**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

FAYETTEVILLE CARE AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

4081 Thornton Taylor Parkway
FAYETTEVILLE, TN 37334

**ID PREFIX TAG**

F 272
SS-D

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Fayetteville Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</td>
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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

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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 patient. (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.
Resident #53's oral status was reassessed by the Director of Nursing Services on 1/31/12 and care was updated as needed. The Social Services Director has scheduled resident #53 to be evaluated by the contracted dental group that is scheduled to come to the facility on 2/17/12.

2. On 1/20/12, the Social Service Director reviewed residents in the facility that have dental concerns and follow up with a dental group has been scheduled as needed on 2/17/12.

On 1/23/12, an audit was conducted by the Assistant Director of Nursing Services and/or Director of Nursing Services of residents Activities of Daily Living flow sheets to identify residents with more than 3 days without a BM and those identified had MD notified and follow up in place.

3. Nurses were re-educated on 1/24/12, 1/31/12, and 2/1/12 by the Assistant Director of Nursing Services, Director of Nursing Services, RN Weekend Supervisor, and/or Unit Managers on evaluating the residents' bowel function and individual needs, and to contact the MD for an order due to no BM for 3 days as needed.

Observations in Resident #58's room on 1/12/12 at 2:00 PM, the Director of Nursing assessed
**F 272.** Continued From page 2

Resident #8's oral cavity and confirmed the resident had missing and broken teeth, and needed to be evaluated by the dentist.

During an interview in the Administrator's office on 1/12/12 at 2:40 PM, the Social Services Director confirmed there was no evidence the oral/dental concerns documented on the dental progress note had been addressed.

2. Medical record review for Resident #28 documented and admission date of 12/2/10, with diagnoses of Alzheimer's Disease, General Anxiety Disorder, Chronic Pain Syndrome, Adult Failure to Thrive, Anemia, and Constipation.

Review of the MDS dated 12/11/11, revealed the resident required total assistance with all activities of daily living, was non-ambulatory, and was totally incontinent of bowel. Review of the December 2011 resident functional performance record had no documentation that Resident #28 had a bowel movement on 12/16/11, 12/17/11, 12/18/11, 12/20/11, 12/21/11, 12/22/11, 12/23/11, 12/24/11 and 12/25/11, (6 days in a row) and 12/28/11, 12/29/11, 12/30/11 and 12/31/11 (4 days in a row). Review of the January 2012 resident functional performance record had no documentation that Resident #28 had a bowel movement for 1/1/12, 1/2/12 and 1/4/12 (6 days in a row including the 12/28-31/11 days). Review of the December 2011 Medication Administration Record (MAR) had no documented interventions to aide with bowel movements. The December 2011 MAR revealed Resident #28 received a stool softener two times a day, and had a suppository to be administered as needed for constipation, with no documentation that a suppository was administered as needed. Review
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| F 272 | Continued From page 3 of the January 2012 MAR revealed the resident received a stool softener two times a day, but had no documentation that a suppository was given as needed. Review of the December 2011 and January 2012 MARs also revealed that Resident #28 received narcotics for pain (narcotics contribute to constipation) and four other medications that list constipation as a common side effect. During an interview at the front nurse's desk on 1/11/12 at 4:00 PM, the Director Of Nursing (DON) revealed the facility had no written program for assessing and intervening for resident's bowel movements. The DON stated the Certified Nurses Assistants were to tell the nurse if a resident did not have a bowel movement for three or more days. The medical record was reviewed with the DON. The DON confirmed that Resident #28 did not have recorded bowel movements in December and January as noted above, and confirmed the resident was not assessed for bowel movements and no interventions were taken to assist the resident with having a bowel movement, during December 2011 and for January 1 through (-) 12, 2012.  
3. Medical record review for Resident #53 documented an admission date of 12/31/09 with diagnoses of Diabetes, Asthma, Hypertension, Iron Deficiency Anemia, Chronic Airway Obstruction, Polyneuropathy in Diabetes, and Esophageal Reflux. Review of the dental progress note dated 1/14/11 documented, "...Patient is in no pain, Patient states lower teeth hurt, X-rays show no infection. Lower teeth are solid. Patient desires upper and lower appliances..." Review of the nursing "Monthly
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Summary" dated 11/20/11 revealed, "...Oral Hygiene... has own teeth... self care... caries... missing several teeth..." Review of the MDS dated 12/16/11, documented Resident #53 scored 15 out of 15 on the brief interview for mental status with 15 being the highest possible score. Review of the same MDS revealed the resident had no oral or dental problems.

Observations in Resident #53's room on 1/9/12 at 4:20 PM, revealed Resident #53 had three teeth visible.

During an interview in Resident #53's room on 1/9/12 at 4:20 PM, Resident #53 stated, "...Can't afford dentures... Would like to have them [three teeth] removed if possible... gums sore at times..."

During an interview in the Social Service Director's office on 1/12/12 at 12:00 PM, the Social Services Director confirmed there was no evidence the concerns from the dental evaluation dated 1/14/11 had been addressed.

F 279 SS=D
483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.
Continued from page 5

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to develop a care plan to reflect range of motion (ROM) exercise or use of a catheter for 2 of 16 (Residents #1 and 16) sampled residents reviewed of the 30 residents in the stage 2 review.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 1/11/07 with diagnoses of Late Effects Cerebrovascular Disease, Unspecified Retention of Urine, Chronic Kidney Disease Stage 3, Peripheral Vascular Disease, Hypertonicity of Bladder, and Polyneuropathy of Diabetes. Review a report dated 9/18/11 titled "Utrasound of Bladder" documented, "Impression: 1. Large post void bladder residual of 100 cc [cubic centimeters]. 2. No gross mass...

   The physician was called and a new order for the indwelling catheter was made on 9/20/11. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/27/11 documented, Resident #1 had an
FAYETTEVILLE CARE AND REHABILITATION CENTER

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<td>indwelling catheter. Review of the physician's orders dated 12/27/11, revealed continuing orders for the indwelling catheter initiated on 9/20/11. The physician orders documented &quot;...16 fr [french]... cath [catheter] with 10 cc bulb... Urinary Retention... Catheter care q [every] shift with soap and water...&quot; Review of the resident's care plan updated on 11/8/11, did not include the indication for the catheter, specific interventions for the care of the catheter, including size of catheter, bulb size, and the frequency for the change/replacement of the catheter. During an interview in the MDS office on 1/11/12 at 10:00 AM, the MDS Coordinator confirmed Resident #1's care plan had not been revised to include the reason for the use of the indwelling catheter, measurable goals, and the specific interventions ordered by the physician to address the care of the indwelling catheter. 2. Medical record review for Resident #16 documented an admission date of 10/1/10 and a readmission date of 12/20/11 with diagnoses of Bipolar Disorder, Hemiplegia Nondominant Side due to Cerebrovascular Accident and Contracture of Hand Joint. Review of the current care plan dated 1/10/12 documented, &quot;...Pain/Potential for pain related to: Hemiplegia... contractures to hand, immobility...&quot; Review of the MDS kardex report documented, &quot;...ROM c [with] ADL [Activities of Daily Living] care as [named resident] will allow...&quot; The current care plan did not include ROM as an intervention for the hand contracture. Observations in Resident #18's room on 1/11/12 at 10:45 AM, revealed Resident #18 lying in bed.</td>
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4. An audit will be completed by the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers and/or Administrator weekly for 4 weeks and then monthly for 2 months on residents with contractures, Range of Motion programs and indwelling catheters to check that care plans were updated. The findings will be reported to the Performance Improvement Committee monthly x 3 months to identify trends or issues for follow up. The Performance Improvement Committee consists of the Administrator, Director of Nursing Services, Medical Director, Clinical Case Manager, Nutritional Services Director, Activities Director, Maintenance Director, and Assistant Director of Nursing Services. Subsequent plans of correction will be implemented as necessary for any areas identified as needing further improvement.
**Fayetteville Care and Rehabilitation Center**

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<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
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- **Resident #16's left hand was contracted.**

  During an interview in the Administrator's office on 1/11/12 at 8:50 AM, Nurse #2 was asked if Resident #16 received ROM exercises for the contracture to his hand. Nurse #2 stated, "He did get restorative care for ROM and putting the splint on... Now the aides give ROM during ADL care every day."

  During an interview at the nurse's station on 1/11/12 at 1:28 PM, Nurse #1 was asked if the care plan for Resident #16 included interventions for ROM. Nurse #1 reviewed the care plan and stated, "...No, I don't see it [ROM]. It needs to be fixed. I'll correct it and add ROM during ADL care.

- **F 309 483.25 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.

  This REQUIREMENT is not met as evidenced by:
  Based on medical record review, observation and interview, it was determined the facility failed to follow physician's orders for assessing bowel functions for 2 of 16 (Resident #28 and #4) sampled residents reviewed of the 30 residents in the stage 2 review and 1 Random Resident (Resident #56) during medication administration.
The findings included:

1. Medical record review for Resident #28 documented an admission date of 12/2/10, with diagnoses of Alzheimer’s Disease, General Anxiety Disorder, Chronic Pain Syndrome, Adult Failure to Thrive, Anemia, and Constipation. Review of the Minimum Data Set dated 12/1/11, revealed the resident required total assistance with all activities of daily living, was non-ambulatory and was totally incontinent of bowel. Review of the December 2011, "Resident Functional Performance Record" revealed the resident had no bowel movement documented for 12/18/11, 12/17/11, 12/18/11, 12/20/11, 12/21/11, 12/22/11, 12/23/11, 12/24/11, 12/25/11. (6 days in a row) 12/29/11, 12/29/11, 12/30/11, and 12/31/11. Review of the January 2012, "Resident Functional Performance Record" revealed the resident had no bowel movement documented for 1/1/12, 1/2/12, 1/4/12 (6 days in a row including the December 28 through 31, 2011). Review of the December 2011 Medication Administration Record (MAR) revealed no as needed interventions were administered to aide bowel movement. Review of the MAR for December 2011, revealed the resident received a stool softener two times a day, and had a suppository ordered to be administered as needed for constipation with no documentation it was administered. Review of the January 2012, MAR revealed the stool softener was administered two times a day, and no order was present for the as needed suppository. Review of the December 2011 and the January 2012 MARs also revealed the resident received narcotics for pain (narcotics contribute to constipation) and four other

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1. Resident #28 was re-assessed for bowel function and needs by the Director of Nursing Services 1/13/12 and care was updated as needed.

Resident #84 was re-assessed for bowel function and needs by the Director of Nursing Services 1/13/12 and care was updated as needed.

Resident #56’s physician provided the licensed nurse an order for tablet/capsules since the resident did not have any difficulty taking medications in that form on 1/16/12.

On 1/12/12, Nurse #3 was re-educated by the SDC on the proper procedure for measuring liquid medications.

2. An audit was conducted by the Unit Managers, Assistant Director of Nursing Services and/or Director of Nursing Services on 1/23/12 of Bowel Movements records and the interventions taken by the nurses.

An audit was conducted by the Unit Managers, ADNS, and/or DNS on 1/23/12 of resident MARS to identify those residents who are currently taking liquid medications and physicians’ orders were clarified as needed.
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| F 309 | Continued From page 9 medications that list constipation as a common side effect. Review of the nurse's notes dated 12/1/11 to 1/12/12, did not reveal any signs or symptoms of a fecal impaction or bowel obstruction. During an interview at the front nurses's desk on 1/11/12 at 4:00 PM, the Director of Nursing (DON) stated the facility had no written program for assessing and intervening for resident's bowel movements. The DON stated the Certified Nurses Assistants were to tell the nurse if a resident did not have a bowel movement for three or more days. The DON reviewed the medical record and confirmed the resident did not have recorded bowel movements on 12/16/11, 12/17/11, 12/18/11, 12/20/11, 12/21/11, 12/22/11, 12/23/11, 12/24/11, 12/25/11, (6 days in a row) 12/26/11, 12/29/11, 12/30/11, 12/31/11 and 1/1/12, 1/2/12, 1/3/12, 1/4/12 (6 days in a row including December 28 through March 1, 2011). The DON also confirmed the resident had no as needed interventions taken to assist the resident with having a bowel movement. 2. Medical record review for Resident #84 documented an admission date of 8/31/11 with diagnoses of Pathologic Fracture of Vertebrae, Lumbago, Constipation, Osteoarthritis, Anxiety, Dementia, Hypertension, Hallucinations and Major Depressive Disorder. Review of a physician's order dated 1/7/12 documented, "...Doscurate Sodium 100 MG [milligrams] Tablet By mouth... Give 2 tabs [tablets] po [by mouth] BID [twice daily] Constipation... Lactulose 10 GM [grams] / [per] ml [milliliter] Solution By mouth... every day Constipation..." Review of the care plan dated 12/22/11 documented, "...Risk for
| F 309 | 3. The nurses were re-educated by the Assistant Director of Nursing Services/designee on 1/24/12, 1/31/12, and 2/1/12 regarding how to correctly measure and administer liquid medications. Nurses were re-educated on 1/24/12, 1/31/12, and 2/1/12 by the Assistant Director of Nursing Services and or designee on evaluating the residents' bowel function and individual needs, and to contact the MD for an order due to no BM for 3 days as needed. 4. A medication pass audit will be conducted by the Assistant Director of Nursing Services/designee for each nurse monthly x 3 months to ensure the nurse measures liquid medications correctly per the MD order. An audit of the MARS will be completed 3 x week by the Director of Nursing Services/designee x 3 months to ensure bowel movements are being documented daily and that the nurse has intervened if the resident does not have a bowel movement recorded by day 3. The Performance Improvement Committee will review and analyze the results of the MAR audit for bowel movements and medication pass audits monthly x 3 months in the Performance Improvement Meeting to identify any
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Constipation related to: Pain Medications and decreased mobility... Record BM [bowel movement]. Note size and consistency. Report any abnormalities to Licensed Nurse..." Review of the "Resident Functional Performance Record" for October 2011, November 2011, December 2011, and January 2012 revealed there was no documentation that bowel function was consistently monitored. Review of the nurse's notes from 10/1/11 through 1/12/12, did not reveal any signs or symptoms of a fecal impaction or bowel obstruction.

During an interview in the Administrator's office on 1/11/12 at 2:20 PM, the DON reviewed the bowel function section of the "Resident Functional Performance Record" and stated, "They [nurses] are supposed to mark "C" for continence or "I" for incontinence in the first row and then mark the BM in the next row... Looks like they are not marking the BM." The DON was asked if the bowel function was monitored. The DON stated, "Well you can't tell cause they didn't document it. They [nurses] should give a laxative or enema after 3 days if no bowel movement. Wouldn't know when to do that because it's not marked."

3. Medical record review for Resident #56 documented an admission date of 4/12/11 with diagnoses of Paralysis Agitans, Osteoporosis, Chronic Pain Syndrome, Anxiety, Hypertension, and Aortic Aneurism. Review of a physician's order dated 12/31/11 documented, ",...Valproic Acid... 1.5 ml [milliliters] Solution By mouth... everyday..."

Observations in Resident #56's room on 1/12/12 at 7:25 AM, Nurse #3 poured Valproic Acid into
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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STREET ADDRESS, CITY, STATE, ZIP CODE
4081 THORNTON TAYLOR PARKWAY
FAYETTEVILLE, TN 37334

FAYETTEVILLE CARE AND REHABILITATION CENTER

NAME OF PROVIDER OR SUPPLIER

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the medication cup and stated, "I give half of the 2.5. [the amount] would be 1.5." Nurse #3 was asked if the amount in the cup was 1.5 ml as ordered. Nurse #3 stated "No, half of 2.5 would be 1.25. I guess I could use a syringe." Nurse #3 was asked how did she know the amount in the cup was 1.5 ml. Nurse #3 stated, "I just put in a little more than half of the 2.5." Nurse #3 then administered the amount of the medication she had poured into the cup to Resident #56.

During an interview in the Administrator's office on 1/12/12 at 10:17 AM, the DON was asked how she expected nursing to measure a liquid medication for 1.5 ml. The DON stated, "Draw it up in a syringe. You can't measure that amount [1.5 ml] in a cup."

F 502 483.75(j)(1) ADMINISTRATION
The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to obtain required laboratory tests for 1 of 16 (Resident #11) sampled residents reviewed of the 30 residents in the stage 2 review.

The findings included:
1. Medical record review for Resident #11 documented an admission date of 10/1/10, with diagnoses of a History of T12 (Thoracic
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Vertebrae) Paraplegia, Multiple Decubiti, Major Depressive Disorder, Chronic Pain Syndrome, Chronic Airway Obstruction, History of Drug Abuse, Bilateral Leg Amputations, and Unspecified Epilepsy. Review of the Minimum Data Set (MDS) assessment dated 12/8/12, revealed Resident #11 scored 15 of 15 on the brief interview for mental status, with 15 being the highest possible score. Review of the physicians recaptulation orders dated 12/28/11 documented, "...Standard Lab, Tegretol level [anticonvulsant medication used in the treatment of epilepsy], CBC [complete blood count] with diff [differential], CMP [comprehensive metabolic panel] yearly (dec) [December]..." with original order date of 12/21/10. Review of the nurse's note dated 12/8/11, documented Resident #11 had refused to have lab drawn for the December 2011 labs scheduled. There was no documentation the physician had been contacted regarding the facility's inability to complete the labs as ordered.

Review of the "Pharmacy Consultation Report" dated 12/9/11, revealed the Tegretol level for December 2010 had not been obtained. The Pharmacy Consultant had noted the missing lab on the consultant's report in June 2011, September 2011, and was reporting the missing lab for the third time on the 12/8/11 report.

During the interview in the Director of Nursing's (DON) office on 1/11/12 at 3:00 PM, the DON confirmed Resident #11's labs had not been monitored as ordered by the physician.

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<td>nurse was unable to obtain the ordered labs. MD orders will be reviewed by the Unit Manager, Assistant Director of Nursing Services and/or Director or Nursing Services weekly x 3 months to identify new labs ordered or discontinued by the physician. The findings will be reported by the Director of Nursing to the Performance Improvement Committee for review and follow up the results of the lab audits monthly x 3 months. The PI Committee consists of the Administrator, Director of Nursing Services, Medical Director, Clinical Case Manager, Nutritional Services Director, Activities Director, Maintenance Director, and Assistant Director of Nursing Services. Subsequent plans of correction will be implemented as necessary for any areas identified as needing further improvement.</td>
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