F 314
SS=D

483.28(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable; and a resident having pressure sores requires necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policy, observation, and interview, the facility failed to implement interventions timely for a pressure ulcer for one (#13) of fifteen residents reviewed.

The findings included:

Resident #13 was admitted to the facility on January 5, 2011, with diagnoses including Hypertension, Pericluos Anemia, and Decubitus Ulcer.

Medical record review of the Braden Scale for Predicting Pressure Ulcer Risk dated April 12, 2011, revealed the resident was at very high risk.

Medical record review of a laboratory report dated May 12, 2011 revealed "...Total Protein 6.6 reference range 6.4-8.3, Albumin 3.3 reference range 3.2-4.6..."

Medical record review of the interdisciplinary

Disclaimer for Plan of Correction

Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Roan Highlands Nursing Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Roan Highlands Nursing Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standards of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.

Roan Highlands Nursing Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 discloseable 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 discloseable 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.
<table>
<thead>
<tr>
<th>Date Survey Completed</th>
<th>08/29/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider or Supplier</td>
<td>ROAN HIGHLANDS NURSING CENTER</td>
</tr>
<tr>
<td>Street Address, City, State, ZIP Code</td>
<td>148 BIGG CREEK ROAD, ROAN MOUNTAIN, TN 37687</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 314</td>
<td>F 314</td>
<td>Corractive Actions for Targeted Residents: Responder #13 was assessed on 6/28/11 by the Clinical Dietician. The MD re-ordered a Multi-Vitamin and Pro-Stat. After reviewing all clinical information, on 7/8/11 the attending physician diagnosed Responder #13 with PVD.</td>
</tr>
</tbody>
</table>

**Medical Record Review**

- Progress note (dietary note) dated May 20, 2011, revealed "...wt (weight) review. Wt. 186.7...wt increase noted...100% Intake...no skin breakdown noted..."
- Medical record review of the interdisciplinary progress note dated May 24, 2011, revealed "...Two new stage IIIs discovered to right foot. 4th digit 1x1 5th digit 1x1...wound beds are red (with) 20% maceration. Appears to have began as a fluid filled blister that ruptured after rubbing against each other. 4 (plus) pitting edema noted to (right) leg (and) foot..."
- Medical record review of a physician's order dated May 24, 2011, revealed "...Cleanse (right) 4th (and) 5th digit (with) NS (normal saline). Apply...bandage. Use telfa to separate (right) 4th (and) 5th digit...MVI (multivitamin) q (every) am (morning)..."
- Medical record review of the Medication Record dated June 1, 2011, through June 30, 2011, revealed no documentation the resident received the MVI from June 1, 2011, through June 29, 2011.

**Other Information**

- Medical record review of the wound evaluation flow sheet dated June 28, 2011, revealed "... (right) 4th digit (1x1) stage II... (right) 6th digit (1.5x1) stage IV..."
- Medical record review of the Nutritional Progress Notes dated June 28, 2011, revealed "...Res (resident) (with) new skin breakdown...Rec (recommend) Prostat 101 30 ml (milliliters) BID (twice a day) to promote wound healing..."
F 314  Continued From page 2  Review of facility policy, Wound Prevention and Management Program, revealed "....Maximize nutritional status....Consult nutritionist for all residents at risk...."

Observation of the pressure ulcers with the wound care nurse on June 29, 2011, at 7:40 a.m., revealed the pressure ulcer on the right 4th digit 1 cm x 1 cm with no drainage, 6th digit 1.8 cm x 1 cm with no drainage, scabbed area in the center as described by the wound care nurse.

Interview on June 28, 2011, at 2:45 p.m., with the Director of Nursing, in the conference room, confirmed no documentation the resident received the MVI from June 1, 2011, through June 28, 2011.

Interview on June 29, 2011, at 9:15 a.m., with the Director of Nursing, in the conference room, confirmed the resident was not evaluated by the Registered Dietician until June 28, 2011, (four weeks after the development of the pressure ulcers).

Interview on June 29, 2011, at 10:55 a.m., with the resident's physician, confirmed the delay in the nutritional consult and not receiving the MVI did not affect the healing of the pressure ulcers on the toes.

F 315  483.26(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that Roan Highlands Nursing Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:
<table>
<thead>
<tr>
<th>ID PRECEDING TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC. IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 315</td>
<td>Continued From page 3 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to provide appropriate perineal care for one (#4) of fifteen residents reviewed. The findings included: Resident #4 was admitted to the facility on September 14, 2009, and readmitted on May 20, 2011, with diagnoses including Urinary Tract Infection, Pneumonia, Congestive Heart Failure, and Left Hip Fracture. Medical record review of the Minimum Data Set (MDS) dated May 27, 2011, revealed the resident required extensive assistance with transfers, hygiene, and bathing. Observation on June 29, 2011, at 9:50 a.m., revealed the resident lying on the bed. Continued observation revealed Licensed Practical Nurse (LPN) #2 removed a bedpan from under the resident, containing urine. Continued observation revealed LPN #1 used a washcloth to cleanse the resident's buttocks, then positioned the resident on the back. Continued observation revealed LPN #2 used a second washcloth and wiped from the rectal area towards the vaginal area (back to front) three times, and placed the sheet over the...</td>
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<table>
<thead>
<tr>
<th>ID PRECEDING TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 315</td>
<td>Corrective Actions for Targeted Residents On 6/29/11, the Director of Nursing reviewed the Peri-Care Policy with LPN #1 and LPN #2 and observed them providing peri-care to resident #4. The Director of Nursing re-educated the LPN's involved on peri-care and observed them providing care to residents on 7/7/11. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected. Systematic Changes The Director of Nursing will re-educate the nursing staff who may perform peri-care on the Peri-Care policy, to be completed by 7/31/11. New hires will continue to be trained during orientation and annually thereafter. Monitoring The Director of Nursing, or her designee, will check off nursing staff on peri-care yearly. Results will be reviewed by the Director of Nursing at the Performance Improvement Committee meetings. The Director of Nursing will review the Infection Control Log for new UTI's and identify trends which will be reported to the Performance Improvement Committee. This committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Certified Dietary Manager, Housekeeping/Laundry Director, Activities Director, HR Clerk, Admissions Coordinator, Rehab Director, Social Worker and Medical Records Clerk. 7/31/11</td>
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</tbody>
</table>
F 315. Continued from page 4

resident and exited the room.

Review of the facility's policy Perineal Care
revealed "...Separate the labia with one hand and
wash with the other, using gentle downward strokes
from the front to the back of the perineum..."

Interview on June 29, 2011, at 9:56 a.m., with
LPN #2, in the hallway, confirmed the resident's
perineal area was cleansed back to front, and
confirmed the facility's policy was not followed.

F 333

SS-D

483.25(m)(2) RESIDENTS FREE OF
SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of
any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation,
and interview, the facility failed to prevent a
significant medication error for one (#5) of fifteen
residents reviewed.

The findings included:

Resident #5 was admitted to the facility on March
25, 2011, with diagnoses including Chronic
Bradycardia with Atrial Fibrillation, Pneumonia,
Aspergillus, Hypothyroidism, Hypertension, and
Chronic Obstructive Pulmonary Disease.

Medical record review of the nursing notes dated
May 3, 2011, at 7:00 a.m., revealed "Resident
inadvertently received m (room) mattes
medication. MD (Medical Doctor) Immediately
notified. Allergies reviewed. B/P 112/60, P
<table>
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<tr>
<th>F 333</th>
<th>Continued From page 5</th>
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<tbody>
<tr>
<td></td>
<td>(pulse) 48, R (respirations) 16; T (temperature) 98.6. Resident up in wc (wheelchair) talkative &amp; alert. Resident aware of receiving medications. (no) c/o (complaints) voiced. MD stated to monitor resident.</td>
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</table>

Medical record review of a nursing note dated May 3, 2011, at 7:16 a.m., revealed "R/P (responsible party) @ facility to transport resident to appt. (appointment) @...R/P informed of medications adm. (administered). R/P request to take to appt. stated "I'm sure...will be fine." MD notified & stated to continue with appt & inform MD @ appt. B/P 100/60 HR (heart rate) 38 @ this time. Resident Up in wc alert & oriented. Color pink, (no) c/o discomfort."

Medical record review of a nursing note dated May 3, 2011, at 7:30 a.m., revealed "B/P 90/60, HR 35, MD notified of vital signs & order received to send to...ER (emergency room) for eval (evaluation)...R/P here & aware. Resident laughing & stated 'My heart rate is always like this, I'm fine.' Color pink, (no) discomfort voiced..."

Medical record review of a nursing note dated May 3, 2011, at 12:00 p.m., revealed the resident was admitted to the hospital.

Review of documentation provided by the facility revealed the following: "(Licensed Practical Nurse, LPN #1) stated the following concerning the med (medication) error on 5/3/11 at 7am. (LPN #1) stated...was preparing to give (resident #10)...medications and was putting them in the med cup when...heard a cell light across the hall going off so...put (resident #10)'s medication..."

<table>
<thead>
<tr>
<th>F 333</th>
<th>Identification of Other Residents with Potential to be Affected</th>
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<tbody>
<tr>
<td></td>
<td>All residents have the potential to be affected.</td>
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</tbody>
</table>

**Systematic Changes**

The Director of Nursing, or her designee, will re-educate licensed nurses and complete a new Medication Pass Check Off to identify the need for further training. This is to be completed by 7/31/11. New hires will continue to be trained during orientation and annually thereafter. Effective 6/30/11, the Pharmacy Consultant will increase the Medication Pass reviews with licensed nurses and report findings to the Director of Nursing monthly.

**Monitoring**

The Director of Nursing will review the Medication Pass Check Off and identify areas to be focused on. Findings will be reported to the Performance Improvement Committee. This committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Certified Dietary Manager, Housekeeping/Laundry Director, Activities Director, HR Clerk, Admissions Coordinator, Rehab Director, Social Worker and medical Records Clerk.

7/31/11
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
</table>
| F 333 |        |     | Continued From page 6 which was now in a med cup into the med cart drawer and locked it up. (LPN #1) then went across the hall and assisted the other resident to the bathroom. When (LPN #1) finished with the resident in the restroom, (LPN #1) went back to the med cart to get the meds. (LPN #1) now had (resident #6) on...mind because (LPN #1) knew (resident #6) was going to be leaving at around 7am to go to a podiatry appointment and needed...meds quickly. (LPN #1) took the meds out of the drawer and went to the resident's room and administered them to (resident #6). These were the meds that (LPN #1) had prepared for (resident #10). (LPN #1) then went and checked off the MAR (Medication Administration Record) that...had given (resident #5's) meds. (LPN #1) went to the nurses' desk and the nurse coming on day shift commented that they needed to quickly give (resident #5's) meds since he was leaving for an appointment. (LPN #1) stated that...thought...already had and then the other nurse stated that they were still in the med cart. They went to the resident's room and (resident #5) told them that (LPN #1) had already given meds... (LPN #1) then went to the med cart and realized what...had done. (LPN #1) immediately checked to see if the resident had any allergies to any of the meds and (resident #5) did not. (LPN #1) called the DON (Director of Nursing) who instructed (LPN #1) to immediately contact the physician. Continued review of documentation provided by the facility revealed resident #6 received the following medications in error on May 3, 2011: Paxil (antidepressant) 10 mg (milligrams); Colace (stool softener) 100 mg; Coreg (antihypertensive medication with a possible side effect of bradycardia) 3.125 mg; Clonidine (antihypertensive) 0.2 mg; Folic acid...
Continued from page 7
(vitamin) 1 mg; Klor-con (potassium) 10 meq (milliequivalent); and Lisinopril (antihypertensive) 20 mg.

Medical record review of a hospital History and Physical dated May 3, 2011, revealed "...Is brought to er as...got wrong medication coreg 3.125 and is bradycardic. Initially on evaluation...denies any complaints...denies any chest pain, any sob (shortness of breath)...hr (heart rate) is ranging from 30-35 and...was on IV (intravenous) fluids. But later on...heart rate dropped to < (less than) 30 and glucagon was given 3 times...has the history of bradycardia for years and...has been evaluated in past for pacemaker and...was not considered a candidate for pacemaker bec (because) of no symptoms and high risk...Assessment/Plan 1, bradycardia in a pt (patient) with previous h/o (history of) chb (complete heart block), who received coreg (accidently) early morning, now heart rate running in 30s...received 3 doses of glucagon in er and a dose of atropine...is asymptomatic and...B.P is 98/40..."

Medical record review of a hospital Discharge Summary dated May 5, 2011, revealed "...Discharge Diagnosis 1, Bradycardia-most likely from coreg 2, Atrial Fibrillation...condition on discharge: stabie..."

Medical record review of a nursing note dated May 6, 2011, at 11:00 p.m., revealed the resident returned to the facility was alert and talking, with a heart rate of thirty-six.

Observation on June 27, 2011, at 1:15 p.m., revealed the resident sitting in a wheelchair, in
**F 333**  
Continued from page 8

the resident's room, eating lunch.

Telephone interview on June 27, 2011, at 1:30 p.m., with LPN #1 confirmed resident #5 received resident #10's medications in error on May 3, 2011, at 7:00 a.m.

Interview on June 26, 2011, at 8:30 a.m., with the Director of Nursing (DON), in the conference room, revealed after LPN #1 administered resident #10's medications in error to resident #5 on May 3, 2011, LPN #1 was re-inaugurated on medication administration, and an observation of a medication pass was conducted with LPN #1 on May 4, 2011. Continued interview revealed 100% of the facility's medication nurses were re-instructed with observations of medication administration.

**F 441**  
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
   The facility must establish an Infection Control Program under which it:
   (1) Investigates, controls, and prevents infections in the facility;
   (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
   (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

**F 333**  
Roan Highlands Nursing Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveys, the facility is taking the following additional actions:

**Corrective Actions for Targeted Resident**

The Director of Nursing reviewed the Infection Control Policy with CNA #1 on 6/27/11. The Director of Nursing also observed CNA #1 perform proper pericare on Resident #8.
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT Is not met as evidenced by:
Based on medical record review, observation, policy review, and interview, the facility failed to maintain infection control for one resident (#8) of fifteen residents reviewed.

The findings included:
Resident #8 was readmitted to the facility on January 20, 2010, with diagnoses including Congestive Heart Failure, Alzheimer’s Disease, and Dementia.

Medical record review of the Minimum Data Set dated June 5, 2011, revealed the resident was non-ambulatory, incontinent of bowel and bladder, and required extensive assistance for
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX/TAO</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 10 personal hygiene.</td>
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<td></td>
<td>Observation on June 27, 2011, at 2:50 p.m., in the resident's room, revealed two CNAs (certified nursing assistants) providing incontinent care. Continued observation revealed the resident had been incontinent of bowels; both CNAs wore gloves. Further observation revealed CNA #1 had cleaned the buttock area, without changing gloves or washing hands opened the bedside table drawer, removed protective cream from a plastic bag, applied the cream to the buttock area, replaced the cream in the plastic bag and placed in the drawer, removed gloves and washed hands.</td>
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<td>Review of the facility policy Infection Control revealed &quot;...maintain a sanitary environment. All employees shall utilize proper hand washing for each...9. Before and after incontinence care...&quot;</td>
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<td></td>
<td>Interview with CNA #1 on June 27, 2011, at 2:56 p.m., in the hallway, confirmed had not removed gloves or disinfected hands after providing incontinence care.</td>
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<td>Interview with Director of Nursing (DON) on June 29, 2011, at 8:35 a.m., in the DON's office, confirmed gloves are to be removed and hands washed after providing incontinence care.</td>
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<tr>
<td>F 514</td>
<td>483.75(0)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
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<tr>
<td></td>
<td>The facility must maintain clinical records on each resident in accordance with accepted professional</td>
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Roan Highlands Nursing Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:
**F 514** Continued From page 11 standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to accurately document the medical record for one (15) of fifteen residents reviewed.

The findings included:

Medical record review of resident #5's nursing notes dated May 3, 2011, at 7:00 a.m., revealed "Resident inadvertently received rm (room) makes medication. MD (Medical Doctor) immediately notified. Allergies reviewed. B/P 112/60, P (pulse) 48, R (respirations) 16, T (temperature) 98.6. Resident up in wc (wheelchair) talkative & alert. Resident aware of receiving medications. No (no) c/o (complaints) voiced. MD stated to monitor resident."

Review of documentation provided by the facility revealed resident #5 received the following medications (medications ordered for resident #10) in error, on May 3, 2011: Paxil (antidepressant) 10 mg (milligrams); Colace (stool softener) 160 mg; Coreg (antihypertensive

**F 514** Corrective Actions for Targeted Residents

The Director of Nursing verified with LPN #1 that on 5/3/11, resident #5 did not receive his regular medications in addition to the medications he received in error.

On 7/8/11, the Director of Nursing re-educated LPN #1 on the Documentation Policy and Procedure.

**Identification of Other Residents with Potential to be Affected**

All residents have the potential to be affected.

**Systematic Changes**

On 7/19/11, the Director of Nursing, or her designee, will review the Medication Pass Check Off Sheets for licensed nurses, which includes proper documentation, to identify areas of concern on documentation. Corrective action and/or re-education will be provided as necessary. New hires will continue to be checked off on the Medication Pass during orientation and at least annually thereafter.
Continued from page 12:

medication with a possible side effect of bradycardia 3.125 mg; Clonidine (antihypertensive) 0.2 mg; Folic acid (vitamin) 1 mg; Klor-con (potassium) 10 mg; Lisinopril (antihypertensive) 20 mg.

Medical record review of the May 2011 Medication Record revealed Licensed Practical Nurse (LPN) #1 initialed as having administered the following medications (medications ordered for resident #5) to resident #6 on May 3, 2011: Amlodipine (antihypertensive) 5 mg (milligrams); Cordura (antihypertensive) 4 mg; Neurontin (anticonvulsant) 200 mg; Levothyroxin (thyroid hormone replacement) 60 mcg (micrograms); Mag Oxide (antacid) 400 mg; and Omeprazole (anilcur) 20 mg.

Interview on June 28, 2011, at 8:20 a.m., with LPN #1, in the dining room, revealed LPN #1 did not administer resident #5's ordered medications on May 3, 2011, after administering resident #10's medications to resident #6 in error.

Continued interview with LPN #1 confirmed resident #6's Medication Record for May 3, 2011, indicated LPN #1 had administered resident #5's ordered medications and confirmed the medical record was not accurate.

Monitoring

The Director of Nursing, or her designee, will report findings from the Medication Pass Check Off audit to the Performance Committee. This committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Certified Dietitian, Administrator, Housekeeping/Laundry Director, Activities Director, HR Clerk, Admissions Coordinator, and Social Worker and Medical Records Clerk.

7/31/11