| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045212 | A. BUILDING _____ B. WING _____ | 11/14/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| HIGHLANDS OF NORTHWEST ARKANSAS THERAPY AND LIVING | 1513 SOUTH DIXIELAND RD ROGERS, AR 72756 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 599) was substantiated (all or in part) in these findings.<br>A. Based on record review and interview, the facility failed to ensure a disinfectant for equipment and non-porous hard medical surfaces was not used as a wound cleanser for 1 (Resident #4) of 6 (Residents #3, #4, #16, #19, #31, and #32) case mix residents who had pressure ulcers. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death for Resident #4 and had the potential to cause more than minimal harm for 7 residents who had pressure ulcers as documented on a list provided by the Administrator on 11/6/14 at 11:45 a.m. On 11/6/14 at 4:40 a.m., the Administrator was informed of the Immediate Jeopardy. The findings are:<br>Resident #4 had [DIAGNOSES REDACTED]. Varicose Veins of Lower Extremities with Ulcer, and Senile Dementia. The Quarterly Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) of 7/28/14 documented the resident had a problem with short term and long term memory per staff assessment and was moderately impaired for cognitive skills for daily decision making, and had 1 Stage 3 Pressure Ulcer.<br>a. The Care Plan dated 5/1/14 documented, Resident is at risk for skin breakdown and pressure ulcers r/t (related to) incontinence, Decreased Mobility, Decreased sensation, [MEDICAL CONDITIONS], hx (history) pressure and vascular ulcer. Assess and record changes in skin status. Report pertinent changes to physician.Resident has Stage 3 ulcer (L) (left) heel. Goal: Ulcer will exhibit evidence of healing as indicated on pressure report (decrease in size, improved appearance, absence of drainage, etc.) through next review. Interventions: Administer/monitor effectiveness of/response to treatment(s) as ordered. Assess/record changes in skin status and report changes to physician. Report improvement and decline to MD (Medical Doctor) and family . Resident to be seen by wound care clinic every two weeks .<br>b. On 11/6/14 at 4:10 a.m., Licensed Practical Nurse (LPN) #1 performed wound care to the Resident's left heel and left lower leg. The LPN stated that the resident had gone to the wound clinic Monday and had measurements there. She also stated, The wound on the lower leg is larger but looks healthier. The wound on the heel is larger and worse.<br>At 4:30 a.m. after completion of the wound, the LPN was asked if she was aware of anyone using something on a wound that was not to be used on wounds. LPN #1 stated, I did. I wouldn't ever mean any harm to a resident. I used this. (The LPN showed the surveyor a spray bottle of Clorox Brand Hydrogen Peroxide Cleaner Disinfectant for hard surfaces and equipment). The LPN continued, (Resident #4) won't let anyone but me and (LPN #2), another LPN that works nights, change his dressing. We were gone about 6 days and his dressing had not been changed for the 6 days. I was trying to find something that would help his wounds. They were draining yellow drainage and looked awful. So, I started using that. The LPN was asked if she was aware the cleaner was not for wounds. She stated, Yes, but it does not have bleach in it. The LPN was asked if she had gotten physician orders [REDACTED]. The LPN also stated that she thought the wound had gotten better with this treatment and that it had not hurt the resident. She was asked how long she used it on the resident and she stated, About 2 weeks (10/6/14 - 10/20/14). She stated that the last time she used it on the resident was the day the resident went to the hospital (10/20/14) and had not used it on any other residents. The LPN was asked if anyone else was aware of her use of the cleaner on Resident #4. She stated, Yes, the Treatment Nurse.<br>1) The October 2014 TAR documented, L medial posterior foot. (Change dressing (every) d (day) (and) PRN. [MEDICATION NAME] (and) Santyl, wet to dry dressing. Kerlix (and) Tape. 10/1/14. L (lower) leg, Change dressing (every) day (and) PRN. [MEDICATION NAME] (and) Santyl wet to dry dressing. Kerlix (and) tape. 10/1/14. LPN #1 initialed 10/9/14, 10/10/14, 10/11/14, 10/15/14, 10/16/14, and 10/19/14 to indicate the treatments to both areas were performed as prescribed by the physician each of these days. The resident went to the hospital on [DATE].<br>2) The label on the bottle of disinfectant read: Kills bacteria [MEDICAL CONDITION] in 30 seconds .Clorox . Hydrogen Peroxide, Cleaner Disinfectant . Compatible with Equipment Surfaces . Non Bleach . Keep out of the reach of children . Directions For Use: It is a violation of Federal law to use the product in a manner inconsistent with its labeling. To operate: To open, Turn nozzle. Spray 6-8 inches from surface. Wipe with cloth. Do not breathe spray or mist. Precautionary statements: Hazards to Humans and Domestic Animals. Caution: Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, chewing tobacco, or using the toilet. First Aid: If in eyes: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing. Call the poison control center at [PHONE NUMBER] or doctor for treatment advice. This product is not to be used as a terminal sterilant/high level disinfectant on any surface or instrument that (1) is introduced directly into the human body, either into or in contact with the bloodstream, or normally sterile areas of the body, or (2) contact intact mucous membranes, but which does not penetrate the blood barrier or otherwise enter normally sterile areas of the body. Disinfection: . This product cleans, disinfects and deodorizes hard, nonporous medical surfaces in one step with no rinsing required.<br>3) On 11/6/14 at 5:55 a.m., the Treatment Nurse was asked if she was aware of anyone using anything other than what was ordered on wounds. She stated, Yep then changed her answer to No. The Treatment Nurse was told that LPN #1 had stated that she had told the treatment nurse what she was using on Resident #4, and showed the Treatment Nurse the bottle of cleaner. She stated, I just thought she was using the wound cleanser that had peroxide in it in the cart. I never looked at what she said she was using. I did not tell the Director of Nursing (DON) or anyone else that she was using something not ordered . I've never used anything like that on any resident's wounds. It (the wound) looked cleaner when (Resident #4) came back from the hospital. I thought they must have debrided it. I just thought anything in the cart we could use without an order. The Treatment Nurse was shown the bottle of equipment cleaner. She confirmed she was not aware that anyone had been using that on wounds.<br>4) On 11/6/14 at 6:08 a.m., the DON was asked if she was aware that (LPN #1) was using the cleaner on wounds. She stated, I was told about 9/30/14 by a nurse, (LPN #2), via text that a CNA (Certified Nurse Assistant) had reported to her that (LPN #1) had been using Peroxide that they had used to clean beds. I sent copies of the text to the nurse consultant and Administrator as soon as I got the text. I was told to interview (LPN #1) and find out what she had been using. I called to find out how the wound was looking and exactly what the treatment was. She (LPN #1) said the wound was looking good and was cleaning with wound cleanser and Santyl. I said, so you're using the wound cleanser in the bottom of the cart. She said, yes. This morning I asked her if she was using this when I called her, she said no, I didn't start using that until approximately 6 times before the resident went to the hospital.<br>5) On 11/6/14 at 10:49 a.m. by telephone, LPN #2 was asked if she was aware of anyone using the cleaner on wounds. She stated, The Treatment Nurse told me one of the nurses had been using a Hydrogen Peroxide Cleaner for equipment and that she |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 0314<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 1)<br>thought it was ok. She stated the cleaner was used on Resident #4. The LPN did not know if it was painful to the resident, but did say the wound got worse. She stated, I voiced my concerns to the DON and asked if the wound care orders could be taken off of our shift. She said she would deal with it. The last time I worked, it was off the night shift.<br>c. On 11/6/14 at 11:00 a.m., the Director of Nursing provided documentation of wound assessments/measurements for September and October 2014:<br>9/5/14: L (left) heel, acquired 9/15/12. There were no measurements or wound descriptions documented.<br>9/18/14: PU (Pressure Ulcer) Stage III, L heel: 1x7.5x3.5 . PU, Stage III, L calf 3x3.5. There were no wound descriptions documented.<br>9/25/14: PU, L shin, 3.7x2.6, Stage III, Avoidable, improved, Treatment Santyl/wet to dry, . PU, L heel, Stage III. There were no additional measurements or wound descriptions documented.<br>10/9/14: PU L shin, 3.7x2.6, Stage III, Avoidable, . Stasis Ulcer, L heel. There were no additional measurements or wound descriptions documented. (Resident #4 was in the hospital from 10/20/14 until 10/30/14.)<br>10/31/14: . L heel, . Stage III, 5x2x0.2. There were no additional measurements or wound descriptions documented.<br>d. The Wound Clinic's documentation included the following assessments and measurements:<br>9/30/14: (There were no measurements or assessments.)<br>10/14/14: #29 L heel: 4.0x2.0x0.2 . #31 LLE (left lower extremity); 2.4x4.0x0.2 .<br>11/3/14: (There were no measurements or assessments).<br>e. On 11/6/14 at 12:20 p.m., the Immediate Jeopardy was removed and the scope/severity reduced to E when the facility implemented the following plan of removal:<br>1) Nurse was immediately removed from the hall and suspended pending investigation by Administrator on 11/6/14 at 5:00 a.m. Resident's wounds were assessed by DON and treatment nurse and documented on a skin audit sheet on 11/6/14 at 8:30 a.m. At that time treatment was provided following correct physician orders. No deterioration was noted. Physician was notified on 11/6/14 at 7:00 a.m. with no new orders noted.<br>2) There were 7 residents found to be at risk for deficient practice based on a list of residents with pressure ulcers provided by treatment nurse on 11/6/14 at 6:00 a.m. All 7 residents will have wounds assessed by treatment nurse for any deterioration by 1:00 p.m. on 11/6/14 using a skin audit sheet. Any negative findings will be corrected immediately and reported to the Administrator.<br>3) All nurses will be re-educated by DON/Designee beginning 11/6/14 at 7:00 a.m.on reporting abuse, following physician orders, wounds must be assessed, measured, and documented weekly using inservice sign-in sheets that include content trained on and this will be included in orientation packet for all new hires. Nurses will be removed from the schedule and not allowed to work until they complete this re-education.<br>4) Nurses will be interviewed in regards to anybody using household cleaners for wound care by DON/Designee beginning 11/6/14 at 5:30 a.m. and will be completed by 11/6/14 at 4:00 p.m. using OLTC (Office of Long Term Care) witness forms. Nurses will be removed from the schedule and not allowed to work until they complete an interview form. Any negative findings will be investigated immediately by Administrator/Designee.<br>5) Cognitive residents will be interviewed in regards to anybody using household cleaners for care by DON/Designee beginning 11/6/14 at 8:00 a.m. and completed by 11/6/14 at 12:00 p.m. using OLTC witness forms. Any negative findings will be investigated immediately by Administrator/Designee.<br>6) DON/Designee will complete nurse competency checklist for all nurses beginning 11/6/14 at 10:00 a.m. and for all new hires prior to working on their own. Nurses will be removed from the schedule and not allowed to work until they complete a competency checklist.<br>7) DON/Designee will monitor wound care and wound care documentation of pressure ulcers for proper protocol and treatment on all residents with pressure ulcers 5 times per week for 2 weeks, then 3 times per week for 2 weeks, then 2 times per week thereafter until substantial compliance achieved. Any negative findings will be corrected immediately and taken to QA (Quality Assurance) meeting by Administrator/Designee.<br>B. Based on observations, record review and interview, the facility failed to ensure assessments that included measurements and wound descriptions were consistently completed and documented for pressure ulcers to determine the healing or failure to heal to ensure prompt changes in treatment and failed to ensure wound treatments and intervals for wound treatments were implemented and performed according to physician orders [REDACTED].#4); and to ensure the physician was immediately notified so appropriate treatment could be initiated to expedite healing of a newly identified wound prior to treatment without a physician order [REDACTED].<br>1. The facility's Skin Program Policy received from the Administrator on 11/7/14 at 9:20 a.m. documented: . 3. A licensed nurse will complete a total body assessment on each resident on admission and weekly. 5. All open areas will be identified and documented on the appropriate forms . 6. Resident(s) with wounds will have appropriate treatment. If there is deterioration or no change in a wound within 2 weeks, the treatment will be changed. 7. Resident(s) with wound acquired in the facility will be assessed to determine if pressure ulcers are unavoidable. 8. Resident's discharged /transferred to hospital will have a skin assessment completed prior to discharge/transfer. 9. All skin conditions will be assessed weekly with documentation of: a. Date, b. Stage, c. Length X width X Depth, d. Drainage, e. Odor, f. Progress / Remarks, g. Current Treatment Plan .<br>2. Resident #4 had [DIAGNOSES REDACTED]. Varicose Veins of Lower Extremities with Ulcer, and Senile Dementia. The Quarterly<br>Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) of 7/28/14 documented the resident had a problem with short term and long term memory per staff assessment and was moderately impaired for cognitive skills for daily decision making, and had 1 Stage 3 Pressure Ulcer.<br>a. The Care Plan dated 5/1/14 documented, Resident is at risk for skin breakdown and pressure ulcers r/t (related to) incontinence, Decreased Mobility, Decreased sensation, [MEDICAL CONDITIONS], hx (history) pressure and vascular ulcer. Assess and record changes in skin status. Report pertinent changes to physician. Weekly skin assessments by nurse. Wound care consult as ordered. Resident has Stage 3 ulcer (L) (left) heel. Goal: Ulcer will exhibit evidence of healing as indicated on pressure report (decrease in size, improved appearance, abscence of drainage, etc.) through next review. Interventions: Administer/monitor effectiveness of/response to treatment(s) as ordered. Assess/record changes in skin status and report changes to physician. Measure and document condition of skin condition weekly. Monitor site for s/sx (signs and symptoms) of infection. Assess, record and monitor wound healing weekly. Measure length width and depth. Assess and document wound perimeter, wound bed and healing process. Report improvement and decline to MD (Medical Doctor) and family . Resident to be seen by wound care clinic every two weeks .<br>b. A physician order [REDACTED].#29 Left, Medial, Posterior Foot: Change dressing every day or as needed for excessive drainage. Wound #31 Left Lower Leg: Change dressing every day or as needed for excessive drainage . Primary Wound Dressing: Wound #29 Left, Medial, Posterior Foot: Apply [MEDICATION NAME] ointment to wound bed. Apply thin layer of Santyl Ointment<br>to wound bed only. Other: - WTD (wet to dry). Wound #31 Left Lower Leg: Apply [MEDICATION NAME] ointment to wound bed. Apply thin layer of Santyl Ointment to wound bed only. Other: - WTD. Secondary Dressing: Wound #29 Left, Medial, Posterior Foot: Secure with rolled gauze (conform or Kerlix). Secure with tape. Wound #31 Left Lower Leg: Secure with rolled gauze (conform or Kerlix). Secure with tape .<br>1) On 11/6/14 at 4:10 a.m., Licensed Practical Nurse (LPN) #1 performed wound care to the Resident's left heel and left lower leg. Both wounds were cleansed using wound cleanser and then dried. [MEDICATION NAME] was applied with a sterile Q-tip. Collagen was applied, then foam, then the wounds were wrapped with gauze and taped. The LPN stated that the resident had gone to the wound clinic Monday and had measurements there. She also stated, The wound on the lower leg is larger but looks healthier. The wound on the heel is larger and worse. The Santyl ointment and the WTD dressings were not applied as per the 11/3/14 physician orders.<br>2) The November 2014 Treatment Administration Record (TAR) documented, Cleanse left heel with wound cleanser, pat dry, apply [MEDICATION NAME] Ointment, then collagen, foam, & (and) secure with Kerlix. Change Mon (Monday), Wed (Wednesday), and Fri<br>(Friday) & PRN (as needed) until resolved. One time a day every Mon, Wed, Fri - Start date - 10/31/14 2300 (11:00 p.m.), Cleanse wound to left lower leg with wound cleanser, pat dry, apply [MEDICATION NAME] Ointment, then collagen, foam, & (and) secure with Kerlix. Change Mon, Wed, and Fri & PRN until resolved. One time a day every Mon, Wed, Fri - Start date - 10/31/14 2300. There were initials by the Treatment Nurse on Monday, 11/3/14, indicating the treatments to both areas was done, and on Wednesday, 11/5/14, the Treatment Nurse's initials were circled to indicate the treatments were not done. The |

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| F 0314<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | (continued... from page 2)<br>TAR documented, 11/5/14 , Res (resident) yelling (and) screaming. Refused to let this nurse do treatment. The new physician orders [REDACTED].<br>3) On 11/6/14 at 10:00 a.m., the DON was asked to review the physician orders [REDACTED]. After the review, the DON was asked who was responsible for noting treatment orders from the wound clinic. She stated, The Treatment Nurse. She was asked if she saw any problem with the comparison. She stated, Yes, the order was not changed on the TAR nor noted by the Treatment Nurse.<br>c. On 11/6/14 at 11:00 a.m., the Director of Nursing provided documentation of wound assessments/measurements for September and October 2014:<br>9/5/14: L (left) heel, acquired 9/15/12. There were no measurements or wound descriptions documented.<br>9/18/14: PU (Pressure Ulcer) Stage III, L heel: 1x7.5x3.5 . PU, Stage III, L calf 3x3.5. There were no wound descriptions documented.<br>9/25/14: PU, L shin, 3.7x2.6, Stage III, Avoidable, improved, Treatment Santyl/wet to dry, . PU, L heel, Stage III. There were no additional measurements or wound descriptions documented.<br>10/9/14: PU L shin, 3.7x2.6, Stage III, Avoidable, . Stasis Ulcer, L heel. There were no additional measurements or wound descriptions documented. (Resident #4 was in the hospital from 10/20/14 until 10/30/14.)<br>10/31/14: . L heel, . Stage III, 5x2x0.2. There were no additional measurements or wound descriptions documented.<br>d. The Wound Clinic's documentation included the following assessments and measurements:<br>6/26/14, . L heel . 4.0x2.0x0.2.<br>7/17/14: Heel 4.6x2.0x0.2. 7/31/14: (There were no measurements or assessments.) 8/28/14: (There were no measurements or assessments.)<br>9/30/14: (There were no measurements or assessments.)<br>10/14/14: #29 L heel: 4.0x2.0x0.2 . #31 LLE (left lower extremity); 2.4x4.0x0.2 .<br>11/3/14: (There were no measurements or assessments).<br>d. The Nurses' Notes from 09/22/14 - 11/06/14 were reviewed:<br>10/6/14 @ (at) 2300 (11:00 p.m.) NO (New Order): 1. Tylenol 500 mg (milligrams) PO (by mouth) q (every) a.m. (The resident was in the hospital from 10/20/14 and re-admitted [DATE].)<br>10/31/14: Wound assessment complete. L lower leg 3x3x (less than) 0.1 wound bed beefy red (no) slough noted. Wound edges dark purple/black, Surrounding tissue pink intact. L heel 5x2x0.2 wound bed beefy red. Scant amount of serosang (serosanguinous) drainage noted to both wounds .<br>11/2/14 0115 (1:15 a.m.) Resting in bed . CNA (Certified Nurse Assistant) notified this nurse @ approx (approximately) 2000 (8:00 p.m.) that resident needed something for pain. Resident unable to tell this nurse where his pain was located. PRN pain med given (with) effective results noted within one hour.<br>11/3/14 1800 (6:00 p.m.) .Wound to heel cont (continues) to worsen - wound clinic appt (appointment) today.<br>11/4/14 0100 (1:00 a.m.) Has Dressings on Lt (left) (and) rt (right) lower legs. Does have some pain of legs @ times.<br>11/5/14 1000 (10:00 a.m.) . Periodically c/o (complains of) pain to L foot. Medicated per orders.<br>3. Resident #3 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date of 9/29/14<br>documented the resident was severely impaired in cognitive skills for daily decision making per staff assessment; needed extensive assistance of one person for bed mobility; had an indwelling Foley catheter; was always incontinent of bowel; was at risk for developing pressure ulcers; and had 1 stage 2 Pressure ulcer.<br>a. A physician's order [REDACTED].<br>b. A Care Plan dated 10/2/14 documented, . Resident has Stage 2 ulcer and Excoriation to Coccyx and peri-area related to incontinence, decreased mobility, fragile skin . Administer/monitor effectiveness of/response to treatment (s) as ordered . Assess/record changes in skin status and then report changes to physician.<br>c. On 11/5/14 at 10:15 a.m., Certified Nursing Assistant (CNA) #1 and CNA # 2 were observed providing incontinent care to Resident #3. When incontinent care was completed CNA # 2 stated that she was going to get the Treatment Nurse to look at Resident #3 since she had not worked with resident for a while and was unaware of current skin condition. The Treatment Nurse entered room, assessed resident and stated, The area to the sacral crease is now open; it wasn't open this morning, I will notify Hospice. The Treatment Nurse then left the room.<br>d. On 11/5/14 at 10:38 a.m., the Treatment Nurse returned to Resident #3 ' s room, wiped area around sacral crease with skin prep, cleansed wound, applied hydrogel and covered area with a [MEDICATION NAME] Border Dressing. She stated, This is a new area; it was not here this morning when I did the body audit.<br>e. On 11/5/14 at 10:50 a.m., the Treatment Nurse was asked for the physician's order [REDACTED]. She stated, It is a standing order from the formulary that I am allowed to use. She was then asked for a copy of the standing order but was unable to provide it.<br>f. On 11/5/14 at 10:55 a.m., the DON was asked if there was a standing order for wound treatments and a wound formulary they used. She stated, No, we do not have standing orders, the Doctor has to be called each time a wound is discovered to get an order to treat. |
| F 0323<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 655) was substantiated (all or in part) in these findings.<br>Based on observation, record review and interview, the facility failed to ensure that staff were trained and oriented to assigned units as evidenced by untrained personal care staff being left alone on 1 (Men's Unit) of 2 secured units with no knowledge of resident needs, security code or how to summons help. The failed practice had the potential to affect 7 residents residing on the Men's Secured per list provided by the MDS Coordinator on 11/7/14 and 11/14/14 and the Director of Nursing (DON) per phone conversation on 11/18/14 at 11:55 a.m.<br>The facility failed to ensure the facility was free from hazards as evidenced by the door to the Electrical Phone System being left unlocked, the exit door leading from the beauty shop to the employee smoking area and the gate surrounding the smoking area and adjoining the women's secured unit being left unlocked making all hazards accessible to self-mobile cognitively impaired residents.<br>The failed practice had the potential to affect 12 self-mobile and cognitively impaired residents residing on the North and South C Hall per list provided by the MDS Coordinator on 11/7/14 and 11/14/14 and the Director of Nursing (DON) per phone conversation on 11/18/14 at 11:55 a.m.<br>The facility failed to ensure planned fall/injury prevention interventions were consistently implemented for 1 (Resident #12) of 1 case mix resident who was care planned for Tubigrips and 1 (Resident #7) of 7 (Residents #1, #2, #3, #6, #7, #20 and #25) who were care planned for chair alarms. The failed practice had the potential to affect 1 Resident care planned to have Tubigrips to extremities and 13 Residents care planned and/or with physician orders [REDACTED].<br>The facility failed to ensure residents who were dependent for transfers and could not bear weight were not transferred with a gait belt for 1(Resident #20) of 6 (Residents #2, #3, #5, #7, #20 and #32) case mix residents who were dependent on staff for transfers.<br>The failed practice had the potential to affect 11 residents transferred with a gait belt per list provided by the MDS Coordinator on 11/7/14 and 11/14/14 and the Director of Nursing (DON) per phone conversation on 11/18/14 at 11:55 a.m.<br>The findings are:<br>1. On 11/3/14 at 11:30 p.m., one Certified Nursing Assistant (CNA) #5 was working alone in the secured men's unit. CNA #5 was asked about the residents and how to care for each resident residing on this hall. She stated, I don't know, this is my first night working this hall. She was then asked how she would call for help if she needed to. She stated, I don't know, they are supposed to check on me every so often but I don't know how to get help in between those times. When asked what the key pad code was to exit the hall. She stated, I don't know what the code is. When asked how she planned on exiting through the locked door when/if she needed to if she did not know what the code was. She stated, I don't know.<br>a. On 11/3/14 at 11:35 p.m., after knocking hard on the exit doors several times to the Men's Secured Unit, Licensed |

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| F 0323<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>Practical Nurse (LPN) #4 came and unlocked the door. At that time he was asked if he was aware that CNA #5 had not been given any instructions on anything about or how to care for the residents, she did not know how to call for help nor had she been told the code to exit the hall before being assigned to work the hall. He stated, No, he was not aware. He was then asked what the last names of each of the Resident's on the Men's Secured Unit and information about the residents and he stated, I don't know, let me look at the census by hall.<br>b. On 11/3/14 at 11:40 p.m., the Administrator arrived and was informed about the staffing situation on the men's secured unit. The Administrator immediately reassigned the CNAs so that there was not any CNAs working on any floor without knowledge of the residents and/or without supervision.<br>c. On 11/4/14 at 12:40 p.m., the Director of Nursing was asked if she was aware that an inexperienced and unsupervised CNA was working the Men's Secure Unit last night and was also unaware how to call for help, and did not know the code to exit the hall. She stated, I was told about it this morning. I do the schedules and I did not schedule her to work that hall. They change the work assignments all the time. I have now put a note by the schedules, (DO NOT CHANGE THE WORK ASSIGNMENTS<br>WITHOUT CONSULTING WITH ME!). She was then asked, ' Since they have changed your work assignments before, have there been<br>any incidences that you can relate to inexperienced staff working without supervision. She stated, No.<br>2. On 11/7/14 during environmental rounds between 12:45 p.m. and 1:45 p.m. the following observations were made:<br>a. The door to the Electrical Phone System was unlocked and accessible to cognitively impaired self-mobile residents.<br>b. The exit door used to enter and exit through the Beauty Shop was unlocked. The doorway led out into the residents ' smoking area. The gate which surrounded the resident smoking area could also be accessed through the exit door of the women's secure unit and was unlocked.<br>3. Resident #12 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date<br>of 8/8/14 documented resident was severely impaired in cognitive skills for daily decision making per a staff assessment for mental status and was totally dependent on one to two staff for all activities of daily living.<br>a. The Residents Plan of Care with a revision date of 10/23/14 documented, .Resident is at risk for skin breakdown and pressure ulcers R/T (related to) incontinence, decreased mobility, decreased sensation.9/22/14 (hand written in) Bruise to (L) (Left) buttock d/t (due to) resident kicking and thrashing feet hitting buttocks.Intervention: (hand written in) Tubigrip to be on right leg to avoid injury.Wedge placed under legs between knees and buttocks.<br>b. The facility's November 2014 Additional Monthly Orders form documented, .11/5/14.1.) D/C (discontinue) lotion to (Right) leg abrasion posterior.2.) (Change) TX (Treatment) to Cleanse (with) WC (Wound Cleanser), pat dry, apply ABT (Antibiotic) ointment & Dry (Change) dressing daily & PRN (as needed) til (until) closed.<br>c. On 11/6/14 at 9:15 a.m., the resident was lying in bed. She had open areas behind her right knee and leg. The only dressing on the open areas was 1 Band-Aid which was hanging by its tip on her right leg. There were no Tubi-grips or wedges in place.<br>d. On 11/7/14 at 10:00 a.m., the Director of Nursing was asked what the facility had in place to help protect (Resident #12) from injury due to her continuous thrashing about due to her [DIAGNOSES REDACTED]. She was then asked if that was what the facility meant by Tubi-grips written in on resident's plan of care. She stated, Yes.<br>4. Resident #20 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of<br>10/7/14 documented the resident was moderately impaired in cognitive skills for daily decision per a staff assessment for mental status, and required extensive one person assist for transfers.<br>a. The Resident ' s Plan of Care with a revision date of 7/11/14 documented, .Focus: Resident requires assistance with ADL's (Activities of Daily Living) r/t (related to) Cognitive deficit related to dementia.Interventions: Extensive assistance x 1 for transfers. May require two person assistance.Requires use of gait belt with transfers.Created on 4/2/2014.<br>b. On 11/13/14 at 11:18 a.m., CNA's #6 and #7 transferred Resident #20 with a gait belt from his low bed (top of bed was approximately 18 inches off of the floor) to his wheel chair (approximately 1 1/2 feet from bed to wheel chair). Both CNAs grabbed the back of the gait belt with one hand and placed their other hand under the resident's arms to pull him up from a sitting position. The resident did not bear any weight and his feet dragged on the floor as the CNAs transferred him from the low bed to his wheelchair.<br>After the transfer was complete, both CNAs were asked if he was able to bear any weight. CNA #6 stated, Sometimes he can, sometimes he can't, sometimes it depends what mood he is in. She was then asked if he was able to bear any weight during that transfer. She stated, No. She was asked if they should have continued the transfer in that manner since during this transfer he was not able to bear any weight. She stated, Probably not. Out in the hallway CNA #7 was asked if the resident was able to bear any weight. She stated, No, he was not able to bear any weight. When asked if the transfer should have continued once they (the CNAs) realized (the resident) was unable to bear weight, CNA #7 stated, No, we should not have continued transferring with a gait belt when he was not able to bear any weight.<br>c. On 11/14/14 12:50 p.m., the MDS Coordinator was asked if during a gait belt transfer the resident is unable to bear any weight should the CNAs stop the transfer and get direction from the Charge Nurse and/or Therapy how to safely transfer the resident to prevent the possibility of injury caused by the inappropriate transfer. She stated, Yes. She was then asked if the facility had a policy and procedure on how to transfer residents appropriately with a gait belt. She left and came back and stated, No, I could not find one. She was asked if the Therapy Department might have one. She left and came back with a procedure for transferring resident's including a gait belt transfer.<br><br>5. Resident #7 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of<br>8/27/14 documented the resident scored 13(13 - 15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS), required extensive assistance of one for transfers and limited assistance of one for locomotion off the unit, used a wheelchair for mobility, had one fall with no injury and one fall with major injury since the last assessment.<br>a. The Resident Plan of Care with a revision date of 9/17/14 documented, .Focus: Resident is at risk for falls/injuries r/t (related to) Medication Usage, Previous or History of Falls, Poor safety awareness from dementia, Unsteady Gait.5/21/14 Fall (without) injury.Intervention: W/C (wheel chair alarm (changed) to pressure.6/6/14 Fall (without) Injury.Inservice staff regarding checking that alarms (Interventions) are in place for safety.6/23/14 Fall (without) injury.chair alarm for safety.6/23/14 1) chair/pressure alarm in W/C (wheel chair) & recliner.2) Dycem in recliner to keep from sliding.6/28/14 Fall (without) injury.check safety alarms frequently.(one-to-one) (with) staff. Reeducate frequent alarm (checks) (with) staff.9/17/14 fall (without) injury.<br>b. On 11/5/14 at 3:35 p.m., the resident was sitting in her wheel chair in her room. There was no alarm in place to her wheel chair.<br>c. On 11/6/14 at 10:26 a.m., the resident was sitting in her wheel chair in the main dining room. There was no alarm in place. Her room was checked at that time and the alarm and Dysem used for her wheelchair was lying in her recliner.<br>d. On 11/7/14 at 9:15 a.m., Resident #7 told CNA #1 she wanted to get in her recliner. CNA #1 pulled the blinds, washed her hands. She applied a gait belt around the resident's waist and transferred her appropriately without incident to her recliner from her wheel chair. The chair alarm was already on her recliner but there was not one on her wheel chair.<br>At 11:55 a.m., CNA #1 was asked if an alarm should have been on Resident #7s wheel chair when the resident was up in her wheelchair earlier in the day. She stated, Yes, it was already on her recliner; someone forgot to put it on her wheel chair.<br>e. On 11/7/14 at 10:30 a.m., the DON was asked if (Resident #7) should have an alarm under when she sat up in her recliner or in her wheelchair. The DON stated, Yes, it should be on (when she is sitting up). |
| F 0490<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Be administered in an acceptable way that maintains the well-being of each resident .**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 599) was substantiated (all or in part) in this finding.<br>Based on record review and interview, Nursing Administration failed to thoroughly investigate allegations that LPN #1 was using a disinfectant for equipment and non-porous hard medical surfaces as a wound cleanser in order to prevent further infection/breakdown in wounds for 1 (Resident #4) of 6 (Residents #3, #4, #16, #19, #31, and #32) case mix residents who had pressure ulcers. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death for Resident #4 and had the potential to cause more than minimal harm for 7 residents who had pressure ulcers as documented on a list provided by the Administrator on 11/6/14 at 11:45 a.m. On 11/6/14 at 4:40 a.m., the |

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|---|---|---|---|
| | 045212 | A. BUILDING _____ B. WING _____ | 11/14/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| HIGHLANDS OF NORTHWEST ARKANSAS THERAPY AND LIVING | 1513 SOUTH DIXIELAND RD ROGERS, AR 72756 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 4)<br>Administrator was informed of the Immediate Jeopardy. The findings are:<br>1. The Job Description of the Director of Nursing documented: . Summary: As our Director of Nursing you will be responsible for overall direction, coordination, and evaluation of nursing care services provided to the residents, as well as assuming daily operations of the facility in Administrator's absence as necessary . Essential Duties and Responsibilities: This list is subject to individual facility policies, procedures and practices, which may require additional duties and responsibilities. Engaging in recruiting, interviewing, counseling, evaluating and retention of staff, Ensuring appropriate review, interpretation, and analysis of records and reports, Scheduling, monitoring and follow-up on all non-nursing resident care services, . conducting facility-wide in-service education programs, . Ensuring compliance with all state and federal guidelines, .<br>2. Resident #4 had [DIAGNOSES REDACTED]. Varicose Veins of Lower Extremities with Ulcer, and Senile Dementia. The Quarterly<br>Minimum Data Sheet (MDS) with an Assessment Reference Date (ARD) of 7/28/14 documented the resident had a problem with short term and long term memory per staff assessment and was moderately impaired for cognitive skills for daily decision making, and had 1 Stage 3 Pressure Ulcer.<br>a. The Care Plan dated 5/1/14 documented, Resident is at risk for skin breakdown and pressure ulcers r/t (related to) incontinence, Decreased Mobility, Decreased sensation, [MEDICAL CONDITIONS], hx (history) pressure and vascular ulcer. Assess and record changes in skin status. Report pertinent changes to physician.Resident has Stage 3 ulcer (L) (left) heel. Goal: Ulcer will exhibit evidence of healing as indicated on pressure report (decrease in size, improved appearance, abscence of drainage, etc.) through next review. Interventions: Administer/monitor effectiveness of/response to treatment(s) as ordered. Assess/record changes in skin status and report changes to physician. Report improvement and decline to MD (Medical Doctor) and family . Resident to be seen by wound care clinic every two weeks .<br>b. On 11/6/14 at 4:10 a.m., Licensed Practical Nurse (LPN) #1 performed wound care to the Resident's left heel and left lower leg. The LPN stated that the resident had gone to the wound clinic Monday and had measurements there. She also stated, The wound on the lower leg is larger but looks healthier. The wound on the heel is larger and worse.<br>At 4:30 a.m. after completion of the wound, the LPN was asked if she was aware of anyone using something on a wound that was not to be used on wounds. LPN #1 stated, I did. I wouldn't ever mean any harm to a resident. I used this. (The LPN showed the surveyor a spray bottle of Clorox Brand Hydrogen Peroxide Cleaner Disinfectant for hard surfaces and equipment). The LPN continued, (Resident #4) won't let anyone but me and (LPN #2), another LPN that works nights, change his dressing. We were gone about 6 days and his dressing had not been changed for the 6 days. I was trying to find something that would help his wounds. They were draining yellow drainage and looked awful. So, I started using that. The LPN was asked if she was aware the cleaner was not for wounds. She stated, Yes, but it does not have bleach in it. The LPN was asked if she had gotten physician orders [REDACTED]. The LPN also stated that she thought the wound had gotten better with this treatment and that it had not hurt the resident. She was asked how long she used it on the resident and she stated, About 2 weeks (10/6/14 - 10/20/14). She stated that the last time she used it on the resident was the day the resident went to the hospital (10/20/14) and had not used it on any other residents. The LPN was asked if anyone else was aware of her use of the cleaner on Resident #4. She stated, Yes, the Treatment Nurse.<br>1) The October 2014 TAR documented, L medial posterior foot. (Change dressing (every) d (day) (and) PRN. [MEDICATION NAME]<br>(and) Santyl, wet to dry dressing. Kerlix (and) Tape. 10/1/14. L (lower) leg, Change dressing (every) day (and) PRN. [MEDICATION NAME] (and) Santyl wet to dry dressing. Kerlix (and) tape. 10/1/14. LPN #1 initialed 10/9/14, 10/10/14, 10/11/14, 10/15/14, 10/16/14, and 10/19/14 to indicate the treatments to both areas were performed as prescribed by the physician each of these days. The resident went to the hospital on [DATE].<br>2) The label on the bottle of disinfectant read: Kills bacteria [MEDICAL CONDITION] in 30 seconds .Clorox . Hydrogen Peroxide, Cleaner Disinfectant . Compatible with Equipment Surfaces . Non Bleach . Keep out of the reach of children . Directions For Use: It is a violation of Federal law to use the product in a manner inconsistent with its labeling. To operate: To open, Turn nozzle. Spray 6-8 inches from surface. Wipe with cloth. Do not breathe spray or mist. Precautionary statements: Hazards to Humans and Domestic Animals. Caution: Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, chewing tobacco, or using the toilet. First Aid: If in eyes: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first 5 minutes, then continue rinsing. Call the poison control center at [PHONE NUMBER] or doctor for treatment advice. This product is not to be used as a terminal sterilant/high level disinfectant on any surface or instrument that (1) is introduced directly into the human body, either into or in contact with the bloodstream, or normally sterile areas of the body, or (2) contact intact mucous membranes, but which does not penetrate the blood barrier or otherwise enter normally sterile areas of the body. Disinfection: . This product cleans, disinfects and deodorizes hard, nonporous medical surfaces in one step with no rinsing required.<br>3) On 11/6/14 at 5:55 a.m., the Treatment Nurse was asked if she was aware of anyone using anything other than what was ordered on wounds. She stated, Yep then changed her answer to No. The Treatment Nurse was told that LPN #1 had stated that she had told the treatment nurse what she was using on Resident #4, and showed the Treatment Nurse the bottle of cleaner. She stated, I just thought she was using the wound cleanser that had peroxide in it in the cart. I never looked at what she said she was using. I did not tell the Director of Nursing (DON) or anyone else that she was using something not ordered . I've never used anything like that on any resident's wounds. It (the wound) looked cleaner when (Resident #4) came back from the hospital. I thought they must have debrided it. I just thought anything in the cart we could use without an order. The Treatment Nurse was shown the bottle of equipment cleaner. She confirmed she was not aware that anyone had been using that on wounds.<br>4) On 11/6/14 at 6:08 a.m., the DON was asked if she was aware that (LPN #1) was using the cleaner on wounds. She stated, I was told about 9/30/14 by a nurse, (LPN #2), via text that a CNA (Certified Nurse Assistant) had reported to her that (LPN #1) had been using Peroxide that they had used to clean beds. I sent copies of the text to the nurse consultant and Administrator as soon as I got the text. I was told to interview (LPN #1) and find out what she had been using. I called to find out how the wound was looking and exactly what the treatment was. She (LPN #1) said the wound was looking good and was cleaning with wound cleanser and Santyl. I said, so you're using the wound cleanser in the bottom of the cart. She said, yes. This morning I asked her if she was using this when I called her, she said no, I didn't start using that until approximately 6 times before the resident went to the hospital.<br>5) On 11/6/14 at 10:49 a.m. by telephone, LPN #2 was asked if she was aware of anyone using the cleaner on wounds. She stated, The Treatment Nurse told me one of the nurses had been using a Hydrogen Peroxide Cleaner for equipment and that she thought it was ok. She stated the cleaner was used on Resident #4. The LPN did not know if it was painful to the resident, but did say the wound got worse. She stated, I voiced my concerns to the DON and asked if the wound care orders could be taken off of our shift. She said she would deal with it. The last time I worked, it was off the night shift.<br>c. On 11/6/14 at 11:00 a.m., the Director of Nursing provided documentation of wound assessments/measurements for September and October 2014:<br>9/5/14: L (left) heel, acquired 9/15/12. There were no measurements or wound descriptions documented.<br>9/18/14: PU (Pressure Ulcer) Stage III, L heel: 1x7.5x3.5 . PU, Stage III, L calf 3x3.5. There were no wound descriptions documented.<br>9/25/14: PU, L shin, 3.7x2.6, Stage III, Avoidable, improved, Treatment Santyl/wet to dry, . PU, L heel, Stage III. There were no additional measurements or wound descriptions documented.<br>10/9/14: PU L shin, 3.7x2.6, Stage III, Avoidable, . Stasis Ulcer, L heel. There were no additional measurements or wound descriptions documented. (Resident #4 was in the hospital from 10/20/14 until 10/30/14.)<br>10/31/14: . L heel, . Stage III, 5x2x0.2. There were no additional measurements or wound descriptions documented.<br>d. The Wound Clinic's documentation included the following assessments and measurements:<br>9/30/14: (There were no measurements or assessments.)<br>10/14/14: #29 L heel: 4.0x2.0x0.2 . #31 LLE (left lower extremity); 2.4x4.0x0.2 .<br>11/3/14: (There were no measurements or assessments).<br>e. On 11/6/14 at 8:30 a.m., the personnel record of LPN #1 was reviewed and the Core Competency Review Checklist documented a self-evaluation by LPN #1. Under the topic of Skin and Wound Prevention the LPN had scored herself a 1 (1 indicates minimal experience) on Non-decub measurement and tracking, decubitus measurement/staging/tracking, Skin Formulary (Treatments, devices), and Nutritional interventions. The Review Dates, Return Demonstration, and Evaluation Signature |

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|---|---|---|---|
| | **045212** | A. BUILDING _____ B. WING _____ | **11/14/2014** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **HIGHLANDS OF NORTHWEST ARKANSAS THERAPY AND LIVING** | **1513 SOUTH DIXIELAND RD ROGERS, AR 72756** |

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| F 0490<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 5)<br>columns were blank.<br>At 9:00 a.m., the RN/Treatment Nurse (Date of Hire: 8/28/14) had no Competency Evaluation form in her personnel records.<br>At 9:10 a.m., the DON was asked where the Competency Checklists were kept. She stated, In their personnel records. She was asked if there wasn't one in there does it mean one was not done. She stated, Who do you have because I've already pulled all charts and have them working on getting that done for the ones I found did not have one in their record. The DON was shown the personnel records of LPN #3, #7, and RN/Treatment Nurse. The DON said she would check on this because she did not do their evaluations. The DON was asked about the Checklist Evaluation on LPN #6 and she stated, Most of it was verbal. I did watch her do a treatment, since that was what she was orginally hired for. Since then she is now not doing treatments she is passing meds, but I have not went back and re-evaluated competency. At 12:15 p.m. the DON stated that no further Competency Checklists were found, but they were working on getting them up to date.<br>f. On 11/6/14 at 12:20 p.m., the Immediate Jeopardy was removed and the scope/severity reduced to E when the facility implemented the following plan of removal:<br>1) Nurse was immediately removed from the hall and suspended pending investigation by Administrator on 11/6/14 at 5:00 a.m. Resident's wounds were assessed by DON and treatment nurse and documented on a skin audit sheet on 11/6/14 at 8:30 a.m. At that time treatment was provided following correct physician orders. No deterioration was noted. Physician was notified on 11/6/14 at 7:00 a.m. with no new orders noted.<br>2) There were 7 residents found to be at risk for deficient practice based on a list of residents with pressure ulcers provided by treatment nurse on 11/6/14 at 6:00 a.m. All 7 residents will have wounds assessed by treatment nurse for any deterioration by 1:00 p.m. on 11/6/14 using a skin audit sheet. Any negative findings will be corrected immediately and reported to the Administrator.<br>3) All nurses will be re-educated by DON/Designee beginning 11/6/14 at 7:00 a.m.on reporting abuse, following physician orders, wounds must be assessed, measured, and documented weekly using inservice sign-in sheets that include content trained on and this will be included in orientation packet for all new hires. Nurses will be removed from the schedule and not allowed to work until they complete this re-education.<br>4) Nurses will be interviewed in regards to anybody using household cleaners for wound care by DON/Designee beginning 11/6/14 at 5:30 a.m. and will be completed by 11/6/14 at 4:00 p.m. using OLTC (Office of Long Term Care) witness forms. Nurses will be removed from the schedule and not allowed to work until they complete an interview form. Any negative findings will be investigated immediately by Administrator/Designee.<br>5) Cognitive residents will be interviewed in regards to anybody using household cleaners for care by DON/Designee beginning 11/6/14 at 8:00 a.m. and completed by 11/6/14 at 12:00 p.m. using OLTC witness forms. Any negative findings will be investigated immediately by Administrator/Designee.<br>6) DON/Designee will complete nurse competency checklist for all nurses beginning 11/6/14 at 10:00 a.m. and for all new hires prior to working on their own. Nurses will be removed from the schedule and not allowed to work until they complete a competency checklist.<br>7) DON/Designee will monitor wound care and wound care documentation of pressure ulcers for proper protocol and treatment on all residents with pressure ulcers 5 times per week for 2 weeks, then 3 times per week for 2 weeks, then 2 times per week thereafter until substantial compliance achieved. Any negative findings will be corrected immediately and taken to QA (Quality Assurance) meeting by Administrator/Designee. |