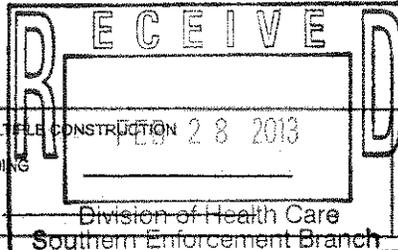


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS: An abbreviated standard survey (KY19699) was initiated on 02/06/13 and concluded on 02/07/13. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "G" level, with the facility having an opportunity to correct.	F 000		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policy, the incident report, and manufacturer's instructions, it was determined the facility failed to ensure services provided by the facility were provided in accordance with the written plan of care for one of three sampled residents (Resident #1). Facility staff assessed Resident #1 to require the assistance of a minimum of two staff persons with the use of a "sit to stand lift" for transfers. However, on 01/20/13, two staff persons transferred Resident #1 from the wheelchair to the bed without the use of the "sit to stand lift" and the resident sustained a fracture of the left shoulder. (Refer to F323.) The findings include: A review of the facility's policy entitled "Care Plan	F 282	1. Physician/family was notified of resident c/o pain immediately on 01/20/13. Resident #1 had a shoulder x-ray completed and Ct scan was performed on 01/23/13 with a non displaced comminuted surg. Neck fracture of shoulder. Resident #1 has since received treatment for the left shoulder fracture, is receiving pain medications, had had a therapy assessment and is currently being transferred with a sit to stand lift. Both Medical Director and family was notified of Accu-nurse and care plan issue. Resident #1 accu-nurse care plan was corrected on 01/21/13 by Director of Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: E. Larue Jones Administrator TITLE: 2/28/13 (X6) DATE

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 282	Continued From page 1 Policy Statement" (not dated) revealed care plans were to be developed that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs. The policy further revealed the care plan was designed to incorporate identified problem areas, incorporate risk factors associated with the identified problems, build on the resident's strengths, and aid in preventing or reducing declines in the resident's functional status or levels. Interview with The Director of Nursing (DON) on 02/06/13 at 12:15 PM revealed the facility also utilized an "AccuNurse" audio system to access each resident's care plan. A review of the "AccuNurse" user manual, dated 2011, revealed the system was command-based speech recognition software that provided staff with real time access to each resident's care plan and interventions by means of a headset. In addition, the user manual revealed staff could update the care plans in the "AccuNurse" system by documenting custom notes under each section; however, according to the directions, staff was not to type the custom notes in capital letters. A review of the medical record of Resident #1 revealed the facility admitted the resident on 02/01/09 with diagnoses including Diabetes Mellitus, Hemiplegia (left side), Hypertension, late effect Cerebral Vascular Disease. A review of Resident #1's written comprehensive care plan that addressed Activities of Daily Living (ADL), dated 01/07/13, revealed the resident required extensive assistance of two persons with the use of a "sit to stand" lift for transfers.	F 282	2. DON/UM/LED/SS completed a 100% audit of all care plans in accunurse to identify if any other careplans that was inaccurate. This was completed 01/24/13. Any issue identified was immediately corrected by DON/UM/LED/SS RNS/DON/UM/LED/SS completed a 100% audit of accu-nurse care plans compared to the written care plan to identify any written care plans that did not match the accu-nurse care plan. This was completed on 01/24/13. Any issue identified was immediately corrected. RN/DON/UM/LED/SS completed a 100% audit of all accu-nurse care plans to identify any capital letters in the accu-nurse care plans for any resident. This was completed on 01/28/13. Any issue identified was immediately corrected.		

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F 282	<p>Continued From page 2</p> <p>In addition, a Quarterly Minimum Data Set (MDS) assessment, dated 01/13/13, revealed the facility had assessed Resident #1 to require the extensive assistance of two persons for transfers.</p> <p>A review of an Accident/Incident Report, dated 01/20/13, revealed on 01/20/13 at approximately 9:00 PM, Certified Nurse Aide (CNA) #1 and CNA #2 transferred Resident #1 from the wheelchair to the bed and the resident stated, "They hurt my arm." The Accident/Incident Report further revealed the resident's physician was contacted on 01/20/13 at 10:15 PM and an order was given to monitor the resident's shoulder. In addition the report revealed staff was reeducated on the resident's care plan for transfers.</p> <p>A review of Resident #1's x-ray obtained on 01/21/13 and the computerized tomography (CT) obtained on 01/23/13 revealed Resident #1 had sustained a fracture to the left shoulder.</p> <p>Interview on 02/06/13 at 12:17 PM with Resident #1 revealed when two aides were helping the resident transfer from the wheelchair to the bed, the resident experienced pain in his/her left shoulder. The interview further revealed that during the transfer one of the aides held onto the resident's left arm and had her hand between the resident's left arm and the resident's body and the other aide held onto the resident's pants. According to the resident, when the aides assisted the resident up from the chair to help him/her to the bed, the resident heard a pop and his/her left shoulder began to hurt. Resident #1 stated staff did not use a "lift" to transfer the resident.</p>	F 282	<p>All nurse care plans were re-copied and plan on nurses' station after corrected on 01/25/13 and all written accu-nurse care plans were reviewed again by 2 staff members to identify any that needed corrections. Any issue identified was immediately corrected.</p> <p>3. ETD/UM/ reeducated all nursing staff regarding to how access information from the care plan in acc-nurse on 01/23/13. Re-educated who to report at any discrepancy to in the center, care plans that are written in chart and where to locate, how to input information into ace-nurse, not to use any capital letters in the ace-nurse system, care plan development, abuse/neglect, following the care plan, supervision of staff while providing care and that all staff must follow plan of care. On 01/25/13. How to set up care plan</p>	

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F 282	<p>Continued From page 3</p> <p>Interview on 02/06/13 at 5:19 PM with Licensed Practical Nurse (LPN) #1 revealed she went into Resident #1's room on 01/20/13 and upon entering the room, observed CNA #1 and CNA #2 in the room and Resident #1 sitting on the side of the bed. According to LPN #1, she did not observe a "lift" in the resident's room when she entered. The interview further revealed CNA #1 and CNA #2 proceeded to assist the resident to lie down in bed and Resident #1 stated, "They hurt my arm."</p> <p>Interview on 02/06/13 at 3:15 PM with CNA #1 revealed she and CNA #2 transferred Resident #1 the same way they always do with two-person physical assistance. The interview further revealed the CNA was not aware Resident #1 required a lift for transfers and stated the "AccuNurse" only stated the resident required the assistance of two persons for assistance with transfers. CNA #1 stated a paper copy of the care plan was available to staff, but it was to be used if the "AccuNurse" system was not functioning.</p> <p>Interview on 02/06/13 at 3:00 PM with CNA #2 confirmed he and CNA #1 transferred Resident #1 from the wheelchair to the bed without a lift on 01/20/13. The interview further revealed CNA #2 was not aware Resident #1 required a lift. According to CNA #2, on the day of the incident, the "AccuNurse" system only stated Resident #1 required the physical assistance of two persons and then the system started "saying letters." CNA #2 stated he did not know what the letters meant, that it just sounded like random letters and that a paper care plan was available if the "AccuNurse" system was not functioning. According to CNA</p>	F 282	<p>in accu-nurse and what is a transfer aid. This was completed on 02/28/13</p> <p>Charge nurse to monitor one staff member 2 x a day 7 days a week performing transfers and validate that is completed per the POC for the next 30 days beginning 02/7/13, then 3 x a week for 4 weeks then 2 x a week for 4 weeks.</p> <p>Don/RNC to monitor five people each week to ensure accu-nurse plan of care is followed for transfers and other care. The written care plan and the accu-nurse care plan will be reviewed to ensure both are correct and reflect the individual needs of the resident. This is to begin 02/01/13 and will continue for 12 weeks.</p>	

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F 282	<p>Continued From page 4</p> <p>#2, on the day of the incident, he did not look at the paper care plan even though he did not know what the "letters" stated by the "AccuNurse" meant.</p> <p>Interview on 02/06/13 at 6:41 PM with LPN #2 revealed the LPN had been trained not to enter items into the comment section of the "AccuNurse" system using capital letters. The interview further revealed if only one capital letter was entered into the "AccuNurse" system, the system would only say the letter that was capitalized, and then attempt to say the rest of the word; for example if the word "the" was entered as "The" the system would say the letter "t" and then the word "he." LPN #2 stated he had not entered Resident #1's information into the "AccuNurse" system, and was unable to determine who had entered the information.</p> <p>On 02/06/13 at approximately 3:45 PM, CNA #3 was requested to demonstrate the use of the "AccuNurse" system as if she was going to transfer Resident #1. According to CNA #3, at that time, the "AccuNurse" system stated the resident required the physical assistance of two with the use of a standing lift. In addition, a review of the "AccuNurse" ADL plan of care on 02/06/13 also revealed Resident #1 required the physical assistance of two or more persons, with the use of a "standing lift" for transfers; however, the only date on the care plan was the date the care plan was printed (02/06/13) and, as a result, it could not be determined when the care plan had been developed/updated.</p> <p>Interview on 02/06/13 at 8:34 PM with the Director of Nursing (DON) and the Regional</p>	F 282	<p>2 staff members consisting of DON/RNC/UM/ETC or Qa nurse will validate any information input into the accunurse system to ensure that it is correct and that there is no capital letters. This will be completed Mon-Friday beginning 02/07/013 for 12 weeks. ETD to complete accunurse re-education every month for 3 months beginning in March 2013 with post test for all nursing staff. All new hires as of 01/25/13 will be re-educated by the ETD to nut use capital letters when inputting information into accu-nurse,</p>		

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F 282	Continued From page 5 Nurse Consultant (RNC) revealed the facility was not aware of the problem related to the "AccuNurse" system and the use of capital letters until the incident occurred. The DON and the RNC stated it was learned after the incident that staff had entered information related to the use of the lift for Resident #1 into the "AccuNurse" system in all capital letters which caused the system to spell out "SIT AND STAND LIFT" instead of speaking the words. Interview also revealed the facility did not have a system in place prior to the incident to monitor the AccuNurse system for accuracy. According to the DON and RNC, they did not have any way of determining who had made the entry into the "AccuNurse" system using all capital letters, and stated that since the incident, all written care plans and "AccuNurse" care plans had been checked for accuracy and corrected. The interview further revealed if the CNAs had any questions about what assistance a resident required a paper copy of the care plan was always available.	F 282	following POC, abuse/Neglect, care-plan development, staff supervision, how to set up a care plan in ace-nurse, what a transfer aid is and where written ace-nurse care plan are kept for use. UM/QA nurse to validate that aides' are providing care to a total of 15 residents each week per ace-nurse care plan and that care plan is correct. This will begin week of 02/26/13 x 6 weeks. 4. QA team consisting of (UM, SS, ETD, DON, Admin, LED, Med. Dir) will meet to review all audit findings x 8 weeks to make recommendations for changes or further monitoring. All audit findings will be reviewed with the RNS every weeks x 8 weeks. QA team to meet weekly beginning week of 02/25/13 5. DOC 03/01/13		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323			

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F 323	<p>Continued From page 6</p> <p>Based on interview, record review, a review of the facility's policy, the incident report, and manufacturer's instruction, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents were provided for one of three sampled residents (Resident #1). Interviews and a review of Resident #1's Care Plan and a Quarterly Minimum Data Set (MDS) assessment, revealed facility staff was to utilize a "sit to stand lift" when transferring the resident. However, on 01/20/13, two staff persons transferred Resident #1 from the wheelchair to the bed without the use of the "sit to stand lift." At the time of the transfer, Resident #1 complained of pain in the left arm, the resident's physician was notified, and radiology reports revealed the resident sustained a fracture of the left shoulder.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Care Plan Policy Statement" (not dated) revealed the care plan was designed to incorporate identified problem areas, incorporate risk factors associated with the identified problems, build on the resident's strengths, and aid in preventing or reducing declines in the resident's functional status or levels. In addition, interview with the Director of Nursing (DON) on 02/06/13 at 12:15 PM revealed the facility also utilized an "AccuNurse" audio system as a means for staff to access each resident's care plan. A review of the "AccuNurse" user manual, dated 2011, revealed the system was command-based speech recognition software that provided staff with real time access to each resident's care plan and interventions by means of a headset. In addition,</p>	F 323	<p>1. Physician/family was notified of resident c/o pain immediately on 01/20/13. Resident #1 had a shoulder x-ray completed and Ct scan was performed on 01/23/13 with a non displaced comminuted surg. Neck fracture of shoulder. Resident #1 has since received treatment for the left shoulder fracture, is receiving pain medications, had had a therapy assessment and is currently being transferred with a sit to stand lift. Both Medical Director and family was notified of Accu-nurse and care plan issue. Resident #1 accu-nurse care plan was corrected on 01/21/13 by Director of Nursing</p>	

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F 323	<p>Continued From page 7</p> <p>the user manual revealed staff could update the care plans in the "AccuNurse" system by documenting custom notes under each section; however, according to the directions, staff was not to type the custom notes in capital letters.</p> <p>A review of an in-service provided to staff by the facility in August 2012 revealed Certified Nursing Assistants (CNAs) were instructed on proper resident lifting and transfers. In addition, a review of an in-service conducted on 10/13/12 revealed staff was instructed to review each resident's "AccuNurse" care plan before providing care to residents and to report any interventions that did not match the paper care plan to a Supervisor.</p> <p>A review of the medical record of Resident #1 revealed the facility admitted the resident on 02/01/09 with diagnoses including Hemiplegia (left side) and late effect Cerebral Vascular Disease. A review of Resident #1's written comprehensive care plan dated 01/07/13 revealed the resident required extensive assistance of two persons with the use of a "sit to stand" lift for transfers. In addition, a Quarterly Minimum Data Set (MDS) assessment, dated 01/13/13, revealed the facility assessed Resident #1 to require the extensive assistance of two persons for transfers.</p> <p>On 01/20/13, staff documented in an Accident/Incident Report that Resident #1 had complained of pain in the arm after two staff persons transferred the resident from a wheelchair to the resident's bed on 01/20/13 at 9:00 PM. Continued review of the report revealed Resident #1's physician was notified on 01/20/13 at 10:15 PM of the resident's complaints of pain,</p>	F 323	<p>2. DON/UM/LED/SS completed a 100% audit of all care plans in accunurse to identify if any other careplans that was inaccurate. This was completed 01/24/13. Any issue identified was immediately corrected by DON/UM/LED/SS</p> <p>RNS/DON/UM/LED/SS completed a 100% audit of accu-nurse care plans compared to the written care plan to identify any written care plans that did not match the accu-nurse care plan.</p> <p>This was completed on 01/24/13. Any issue identified was immediately corrected.</p> <p>RN/DON/UM/LED/SS completed a 100% audit of all accu-nurse care plans to identify any capital letters in the accu-nurse care plans for any resident. This was completed on 01/28/13. Any issue identified was immediately corrected.</p>		

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F 323	<p>Continued From page 8</p> <p>and the physician requested for staff to monitor the resident.</p> <p>On 01/21/13 at 6:20 AM, nursing staff documented Resident #1 continued to complain of pain of the left shoulder, the physician was contacted, and a portable x-ray of the resident's shoulder was ordered and obtained. Continued review of nursing documentation in the nurse's notes revealed the results of the shoulder x-ray were received by the facility on 01/22/13 and a (Computerized Tomography) CT of the shoulder was ordered and completed on 01/23/13.</p> <p>A review of a radiology report dated 01/21/13, one day after the incident, revealed Resident #1 sustained a fracture of the left shoulder area. A review of a report of Resident #1's CT scan, dated 01/23/13 (three days after the incident), also revealed the resident had a non-displaced fracture of the shoulder area. Based on documentation in the medical record, facility staff administered pain medications to the resident on an as needed basis as ordered by the physician. In addition, the report revealed evidence the resident had osteopenia/osteoporosis.</p> <p>Resident #1 stated in an interview on 02/06/13 at 12:17 PM that two nurse aides had assisted the resident to transfer from the wheelchair to the bed by holding onto the resident's left arm between the arm and body, and to the resident's pants. According to Resident #1, during the transfer he/she heard a "pop" and his/her left shoulder began to hurt. Resident #1 stated staff did not use a "liff" to transfer the resident.</p> <p>Licensed Practical Nurse (LPN) #1 stated in an</p>	F 323	<p>All nurse care plans were re-copied and plan on nurses' station after corrected on 01/25/13 and all written accu-nurse care plans were reviewed again by 2 staff members to identify any that needed corrections. Any issue identified was immediately corrected.</p> <p>3. ETD/UM/ reeducated all nursing staff regarding to how access information from the care plan in acc-nurse on 01/23/13. Re-educated who to report at any discrepancy to in the center, care plans that are written in chart and where to locate, how to input information into ace-nurse, not to use any capital letters in the ace-nurse system, care plan development, abuse/neglect, following the care plan, supervision of staff while providing care and that all staff must follow plan of care. On 01/25/13. How to set up care plan</p>	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 323	<p>Continued From page 9</p> <p>interview on 02/06/13 at 5:19 PM that she went into Resident #1's room on 01/20/13 to check the resident's blood sugar and, upon entering the room, observed Certified Nurse Aides (CNAs) #1 and #2 in the room and Resident #1 sitting on the side of the bed. The interview further revealed CNAs #1 and #2 proceeded to assist the resident to lie down in bed and Resident #1 stated, "They hurt my arm." LPN #1 stated Resident #1 was assessed, the resident's doctor was contacted and requested staff to monitor the resident. Further interview revealed Resident #1 continued to complain of pain throughout the night and on the morning of 01/21/13, the resident's physician was contacted again, and orders were received for a portable x-ray of the resident's left arm/shoulder. LPN #1 stated she did not observe a "lift" in the resident's room when she entered on 01/20/13.</p> <p>CNA #1 stated in an interview on 02/06/13 at 3:15 PM that she and CNA #2 transferred Resident #1 on 01/20/13 and was not aware Resident #1 required a lift for transfers. According to CNA #1, the "AccuNurse" only stated the resident required the assistance of two persons for assistance with transfers. CNA #1 stated a paper copy of the care plan was available to staff, but it was to be used if the "AccuNurse" system was not functioning.</p> <p>CNA #2 acknowledged in an interview conducted on 02/06/13 at 3:00 PM that he and CNA #1 transferred Resident #1 from the wheelchair to the bed without a lift on 01/20/13. The interview further revealed CNA #2 was not aware Resident #1 required a lift. According to CNA #2, on the day of the incident, the "AccuNurse" system only</p>	F 323	<p>in accu-nurse and what is a transfer aid. This was completed on 02/28/13</p> <p>Charge nurse to monitor one staff member 2 x a day 7 days a week performing transfers and validate that is completed per the POC for the next 30 days beginning 02/7/13, then 3 x a week for 4 weeks then 2 x a week for 4 weeks.</p> <p>Don/RNC to monitor five people each week to ensure accu-nurse plan of care is followed for transfers and other care. The written care plan and the accu-nurse care plan will be reviewed to ensure both are correct and reflect the individual needs of the resident. This is to begin 02/01/13 and will continue for 12 weeks.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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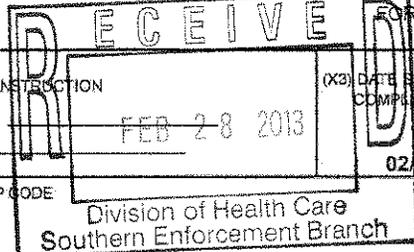
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F 323	<p>Continued From page 10</p> <p>stated Resident #1 required the physical assistance of two persons and then the system started "saying letters." CNA #2 stated he did not know what the letters meant, that it just sounded like random letters and that a paper care plan was available if the "AccuNurse" system was not functioning. According to CNA #2, on the day of the incident, he did not look at the paper care plan even though he did not know what the "letters" stated by the "AccuNurse" meant.</p> <p>Interview on 02/06/13 at 6:41 PM with LPN #2 revealed if staff entered any letters into the "AccuNurse" using capital letters, the system would only say the letter that was capitalized, and then attempt to say the rest of the word; for example if the word "the" was entered as "The," the system would say the letter "t" and then the word "he." LPN #2 stated he had not entered Resident #1's information into the "AccuNurse" system, and was unable to determine who had entered the information.</p> <p>Interviews were conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) on 02/06/13 at 8:34 PM. The DON and the RNC stated it was identified after the incident that staff had entered information related to the use of the lift for Resident #1 into the "AccuNurse" system in all capital letters which caused the system to spell out "SIT AND STAND LIFT" instead of speaking the words. Interview also revealed the facility did not have a system in place prior to the incident to monitor the "AccuNurse" system for accuracy. The interview further revealed if the CNAs had any questions about what assistance a resident required, a paper copy of the care plan was always available.</p>	F 323	<p>2 staff members consisting of DON/RNC/UM/ETC or Qa nurse will validate any information input into the accunurse system to ensure that it is correct and that there is no capital letters. This will be completed Mon-Friday beginning 02/07/013 for 12 weeks. ETD to complete accunurse re-education every month for 3 months beginning in March 2013 with post test for all nursing staff. All new hires as of 01/25/13 will be re-educated by the ETD to nut use capital letters when inputting information into accu-nurse,</p>		

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F 323	Continued From page 11 According to the DON and RNC, since the incident, all written care plans and "AccuNurse" care plans have been checked for accuracy and corrected.	F 323	following POC, abuse/Neglect, care-plan development, staff supervision, how to set up a care plan in ace-nurse, what a transfer aid is and where written ace-nurse care plan are kept for use. UM/QA nurse to validate that aides' are providing care to a total of 15 residents each week per ace-nurse care plan and that care plan is correct. This will begin week of 02/26/13 x 6 weeks. 4. QA team consisting of (UM, SS, ETD, DON, Admin, LED, Med. Dir) will meet to review all audit findings x 8 weeks to make recommendations for changes or further monitoring. All audit findings will be reviewed with the RNS every weeks x 8 weeks. QA team to meet weekly beginning week of 02/25/13 5. DOC 03/01/13		



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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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N 000	INITIAL COMMENTS An abbreviated standard survey (KY19699) was initiated on 02/06/13 and concluded on 02/07/13. The complaint was substantiated. Deficient practice was identified.	N 000		
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care. This requirement is not met as evidenced by: Based on interview, record review, and a review of the facility's policy, the incident report, and manufacturer's instructions, it was determined the facility failed to ensure services provided by the facility were provided in accordance with the written plan of care for one of three sampled residents (Resident #1). Facility staff assessed Resident #1 to require the assistance of a minimum of two staff persons with the use of a "sit to stand lift" for transfers. However, on 01/20/13, two staff persons transferred Resident #1 from the wheelchair to the bed without the use of the "sit to stand lift" and the resident sustained a fracture of the left shoulder. (Refer to F323.) The findings include: A review of the facility's policy entitled "Care Plan Policy Statement" (not dated) revealed care plans were to be developed that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs. The policy further revealed the care plan	N 194	1. Physician/family was notified of resident c/o pain immediately on 01/20/13. Resident #1 had a shoulder x-ray completed and Ct scan was performed on 01/23/13 with a non displaced comminuted surg. Neck fracture of shoulder. Resident #1 has since received treatment for the left shoulder fracture, is receiving pain medications, had had a therapy assessment and is currently being transferred with a sit to stand lift. Both Medical Director and family was notified of Accu-nurse and care plan issue. Resident #1 accu-nurse care plan was corrected on 01/21/13 by Director of Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Elaine Jones* TITLE: *Admin. Assistant* (X6) DATE: *2/28/13*

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N 194	<p>Continued From page 1</p> <p>was designed to incorporate identified problem areas, incorporate risk factors associated with the identified problems, build on the resident's strengths, and aid in preventing or reducing declines in the resident's functional status or levels. Interview with The Director of Nursing (DON) on 02/06/13 at 12:15 PM revealed the facility also utilized an "AccuNurse" audio system to access each resident's care plan. A review of the "AccuNurse" user manual, dated 2011, revealed the system was command-based speech recognition software that provided staff with real time access to each resident's care plan and interventions by means of a headset. In addition, the user manual revealed staff could update the care plans in the "AccuNurse" system by documenting custom notes under each section; however, according to the directions, staff was not to type the custom notes in capital letters.</p> <p>A review of the medical record of Resident #1 revealed the facility admitted the resident on 02/01/09 with diagnoses including Diabetes Mellitus, Hemiplegia (left side), Hypertension, late effect Cerebral Vascular Disease.</p> <p>A review of Resident #1's written comprehensive care plan that addressed Activities of Daily Living (ADL), dated 01/07/13, revealed the resident required extensive assistance of two persons with the use of a "sit to stand" lift for transfers.</p> <p>In addition, a Quarterly Minimum Data Set (MDS) assessment, dated 01/13/13, revealed the facility had assessed Resident #1 to require the extensive assistance of two persons for transfers.</p> <p>A review of an Accident/Incident Report, dated 01/20/13, revealed on 01/20/13 at approximately</p>	N 194	<p>2. DON/UM/LED/SS completed a 100% audit of all care plans in accunurse to identify if any other careplans that was inaccurate. This was completed 01/24/13. Any issue identified was immediately corrected by DON/UM/LED/SS</p> <p>RNS/DON/UM/LED/SS completed a 100% audit of accu-nurse care plans compared to the written care plan to identify any written care plans that did not match the accu-nurse care plan.</p> <p>This was completed on 01/24/13. Any issue identified was immediately corrected.</p> <p>RN/DON/UM/LED/SS completed a 100% audit of all accu-nurse care plans to identify any capital letters in the accu-nurse care plans for any resident. This was completed on 01/28/13. Any issue identified was immediately corrected.</p>	

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N 194	Continued From page 2 9:00 PM, Certified Nurse Aide (CNA) #1 and CNA #2 transferred Resident #1 from the wheelchair to the bed and the resident stated, "They hurt my arm." The Accident/Incident Report further revealed the resident's physician was contacted on 01/20/13 at 10:15 PM and an order was given to monitor the resident's shoulder. In addition the report revealed staff was reeducated on the resident's care plan for transfers. A review of Resident #1's x-ray obtained on 01/21/13 and the computerized tomography (CT) obtained on 01/23/13 revealed Resident #1 had sustained a fracture to the left shoulder. Interview on 02/06/13 at 12:17 PM with Resident #1 revealed when two aides were helping the resident transfer from the wheelchair to the bed, the resident experienced pain in his/her left shoulder. The interview further revealed that during the transfer one of the aides held onto the resident's left arm and had her hand between the resident's left arm and the resident's body and the other aide held onto the resident's pants. According to the resident, when the aides assisted the resident up from the chair to help him/her to the bed, the resident heard a pop and his/her left shoulder began to hurt. Resident #1 stated staff did not use a "lift" to transfer the resident. Interview on 02/06/13 at 5:19 PM with Licensed Practical Nurse (LPN) #1 revealed she went into Resident #1's room on 01/20/13 and upon entering the room, observed CNA #1 and CNA #2 in the room and Resident #1 sitting on the side of the bed. According to LPN #1, she did not observe a "lift" in the resident's room when she entered. The interview further revealed CNA #1 and CNA #2 proceeded to assist the resident to	N 194	All nurse care plans were re-copied and plan on nurses' station after corrected on 01/25/13 and all written accu-nurse care plans were reviewed again by 2 staff members to identify any that needed corrections. Any issue identified was immediately corrected. 3. ETD/UM/ reeducated all nursing staff regarding to how access information from the care plan in acc-nurse on 01/23/13. Re-educated who to report at any discrepancy to in the center, care plans that are written in chart and where to locate, how to input information into ace-nurse, not to use any capital letters in the ace-nurse system, care plan development, abuse/neglect, following the care plan, supervision of staff while providing care and that all staff must f allow plan of care. On 01/25/13. How to set up care plan	

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N 194	Continued From page 3 lie down in bed and Resident #1 stated, "They hurt my arm." Interview on 02/06/13 at 3:15 PM with CNA #1 revealed she and CNA #2 transferred Resident #1 the same way they always do with two-person physical assistance. The interview further revealed the CNA was not aware Resident #1 required a lift for transfers and stated the "AccuNurse" only stated the resident required the assistance of two persons for assistance with transfers. CNA #1 stated a paper copy of the care plan was available to staff, but it was to be used if the "AccuNurse" system was not functioning. Interview on 02/06/13 at 3:00 PM with CNA #2 confirmed he and CNA #1 transferred Resident #1 from the wheelchair to the bed without a lift on 01/20/13. The interview further revealed CNA #2 was not aware Resident #1 required a lift. According to CNA #2, on the day of the incident, the "AccuNurse" system only stated Resident #1 required the physical assistance of two persons and then the system started "saying letters." CNA #2 stated he did not know what the letters meant, that it just sounded like random letters and that a paper care plan was available if the "AccuNurse" system was not functioning. According to CNA #2, on the day of the incident, he did not look at the paper care plan even though he did not know what the "letters" stated by the "AccuNurse" meant. Interview on 02/06/13 at 6:41 PM with LPN #2 revealed the LPN had been trained not to enter items into the comment section of the "AccuNurse" system using capital letters. The interview further revealed if only one capital letter was entered into the "AccuNurse" system, the	N 194	in accu-nurse and what is a transfer aid. This was completed on 02/28/13 Charge nurse to monitor one staff member 2 x a day 7 days a week performing transfers and validate that is completed per the POC for the next 30 days beginning 02/7/13, then 3 x a week for 4 weeks then 2 x a week for 4 weeks. Don/RNC to monitor five people each week to ensure accu-nurse plan of care is followed for transfers and other care. The written care plan and the accu-nurse care plan will be reviewed to ensure both are correct and reflect the individual needs of the resident. This is to begin 02/01/13 and will continue for 12 weeks.	

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N 194	<p>Continued From page 4</p> <p>system would only say the letter that was capitalized, and then attempt to say the rest of the word; for example if the word "the" was entered as "The" the system would say the letter "t" and then the word "he." LPN #2 stated he had not entered Resident #1's information into the "AccuNurse" system, and was unable to determine who had entered the information.</p> <p>On 02/06/13 at approximately 3:45 PM, CNA #3 was requested to demonstrate the use of the "AccuNurse" system as if she was going to transfer Resident #1. According to CNA #3, at that time, the "AccuNurse" system stated the resident required the physical assistance of two with the use of a standing lift. In addition, a review of the "AccuNurse" ADL plan of care on 02/06/13 also revealed Resident #1 required the physical assistance of two or more persons, with the use of a "standing lift" for transfers; however, the only date on the care plan was the date the care plan was printed (02/06/13) and, as a result, it could not be determined when the care plan had been developed/updated.</p> <p>Interview on 02/06/13 at 8:34 PM with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) revealed the facility was not aware of the problem related to the "AccuNurse" system and the use of capital letters until the incident occurred. The DON and the RNC stated it was learned after the incident that staff had entered information related to the use of the lift for Resident #1 into the "AccuNurse" system in all capital letters which caused the system to spell out "SIT AND STAND LIFT" instead of speaking the words. Interview also revealed the facility did not have a system in place prior to the incident to monitor the AccuNurse system for accuracy. According to</p>	N 194	<p>2 staff members consisting of DON/RNC/UM/ETC or Qa nurse will validate any information input into the accunurse system to ensure that it is correct and that there is no capital letters. This will be completed Mon-Friday beginning 02/07/013 for 12 weeks. ETD to complete accu-nurse re-education every month for 3 months beginning in March 2013 with post test for all nursing staff. All new hires as of 01/25/13 will be re-educated by the ETD to not use capital letters when inputting information into accu-nurse,</p>	

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N 194	Continued From page 5 the DON and RNC, they did not have any way of determining who had made the entry into the "AccuNurse" system using all capital letters, and stated that since the incident, all written care plans and "AccuNurse" care plans had been checked for accuracy and corrected. The interview further revealed if the CNAs had any questions about what assistance a resident required a paper copy of the care plan was always available.	N 194	following POC, abuse/Neglect, care-plan development, staff supervision, how to set up a care plan in ace-nurse, what a transfer aid is and where written ace-nurse care plan are kept for use. UM/QA nurse to validate that aides' are providing care to a total of 15 residents each week per ace-nurse care plan and that care plan is correct. This will begin week of 02/26/13 x 6 weeks. 4. QA team consisting of (UM, SS, ETD, DON, Admin, LED, Med. Dir) will meet to review all audit findings x 8 weeks to make recommendations for changes or further monitoring. All audit findings will be reviewed with the RNS every weeks x 8 weeks. QA team to meet weekly beginning week of 02/25/13 5. DOC 03/01/13	
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents. This requirement is not met as evidenced by: Based on interview, record review, a review of the facility's policy, the incident report, and manufacturer's instruction, it was determined the facility failed to ensure adequate supervision and assistive devices to prevent accidents were provided for one of three sampled residents (Resident #1). Interviews and a review of Resident #1's Care Plan and a Quarterly Minimum Data Set (MDS) assessment, revealed facility staff was to utilize a "sit to stand lift" when transferring the resident. However, on 01/20/13, two staff persons transferred Resident #1 from the wheelchair to the bed without the use of the "sit to stand lift." At the time of the transfer, Resident #1 complained of pain in the left arm, the resident's physician was notified, and radiology reports revealed the resident sustained	N 220		

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N 220	<p>Continued From page 6</p> <p>a fracture of the left shoulder.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Care Plan Policy Statement" (not dated) revealed the care plan was designed to incorporate identified problem areas, incorporate risk factors associated with the identified problems, build on the resident's strengths, and aid in preventing or reducing declines in the resident's functional status or levels. In addition, interview with the Director of Nursing (DON) on 02/06/13 at 12:15 PM revealed the facility also utilized an "AccuNurse" audio system as a means for staff to access each resident's care plan. A review of the "AccuNurse" user manual, dated 2011, revealed the system was command-based speech recognition software that provided staff with real time access to each resident's care plan and interventions by means of a headset. In addition, the user manual revealed staff could update the care plans in the "AccuNurse" system by documenting custom notes under each section; however, according to the directions, staff was not to type the custom notes in capital letters.</p> <p>A review of an in-service provided to staff by the facility in August 2012 revealed Certified Nursing Assistants (CNAs) were instructed on proper resident lifting and transfers. In addition, a review of an in-service conducted on 10/13/12 revealed staff was instructed to review each resident's "AccuNurse" care plan before providing care to residents and to report any interventions that did not match the paper care plan to a Supervisor.</p> <p>A review of the medical record of Resident #1 revealed the facility admitted the resident on 02/01/09 with diagnoses including Hemiplegia</p>	N 220	<ol style="list-style-type: none"> 1. Physician/family was notified of resident c/o pain immediately on 01/20/13. Resident #1 had a shoulder x-ray completed and Ct scan was performed on 01/23/13 with a non displaced comminuted surg. Neck fracture of shoulder. Resident #1 has since received treatment for the left shoulder fracture, is receiving pain medications, had a therapy assessment and is currently being transferred with a sit to stand lift. Both Medical Director and family was notified of Accu-nurse and care plan issue. Resident #1 accu-nurse care plan was corrected on 01/21/13 by Director of Nursing 	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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N 220	<p>Continued From page 7</p> <p>(left side) and late effect Cerebral Vascular Disease. A review of Resident #1's written comprehensive care plan dated 01/07/13 revealed the resident required extensive assistance of two persons with the use of a "sit to stand" lift for transfers. In addition, a Quarterly Minimum Data Set (MDS) assessment, dated 01/13/13, revealed the facility assessed Resident #1 to require the extensive assistance of two persons for transfers.</p> <p>On 01/20/13, staff documented in an Accident/Incident Report that Resident #1 had complained of pain in the arm after two staff persons transferred the resident from a wheelchair to the resident's bed on 01/20/13 at 9:00 PM. Continued review of the report revealed Resident #1's physician was notified on 01/20/13 at 10:15 PM of the resident's complaints of pain, and the physician requested for staff to monitor the resident.</p> <p>On 01/21/13 at 6:20 AM, nursing staff documented Resident #1 continued to complain of pain of the left shoulder, the physician was contacted, and a portable x-ray of the resident's shoulder was ordered and obtained. Continued review of nursing documentation in the nurse's notes revealed the results of the shoulder x-ray were received by the facility on 01/22/13 and a (Computerized Tomography) CT of the shoulder was ordered and completed on 01/23/13.</p> <p>A review of a radiology report dated 01/21/13, one day after the incident, revealed Resident #1 sustained a fracture of the left shoulder area. A review of a report of Resident #1's CT scan, dated 01/23/13 (three days after the incident), also revealed the resident had a non-displaced fracture of the shoulder area. Based on</p>	N 220	<p>2. DON/UM/LED/SS completed a 100% audit of all care plans in accunurse to identify if any other careplans that was inaccurate. This was completed 01/24/13. Any issue identified was immediately corrected by DON/UM/LED/SS</p> <p>RNS/DON/UM/LED/SS completed a 100% audit of accu-nurse care plans compared to the written care plan to identify any written care plans that did not match the accu-nurse care plan.</p> <p>This was completed on 01/24/13. Any issue identified was immediately corrected.</p> <p>RN/DON/UM/LED/SS completed a 100% audit of all accu-nurse care plans to identify any capital letters in the accu-nurse care plans for any resident. This was completed on 01/28/13. Any issue identified was immediately corrected.</p>	

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N 220	<p>Continued From page 8</p> <p>documentation in the medical record, facility staff administered pain medications to the resident on an as needed basis as ordered by the physician. In addition, the report revealed evidence the resident had osteopenia/osteoporosis.</p> <p>Resident #1 stated in an interview on 02/06/13 at 12:17 PM that two nurse aides had assisted the resident to transfer from the wheelchair to the bed by holding onto the resident's left arm between the arm and body, and to the resident's pants. According to Resident #1, during the transfer he/she heard a "pop" and his/her left shoulder began to hurt. Resident #1 stated staff did not use a "lift" to transfer the resident.</p> <p>Licensed Practical Nurse (LPN) #1 stated in an interview on 02/06/13 at 5:19 PM that she went into Resident #1's room on 01/20/13 to check the resident's blood sugar and, upon entering the room, observed Certified Nurse Aides (CNAs) #1 and #2 in the room and Resident #1 sitting on the side of the bed. The interview further revealed CNAs #1 and #2 proceeded to assist the resident to lie down in bed and Resident #1 stated, "They hurt my arm." LPN #1 stated Resident #1 was assessed, the resident's doctor was contacted and requested staff to monitor the resident. Further interview revealed Resident #1 continued to complain of pain throughout the night and on the morning of 01/21/13, the resident's physician was contacted again, and orders were received for a portable x-ray of the resident's left arm/shoulder. LPN #1 stated she did not observe a "lift" in the resident's room when she entered on 01/20/13.</p> <p>CNA #1 stated in an interview on 02/06/13 at 3:15 PM that she and CNA #2 transferred Resident #1 on 01/20/13 and was not aware Resident #1</p>	N 220	<p>All nurse care plans were re-copied and plan on nurses' station after corrected on 01/25/13 and all written accu-nurse care plans were reviewed again by 2 staff members to identify any that needed corrections. Any issue identified was immediately corrected.</p> <p>3. ETD/UM/ reeducated all nursing staff regarding to how access information from the care plan in acc-nurse on 01/23/13. Re-educated who to report at any discrepancy to in the center, care plans that are written in chart and where to locate, how to input information into ace-nurse, not to use any capital letters in the acc-nurse system, care plan development, abuse/neglect, following the care plan, supervision of staff while providing care and that all staff must f allow plan of care. On 01/25/13. How to set up care plan</p>	

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N 220	<p>Continued From page 9</p> <p>required a lift for transfers. According to CNA #1, the "AccuNurse" only stated the resident required the assistance of two persons for assistance with transfers. CNA #1 stated a paper copy of the care plan was available to staff, but it was to be used if the "AccuNurse" system was not functioning.</p> <p>CNA #2 acknowledged in an interview conducted on 02/06/13 at 3:00 PM that he and CNA #1 transferred Resident #1 from the wheelchair to the bed without a lift on 01/20/13. The interview further revealed CNA #2 was not aware Resident #1 required a lift. According to CNA #2, on the day of the incident, the "AccuNurse" system only stated Resident #1 required the physical assistance of two persons and then the system started "saying letters." CNA #2 stated he did not know what the letters meant, that it just sounded like random letters and that a paper care plan was available if the "AccuNurse" system was not functioning. According to CNA #2, on the day of the incident, he did not look at the paper care plan even though he did not know what the "letters" stated by the "AccuNurse" meant.</p> <p>Interview on 02/06/13 at 6:41 PM with LPN #2 revealed if staff entered any letters into the "AccuNurse" using capital letters, the system would only say the letter that was capitalized, and then attempt to say the rest of the word; for example if the word "the" was entered as "The," the system would say the letter "t" and then the word "he." LPN #2 stated he had not entered Resident #1's information into the "AccuNurse" system, and was unable to determine who had entered the information.</p> <p>Interviews were conducted with the Director of Nursing (DON) and the Regional Nurse</p>	N 220	<p>in accu-nurse and what is a transfer aid. This was completed on 02/28/13</p> <p>Charge nurse to monitor one staff member 2 x a day 7 days a week performing transfers and validate that is completed per the POC for the next 30 days beginning 02/7/13, then 3 x a week for 4 weeks then 2 x a week for 4 weeks.</p> <p>Don/RNC to monitor five people each week to ensure accu-nurse plan of care is followed for transfers and other care. The written care plan and the accu-nurse care plan will be reviewed to ensure both are correct and reflect the individual needs of the resident. This is to begin 02/01/13 and will continue for 12 weeks.</p> <p>2 staff members consisting of DON/RNC/UM/ETC or Qa nurse will validate any information input into the accunurse system to ensure that it is correct and that there is no capital letters. This will be completed Mon-Friday beginning 02/07/013 for 12 weeks. ETD to complete accu-nurse re-education every month for 3 months beginning in March</p>	

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N 220	Continued From page 10 Consultant (RNC) on 02/06/13 at 8:34 PM. The DON and the RNC stated it was identified after the incident that staff had entered information related to the use of the lift for Resident #1 into the "AccuNurse" system in all capital letters which caused the system to spell out "SIT AND STAND LIFT" instead of speaking the words. Interview also revealed the facility did not have a system in place prior to the incident to monitor the "AccuNurse" system for accuracy. The interview further revealed if the CNAs had any questions about what assistance a resident required, a paper copy of the care plan was always available. According to the DON and RNC, since the incident, all written care plans and "AccuNurse" care plans have been checked for accuracy and corrected.	N 220	2013 with post test for all nursing staff. All new hires as of 01/25/13 will be re-educated by the ETD to not use capital letters when inputting information into accu-nurse, following POC, abuse/Neglect, care-plan development, staff supervision, how to set up a care plan in ace-nurse, what a transfer aid is and where written ace-nurse care plan are kept for use. UM/QA nurse to validate that aides are providing care to a total of 15 residents each week per ace-nurse care plan and that care plan is correct. This will begin week of 02/26/13 x 6 weeks. 4. QA team consisting of (UM, SS, ETD, DON, Admin, LED, Med. Dir) will meet to review all audit findings x 8 weeks to make recommendations for changes or further monitoring. All audit findings will be reviewed with the RNS every weeks x 8 weeks. QA team to meet weekly beginning week of 02/25/13	