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F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		1/12/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide Care Area Assessment Summaries which included underlying causes, risk factors and factors to be considered in developing individualized care plan interventions for 4 of 5 sampled residents (Residents #10, #31, #52 and #85) with comprehensive assessments. The findings included: 1. Resident #10 was originally admitted to the facility on 08/23/13 with a recent readmission on 12/09/17 with diagnoses that included diverticulitis and end stage renal disease requiring dialysis. Resident #10's Annual Minimum Data Set (MDS) dated 09/19/17	F 636	A deficient practice occurred when the Food Service Manager failed to provide CAAs which included underlying causes, risk factors and approaches specific to the development of each care plan problem. The facility will conduct initially and as required comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity. The facility will provide Care Area Assessment Summaries which include underlying causes, risk factors and factors to be considered in developing individualized care plan interventions. The Care Area Assessment of Resident #10 in MDS dated 12/9/17 was revised to include risk factors, underlying causes	

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F 636	Continued From page 2 indicated her cognition was intact for daily decision making and she required supervision with eating. The MDS specified the resident was on a therapeutic diet. Review of Resident #10's Care Area Assessment (CAA) of Nutrition dated 12/09/17 stated she "was a dialysis patient who is on a 1500 cc (cubic centimeter) fluid restriction. She has ESRD (end stage renal disease), nutritional risk present with ESRD and fluid restriction". The CAA did not contain a clear description of Resident #10's nutrition, underlying causes, contributing factors or approaches specific to this resident to consider in developing an individualized care plan. During an interview with the Dietary Manager (DM) on 12/15/17 at 5:20 PM, the DM stated he completed section K (Nutrition) on the MDS, completed the CAA and wrote the care plan when nutrition triggered for the resident. The DM also stated the purpose of the CAA was to gather information for the care plan. The DM further stated he had been focused more on the care plan than the CAA. During an interview with the MDS Coordinator (MDSC) on 12/15/17 at 5:59 PM, the MDSC read the analysis of findings for the annual MDS for Resident #10 and stated it was short and the DM could have added more information. During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON acknowledged her expectation was for the CAA of the MDS to be comprehensive.	F 636	and approaches relating to her nutrition. The CAA of Resident #31 in MDS dated 11/30/17 was revised to include risk factors, underlying causes and approaches relating to his nutrition. The CAA of Resident #85 in MDS dated 4/11/17 was revised to include risk factors, underlying causes and approaches relating to her nutrition needs. The Resident #52 in MDS dated 2/16/17 have been revised to be comprehensive and include the underlying causes, risk factors and approaches to be considered in developing the care plans. These revisions have been added to the cited MDS's in the AHT system in order to correct the cited deficiency as of Jan 11 2018. The Administrator has inserviced the FSM, the Social Worker, the Activity Director and the MDS Coordinator on the procedures to follow per the RAI MDS Manual when writing CAAs which include underlying causes, risk factors and approaches which are needed to develop care plan interventions on Jan 5 2018. The Director of Nursing has reviewed all Care Area Assessments from the MDS Assessments which were completed from Dec 15 2017 through January 12 2018 in order to ensure all CAAs are comprehensive and speak to the underlying causes, risk factors and factors to be considered in the development of care plans. The results of this CAA monitoring has been documented in a census log form by the Director of Nursing. The D.O.N. will continue with CAA monitoring for the next 12 weeks	

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F 636	Continued From page 3 2. Resident #31 was originally admitted to the facility on 07/09/13 with numerous diagnosis which included dementia and recently readmitted on 11/30/17 with diagnoses that included aspiration pneumonia. His annual Minimum Data Set (MDS) dated 10/09/17 revealed him to have severely impaired cognition for daily decision making. The MDS also indicated Resident #31 required extensive assistance with eating, received a mechanically altered diet and had no natural teeth (edentulous). Review of Resident #31's Care Area Assessment (CAA) of Nutrition dated 10/09/17, stated "he has varied intake and has some cognitive deficits which may affect his intake, he has nutritional risks present". The CAA did not contain a clear description of Resident #31's nutrition, underlying causes, contributing factors or approaches specific to this resident to consider in developing an individualized care plan. During an interview with the Dietary Manager (DM) on 12/15/17 at 5:20 PM, the DM stated he completed section K (Nutrition) on the MDS, completed the CAA and wrote the care plan when nutrition triggered for the resident. The DM also stated the purpose of the CAA was to gather information for the care plan. The DM further stated he had been focused more on the care plan than the CAA. During an interview with the MDS Coordinator (MDSC) on 12/15/17 at 5:59 PM, the MDSC read the analysis of findings for the annual MDS for Resident #31 and stated it was short and the DM could have added more information.	F 636	with the results being included in the quarterly Quality Assurance Committee meeting. The education of the staff, the review of CAAs from Dec 15 through Jan 12 2018 and for the upcoming twelve weeks will ensure the plan of care is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The QA Committee is responsible for any decision to extend the monitoring of CAAs. The Director of Nursing is the person responsible for implementing the acceptable plan of correction.	

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During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON acknowledged her expectation was for the CAA of the MDS to be comprehensive.

3. Resident #85 was readmitted to the facility on 04/04/17 with diagnoses that included diabetes mellitus, anemia and dementia. The Significant Change Minimum Data Set (MDS) dated 04/11/17 indicated the resident had severely impaired cognition for daily decision making. The MDS also indicated Resident #85 required extensive assistance with eating, received a mechanically altered diet and obvious or likely cavity or broken natural teeth.

Review of the Care Area Triggers (CAT) dated for the Significant Change MDS 04/11/17 indicated Nutrition triggered as an area of concern. The Care Area Assessment (CAA) for the Significant Change MDS was incomplete. The CAA did not contain a clear description of Resident #85's nutrition, underlying causes, contributing factors or approaches specific to this resident to consider in developing an individualized care plan.

The CAA did not contain a clear description of Resident #85's nutrition, underlying causes, contributing factors or approaches specific to this resident to consider in developing an individualized care plan.

During an interview with the Dietary Manager (DM) on 12/15/17 at 5:20 PM, the DM stated he completed section K (Nutrition) on the MDS, completed the CAA and wrote the care plan when nutrition triggered for the resident. The DM also stated the purpose of the CAA was to gather

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F 636	Continued From page 5	F 636		

information for the care plan. The DM further stated he had been focused more on the care plan than the CAA.

During an interview with the MDS Coordinator (MDSC) on 12/15/17 at 5:59 PM, the MDSC read the analysis of findings for the annual MDS for Resident #85 and stated it was short and the DM could have added more information.

During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON acknowledged her expectation was for the CAA of the MDS to be comprehensive.
4. Resident #52 was admitted to the facility on 07/01/15. The most recent annual Minimum Data Set (MDS) dated 02/16/17 indicated Resident #52 had diagnoses including non-Alzheimer's dementia among others. The MDS also indicated Resident #52 required extensive assistance for eating and was on a mechanically altered diet.

Review of the Care Area Triggers for the annual MDS dated 02/16/17 indicated nutrition triggered as an area of concern. The Care Area Assessment (CAA) for the annual MDS dated 02/16/17 under analysis of findings indicated the following: "has diagnosis of dementia and dysphagia which both pose risk for weight loss" and "proceed to care plan for weight loss related to nutritional risk."

During an interview with the Dietary Manager (DM) on 12/15/17 at 5:20 PM, the DM stated he completed Section K (Nutrition) on the MDS, completed the CAA and wrote the care plan when nutrition triggered for the resident. The DM also stated the purpose of the CAA was to gather information for the care plan. The DM further

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F 636	Continued From page 6 stated he had been more focused on the care plan than the CAA. During an interview with the MDS Coordinator (MDSC) on 12/15/17 at 5:59 PM, the MDSC read the analysis of findings for the annual MDS for Resident #52 and stated it was short and the DM could have added in more information. During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON acknowledged her expectation was for the CAA of the MDS to be comprehensive.	F 636		
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 record review and staff interviews the facility failed to accurately assess 1 of 1 sampled residents utilizing the Minimum Data Set (MDS) reviewed for indwelling catheter to reflect active diagnoses (Resident #1) and failed to accurately assess 1 of 1 sampled residents for dental (Resident #28). Findings included: 1. Resident #1 was admitted to the facility on 05/09/17. A review of the physician's order dated 05/23/17 and was signed by the physician indicated Resident #1 had a clarification order that indicated indwelling catheter care due to	F 641	The deficient practice occurred when the MDS Coordinator failed to reference diagnosis (catheter with neuogenic bladder) and chewing problems noted in the Admission Assessment. Resident #1 clarification order that indicated indwelling catheter care due to neurogenic bladder was corrected and transmitted on the MDS dated 5/25/17, 8/25/17 and 11/24/17 before the survey exit on 12/15/17. This action corrected the specific deficiency for Resident #1. A chart audit and a MDS audit was completed on Dec 15, 2017 for the other inhouse Residents that have a catheter with neurogenic bladder diagnosis to ensure that their MDS's have been coded	1/12/18

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neurogenic bladder.

A review of Resident #1's admission Minimum Data Set (MDS) assessment dated 05/25/17, quarterly MDS assessment dated 08/25/17, and quarterly MDS assessment dated 11/24/17 indicated Resident #1 had not been coded under Section I Active Diagnoses as having a diagnoses of neurogenic bladder.

On 12/14/17 at 4:40 PM an interview was conducted with the MDS Coordinator who stated she coded Section I Active Diagnoses on Resident #1's admission MDS dated 05/25/17, quarterly MDS assessment dated 08/25/17, and quarterly MDS assessment dated 11/24/17. The MDS Coordinator stated Resident #1 had not been coded as having a diagnoses of neurogenic bladder on the admission MDS assessment dated 05/25/17, quarterly assessment dated 08/25/17, and the quarterly assessment dated 11/24/17 and should have been coded as having an active diagnoses of neurogenic bladder and was an error in coding. The MDS Coordinator stated she would need to submit a modification to Resident #1's admission MDS assessment dated 05/25/17, quarterly MDS assessment dated 08/25/17, and quarterly MDS assessment dated 11/24/17 to reflect active diagnoses of neurogenic bladder.

On 12/14/17 at 5:00 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #1's admission MDS assessment dated 05/25/17, quarterly assessment dated 08/25/17, and quarterly MDS assessment dated 11/24/17 would have been accurately coded under Section I Active Diagnoses to reflect active diagnoses of

appropriately. The Director of Nursing has inserviced the MDS Coordinator on Dec 15, 2017 regarding the need to use the Admission Assessment form to pull needed information in completing MDS Assessments.
The Director of Nursing will continue to monitor MDS Assessments for a twelve week period and has developed a weekly monitoring log to ensure that the diagnosis of catheters with neurogenic bladders are listed in the MDS assessments. The weekly monitoring log will be maintained by the Director of Nursing for a twelve week period with results being reviewed at the quarterly Quality Assurance Committee meeting and the QA Committee making the decision of whether there is a need for further monitoring. These new procedures will correct the specific deficiency as cited and the monitoring procedure developed by the Director of Nursing will ensure the plan of correction is effective and the cited deficiency remains corrected. The Director of Nursing is responsible for implementing the acceptable plan of correction.
The 7/7/17 MDS in the AHT system for Resident #28 has been corrected and on Jan 12, 2018 was transmitted to show chewing difficulties. A dental care plan was developed and added as of Jan 12 2018. These actions corrected the specific deficiency affecting Resident #28. The Director of Nursing inserviced the MDS Coordinator on Jan 8 2018 on the need to review the information noted by the Admission Nurse on the Admission

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F 641	Continued From page 8 neurogenic bladder. The DON stated her expectation was that the admission MDS assessment dated 05/25/17, quarterly MDS assessment dated 08/25/17, and quarterly MDS assessment dated 11/24/17 would be modified and submitted to accurately reflect active diagnoses of neurogenic bladder for Resident #1. On 12/14/17 at 5:10 PM an interview was conducted with the Administrator who stated her expectation was that the admission MDS assessment dated 05/25/17, quarterly MDS assessment dated 08/25/17, and the quarterly MDS dated 11/24/17 would have been accurately coded to reflect active diagnoses of neurogenic bladder for Resident #1. The Administrator stated her expectation was the admission MDS assessment dated 05/25/17, quarterly MDS assessment dated 08/25/17, and the quarterly MDS assessment dated 11/24/17 would be modified and submitted to accurately reflect Resident #1's active diagnoses of neurogenic bladder. 2. Resident #28 was admitted to the facility on 07/01/17 with diagnoses of high blood pressure and depression among others. Review of the admission Minimum Data Set (MDS) dated 07/07/17 indicated Resident #28 was cognitively intact and required supervision with eating. There were no dental/oral concerns noted on this admission assessment and no development of a dental care plan. Record review of the nurses' note dated 07/07/17 indicated Resident #28 had 12 teeth with 18 in the back missing. The nurses' note also stated	F 641	Assessment as she develops each MDS Assessment in order to ensure accuracy. A medical record and MDS Assessment audit was completed on all admissions between December 15 2017 and January 12 2018 by the MDS Coordinator to ensure that any chewing problems have been identified, noted on the MDS Assessment and care planned. The Director of Nursing will continue the monitoring of Admission Assessments and MDS Assessments for chewing issues for the next twelve weeks in order to ensure the specific deficiency continues to be corrected. The D.O.N. developed a weekly monitoring log which will identify residents who are affected by chewing difficulties as noted during the admission process on the Admission Assessment and through changes in physician orders on diet consistency and will cross reference to their MDS to ensure accuracy for all inhouse residents. These actions will correct the specific deficiency . The Director of Nursing will maintain the weekly monitoring log for twelve weeks with results submitted to the quarterly Quality Assurance Committee meeting and the QA Committee making the decision if further monitoring is needed. These actions will ensure that the plan of correction is effective and that specific deficiency cited remains corrected and is in compliance with the regulatory requirements. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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Resident #28 "stated sometimes has trouble chewing meats and salads."

Record review of the Registered Dietician (RD) note dated 07/07/17 indicated Resident #28 had 12 teeth with 18 back teeth missing. The RD note further indicated Resident #28 stated sometimes he "has problems chewing raw fruit, vegetables and some meats."

During an interview with Resident #28 on 12/15/17 at 4:00 PM, he stated he had a difficult time chewing his food because of multiple missing teeth in the back and in his upper and lower jaws.

During an interview with the MDS Coordinator (MDSC) on 12/15/17 at 7:08 PM, she stated she remembered talking with Resident #28 about going out of the facility to have dental work but could not remember if he told her he was having difficulties chewing. The MDSC also stated she reads the nurses' notes and the RD notes during the lookback period and must have overlooked the notes written about his difficulty with chewing. The MDSC further stated the MDS was coded incorrectly.

During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON stated her expectations were for the MDS to be coded correctly.

F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		1/12/18

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a

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F 756	Continued From page 10 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacist, and Family Nurse Practitioner (FNP) interviews the consultant pharmacist failed to identify 1 of 5	F 756	The process that led to the cited deficiency was due to a change in Medical Director in August 2017 and the new	

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MADISON HEALTH AND REHABILITATION	**345 MANOR ROAD** **MARS HILL, NC 28754**

(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 756	Continued From page 11 residents (Resident #28) reviewed for unnecessary medications without a physician follow up for a recommended cessation of a medication. The findings included: Resident #28 was admitted to the facility on 07/01/17. The admission Minimum Data Set (MDS) dated 07/07/17 indicated Resident #28 had high blood pressure and depression among other diagnoses. The MDS also indicated Resident #28 was cognitively intact. The MDS also indicated Resident #28 required limited to extensive assistance with most activities of daily living. Review of the monthly pharmacy medication reviews indicated a cholesterol lowering medication was recommended to be discontinued by the consultant pharmacist during a facility visit on 09/15/17. During a medical record review of the pharmacist note in the Physician Recommendation Summary in September 2017, the following notation was written regarding the cholesterol lowering medication: "The benefits of statin therapy is not clear in patients over the age of 75 per the current literature. There is a question as to the effects of lipids on stenosed vessels. With this in mind please consider benefits versus cost of continuing this therapy." During a medical record review of the Medication Administration Record (MAR) for December 2017, the cholesterol lowering medication was	F 756	Medical Director/Nurse Practioner not understanding the internal system for pharmacy recommendation follow-ups. The Pharmacist reviews the medical chart and will report any irregularities to the Medical Director,and D.O.N. in the form of written pharmacy recommendations which address any irregularity that was identified. The Physician must document in the resident's medical record that the identified irregularity has been reviewed and if any action has been taken to address the pharmacy recommendation.If there is no change in the medication the Physician should document his or her rationale in the medical record. The Director of Nursing was inserviced by the Regional Nurse Consultant on December 15 2017 on the procedures to follow when addressing the monthly pharmacy recommendations. The Director of Nursing has developed revised policies and procedures for handling the monthly drug regimen reviews, including recommendations are to be addressed in a timely manner and steps to take by the Pharmacist when there is an identified irregularity that requires urgent action to protect any Resident. The Pharmacy Recommendation for Resident #28 dated 9/15/17 has been addressed by the Physician as of Dec 19, 2017. This action has corrected the specific deficiency for Resident #28. The Director of Nursing has reviewed all Pharmacy Recommendations from September 1 2017 through November 30, 2017 to ensure that all have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345206	A. BUILDING ______ B. WING ______	12/15/2017

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F 756	Continued From page 12 listed as being given every evening to Resident #28. Previous MARs reviewed for September through November of 2017 also indicated the same cholesterol lowering medication was being given every evening to Resident #28. During a phone interview with the consultant pharmacist on 12/15/17 at 1:47 PM, he stated he never let follow ups for recommendations for the physician regarding medications go past 60 days. During the interview, he reviewed his notes and stated he had never received a response from the physician regarding discontinuing the cholesterol lowering medication. He further stated it was an accidental oversight and that the Family Nurse Practitioner (FNP) may have looked at the recommendation but did not sign off on it, but he was not sure whether she actually saw the recommendation for cessation of the medication or not. During a phone interview with the FNP on 12/15/17 at 2:45 PM, the FNP stated she always signed off on the pharmacy recommendations and she did not remember seeing the recommendation regarding statin medication for Resident #28. The FNP also stated if she had seen this recommendation she would have signed off on it and if it was not signed then it had not been addressed. During the phone interview, the FNP stated she double checked her personal calendar for any follow up she had for Resident #28 and had nothing listed and this indicated to her that she had not seen the pharmacy recommendation for cessation of the medication. During an interview with the Director of Nursing (DON) on 12/15/17 at 7:24 PM, the DON stated her expectation was for the pharmacist to review	F 756	completed. The Medical Director, Nurse Practioner and Nurse Managers have been inserviced by the Director of Nursing on Dec 18 2017 on the revised internal system of addressing all pharmacy recommendations in a timely manner and the procedure to follow if the Pharmacist feels an irregularity needs to be addressed immediately. The D.O.N. will be responsible for ensuring all pharmacy recommendations are completed prior to the next pharmacy review. These procedures have developed an acceptable plan of correction for the specific deficiency cited. Findings of the monthly audit will be documented on a Summary Pharmacy form by the Director of Nursing which cross references the pharmacy recommendations and results will be presented at the quarterly Quality Assurance Meeting by the Director of Nursing. This ongoing monthly monitoring procedure will ensure the plan of correction is effective and that the specific deficiency cited remains corrected and in compliance with regulatory requirements. The Director of Nursing is responsible for implementing the plan of correction. Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law.	

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F 756	Continued From page 13 the notes and follow up with recommendation the following month. The DON further stated she thought it was just an accidental oversight on behalf of the pharmacist.	F 756		