STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	3400 NEBRASKA DRIVE BISMARCK, ND 58503

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 02/08/16 and completed on 02/11/16, the sample included five (5) residents for complete review, sixteen (16) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		3/17/16

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

Electronically Signed | 03/04/2016

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of the RAI (Resident Assessment Instrument) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 2 of 21 sampled residents (Resident #12 and #18), and for 2 of 3 closed records reviewed (Resident #23 and #24). Failure to accurately code behaviors, determination of pressure ulcer risk, and skin and ulcer treatments does not allow the residents' assessments to reflect their current statuses/needs, and has the potential to affect the accurate development of a comprehensive care plan and a potential to affect the care provided to these residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2015, Chapter 1 page 1-8, stated, ". . . While CMS [Centers for Medicare and Medicaid Services] does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not	F 278	It is the intent of this facility to continue to complete MDS assessments accurately as evidenced by the following: 1. The most recent MDS was reviewed for resident's #12 and #18 regarding coding in the following sections: Behavior, determination of pressure ulcer risk, and skin and ulcer treatments. Modifications were done for these MDS's. Upon review of the facility roster, there were 4 other residents that needed modifications in regards to behaviors, and 56 MDS's that needed modifications in relation to the determination of pressure ulcer risk. No other MDS's were identified as being inaccurately coded for Skin and ulcer treatments. The MDS's have been modified and resubmitted to CMS and the North Dakota Department of Human Services. If the correction(s) affect payment the facility will do billing adjustments accordingly. An MDS correction (modification) will not be done for resident's #23 and #24 as they were both closed charts. 2.All residents coded under Behaviors, determination of pressure ulcer risk, and skin and ulcer treatments on the MDS have the potential to be affected. 3. Current policy related to MDS	

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F 278	Continued From page 2 remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. . . ." BEHAVIORS The Long-Term Care Facility RAI Manual, revised October 2015, Chapter 3 pages E-4, E-5, and E-18 stated, ". . . E0200: Behavioral Symptom - Presence and Frequency . . . B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others). . . E0900: Wandering - Presence and Frequency. Has the resident wandered? . . . Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems - and may therefore require treatment planning and intervention - from those that are not problematic. These behaviors may indicate unrecognized needs, preferences, or illness. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and interventions can be developed to improve the symptoms or reduce their impact . . . Steps for Assessment. 1. Review the medical record for the 7-day look-back period . . . Coding Instructions . . . Code 1, behavior of this type occurred 1-3 days . . . Code 2, behavior of this type occurred 4-6 days, but less than daily . . . Code 3, behavior of this type occurred daily . . ." - Review of Resident #23's medical record	F 278	Completion was reviewed and remains unchanged. Education was provided to the staff member completing the MDS areas B1000, B1200 and F0800 that these areas cannot be completed until after midnight of the ARD. The date in Z0400 must accurately reflect that the area was completed after Midnight of A2300. A new process for documentation of behaviors was started on 03/01/2016. Also, a Braden/Skin Observation will be implemented to be completed on all residents during the 7 day window when an MDS is due. These observations were started on 03/01/2016. Nursing staff were educated on 03/02/2016 through 03/04/2016 regarding the correct process for MDS completion and the new process implemented for documentation. 4. On or before March 17, 2016 5. The Quality Assurance Coordinator and/or designee will audit the next MDS's completed on resident #12 and #18 to assure that correct coding was completed. Random audits will be done on 4 residents a week to assure correct coding and signature dates. These audits will be conducted weekly X4 weeks, monthly X3 months and then quarterly X2. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report to the Quality Assurance Committee at each scheduled meeting and necessity of further	

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F 278	Continued From page 3 occurred on February 10-11, 2016. A quarterly MDS, dated 10/13/15, identified the resident as cognitively intact, and verbal behavioral symptoms directed toward others occurred daily during the 7-day assessment period. The medical record lacked evidence of daily verbal behaviors demonstrated by Resident #23. - Review of Resident #24's medical record occurred on February 10-11, 2016. A quarterly MDS, dated 09/28/15, identified the resident had long and short term memory impairments, and wandered daily during the 7-day assessment period. The medical record lacked evidence of daily wandering behaviors demonstrated by Resident #24. During an interview on 02/11/16, at 8:15 a.m., MDS staff members (#3 and #4) confirmed the medical records for Resident #23 and #24 failed to contain documentation of daily behaviors as identified by the MDSs. DETERMINATION OF PRESSURE ULCER RISK The Long-Term Care Facility RAI Manual, October 2015, Chapter 3 page M-2 stated, ". . . Check C if the resident's risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Example of risk factors include the following: - impaired/decreased mobility and decreased functional ability - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes	F 278	monitoring will be determined.	

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F 278	Continued From page 4 mellitus; - drugs, such as steroids, that may affect wound healing; - impaired diffuse or localized blood flow. . . - resident refusal of some aspects of care and treatment; - cognitive impairment; - urinary and fecal incontinence; - under nutrition, malnutrition, and hydration deficits; and - healed pressure ulcers . . . " - Review of Resident #18's medical record occurred on February 10-11, 2016. Resident #18's quarterly MDS, dated 11/30/15, identified the resident's risk for pressure ulcer development was based on clinical assessment (item M0100C checked). Facility staff failed to code Resident #18's MDS accurately for item M0100C, as the medical record lacked evidence of a clinical assessment completed during the look-back period. During an interview on the morning of 02/11/16, a MDS staff member (#4) provided documentation which showed staff monitored Resident #18's bilateral lower extremities, and provided no evidence of a completed clinical assessment. SKIN AND ULCER TREATMENTS The Long-Term Care Facility RAI Manual, October 2015, Chapter 3 page M-37 stated, ". . . Pressure Reducing Device(s). Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or cushioning placed on a chair, wheelchair, or bed.	F 278		

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F 278	Continued From page 5 . . . Coding Instructions. Check all that apply in the last 7 days. . . . M1200A, Pressure reducing device for chair . . ." - On February 08-11, 2016, observations showed Resident #12 sitting in her wheelchair with a pressure reducing cushion located in the seat. Review of Resident #12's medical record occurred on February 09-11, 2016. Resident #12's significant change MDS, dated 01/10/16, and quarterly MDS, dated 12/23/15, identified this resident normally utilized a wheelchair for locomotion, had a Stage 2 pressure ulcer, and had no pressure reducing device provided for chair (item M1200A not checked). During an interview on 02/09/16 at 4:45 p.m., a MDS staff member (#3) verified the facility staff failed to code and identify on the MDSs that Resident #12 utilized a pressure reducing device in her wheelchair. 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), and staff interview, the facility failed to use the entire required days of observation when completing MDS items B1000, B1200, and/or F0800 on 21 of 21 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20 and #21). Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident's vision, and daily and activity preferences.	F 278		

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F 278	Continued From page 6 Findings include: MINIMUM DATA SET - ITEM Z0400 (ATTESTATION STATEMENT) The Long-Term Care Facility Resident Assessment Instrument User's Manual (Version 3.0), page A-23 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . ." Page B-9, B-11, and F-15 stated, item B1000 Vision, item B1200 Corrective Lenses, and item F0800 Staff Assessment of Daily Living and Activity Preferences have a 7-day look-back period. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Record review for Resident #1, #2, #3, #4, #5,	F 278		

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F 278	Continued From page 7 #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20 and #21 occurred between February 08 and February 11 of 2016. Review of these records revealed a facility staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (B1000, B1200, and/or F0800), as the staff member signed and dated each assessment as completed prior to the the ARD. For Residents #1 through #21, listed below is the ARD of the current OBRA (Omnibus Budget Reconciliation Act) MDS; and the completion date identified at Z0400 for items B1000, B1200, and/or F0800: * Resident #1 - ARD 02/03/16. B1000 and B1200 completed 01/29/16 * Resident #2 - ARD 12/29/15. B1000 and B1200 completed 12/28/15 * Resident #3 - ARD 12/29/15. B1000 and B1200 completed 12/28/15 * Resident #4 - ARD 11/26/15. B1000 and B1200 completed 11/24/15 * Resident #5 - ARD 12/16/15. B1000 and B1200 completed 12/10/15 * Resident #6 - ARD 01/14/16. B1000 and B1200 completed 01/11/16 * Resident #7 - ARD 01/19/16. B1000 and B1200 completed 01/15/16 * Resident #8 - ARD 01/19/16. B1000 and B1200 completed 01/15/16 * Resident #9 - ARD 12/18/15. B1000 and B1200 completed 12/16/15 * Resident #10 - ARD 01/20/16. B1000 and B1200 completed 01/15/16 * Resident #11 - ARD 01/27/16. B1000 and B1200 completed 01/22/16	F 278		

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F 278	Continued From page 8 * Resident #12 - ARD 01/10/16. B1000 and B1200 completed 01/08/16 * Resident #13 - ARD 12/14/15. B1000 and B1200 completed 12/14/15 * Resident #14 - ARD 11/10/15. B1000 and B1200 completed 11/09/15 * Resident #15 - ARD 12/02/15. B1000, B1200 & F0800 completed 11/30/15 * Resident #16 - ARD 11/18/15. B1000 and B1200 completed 11/16/15 * Resident #17 - ARD 01/19/16. B1000 and B1200 completed 01/15/16 * Resident #18 - ARD 11/30/15. B1000 and B1200 completed 11/30/15 * Resident #19 - ARD 12/02/15. B1000 and B1200 completed 12/01/15 * Resident #20 - ARD 01/06/16. B1000 and B1200 completed 01/04/16 * Resident #21 - ARD 01/13/16. B1000 and B1200 completed 01/11/16 During an interview on the afternoon of 02/09/16, MDS staff members (#3 and #4) verified a staff member failed to observe and collect MDS assessment information through the end of the day of the ARD (up until midnight) on three items (B1000, B1200, and/or F0800) having a 7-day look-back period.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		3/17/16

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F 309	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to maintain overall well-being for 1 of 3 sampled residents (Resident #4) who experienced a recent fracture. Failure to ensure an x-ray order was completed resulted in delayed treatment of Resident #4's fractured ankle and may have contributed to Resident #4's pain. Findings include: Review of Resident #4's medical record occurred on all days of survey. Diagnoses included fracture of right ankle. Medications included Oxycodone; acetaminophen (pain medication) 5-325 milligram (mg) three times a day. Review of the physician/practitioner's notes stated the following: * 12/02/15: ". . . Resident being seen today for Nursing Home Visit. C/o's [complaints of] 'my legs just give out . . . two days ago I was walking around some with my walker . . . today, I can't.' . . . He cannot bear weight today, even to transfer. . . . He does note that his right LE [lower extremity] seems weaker than his left . . . Plan: Will follow up with resident on next routine nursing home rounds or sooner if problems or concerns exist. . . ." *12/07/15: ". . . On local examination, on following up with the patient, I did note he had some tenderness on the medial side of the right ankle, as is increased swelling also noted. I was concerned also with some bruising. With his	F 309	It is the intent of this facility to remain in compliance with F-309 as evidenced by the following: 1. Staff that were involved with the missed x-ray for resident #4 were educated on the new process. 2. Any resident that requires an x-ray has the potential to be affected. 3. The process of entering radiology appointments has been reviewed by the management team. All radiology orders going forward will be entered as "Radiology" orders instead of "General" orders. Education will be provided to all team leaders and ward clerks on 03/02/2016 through 03/04/2016 to emphasize the importance of scheduling x-rays as soon as orders are observed and entered. 4. On or before March 17, 2016 5. Quality Nurse or designee will do random audits weekly X4, monthly X3 and then quarterly X2, beginning the week of 02/29/2016 to be sure that x-rays that are ordered are scheduled within 24 hours. Results will be communicated immediately to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented.	

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F 309	Continued From page 10 history of falls, I was concerned with possible ligament injury. Nevertheless, it is hard to rule out a fracture without getting an x-ray. . . . Plan: To get an x-ray. . . ." * 12/17/15: ". . . 12/15/15 . . . Procedure: XRAY ANKLE . . . RT [right] . . . fracture through the distal fibula is identified. . . . Assessment and Plan . . . 3. Rt fibular fracture, non displaced, currently on hoyer lift until seen by ortho [orthopedic]. . . ." * 12/18/15: ". . . Orthopedic Clinic . . . high risk for surgery, and I do not think it is necessary as this is not a displaced fracture. It could become displaced and this would be problematic. It needs to be splinted and I think we should use an AFO [ankle foot orhtosis/splint] and probably x-ray him every 10 days. . . ." Review of Resident #4's progress notes showed the following: * 12/02/15 at 7:17 p.m.: ". . . Resident had fall this afternoon 1045 [10:45 a.m.]. Please see fall event. Residents weakness continued to worsen over the course of the day and [name of nurse practitioner] notified . . . Resident has c/o pain in his B/L [bilateral] LE and also some numbness. . . ." * 12/03/15 at 5:29 p.m.: ". . . Resident transferring with full body lift extensive assistance . . . due to recent fall. . . . Resident has c/o pain in his LE B/L also c/o numbness and tingling. Some moderate pain is noted in his R) [sic] ankle. * 12/04/15 at 6:20 p.m.: ". . . Resident has c/o pain in his LE, numbness and tingling. He notes slightly more pain in his R) [sic] ankle, some slight +1 edema in [right] ankle. . . ." * 12/05/15 at 1:28 p.m.: ". . . He complains of some discomfort in his leg . . ."	F 309	The Quality Nurse or designee will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	

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F 309	Continued From page 11 * 12/06/15 at 1:00 p.m.: ". . . He complains of some discomfort in his leg . . ." * 12/07/15 at 12:44 p.m.: ". . . NEW ORDERS: X-ray Rt [right] ankle complete view. RE: ankle pain S/P [status post] fall. Ace wrap to Rt ankle. Heat/pack q [every] BID [two times a day] and PRN [as needed]." * 12/07/15 at 6:15 p.m.: ". . . Some +1 edema noted in [right] ankle as well as some mild bruising on the lateral aspect, ACE wrap applied, most likely due to his last fall. Cold pack applied today and foot elevated on chair. . . ." * 12/09/15 at 5:24 p.m.: ". . . ACE wrap changed to [right] LE, mild +1 swelling noted on [right] LE and also light purple along lateral aspect of [right] lower foot. Resident notes that his feet still feel heavy at times and also have some light numbness. . . ." * 12/10/15 at 5:46 p.m.: ". . . He complains of some discomfort in his leg . . ." * 12/11/15 at 3:40 a.m.: ". . . sitting up in w/c [wheelchair] watching television . . . swelling continues from the toes to the ankle-tender to the touch . . ." * 12/12/15 at 5:18 p.m.: ". . . some trace swelling still noted as well as slight bruising along the lateral aspect. . . ." * 12/13/15 at 3:54 p.m.: ". . . Pain in [right] LE on and off throughout the day, . . . Slight bruising note noted on [right] lateral ankle, ACE wrap reapplied, ice applied PRN for swelling. Trace swelling noted. . . ." *12/14/15 at 2:17 p.m.: ". . . He complains of some discomfort in his leg . . ." * 12/15/15 at 4:11 a.m.: ". . . ACE wrap to right foot-ice applied on and off- trace swelling continues. Does not want any medicine for the pain."	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 12 * 12/15/15 at 5:12 p.m.: ". . . There is some mild pedal ankle edema to right leg. He has a right ankle fracture and will be since [sic] by an orthopedic specialist . . ." * 12/15/15 at 5:58 p.m.: "ORDERS: Orders received from [name of physician] as follow; pt [patient] to see orthopedic specialist ASAP [as soon as possible] for fracture right ankle, no weight baring [sic] to right leg." * 12/18/15 at 3:17 p.m.: ". . . He went to appt [appointment] today for [Orthopedic specialist name] for ultrasound of right ankle, leg. There is some mild pedal ankle edema to the right leg. He has a right ankle fracture . . . ." * 12/19/15 at 4:21 a.m.: ". . . non weight bearing to right leg-right ankle fx [fracture]. . . . ACE wrap to right foot- boot in place . . ." During an interview on 02/08/16 at 5:45 p.m., a supervisory nurse (#1) verified the facility missed the x-ray order from 12/7/15. The x-ray was not done until 12/15/15. The facility failed to ensure an x-ray order was completed when ordered which resulted in delayed treatment of Resident #4's fractured ankle and may have contributed to Resident #4's pain.	F 309		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		3/17/16

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F 356	Continued From page 13 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to post accurate nurse staffing data on 3 of 6 units (Meadowlark, Prairie View, and Western Skies) for 2 of 3 days of survey (February 9-10, 2016) the nursing staffing data was observed. Failure to post accurate nurse staffing data denied residents and visitors the opportunity to be informed regarding the level of staffing provided. Findings include:	F 356	It is the intent of this facility to remain in compliance with F-356 and post accurate nurse staffing data on all neighborhoods on a daily basis at the beginning of the shift. This is evidenced by the following: 1. Re-educate team leaders working Meadowlark, Prairie View and Western Skies Neighborhoods. 2. All residents and visitors have the potential to be affected.	

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F 356	Continued From page 14 Review of the facility policy titled "Staffing Information Posting for Nursing Department" occurred on 02/11/16. This policy, dated August 2015, stated, "1. Nurse staff information will be posted on each neighborhood and contain the following information . . . Current date . . . Total number and actual hours worked by the following staff . . . RN [registered nurse]/LPN [licensed practical nurse] . . . The team leader on each neighborhood will post the nurse staffing daily. . . ." - On 02/09/16 at 8:32 a.m., 2:10 p.m., and 5:58 p.m., observations on Meadowlark showed posted nurse staffing data, dated 02/08/16. On 02/10/16, at 8:17 a.m., the posted nurse staffing data on Meadowlark remained dated 02/08/16. - On 02/09/16 at 9:16 a.m., 10:45 a.m., and 2:10 p.m., observation showed Prairie View failed to post nurse staffing data. - On 02/09/16 at 9:05 a.m., observation on Western Skies showed no nurse staffing data posted. An interview at that same time with an administrative nursing staff member (#2), identified the posted nurse staffing information was incorrect and she was in the process of reposting the nursing staff data. At 9:10 a.m., observation showed the nurse staffing data posted on Western Skies identified 12 licensed nurses working both the day and the night shift for this unit. Observation of nursing staff showed one licensed nurse working on Western Skies, during the day shift, on 02/09/16.	F 356	3. The policy and procedure titled, "Staffing Information Posting for Nursing Department" has been reviewed and remains unchanged. Education was provided to all nursing team leaders on 03/02/2016 through 03/04/2016 with emphasis placed on adherence to the current policy and the importance of the form being accurate and updated with changes in staffing throughout the shift. 4. On or before March 17, 2016 5. Quality Nurse or designee will conduct random audits for accurate staff posting on two neighborhoods weekly X4 and monthly X2. Results will be communicated immediately to the Director of Nursing. If concerns are identified, immediate corrective action will be implemented. The Quality Nurse or designee will submit a report of the QA monitoring to the QA committee at each scheduled meeting and necessity of further monitoring will be determined.	