STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITAL NURSING AND REHABILITATION CENTER	**3000 HOLSTON LANE RALEIGH, NC 27610**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/6/23 through 3/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # NC5111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/6/23 through 3/9/23. Event ID# NC5111. The following intakes were investigated NC00193035, NC00194279, NC00198825 and NC00199301. 16 of the 16 complaint allegations did not result in deficiency.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		3/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 03/25/2023

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 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to provide written notice of discharge to the resident and the	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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F 623 Continued From page 3

resident's representative for residents who were transferred to the hospital and notification to the ombudsman (Resident #48) and failed to provide written notice of discharge to the resident or the resident's representatives (Resident # 63 and Resident #30) for 3 of 3 residents reviewed for facility-initiated discharge.

The findings included:

1. Resident #48 was admitted to the facility on 12/17/20.

Review of Resident #48' s records revealed she was sent to the hospital on 2/20/23.

Review of Resident #48's medical record revealed no evidence that written notification of discharge was provided to the resident or resident representative for hospitalization on 2/20/23.

She returned to the facility on 2/23/23.

An interview was conducted with the Admissions Coordinator on 3/8/23 at 11:37 AM who reported the Health Information Management (HIM) Coordinator was responsible for sending a list monthly to the Ombudsman of discharged residents. She reviewed the list of discharged residents for February 2023 and stated Resident #48 was not on the list. The Admissions Coordinator stated she was unsure who was responsible for sending written notification to residents or resident's representatives when they were discharged to the hospital.

During an interview with the Social Services Director on 3/8/23 at 1:05 PM she stated she was

F 623

alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F623
1. Corrective action for resident(s) affected by the alleged deficient practice:
On 03/24/2023, the Social Services Director provided written notice of discharge to Resident #48 and the resident's representative. On 03/24/2023, the Social Services Director provided notification to the Ombudsman of Resident #48's discharge.
On 03/24/2023, the Social Services Director provided written notice of discharge to Resident #63 and Resident #30 and the resident's representatives.
2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
On 03/24/2023, the Social Services Director identified residents that were potentially impacted by this practice by completing an audit of the discharges in the last 14 days. This audit consisted of reviewing the transfer discharge residents where the resident and the resident's representative had not received written notice of discharge for facility-initiated discharge. The results included: 3 residents' representatives had not received written notice of discharge. On 03/24/2023, the Social Services Director

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F 623	Continued From page 4 not aware that written notification needed to be provided for residents who discharged to the hospital. On 3/9/2023 at 1:27 p.m. in an interview with the Administrator, he said Resident #48 did not receive written notification for the reason of her discharge. He explained the person in the Health Information Management position (who left the position last week) was contacting the ombudsman and was not sending written letters to the responsible parties and the ombudsman. He stated the social worker was transitioning into her new role and was not aware of the requirement to send written notification to the ombudsman and the responsible parties. 2. Resident #63 was admitted to the facility on 5/19/20. Review of Resident #63 ' s records revealed she was sent to the hospital on 7/9/22. Review of Resident #63's medical record revealed no evidence that written notification of discharge was not provided to the resident or resident representative for hospitalization on 7/9/22. An interview was conducted with the Admissions Coordinator on 3/8/23 at 11:37 AM who reported the Health Information Management (HIM) Coordinator was responsible for sending a list monthly to the Ombudsman of discharged residents. The Admissions Coordinator stated she was unsure who was responsible for sending written notification to residents or resident's representatives when they were discharged to the hospital.	F 623	mailed written notice of discharge to the resident representatives who had not previously received notification. Additionally, the Social Services Director reviewed all residents who had been transferred or discharged from the facility in the past 30 days to ensure notification of the discharges was sent to the Ombudsman. Results: 2 additional residents were added to the Ombudsman notification list. On 03/24/2023 the Social Services Director sent the Ombudsman notification of all residents who were transferred or discharged from the facility in the past 30 days. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 03/16/2023, the Staff Development Coordinator began education of licensed nurses Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) and the Social Services Director on the requirement to provide written notice of discharge to the resident or the resident's representatives. Additionally, on 03/16/2023, the Social Services Director was educated on the requirement of notifying the Ombudsman of all facility transfers and discharges. This in-service was incorporated in the new employee facility orientation for the employees identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 03/20/2023.	

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F 623	Continued From page 5 During an interview with the Social Services Director on 3/8/23 at 1:05 PM she stated she was not aware that written notification needed to be provided for residents who discharged to the hospital. On 3/9/2023 at 1:27 p.m. in an interview with the Administrator, he said Resident #63 did not receive written notification for the reason of his discharge. He explained the person in the Health Information Management position (who left the position last week) was contacting the ombudsman and was not sending written letters to the responsible parties and the ombudsman. He stated the social worker was transitioning into her new role and was not aware of the requirement to send written notification to the ombudsman and the responsible parties. 3. Resident #30 was admitted to the facility on 10/13/2021. Resident #30 was discharged from the facility and admitted to the hospital on 1/27/2023. Resident #30 returned to the facility on 1/31/2023. A review of Resident #30's medical record revealed Resident #30 acted as her own responsible party. A review of Resident #30's medical record revealed no written communication to Resident #30 related to the hospitalization on 1/27/2023. The 5-day Minimum Data Set (MDS) assessment dated 2/3/2023 indicated Resident #30 was cognitively intact. On 3/9/2023 at 8:31 a.m. in an interview with	F 623	Additionally, each morning at standup/clinical meeting the interdisciplinary team will add any transfers or discharges from the night or weekend before, to a list compiled to be sent to the Ombudsman at the end of the month and ensure that the written notifications are sent per protocol. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F623 Quality Assurance Tool. The tool will monitor 5 resident transfers and discharges to ensure that each resident and the resident's representatives that transferred or discharged receives written notice of discharge. This will be monitored weekly x 3 weeks then monthly x 2 months. Additionally, the administrator or designee will monitor the monthly reporting to the Ombudsman to ensure he/she has received monthly notification of all residents transferred or discharged from the facility. This audit will be performed monthly times 3 months. Reports will be presented to the monthly Quality Assurance (QA) committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality A Meeting or until no longer deemed necessary. The QA Meeting is attended by the	

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F 623	Continued From page 6 Resident #30, she stated she had not received a written letter notifying her the reason she was discharged to the hospital on 1/27/2023. On 3/9/2023 at 12:18 p.m. in an interview with the Social Services Director (who assumed the responsibility one week ago for notifying the ombudsman and the responsible party in writing for the reason for transfer/discharge to the hospital), she stated she didn't know if Resident #30 received a written notification for the reason of her discharge to the hospital. On 3/9/2023 at 1:27 p.m. in an interview with the Administrator, he said Resident #30 did not receive written notification for the reason of her discharge. He explained the person in the Health Information Management position (who left the position last week) was contacting the ombudsman and was not sending written letters to the responsible parties and the ombudsman. He stated the social worker was transitioning into her new role and was not aware of the requirement to send written notification to the ombudsman and the responsible parties.	F 623	Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/25/2023	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		3/18/23

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F 693	Continued From page 7 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer enteral feeding formula at the correct rate as ordered by the physician for 1 of 1 resident (Resident #4) reviewed for enteral feedings. Findings included: Resident #4 was admitted to the facility on 12/17/2020. Diagnoses included dysphagia (difficultly swallowing) and gastrostomy (opening of the stomach) for enteral feedings. The revised care plan dated 9/14/2022 indicated Resident #4 required enteral feedings to assist her in maintaining or improving her nutritional status. Interventions included administering enteral feeding formula as ordered by the physician. The annual Minimum Data Set (MDS) assessment dated 12/15/2022 indicated Resident #4 received enteral feedings for nutrition for greater than 51% of total calories.	F 693	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F693 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/08/2023, Nurse #1 increased the enteral feeding of Resident #4 to the ordered amount. Resident #4's attending physician was notified that enteral feeding was observed running at a lower rate than the rate ordered by the physician. Resident's weights were evaluated to ensure no weight loss had occurred as a result of alleged deficient practice. A head to toe skin assessment was	

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Dietary notes dated 2/9/2023 recorded Resident #4 was receiving an enteral feeding at 40 milliliters (mL) per hour (hr) and increased the enteral feeding to 50 mL/hr due to weight loss.

Physician orders dated 2/9/2023 included an order for an enteral feeding continuously at 50 mL/hr.

A review of the February 2023 Medication Administration Record (MAR) recorded Resident #4 started receiving enteral feedings continuously at 50 mL/hr on 2/9/2023 on the evening shift (3:00 p.m. to 11:00 p.m.). A review of the March 2023 MAR recorded Resident #4 continued to receive enteral feedings continuously at 50 mL/hr.

On 3/6/2023 at 10:45 a.m., the enteral feeding was observed infusing continuously at 40 mL/hr via a pump.

On 3/8/2023 at 8:42 a.m., the enteral feeding was observed infusing via pump at 40 mL/hr. The label on the enteral feeding bag read the enteral feeding was started at 12:35 a.m. on 3/8/23 at 40 mL/ hr.

On 3/8/2023 at 11:10 a.m., Nurse #1 was observed placing the continuously enteral feeding on hold while administering a bolus of 200 mL water flush via gravity using a syringe. Nurse #1 was observed restarting the enteral feeding via pump at 40 mL/ hr.

In an interview with Nurse #1 on 3/8/2023 at 11:20 a.m., she stated she needed to check the physicians order on the rate of the enteral feeding for Resident #4. After Nurse #1 checked the electronic MAR and the physician's orders, she

F 693

completed to ensure there were no skin integrity issues. Results included no further problems and resident was actually found to have gained some weight over the previous 30 days.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents with enteral feeding in the facility have the potential to be affected by this alleged deficient practice.

On 03/08/2023, the Director of Nursing (DON) completed an audit of 100% of residents with enteral feeding. This audit consisted of review of all residents with orders for enteral feeding to identify that the enteral feeding was running at the rate ordered by the physician. The Results included; no further inconsistencies noted and no further corrective action needed at that time.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

Education:

The facility Policy and Procedure was reviewed and no changes are warranted at this time. On 03/08/2023, The Staff Development Coordinator began in-servicing all licensed nurses Registered Nurses (RN's) and Licensed Practical Nurses (LPN's) FT, PT, and PRN including agency staff on the procedure for administration of enteral feedings as well as proper documentation for enteral feedings.

This in-service was incorporated in the new employee facility orientation for the

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stated the enteral feeding was ordered to infuse at 50 mL/hr. She explained Nurse #2 (the 11:00 p.m. to 7:00 a.m. nurse) started the new bag of enteral feeding and didn't know why the enteral feeding was at 40 mL/hr. Nurse #1 was observed increasing the enteral feeding to 50 mL/hr.

In an interview with the Director of Nursing on 3/8/2023 at 11:45 a.m., she recalled Resident #4's weight loss was discussed in the interdisciplinary meetings, and the dietician increased the enteral feeding rate due to weight loss. She stated the enteral feeding should be infusing at 50 mL/hr as ordered by the physician.

In a phone interview with Nurse #2 on 3/8/2023 at 5:28 a.m., she stated she worked the 11:00 p.m. to 7:00 a.m. shift on 3/7/2023 and changed Resident #4's enteral feeding bag. She explained the infusion rate for the enteral feeding was indicated on the Resident #4's MAR and was unsure what the MAR indicated as the rate of infusion for the enteral feeding. She said she thought the infusion rate was still at 40 mL/hr and had not adjusted the infusion rate of the enteral feeding to 50 mL/hr.

employees identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 03/17/2023.
On 03/16/2023 DON received notification of enteral products not available due to backorder. Alternative enteral products were provided with newly calculated rates/orders from the physician. The new orders were entered promptly, the nurses were notified, and the DON performed an audit to ensure the accuracy of the changes. The DON will continue to perform an audit for any alternative enteral products to ensure enteral feed rates are changed to reflect the alternative enteral products.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The DON or designee will monitor compliance completing 4 random observations utilizing the F693 Quality Assurance Tool to ensure enteral feeding is running at the rate ordered by the physician. Audits will be completed on various shifts and days weekly x 3 weeks then monthly x 2 months or until resolved by the Quality Assurance Committee.
Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate.

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F 693	Continued From page 10	F 693	Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance of proper procedure for enteral feeding and accurate order implementation. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/18/2023	
F 867 SS=B	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		3/25/23

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	345202	A. BUILDING ______ B. WING ______	C 03/09/2023

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F 867	Continued From page 11	F 867		

will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 12 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI	F 867		

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program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint survey of 7/1/21. The deficiency is in the area of Notification of Discharge (623). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross referenced to:
F623: Based on record review, resident interview, and staff interviews the facility failed to provide written notice of discharge to the resident and the resident's representative for residents who were transferred to the hospital and notification to the ombudsman (Resident #48) and failed to provide written notice of discharge to the resident or the resident's representatives (Resident # 63 and Resident #30) for 3 of 3 residents reviewed for facility-initiated discharge.

During the recertification and complaint survey of 7/1/21, the facility was cited for failing to notify the

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The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F867

1. Corrective action for resident(s) affected by the alleged deficient practice:
On 03/20/2023, the Regional Director of Operations (RDO) educated the Quality Assurance Committee on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Notice Requirements Before Transfer/Discharge (F623).
This deficiency was cited again on the current recertification survey completed on 03/09/2023.

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F 867	Continued From page 14 ombudsman of facility-initiated discharges to the hospital. An interview with the Administrator was conducted on 3/9/23 at 11:01 AM. The Administrator stated the facility had some turnover in staff which contributed to the repeated citation.	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: Corrective action has been taken for the identified concerns in the areas of: Notice Requirements Before Transfer/Discharge (F623) for Resident #48, #63, and #30. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 03/24/2023 to review the deficiencies from the annual recertification survey completed on 03/09/2023 and reviewed the citations. On 03/20/2023, the RDO in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the areas of Notice Requirements Before Transfer/Discharge (F623). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 03/24/2023, the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Notice Requirements Before Transfer/Discharge (F623).	

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F 867	Continued From page 15	F 867	This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any QAPI team members who does not receive scheduled in-service training will not be allowed to work until training has been completed by 03/24/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool monthly x 3 months. The tool will monitor facility identified concerns including F623 that need to be addressed by the QA Committee. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting, indefinitely or until no longer deemed necessary. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 03/25/2023	