11/8/2022 at 4:00 p.m. in an interview with the Director of Nursing, she stated Nurse #3 should have performed tracheostomy care for Resident	F 695	extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F695 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident #1 was discharged from the facility on 10/28/22. 2. On 11/28/22, Nurse #3 was counseled and educated on the proper way to administer tracheostomy care as ordered by the physician; appropriate and accurate documentation on the EMAR (electronic medical administration record). 3. All licensed nurses were educated on	

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F 695	Continued From page 16 #1 as prescribed by the physician.	F 695	the proper procedure for administering tracheostomy care as ordered by the physician and appropriate and accurate document on the EMAR (electronic medical administration record). Inservice□s began on 11/25/22 and will be completed by 12/7/22. Nurses will not be allowed to work until they have completed the in-service training. 4. All licensed nurses will demonstrate competence on tracheostomy care utilizing the Tracheostomy Care Validation Checklist by 12/6/22. 5. New clinical staff members will receive education on the proper procedures for administering tracheostomy care. Orientation will be completed by the DON and / or ADON Action taken/systems put into place to reduce the risk of future occurrence include: 1. All residents within the facility will receive appropriate tracheostomy care. 2. On 11/28/22, Nurse #3 was counseled and educated on the proper way to administer tracheostomy care as ordered by	

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F 695	Continued From page 17	F 695	the physician; appropriate and accurate documentation on the EMAR (electronic medical administration record). 3. All residents with tracheostomies were assessed on 11/25/22, to observe the trach and dressing for cleanliness, fit, and intact dressing by administrative nurses. There were no areas of concern revealed during the assessment. 4. A 100% chart review was initiated on 11/14/11 to ensure the accuracy of orders, EMARs, trach care administration, inner cannula change, and trach dressing change instructions and frequency. Chart audits will be completed on 12/6/22. 5. All licensed nurses were educated on the proper procedure for administering tracheostomy care as ordered by the physician and appropriate and accurate document on the EMAR (electronic medical administration record). Inservice□s began on 11/25/22 and will be completed by 12/7/22. Nurses will not be allowed to work until they have completed the in-service training. 6. All licensed nurses will demonstrate competence on tracheostomy care	

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F 695	Continued From page 18	F 695	utilizing the Tracheostomy Care Validation Checklist by 12/6/22. 7. New clinical staff members will receive education on the proper procedures for administering tracheostomy care. Orientation will be completed by the DON and / or ADON. Nurses will not be allowed to work until they have completed the in-service training. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. Utilizing the Tracheostomy Care Validation Checklist, tracheostomy care for all trach patients will be observed and monitored to ensure that tracheostomy care is provided in a private environment utilizing proper technique per MD order. This will occur 3 x per week for four weeks. Areas of concern will be addressed immediately by the ADON / DON and nurses will receive immediate education to correct behavior and technique.	

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F 695	Continued From page 19	F 695	2. Utilizing the Tracheostomy Care Validation Checklist, beginning the fifth week, monitoring will continue once weekly for 4 weeks. 3. Any areas of concern identified during the monitoring process will be addressed immediately and additional staff training will be conducted as needed. 4. The DON and Administrator will review and initial the Resident Privacy Monitoring tool weekly during the monitoring process. 5. The DON and/or designee will present the findings of the to the Administrator and Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. 6. All issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 726		12/7/22

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F 726	Continued From page 20 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to educate nursing staff and verify competency to provide respiratory care needs for 1 of 2 residents (Resident #1) reviewed for tracheostomy care. Findings included: Resident #1 was admitted to the facility on 10/7/2022 with diagnoses of respiratory failure and tracheostomy. Physician orders dated 10/7/2022 revealed to	F 726	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of	

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F 726	Continued From page 21 suction and change the inner cannula of the tracheostomy tube every shift and as needed for occlusion and to change the tracheostomy dressing every shift. A review of October 2022 Medication Administration Record revealed nursing documentation of tracheostomy care was provided to Resident #1. A review of the educational classes revealed respiratory therapy personnel provided classes on tracheostomy care and management on 3/3/2022, 3/1/2022 and 9/2/2022 and attendees did not include Nurse #4 and Nurse #5 that provided care to Resident #1. Education class dated 3/1/2022 revealed Nurse #1 and Nurse #3, who provided tracheostomy care to resident #1, attended the tracheostomy class. In an interview with Nurse #1 on 11/7/2022 at 2:06 p.m., she stated she had worked with tracheostomy residents prior to her employment at the facility and she had received training on orientation for tracheostomy care and attended a respiratory therapy class on tracheostomy care at the facility. In a phone interview with Nurse #4 on 11/7/2022 at 8:44 p.m., she stated she did not receive tracheostomy care training from the facility at orientation. She stated when she was assigned to Resident #1, she asked a registered nurse to show her how to do perform tracheostomy care. In a phone interview with Nurse #5 on 11/8/2022 at 8:58 a.m., she stated she had been employed with the facility for 4 months. She stated she did not recall tracheostomy care as part of orientation	F 726	Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F726 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident #1 was discharged from the facility on 10/28/2022. Action taken/systems put into place to reduce the risk of future occurrence include: 1. On 11/14/22, A contracted Respiratory Therapist completed training and completion of the tracheostomy care skills validation/ competency check off with return demonstration to include all licensed nurses, including Nurse # 4 and Nurse #5. 2. On 11/14/2022, an in-service was initiated with all license nurses, by a contracted Respiratory Therapist on providing tracheostomy care as ordered by the physician. The in-service	

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F 726	Continued From page 22 and did not attend the tracheostomy care class held on 9/2/2022 due to having a scheduled appointment. In a phone interview with Nurse #3 on 11/8/2022 at 9:19 a.m., she stated the facility started accepting residents with tracheostomy tubes in the last four months. She stated she attended one class on tracheostomy care and did not attend the second class. She stated she worked part-time. On 11/8/2022 at 11:48 a.m. in an interview with the Director of Nursing (DON), she stated the facility did not have a staff development coordinator and education was conducted at the corporate level. She stated orientation of new staff was held every Tuesday, and corporate personnel came to the facility to checkoff the new employees on their competencies. In a follow-up interview on 11/8/2022 at 12:30 p.m. with the DON, she stated the facility had provided classes for the staff on tracheostomy care, and there were no competencies for tracheostomy care for the nursing staff. On 11/8/2022 at 2:46 p.m. in an interview with the DON with the Administrator present, the DON stated all staff should had attended the tracheostomy class held on 9/2/2022 and with the increase of residents with tracheostomy tubes in the facility, all nursing staff should have had a competency check off on tracheostomy care.	F 726	also addressed the expectation that documentation must be present on the Medication Administration Record (MAR) after providing tracheostomy care. The in-service will be completed by 12/7/2022. No licensed nurse will be allowed to work until receiving the in-service and performing successful return demonstration of tracheostomy care skills validation. All newly hired licensed nurses will complete the tracheostomy care in-service and perform successful return demonstration of tracheostomy care skills validation during the orientation process as provided by the Respiratory Therapist and/or the Director of Nursing (DON), the Assistant Director of Nursing (ADON). How the corrective action(s) will be monitored to ensure the practice will not recur: 1. 10% of licensed nurses to include Nurse #4 and Nurse #5 will be monitored for competency in providing tracheostomy care by the ADON, treatment nurse, and/or the resource nurses utilizing the Tracheostomy Care Validation Checklist weekly x 4 weeks, then monthly x 1 month.	

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F 726	Continued From page 23	F 726	2. This skills validation will verify that: " tracheostomy care is performed per MD order and policy and procedure, " assessments have been completed per protocol, " documentation is completed on the MAR and " the tracheostomy site is clean and odor free. Areas of concern identified during the audit will be addressed immediately by the ADON/DON to include MD notification, assessment of affected resident, and/or providing additional retraining. 3. The administrator and/or designee will present the findings of the Tracheostomy Care Validation Checklist to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI Committee will review the audit results monthly for 3 months and review the Tracheostomy Care Validation Checklist to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 726	Continued From page 24	F 726	4. The administrator and DON will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to schedule an appointment with an otolaryngologist (ear, nose and throat doctor) as ordered by the physician for a resident with a tracheostomy (Resident #1) and coordinate follow up appointments and transportation with the neurologist for a resident after craniotomy surgery (Resident #5) for 2 of 2 residents reviewed for medically related social services. Findings included: 1. Resident #1 was admitted to the facility on 10/7/2022 with diagnoses including respiratory failure. The admission Minimum Data Set (MDS) dated 10/14/2022 indicated Resident #1 was cognitively intact and was receiving tracheostomy care. Physician orders dated 10/22/2022 revealed an	F 745	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	12/7/22

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F 745	Continued From page 25 order to arrange for an appointment for Resident #1 to see an otolaryngologist on 10/24/2022. Nursing documentation dated 10/28/2022 revealed Resident #1 was discharged to the Emergency Room for possible decannulation of tracheostomy. In an interview with the Scheduler on 11/8/2022 at 8:33 a.m., she stated the nursing staff communicated resident appointments that needed to be scheduled verbally or left her a written note and was unable to recall anyone requesting her to make an otolaryngologist appointment for Resident #1. In an interview with Nurse #5 on 11/8/2022 at 8:58 a.m., she stated there was no way to scheduling the otolaryngologist appointment because the order was written on a weekend, and she gave the Director of Nursing (DON) a copy of the order on the morning of 10/24/2022 so the appointment could be scheduled. In an interview with the Physician on 11/8/2022 at 12:05 p.m., he stated he wanted Resident #1 to see the otolaryngologist for guidance on how to proceed in decannulation of Resident #1's tracheostomy in the nursing home setting and did not know why the appointment was not scheduled. He stated he knew the DON was working on a planned discharge for Resident #1 to a multiple specialty facility as well, and the otolaryngologist appointment was not discontinued. In an interview with the DON with the Administrator present on 11/8/2022 at 2:46 p.m., she stated an otolaryngologist appointment was	F 745	F745 Immediate Action Taken for the resident(s) found to have been affected: The facility will provide medically related social services to attain and maintain the Highest practicable physical, mental, and psychosocial well-being of each patient. 1. Resident # 1 has an appointment with Vidant Neurology on December 13, 2022. His mother (responsible party) and sister will accompany him to the appointment. Actions taken to reduce the risk of future occurrence include the following: 1. An in-service regarding timely follow up of ordered appointments to include ensuring a date and time for appointment is scheduled, documentation of RR refusals is present in the progress note, and that the RR or representative from the facility accompanies the patient. 2. The scheduler has been counseled and educated about the importance of notifying the DON, SW, and other care team members of issues regarding appointments (ex. delays,	

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not made for Resident #1, and the facility was unable to provide twenty-four hour respiratory and speech therapy services for monitoring Resident #1 for decannulation. After discussion with the family and physician on 10/25/2022, she stated the family declined the otolaryngologist appointment and a planned discharge to an Emergency Room was scheduled for Resident #1 for decannulation of the tracheostomy.
2. Resident #5 was admitted to the facility on 7/22/22 with diagnoses that included hypertension and left parietal craniotomy (surgical opening into the skull).

The admission Minimum Data Set (MDS) dated 7/29/22 indicated Resident #5 had significant cognitive impairment.
Review of a note dated 7/29/22 revealed the Director of Nursing (DON) spoke with staff at the neurologist's office who stated Resident #5 could not be seen if his guardian could not accompany him to his follow-up appointment.

An interview was conducted with the facility Scheduler on 11/8/22 at 2:56 PM. She reported she had attempted to schedule appointments, but his family members were unable to go. The scheduler stated if family members were unable to attend the appointment she did not keep a record of the appointments. She stated she notified the DON sometimes of her difficulty scheduling appointments. The scheduler verified Resident #5 had not been seen by his neurologist since admission.

During an interview with the DON on 11/8/22 at 3:15 PM she reported she was aware there had been difficulties with Resident #5 attending scheduled neurology appointments. She stated

timeliness, and family follow up).

3. An audit of physician□s orders and discharge summaries for ordered appointments
was initiated on 11/14/2022 for 100% of residents
including Resident #1 by the RN Unit Manager
and the Resource Nurse.

The audit will be completed on 11/18/2022 with
any identified areas of concern immediately
addressed by DON to include re-scheduling
appointments and/or providing additional staff
training.

4. All upcoming appointments will be reviewed by the Director of Nursing (or designee)
weekly x 8 weeks, then monthly x 1 month,
utilizing the Resident Appointment Monitoring tool
to ensure that all ordered appointments are
scheduled timely.
Areas of concern identified during monitoring will
be immediately addressed by DON to include re□scheduling appointments and/or providing
additional staff training.

How the corrective action will be

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F 745	Continued From page 27 no alternatives had been explored. An interview was conducted with the Administrator on 11/8/22 at 3:20 PM who stated he was made aware of the issue with Resident #5's transportation on 11/7/22. He indicated his expectation is residents attend outside medical appointments. During an interview with the Medical Director on 11/8/22 at 3:45 PM he stated Resident #5 was doing well and had not had any adverse effects from not being seen by his neurologist.	F 745	monitored: 1. The DON will review and initial the Resident Appointment Monitoring tool weekly for 4 weeks then monthly x 1 month for compliance with timely follow up of scheduled appointments, ensuring cancellations are addressed with follow□up re-scheduling, if applicable. 2. The Administrator and/or the DON will present the findings of the Resident Appointment Monitoring tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months. Issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		12/7/22

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to do so.

§483.70(i) Medical records.
§483.70(i)(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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or

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F 842	Continued From page 29 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (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 review and staff interviews, the facility failed to document performing tracheostomy care (Resident #1) and wound care (Resident #6) as ordered by the physician for 2 of 2 residents reviewed for identifiable information on resident records. Findings included: 1. Resident #1 was admitted to the facility on 10/7/2022 with diagnoses including respiratory failure and tracheostomy. Physician orders dated 10/7/2022 stated to suction and change the inner cannula of the tracheostomy tube every shift and as needed for occlusion and to change the tracheostomy dressing every shift. The admission Minimum Data Set (MDS) dated	F 842	Carrolton of Dunn acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Carrolton of Dunn□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other	

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F 842	Continued From page 30 10/14/2022 revealed Resident #1 was cognitively intact and was receiving oxygen, suctioning and tracheostomy care. The October 2022 Medication Administration Record (MAR) revealed suctioning of the tracheostomy tube and tracheostomy care was not documented as performed on 10/8/2022 and 10/21/2022 for the 7:00 p.m. to 7:00 a.m. shift. Nursing documentation dated 10/21/2022 revealed Resident #1 was sent to the Emergency Room at 8:15 p.m. due to the family's concerns with tracheostomy tube dislodgement. Nursing documentation further revealed, Resident #1 returned to the facility on 10/22/2022 at 1:15 a.m. and tracheostomy care was provided during the Emergency Room visit. In a phone interview with Nurse #4 on 11/7/2022 at 8:44 p.m., she stated she provided suctioning and tracheostomy care to Resident #1 on 10/8/2021 and thought she had documented providing tracheostomy care. On 10/21/2022, she stated she documented in the nurses notes Resident #1 was sent to the Emergency Room, and tracheostomy care was provided while she was at the Emergency Room. In a phone interview with Nurse #3 on 11/8/2022 at 9:19 a.m., she stated tracheostomy care was not documented on 10/11/2022 because she did not have time to provided tracheostomy care to Resident #1 during the 7:00 p.m. to 7:00 a.m. shift. She stated she did provide suctioning once to Resident #1 on 10/11/2022 during the 7:00 p.m. to 7:00 a.m. shift. In an interview with the Director of Nursing on	F 842	administrative or legal proceeding. F842 Immediate action(s) taken for the resident(s) found to have been affected include: 1. Resident #1 was discharged from the facility on 10/28/2022. 2. On 11/7/2022, Resident #6 sacral wound was assessed with documentation in the electronic medical record (eMAR) to include wound care on the electronic Treatment Administration Record (eTAR). 3. On 11/28/22, Nurse #3 was in-serviced on the Carrolton Tracheostomy Care Policy and providing tracheostomy care as ordered by the physician and documenting on the electronic medication administration record (eMAR) after care is provided. 4. On 11/28/22, Nurse #4 was in-serviced on providing wound care and documenting on the electronic Treatment Administration Record (eTAR) after providing wound care. 5. Administrative staff members were in□serviced during a staff meeting on	

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F 842	Continued From page 31 11/8/2022 at 2: 46 p.m., she stated nurses should document tracheostomy care as ordered by the physician on the MAR after completion of the care for Resident #1. 2. Resident #6 was admitted to the facility on 10/11/2021 with a diagnoses of pressure ulcer. The quarterly Minimum Data Set (MDS) assessment dated 6/17/2022 indicated Resident #6 was cognitively intact and had an unhealed pressure ulcer. Physician orders dated 6/14/2022 revealed an order to clean the pressure ulcer wound to the sacrum with wound cleanser, apply collagen and silver alginate to wound bed and cover with foam dressing daily on the day shift and an order dated 9/15/2022 to clean scar to the sacrum with normal saline and apply a foam dressing daily for seven days on the day shift. A review of the September 2022 Treatment Administration Record (TAR) revealed wound care was not documented as provided as ordered by the physician on 9/4/2022, 9/8/2022, 9/15/2022, 9/16/2022, 9/17/2022 and 9/18/2022. In an interview with the Director of Nursing on 11/8/2022 at 2:46 p.m., she stated wound care should be provided as ordered by the physician and documented on the TAR after completion of the care for Resident #6. In an interview with Nurse #2 on 11/8/2022 at 3:08 p.m., she stated when the wound nurse was not present to perform the care, the nurse assigned to Resident #6 was responsible for providing the wound care on the day shift. She	F 842	11/10/22 regarding documentation, including: Action taken/systems put into place to reduce the risk of future occurrence include: 1. A 100% audit of all eMARs and eTARs for the last 3 months was initiated on 11/25/2022 by the resource nurse to identify omissions to documentation to include tracheostomy care and wound care. The audit will be completed by 12/7/2022. Areas of concern identified during the audit will be immediately addressed by the ADON/DON to include providing additional training and assessment of the resident affected. 2. New Policy Addition: Carrolton Policy # 17.13 Documentation in the Medical Record was added to outline the company□s expectations regarding timely and accurate documentation of identifiable information in the medical record. 3. 100% in-service for all licensed nurses was initiated on 11/29/2022 by administrative nurses. The in-service will be completed by	

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F 842	Continued From page 32 stated wound care was provided to Resident #6 on 9/4/2022, 9/8/2022, 9/15/2022, 9/16/2022, 9/17/2022 and 9/18/2022 and should have been documented on the TAR. She stated when the nursing staff divided wound care tasks between the day and night shift staff, the night shift staff verbally communicated the wound care was provided, and she forgot to document wound care was provided.	F 842	12/7/2022 and will include: " Carrolton Policy # 17.13 Documentation in the Medical Record " Completing tracheostomy care as ordered by the physician to include documenting on the eMAR after care is provided. " Providing wound care as ordered to include documenting on the electronic eTAR after wound care is provided. " Policy Review Test 4. All newly hired licensed nurses will receive the in-service during orientation by the ADON/DON or Staff Development personnel. How the corrective action(s) will be monitored to ensure the practice will not recur: 1. 10% of eMARs to include all residents with tracheostomies will be monitored by the administrative nurses weekly x 4 weeks, then monthly x 2 months, utilizing the Care Documentation Monitoring tool. Areas of concern identified during the monitoring process will be addressed immediately by the ADON/ DON to include providing additional staff training. 2. The DON will review and sign the Care	

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F 842	Continued From page 33	F 842	Documentation Monitoring tool weekly x 4 weeks, then monthly x 2 month. 3. 10% of eTARs to include Resident #6, will be monitored by administrative nurses weekly x 4 weeks, then monthly x 2 months, utilizing the Care Documentation Monitoring tool to ensure documentation of wound care is present on the resident eTAR. Areas of concern identified during the monitoring process will be addressed immediately by the ADON/DON and/or the resource nurses to include providing additional staff training. 4. The DON will review and sign the Care Documentation Monitoring tool weekly x 4 weeks, then monthly x 2 months. 5. The administrator and/or designee will present the findings of the Care Documentation Monitoring tool to the Executive Quality Assurance (QA) committee monthly for 3 months. 6. The Executive QA Committee will review the Care Documentation Monitoring tool to determine trends and/or issues that may need further interventions and determine the need for further monitoring.	

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F 842	Continued From page 34	F 842	7. The administrator and DON will be responsible for the implementation of corrective actions to include all audits, in-services, and monitoring related to the plan of correction.	