STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual and a follow -up survey from March 15, 2023 to March 16, 2023.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure physician's orders were implemented for 1 of 3 sampled residents related to a medication used to treat depression and anxiety (#2). . The findings are: Review of Resident #2's current FL2 dated 02/28/23 revealed a diagnosis of dementia. Review of a physician order dated 03/14/23 revealed an order for sertraline (a medication used to treat depression and anxiety) 25mg by mouth daily for one week, then increase to 50mg by mouth daily. Review of Resident #2's March 2023 Medication Administration Record (MAR) revealed: -There was an entry for sertraline 25mg by mouth daily times one week.	D 276		

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-There was an entry for sertraline 50mg by mouth daily.
-There was no documentation that sertraline was administered.
-There was no comment for the reason sertraline was not administered.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) 03/16/23 at 10:46am was unsuccessful.

Attempted telephone interview with Resident #1's responsible party on 03/16/23 at 12:43pm was unsuccessful.

Observation of medications on hand for Resident #2 on 03/16/23 at 2:50pm revealed there was no sertraline 25mg located on the medication cart.

Telephone interview with the Pharmacy Technician at the facility's contracted pharmacy on 03/16/23 at 12:36pm revealed the pharmacy had not received an order for Resident #2's sertraline.

Interview with the Assistant Resident Care Director (ARCD) on 03/16/23 at 11:28am and 3:27pm revealed:
-She was responsible for faxing all orders to the pharmacy or the medications aides (MAs) or the Resident Care Director (RCD).
-She did not fax the order for sertraline.
-She was responsible for auditing the medication cart and MAR when new orders were received.
-The facility could not access the pharmacy fax confirmations due to issues with facility fax machine.

Interview with the Resident Care Director (RCD) on 03/16/23 at 11:28am revealed:

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-He did not know Resident #2's sertraline was not available.
-The MAs, RCD or ARCD were responsible for faxing all orders to the pharmacy.
-The MAs were to document on the MARs why any medication was not given or not available.

Interview with a medication aide (MA) on 03/16/23 at 3:42pm revealed:
-She was working on 03/14/23 when the order was received from the Primary Care Provider (PCP).
-She did not fax the orders to the pharmacy.
-She thought the PCP faxed the order to the pharmacy.
-She documented the orders for sertraline 25mg by mouth daily for one week and sertraline 50mg daily on the MAR.
-The new orders should have been checked on the MAR by the ARCD.

Interview with the Administrator on 03/16/23 at 4:40pm revealed:
-She did not know Resident #2's sertraline was not available.
-The MAs, RCD or ARCD were responsible for faxing all orders to the pharmacy.
-The MAs were responsible for checking all orders prior to the end of shift.
-MAs were to place faxed pharmacy orders, with their initials verifying who faxed the order to the pharmacy, in the resident's chart.
-The RCD or ARCD were responsible for weekly medication cart audits.
-The RCD or ARCD were to compare medications on the medication cart to the MARs.
-There was no documentation of the medication cart audits available.
-She expected the MAs, ARCD and RCD to notify the pharmacy, PCP and responsible party of any

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D 276	Continued From page 3 medications that were not available. -The MAs, RCD or ARCD were to add orders to the MAR only when the medication was received from the pharmacy.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a medication was administered as ordered for 1 of 3 sampled residents related to a medication used to treat depression, anxiety, and insomnia (#1). The findings are: Review of Resident #1's current FL2 dated 09/14/21 revealed: -Diagnoses included Alzheimer's dementia. -The resident was disoriented intermittently. -The resident resided in a special care unit (SCU). -There was an order for trazodone (a medication used to treat depression, anxiety, and insomnia)100mg by mouth at bedtime. Review of Resident #1's March 2023 medication administration record (MAR) revealed:	D 358		

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-There was an entry for trazodone 100mg by mouth at bedtime.
-Trazodone was documented as not administered at bedtime from 03/10/23 to 03/12/23.
-There was no comment for the reason trazodone was not documented as administered.
-Trazodone was documented as not administered on 03/14/23 and 03/15/23 with a comment as not available.

Observation of Resident #1's medications on hand on 03/16/23 at 10:55am revealed there was no trazodone 100mg available on the medication cart.

Interview with an agency medication aide (MA) on 03/16/23 at 11:07am revealed:
-She worked first shift on 03/15/23 and 03/16/23.
-Resident #1 was not administered trazodone last night due to medication unavailable.
-She did not know why Resident #1's trazodone was not available.
-She did not know if a another MA notified the pharmacy, the Assistant Resident Care Director (ARCD), the Resident Care Director (RCD), the Administrator or the Primary Care Provider (PCP) that Resident #1 did not have trazodone available.

Attempted telephone interview with Resident #1's family member on 03/16/23 at 2:57pm was unsuccessful.

Telephone interview with the Pharmacy Technician at the facility's contracted pharmacy on 03/16/23 at 12:36pm revealed trazodone 100mg my mouth at bedtime, for a quantity of 30 tablets was dispensed to the facility on 02/21/23.

Telephone interview with the Pharmacist at the

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facility's contracted pharmacy on 03/16/23 at 3:19pm revealed:
-The pharmacy received a physician's order for trazodone 100mg by mouth at bedtime to the pharmacy on 03/16/23.
-Resident # 1's trazadone was not authorized by his insurance for a refill until 03/17/23 and the facility was notified.
-If Resident #1 did not receive scheduled trazodone, he could experience fatigue, irritability, and drowsiness.

Telephone interview with a night shift MA on 03/16/23 at 3:45pm revealed she was aware that Resident #1 did not have trazodone available, and she notified the ARCD on 03/03/23.

Interview with ARCD on 03/16/23 at 3:27pm revealed:
-She was aware that Resident #1 did not have trazodone available.
-She thought she had faxed a request to the pharmacy for a seven-day supply of trazodone, with the facility being responsible for cost of medication but had not.
-She stated the pharmacy had not delivered Resident #1's trazodone on 02/21/23.

Review of Pharmacy shipment order log dated 02/21/23 revealed Resident #1 had five separate medications listed as being delivered on 02/21/23 with trazodone 100mg by mouth at bedtime for a quantity of 30 tablets listed.

Interview with the RCD on 03/16/23 at 11:39am revealed:
-He did not know Resident #1 did not have trazodone available.
-He expected the MAs to reorder medication seven days prior to medication running out.

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D 358	Continued From page 6 -He did not know why Resident #1 did not have any trazodone available. -The MAs were to document on the MARs why a medication was not given or not available. -Medication cart audits were to be completed weekly by the MAs, ADRC or the DRC. -There was no documentation of medication cart audits available. Interview with the Administrator on 03/16/23 at 4:40pm revealed: -She did not know Resident #1 did not have trazodone available prior to 03/16/23 when she was notified by the ARCD. -The RCD or ARCD were responsible for weekly medication cart audits. -The RCD or ARCD were to compare medications on the medication cart to the MARs. -There was no documentation of medication cart audits available. -She expected the MAs, ARCD and RCD to notify the pharmacy, PCP and resident's responsible party of any medications that are not available.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: TYPE B VIOLATION	D 378		

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D 378	Continued From page 7 Based on observations, record reviews, and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration in the Special Care Unit for 2 of 3 sampled residents (Resident #1 and #2). The findings are: Review of the daily census report for the Special Care Unit (SCU) on 03/15/23 revealed the total census was 20, with 8 residents on the middle hall and 12 on the other hall. Observation of the SCU on 03/15/23 from 10:22am to 10:43am revealed: -There were no personal care aides (PCAs) on the middle hall. -There were two PCAs and one medication aide (MA) on the other hall. -On the middle hall there was a housekeeper and a hospice certified nursing assistant (CNA). -There were 3 residents on the middle hall, in their rooms during this time. -There were two unsupervised residents, in their rooms on the middle hall, and one resident who was working with the hospice CNA. 1. Review of Resident #2's current FL2 dated 02/28/23 revealed: -Diagnoses included dementia and hearing loss. -The resident was disoriented constantly. -The recommended level of care was SCU. -There were no orders for topical creams to be kept in the resident's room. Observation of Resident #2's room on 03/15/23 from 10:12am to 10:29am revealed: -Her room was the second room on the left upon	D 378		

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D 378	Continued From page 8 entering the middle hall. -Resident #2 was in her room, sitting in a recliner, with eyes closed. a. Observation of Resident #2's room on 03/15/23 from 10:12am to 10:29am revealed: -There was an open, partially used 1.8 ounce (51 g) tube of maximum strength pain relief hemorrhoid cream, in which ingredients were glycerin 14.4%, phenylephrine 0.25%, pramoxine 1% and white petrolatum 15% (used to relieve inflammation, pain, and itching) on a shelf in the bathroom. -There was no pharmacy label on the tube. -There was a warning on the tube for external use only, if swallowed, get medical help or contact Poison Control Center right away. Review of Resident #2's record on 03/15/23 revealed there was no order for the maximum strength pain relief hemorrhoid cream to be applied at the bedside. Review of Resident #2's March 2023 Medication Administration Record (MAR) revealed there was no entry for extra strength hemorrhoid cream to be self-administered at the bedside. Telephone interview with a Poison Control representative on 03/15/23 at 3:27pm revealed: -Pramoxine 1% can cause difficulty swallowing and numbness of the throat. -Glycerin and white petrolatum could cause diarrhea. -Phenylephrine could cause dizziness and dry mouth. -If a person ingested 25 grams or more to see side effects, and side effects would be seen immediately.	D 378		

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b. Observation of Resident #2's room on 03/15/23 from 10:12am to 10:29am revealed:
-There was an open, partially used 1.0 ounce (28.4g) tube of extra strength anti-itch allergy cream, in which ingredients were diphenhydramine hydrochloride 2% and zinc acetate 0.1% (used to relieve inflammation, pain, and irritation of skin) on a shelf in the bathroom.
-There was no pharmacy label on the tube.
-There was a warning on the tube for external use only, do not use on large areas of the body or with any other product containing diphenhydramine, even one taken by mouth.

Review of Resident #2's record on 03/15/23 revealed there was no order for the extra strength anti-itch allergy cream to be applied at the bedside.

Review of Resident #2's March 2023 MAR revealed there was no entry for extra strength anti-itch allergy cream to be self-administered at the bedside.

Telephone interview with a Poison Control representative on 03/15/23 at 3:30pm revealed ingestion by an adult of 15 grams (one-half of a tube) or more would cause drowsiness, and side effects would be seen immediately.

c. Observation of Resident #2's room on 03/15/23 from 10:12am to 10:29am revealed:
-There was an open, partially used 1.0 ounce (28.4g) tube of hydrocortisone cream ½% (used to decrease pain, itching, and inflammation of the skin) on a shelf in the bathroom.
-There was no pharmacy label on the tube.
-There was a warning on the tube for external use only, do not use in the eyes or by putting into the rectum using fingers or other mechanical device

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D 378	Continued From page 10 or applicator. Review of Resident #2's record on 03/15/23 revealed there was no order for the hydrocortisone cream to be applied at the bedside. Review of Resident #2's March 2023 MAR revealed there was no entry for hydrocortisone cream to be self-administered at the bedside. Telephone interview with a Poison Control representative on 03/15/23 at 3:27pm revealed there were no issues with ingestion of hydrocortisone cream ½%. Interview with the Administrator on 03/15/23 at 12:30pm revealed she did not know Resident #2 had 3 medicated creams in her bathroom. Interview with a personal care aide (PCA) on 03/15/23 at 2:45pm revealed she was not aware of any medicated creams in Resident #2's room. Interview with Assistant Resident Care Director (ARCD) on 03/15/23 at 3:00pm revealed: -She was not aware that Resident #2 had 3 medicated creams on the shelf in the bathroom. -In the past, Resident #2's family member would bring over the counter items and not notify staff. -She had instructed the family member to not bring medicated items in the resident's room. Interview with the SCU Coordinator on 03/15/23 at 3:52pm revealed: -She was not aware of the 3 medicated creams in Resident #2's bathroom. -She was not aware that they were located on the same shelf as her toothpaste and toothbrush.	D 378		

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Interview with the Resident Care Director (RCD) on 03/16/23 at 11:28am revealed:
-He did not know Resident #2 had 3 medicated creams in her bathroom.
-She was only prescribed one oral medication until March 2023.

Attempted telephone interview with Resident #2's responsible party on 03/16/23 at 12:43pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 03/16/23 at 2:00pm was unsuccessful.

Refer to interview with the Administrator on 03/15/23 at 12:30pm.

Refer to interview with ARCD on 03/15/23 at 3:00pm.

Refer to interview with an agency MA on 03/16/23 at 11:07am.

Refer to interview with the RCD on 03/16/23 at 11:28am.

2. Review of Resident #1's current FL2 dated 09/14/21 revealed:
-Diagnoses included Alzheimer's dementia.
-The resident was disoriented intermittently.
-The residents recommended level of care was special care unit (SCU).

Review of Resident #1's SCU resident profile dated 03/13/23 revealed Resident #1 required assistance for medication administration.

Observation of Resident #1's room on 03/15/23 at 10:05am revealed:
-Resident #1's room was the second room on the

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right,upon entering the hallway on the right, in the SCU.
-There was a resident that walked past Resident #1's room and around the SCU.
-There was one medication aide (MA) and two personal care aides (PCA) at the nurses station, located in the center of the SCU.
-There were several residents sitting at the opposite end of the SCU in the common area.

Observation of Resident #1's room on 03/15/23 at 10:05am revealed:
-He was out of the facility with a family member.
-There was an opened, and partially used 0.5oz (142g) tube of Baza Protect cream 1%-12% (used to protect skin from irritants and moisture) on his nightstand.
-There was a pharmacy label on the tube with a dispense date of 02/28/23, the resident's name, and instructions to apply to groin and buttocks area every day, and may keep at bedside.

Review of Resident #1's signed physician's orders dated 02/28/23 revealed there was an order for Baza Protect cream to apply to groin and buttocks area every day, at his bedside.

Review of Resident #1's March 2023 Medication Administration Record (MAR) revealed:
-There was a hand-written entry for Baza Protect cream, apply to groin and buttocks area daily, to be self-administered, may store by bedside table.
-There was no documentation the Baza Protect cream was administered by a MA.

Telephone interview with a Poison Control representative on 03/15/23 at 3:27pm revealed ingestion by an adult could cause diarrhea, and symptoms would be seen immediately.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HAVEN IN THE VILLAGE AT CAROLINA PLACE	13150 DORMAN ROAD PINEVILLE, NC 28134

(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) COMPLETE DATE
D 378	Continued From page 13 Attempted telephone interview with Resident #1's family member on 03/16/23 at 2:57pm was unsuccessful. Interview with an MA on 03/16/23 at 11:07am revealed: -She knew that Resident #1 had an entry on the MAR for Baza Protect cream, self-administered, by bedside table written on the MAR. -She had never been in Resident #1's room. Interview with the Assistant Resident Care Director (ARCD) on 03/15/23 at 2:54pm revealed: -She was aware that Resident #1 had Baza Protect Cream at his bedside table. -She said Resident #1 only allowed a family member to apply the Baza Protect Cream. Interview with the Resident Care Director (RCD) on 03/16/23 at 11:28am revealed he did not know Resident #1 had Baza Protect Cream in his room or at his bedside table. Interview with the Administrator on 03/15/23 at 12:30pm revealed she did not know Resident #1 had Baza Protect Cream in his room or at his bedside table. Refer to interview with the Administrator on 03/15/23 at 12:30pm. Refer to interview with the ARCD on 03/15/23 at 3:00pm. Refer to interview with an agency MA on 03/16/23 at 11:07am. Refer to interview with the RCD on 03/16/23 at 11:28am.	D 378		

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D 378	Continued From page 14 Interview with the Administrator on 03/15/23 at 12:30pm revealed: -The facility did not allow residents on the SCU to self-administer any medications, nor keep medications in their rooms. -The MA's, ARCD and the RCD were responsible for ensuring all medications were stored and secured in the medication carts. -He had not performed any room checks for medications. Interview with the ARCD on 03/15/23 at 3:00pm revealed: -She worked as the ARCD since 02/06/23. -She had not performed any room checks for medications. -Resident's were not allowed to keep any medications in their rooms. -She did not know if the facility had a medication administration policy specific to the SCU. Interview with a MA on 03/16/23 at 11:07am revealed she did not believe SCU residents were allowed to self-administer any medications. Interview with the RCD on 03/16/23 at 11:28am revealed: -The facility's policy per the Director of Clinical Operations was to not allow any medications to be self-administered or left in resident rooms in the SCU. -There was no written medication administration policy specific to the SCU. -Staff was aware that medications or medicated creams should not be self administered and not left in the residents' rooms. -There should not be any medicated creams in resident rooms. -He was not aware that the creams were left in the residents room unsecured.	D 378		

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D 378	Continued From page 15 The facility failed to ensure medications were maintained under locked security or under direct supervision of staff in charge of medication administration allowing medications to be left in two resident's (#1 and #2) rooms in the SCU putting them at risk for harm if they ingested them. This failure was detrimental to the health and safety of the residents which constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 03/15/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2023.	D 378		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental,	D 464		

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D 464	Continued From page 16	D 464		

social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2 and #3) had care plans signed within 15 days of completion.

The findings are:

Review of Resident #1's current FL2 dated 03/14/23 revealed:
-Diagnoses included Alzheimer's disease.
-Documented level of orientation was constantly disoriented.

Review of Resident #1's Resident Register revealed an admission date of 09/20/21.

Review of Resident #1's record on 03/15/23 revealed a SCU care plan dated 02/28/23 that was not signed.

Telephone interview with the facility's contracted primary care provider on 03/16/23 at 10:49am revealed:
-She saw Resident #1 last on 03/14/23.
-The Health and Wellness Director (HWD) was responsible for faxing the care plans for her review and then to sign.
-If there was a care plan completed at the facility that was not faxed, it was placed in the resident's folder for review and to be signed.
-There was no care plan for Resident #1 faxed or in the folder at the facility available for her signature.

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D 464	Continued From page 17 Refer to interview with the Assistant RCD on 03/16/23 at 11:22am. Refer to interview with the RCD on 03/16/23 at 11:23am. Refer to interview with the Administrator on 03/16/23 at 4:00pm. 2. Review of Resident #2's current FL2 dated 02/28/23 revealed: -Diagnoses included dementia. -Documented level of orientation was constantly disoriented. Review of Resident #2's Resident Register revealed an admission date of 01/24/23. Review of Resident #2's record on 03/15/23 revealed a SCU care plan dated 02/14/23 that was not signed. Telephone interview with the facility's contracted primary care provider on 03/16/23 at 10:49am revealed: -She saw Resident #1 last on 03/14/23. -The Health and Wellness Director (HWD) was responsible for faxing the care plans for her review and then to sign. -If there was a care plan completed at the facility that was not faxed, it was placed in the resident's folder for review and to be signed. -There was no care plan for Resident #1 faxed or in the folder at the facility available for her signature. Refer to interview with the Assistant Resident Care Director (RCD) on 03/16/23 at 11:22am. Refer to interview with the RCD on 03/16/23 at	D 464		

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D 464	Continued From page 18 11:23am. Refer to interview with the Administrator on 03/16/23 at 4:00pm. 3. Review of Resident #3's current FL2 dated 04/19/22 revealed: -Diagnoses included Alzheimer's dementia. -There was no level of orientation documented. Review of Resident #3's Resident Register revealed an admission date of 08/02/21. Review of Resident #3's record on 03/15/23 revealed a SCU care plan dated 02/22/23 that was not signed. Telephone interview with Resident #3's primary care provider on 03/16/23 at 10:55am revealed: -She last saw Resident #3 on 03/06/23. -The facility was responsible for providing a care plan for her to sign by fax or during a visit. -She had not signed a care plan for Resident #3 since admission on 08/02/21. Refer to interview with the Assistant Resident Care Director (RCD) on 03/16/23 at 11:22am. Refer to interview with the RCD on 03/16/23 at 11:23am. Refer to interview with the Administrator on 03/16/23 at 4:00pm. _____ Interview with the Assistant RCD on 03/16/23 at 11:22am revealed: -The Business Office Manager (BOM) was responsible for completing the care conference and sending the care plan to the RCD to be signed.	D 464		

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D 464	Continued From page 19 -The RCD was responsible for faxing the care plan to the provider for review and signature. -After the care plans were faxed to the provider, the RCD would follow-up in 3 days if he did not receive a signed care plan. -The current HWD was a new hire, still in training and was not responsible for completing the care conference until trained. -The HWD was to be trained by the RCD on how to complete the care plans. -The RCD was responsible for weekly audits to make sure the care plans were completed. Interview with the RCD on 03/16/23 at 11:23am revealed: -The BOM was responsible for completing the care conference and sending the care plans to him to be signed. -He was responsible for faxing the care plan to the provider for review and signatures. -He would follow-up with the provider after three days if he did not receive the signed care plans. -He was responsible for weekly audits of the care plans to make sure they were completed. -He would only have a care plan signed if there was a change or a new care plan. -He did not know all care plans were to be signed by the provider. Interview with the Administrator on 03/16/23 at 4:00pm revealed: -A care plan was to be completed within 30 days of admission, yearly and with a change of condition. -A care plan was to be signed within 15 days of completion. -The RCD was responsible for completion of the care plans and giving them to the RCD for completion including obtaining the provider's signature.	D 464		

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D 464	Continued From page 20 -The Assistant RCD and the RCD were responsible for weekly audit to make sure the care plans were completed. -She was not aware the care plans were not signed.	D 464		