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	165497	A. BUILDING _____ B. WING _____	C 01/16/2019

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F 000	INITIAL COMMENTS Correction Date 2-8-19 Complaints # 80593-C and # 80745-C were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristy A Puppett, LWHA — TITLE — (X6) DATE: 2-5-19

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.

POC accepted 3/18/19 VR

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on clinical review and staff interviews, the facility failed to establish a care plan reflective of an assessment that identified resident's need for medical, nursing, mental and psychosocial care for one of four residents reviewed (Resident #2). The facility reported a census of 57 residents. Findings include: 1. Resident #2 had a Minimum Data Set (MDS) assessment dated 9/218 that documented a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. The MDS documented diagnoses of combined systolic and diastolic congestive heart failure and diabetes mellitus type 2. The resident needed the assistance of one staff with transfer, ambulation, toilet use and hygiene and used a wheelchair and walker for mobility. An Order Summary Report dated 11/14/18 documented physician orders dated 10/19/18 at 9/16/18 instructed staff to obtain blood sugar checks daily and administer aspirin 81 milligrams	F 656		

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F 656	Continued From page 2	F 656		

(mg) daily for cardiac concerns. A physician order dated 10/23/18 directed administration of Apixaben (an anticoagulant) 2.5 mg twice daily.

The Care Plan with a focus area dated 11/12/18 identified altered cognition and rejection of care but did not establish interventions directing staff when the resident refused staff assistance, as a fall risk, monitor for hypoglycemia/hyperglycemia, history of incontinence, diabetes mellitus, the use of anticoagulants and possible elopement.

Progress notes dated 9/26/18 at 5:56 a.m. documented staff assisted the resident with toilet use. Notes of 10/9/18 at 3:39 p.m. documented the resident INR (blood clotting factor) at 4.9 mg. /dl and an order to hold Coumadin (an oral blood thinner) dose and restart 10/10/18 and check the INR on 10/17/18.

Progress notes dated 10/10/18 at 1:08 p.m. noted the resident refused staff with assistance with all cares. Notes dated 10/22/18 at 9:02 p.m. noted she had episodes of confusion. Notes dated 10/26/18 at 5:06 p.m. noted the resident attempted to shut alarm off and opened an outside door but hadn't gone through. Resident had belongings in a pillow case and reported h/she was going home.

Progress notes of 11/1/18 at 9:03 p.m. documented Resident #2 asked several time if she could leave the facility and asked if the place was a prison. An entry dated 11/6/18 at 8:31 a.m. documented the resident refused staff assistance with cares.

Progress notes dated 11/18/18 at 2:56 p.m. documented the resident had intense pain the

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F 656	Continued From page 3	F 656		

right ankle. The area slightly swollen and warm to touch. Tenderness/pain noted upon touch and movement. The resident had increased confusion and episodes of incontinence. An X-ray report dated 11/18/18 noted the clinical indication noted swelling and pain of the right ankle, diffuse osteopenia and no acute displaced fracture or dislocation.

Progress notes dated 11/30/18 at 9:45 p.m. recorded staff completing 15 minute checks on the resident's safety but no reason given as to why the checks were initiated.

Progress notes dated 12/11/18 at 7:17 a.m. documented Staff A, a registered nurse (RN) had heard a housekeeper yell that a resident was on the floor. An aide went into the room and called for assistance. Staff A noted the resident lying on the her right side parallel to the bed with a small amount of blood pooling on the floor beneath her head. The resident's pants were around her ankles. Staff noted the walker adjacent to the resident and wheelchair in front of the bathroom door. Upon assessment, staff noted an egg size knot above the right eye and bruising to the right hand. The resident stated her head hurt and she couldn't see out of her right eye. Local emergency medical services arrived and transported Resident #2 to a local hospital emergency room.

On 1/16/19 at 9:25 a.m. Staff C reported the resident's comprehension of what staff told her as elusive to the resident. There were times the resident understood the directions given and questions asked but at other times she didn't comprehend. Because of the resident's dementia, staff didn't know if the resident

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F 656	Continued From page 4 understood what had been said to" him/her. During an interview on 1/16/19 at 9:45 a.m. Staff D reported the resident needed assistance with transfer, ambulation, toileting, dressing and grooming, but often non-compliant and self-transferred and used the toilet on her own. She reported the resident often refused staff assistance but she would provide stand-by assistance with cares. She reported the resident didn't always understand what staff said to h/her. On 1/15/19 at 1:14 p.m. Staff A reported the resident had a history of non-compliance and needed assistance with all cares. Staff should assist with cares but let her do her cares on her own. During an interview on 1/16/19 at 9:25 p.m., the facility's nurse consultant reported it is the facility's expectation residents who are prescribed anti-coagulants, checked for blood sugar levels have focus areas and interventions identified their care plan. She stated the facility didn't have a policy/procedure relevant to this but stated it is an implied standard of care/practice for nursing to identify these focus area and interventions into a resident's care plan.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		

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F 658	Continued From page 5	F 658		

Based on clinical record review and staff interviews, the facility failed to provide appropriate care in accordance to accepted professional standards of clinical practice for two of four sampled residents (#1 & #3). The facility reported a census of 57 residents.

Findings include:

1. Resident #1 had a Minimum Data Set (MDS) assessment dated 10/20/18 that documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. The MDS documented the resident needed the assistance of one staff with transfers, walking, toilet use, dressing, bathing and grooming. The resident used a wheelchair for mobility.

An Order Listing Report dated 1/10/18 documented an order dated 8/1/18 for Fentanyl 72 hour apply 1 patch transdermally (to the skin) one time a day every three days for pain and remove per schedule.

The Controlled Drug Administration Record dated 12/11/18 revealed one fentanyl 25 mcg patch administered, leaving 0 patches remaining. Medication Administration Records (MARs) for 12/11/18 revealed one patch administered. MARs for 12/14/18 and 12/17/18 revealed fentanyl 25 mcg had not been administered as ordered. MARs for 12/2/18-12/11/18 noted the resident's pain level at 2; using a pain scale of 0-10. MARs for 12/14/18-12/17/18 revealed a pain level of 6 and 4 respectively, indicating the resident's increased pain.

Facility staff ordered Fentanyl 25 mcg on

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F 658	Continued From page 6 12/10/18 but didn't receive the medication until 12/20/18. Delivery Log sheet for 12/20/18 revealed 10 Fentanyl patches were delivered. The MARs for 12/20/18 noted 25 mcg Fentanyl was administered to the resident. The MARs for 12/20/18 revealed the resident's pain level at 2, indicating the resident's pain had diminished. During an interview on 1/16/19 at 2:30 p.m. Staff B LPN and Assistant Director of Nursing reported Resident #1's Fentanyl 25 mcg patches reorder had previously taken two days for the pharmacy to refill. Staff had ordered refills on 12/10/18, 12/14/18 and 12/19/18. On 12/20/18 the order arrived and staff administered the medication. 2. Resident #3's MDS assessment dated 8/17/18 documented a BIMS documented a score of 15 which indicated normal cognition. The MDS documented diagnoses of renal insufficiency and presence of a cardiac pacemaker. The resident needed the assistance of two staff with transfers, bed mobility, grooming, hygiene and dressing and the assistance of one staff with locomotion as he did not walk. Progress notes dated 10/13/18 at 5:50 a.m. documented the resident complained of not being able to breathe. His color was gray, lung sounds diminished and coarse in the lower lobes. The resident was lethargic and hard to arouse. The resident's physician ordered the resident transported to local hospital emergency room for evaluation and treatment. Progress notes dated 10/13/18 at 10:43 a.m. noted the resident admitted to the hospital with a diagnosis of pneumonia and an elevated white blood count. Progress notes dated 10/29/18 at 7:07 p.m.	F 658		

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F 658	Continued From page 7	F 658		

documented the resident returned to the facility. Hospital discharge orders dated 10/29/18 revealed an order for Fentanyl 25 micrograms (mcg), place one patch onto the skin every third day with the earliest fill date of 10/29/18. A physician's fax order dated 10/29/18 directed staff to review, sign and return attached orders. The order also noted a change of Fentanyl dosage to decrease from 100 mcg/hr to 25 mcg/hr every 3 days. The Controlled Drug Administration Record dated 10/31/18 at 9:00 p.m. documented one Fentanyl 25 mcg patch was removed from the narcotic lock box.

The MAR dated 10/31/18 at 5:59 p.m. documented staff removed one Fentanyl patch from the left rear shoulder.
The MAR for the same date at 6:00 p.m. documented a Fentanyl patch 25 mcg applied to his left chest. The MAR dated 11/3/18 documented a Fentanyl patch removed at 5:59 p.m. from the left chest. The MAR for the same date at 6:00 p.m. documented a Fentanyl patch 25 mcg applied to his right chest. The MARs for October & November 2018 documented staff checked placement of Fentanyl patches three times daily from 10/30/18 to 11/5/18.

Progress notes dated 11/5/18 at 7:45 p.m. documented staff received a phone call from family requesting an update on the resident's status. Information conveyed and family wanted him transferred to the hospital as the resident has a history of significant rapid change in health status. Staff reported to family the resident would be seen by a physician the following day. Family members wanted the resident be transferred to a local hospital for evaluation. Emergency Medical Services were notified of transfer. The resident's

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F 658	Continued From page 8 skin was clammy, he remained lethargic and answered questions slowly but appropriately. Hospital records dated 11/6/18 at 3:59 p.m., page 21-22 documented the resident transferred from the nursing facility for increased lethargy within the last 24 hours, shortness of breath and a change in mental status. An evaluation conducted at the hospital revealed acute onset chronic hypercapnic respiratory failure and right pleural effusion. A history and physical-consultation (page 26), documented hospital staff removed two 25 mcg Fentanyl patches when the resident arrived at the hospital on 11/6/18. During an interview on 1/16/18, the facility's nurse consultant stated facility staff may not have found a Fentanyl 25 mcg patch with the resident returned for the hospital on 10/29/18. She could not explain why hospital staff found two of the Fentanyl 25 mcg patches on the resident when he transported to a local hospital emergency room on 11/6/18.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		

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F 684	Continued From page 9 Based on clinical record review and staff interviews, the facility failed to provide appropriate treatment of a diabetic foot ulcer for one of four residents reviewed (Resident #3). The facility reported a census of 57 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated 8/17/18 documented a brief interview for mental status score of 15 which indicated normal cognition. The MDS documented diagnoses that included renal insufficiency, obesity and a cardiac pacemaker. The resident needed the assistance of two with transfers, bed mobility, grooming, hygiene and dressing. The care plan with a print date of 1/14/19 indicated the resident needed three staff with a bariatric Hoyer lift for transfer. A focus area dated 7/2/18 identified potential for altered nutrition related to a history of morbid obesity, limited mobility, skin areas, diabetes mellitus and chronic kidney disease. Interventions included treatment to compromised skin areas per physician orders. A Discharge Summary dated 9/19/18 documented Resident #3 had been hospitalized 9/12 to 9/19/18. Discharge instructions included a scheduled appointment for 10/4/18 at 10:40 a.m. as a follow-up for status-post partial amputation of the 5th metatarsal of the left foot. Progress notes dated 10/5/18 at 4:03 p.m. revealed staff rescheduled the appointment for 10/10/18 at 8:30 a.m. Clinical record review revealed no explanation of rescheduling of the appointment or notification to the resident's	F 684		

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F 684	Continued From page 10 physician and immediate family. Progress notes dated 10/5/18 at 4:03 p.m. revealed the post-operative appointment scheduled for 10/10/18 at 8:30 would be done at the facility at 7:15 a.m. A letter from the resident's podiatric physician dated 10/10/18 documented the dressing change and suture removal could be done by the resident's primary provider. Progress notes dated 10/10/18 at 7:46 a.m. documented the appointment scheduled had been canceled as the resident needed to be transferred via a bariatric stretcher which was not available at time of transport. Clinical record review revealed no notification to the resident's physician and immediate family of the cancellations. Clinical record review revealed no documentation of a post-surgical dressing change and suture removal. The Wound Treatment Plan dated 10/1/18 documented a wound to the third toe of the resident's right foot. The wound was not measured due to surgical dressing that could not be removed per the surgeon's order. The would treatment plan directed staff to cleanse the right third toe with cleanser of facility's choice, apply skin prep daily and for the back of the left leg, cleanse with a cleanser of choice and apply skin prep daily. Facility staff noted the order on 10/2/18 at 4:30 a.m. but review of the Treatment Administration Records (TARs) for 10/2/18 - 10/13/18 revealed staff did not implement the physician's orders of 10/1/18. During an interview on 1/16/19, Staff B, Licensed Practical Nurse (LPN) and Assistant Director of	F 684		

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F 684	Continued From page 11 Nursing reported the podiatry appointments scheduled for 10/4/18 and the re-scheduled appointment for 10/10/18 had been canceled and there was no record of the resident's physician and family notified of the cancellations.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and resident interviews, facility staff left a resident at the edge of the bed in the middle of dressing, exited the room and staff found her on the floor a few moments later. The resident required the assistance of one staff to dress and walk. The concern affected one of four residents reviewed (#2). The facility reported a census of 57 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated 9/28/18 documented a Brief Interview for Mental Status (BIMS) score of 4 which indicated severe cognitive impairment. The assessment documented she had diagnoses that included combined systolic and diastolic congestive heart failure and diabetes mellitus type 2. The MDS documented the resident	F 689		

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F 689	Continued From page 12	F 689		

needed the assistance of one staff with transfers, walking, toileting and hygiene and used a wheelchair and walker for mobility. The resident had no fall history upon her admission to the facility on 9/20/18.

The care plan with a focus area dated 11/12/18 identified Resident #2 had altered cognition and rejection of care and directed staff to assist the resident with activities of daily living (ADL's) as needed.

Progress notes dated 10/10/18 at 1:08 p.m. documented the resident refused staff assistance with all cares. Notes dated 10/22/18 at 9:02 p.m. noted the resident having episodes of confusion.

A Progress note dated 10/22/18 at 9:02 p.m. documented the resident had episodes of confusion and redirected without difficulty. An entry dated 11/6/18 at 8:30 a.m. documented she refused to allow staff to assist with ADLs that morning.

Progress notes dated 11/18/18 at 2:56 p.m. recorded the resident had intense pain the right ankle. Staff noted the area as slightly swollen and warm to touch. Resident #2 had tenderness/pain with touch and movement. The resident had increased confusion and episodes of incontinence. An X-ray report dated 11/18/18 noted diffuse osteopenia and no acute displaced fracture or dislocation.

Progress notes dated 11/30/18 at 9:45 p.m. recorded staff completed 15 minute checks on the resident's safety but no reason given as to why the checks were completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165497	A. BUILDING _____ B. WING _____	C 01/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

Progress notes dated 12/11/18 at 7:17 a.m. documented Staff A, a registered nurse (RN) heard a housekeeper yell a resident is on the floor. An aide went into the room and called for assistance. Staff A observed Resident #2 lying on the her right side parallel to the bed with a small amount of blood pooling on the floor beneath her head. The resident's pants were around her ankles. Staff noted the walker adjacent to the resident and wheelchair in front of the bathroom door. With assessment, staff noted an egg size knot above her right eye and bruising to the right hand. The resident stated her head hurt and she couldn't see out of her right eye. Local emergency medical services arrived and transported Resident #2 to a local hospital emergency room.

The Incident Report dated 12/11/8 at 12:59 recorded that when asked what happened, Resident #2 informed staff she got tangled up in her britches.

During an interview on 1/15/19 at 1:30 p.m., Staff E, a housekeeper reported she worked on 12/11/18 when the resident fell to the floor. She heard the resident call out 'help me, help me' and she called out that a resident was on the floor. Two certified nursing assistants (CNAs), Staff C and Staff D went into the room to assist the resident. Staff E reported she saw the resident on the floor. The resident had a shirt on and her pants were partially up her legs. It appeared the resident attempted to dress herself. Staff E reported the resident wanted to be independent but she needed assistance with cares. The resident had been confused and combative with cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 14 During an interview on 1/15/19 at 1:02 p.m. Staff C reported she had worked the morning of 12/11/18 when the resident fell. She reported Staff D assisted the resident with cares but then shortly left the resident's room. She Resident#2 call out and she went in to assist, then left to assist another resident when she heard staff yell that a resident had been seen on the floor. She and Staff D when into the resident's room and saw her on the floor. The resident had attempted to dress herself and there was blood everywhere. She reported she had been told to let the resident do things on her own and she had been non-compliant with staff assistance with cares. The resident had been confused and wouldn't wait for assistance. Staff C stated when she entered the resident's room the first time she saw the resident sitting on the edge of the bed and reported her pants wouldn't fit. During a second interview on 1/16/19 at 9:25 a.m. Staff C reported the resident's comprehension of what staff told her as elusive to the resident. There were times the resident understood given directions and questions but at other times the resident didn't comprehend. Because of the resident's dementia, staff didn't know if she understood what had been said to her. During an interview on 1/16/19 at 9:45 a.m. Staff D reported the morning of 12/11/18 she went to the resident's room and said good morning and asked if the resident wanted her light turned on to get up from bed. The resident said yes to the light but then rolled over on her side in bed. Staff D left the room and went up to the front to the nurse's station. On her way back she heard the housekeeper yell the resident was on the floor. She and Staff C found the resident on the floor. It	F 689		

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F 689	Continued From page 15 appeared the resident had hit her head on the electric heat register. She reported the resident is often confused, wanders throughout the facility looking for her spouse. The resident needed assistance with transfers, walking, toilet use, dressing and grooming, but often is noncompliant, transferred herself and used the toilet on her own. She reported the resident often refused staff assistance but she would provide stand-by assistance with cares. She reported the resident didn't always understand what staff said to her. During an interview on 1/15/19 at 1:14 p.m. Staff A RN reported the resident had a history of non-compliance and needed assistance with all cares. Staff were to assist with cares but let her do her cares on her own. During an interview on 1/15/19 at 2:07 p.m. Staff B, a licensed practical nurse (LPN) and Assistant Director of Nursing reported the resident admitted to the hospital for care and later transferred to another facility. Information provided by the resident's family revealed she experienced facial contusions and fractured nasal bones following the fall.	F 689		

The response or providers plan of correction contained herein shall not be considered to be or construed as an admission of the validity of the citation or alleged deficiency to which it is addressed.

F000 This plan of correction constitutes my written credible allegation of compliance. All deficiencies will be corrected by Feb. 8, 2019.

F656

1. Resident #2 is no longer a resident in our facility.
2. All residents will have comprehensive care plans that meet the residents' medical and nursing needs as identified on the MDS assessment.
3. MDS/Care Plan coordinator was educated on February 5, 2019, by the Administrator on the requirement and importance of having a current and comprehensive care plan on all residents.
4. The D.O.N. or designee will randomly audit care plans to ensure they have a comprehensive care plan in place. This will be done weekly for four weeks and the results will then be reviewed by QAPI for the need for further monitoring.

F658

1. Resident #1 has had her care in accordance with acceptance clinical standards of practice in receiving both Fentanyl patches as prescribed by her physician. Resident #3 is no longer a resident in our facility.
2. All residents are provided appropriate care in accordance to accepted professional standards of clinical practice.
3. All licensed personnel were in-serviced on the importance of Fentanyl patches in administration, removal and documentation started on January 25, 2019 and continuing until all receive education.
4. The D.O.N. or designee will monitor for accuracy of placement, removal and documentation of Fentanyl patches.

F684

1. Resident #3 is no longer a resident in this facility.
2. All residents with treatments will receive appropriate care as ordered by their physician.
3. All treatments will be moved to the MAR. Licensed personnel will be in-serviced beginning on 2/8/2019 and continuing until all receive education.
4. The D.O.N. or designee will randomly audit treatment orders for accuracy weekly for four weeks to make sure orders are being followed and assessments/interventions are appropriate. The results will then be reviewed by QAPI for the need for further monitoring.

F689

1. Resident #2 is no longer a resident in this facility.
2. All resident environments will remain as free of accident hazards as is possible and each resident will receive adequate supervision and assistance devices to prevent accidents.
3. DON was educated on 1/29/2019 on the importance of keeping the Pocket Care Plans updated and current regarding resident needs.
4. The Administrator or designee will randomly audit Pocket Care Plans for accuracy weekly for four weeks to make sure orders are being followed and assessments/interventions are appropriate. The results will then be reviewed by QAPI for the need for further monitoring.