STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345367	A. BUILDING _____ B. WING _____	C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY HC SVCS OF GOLDEN YEARS NSG CTR, LLC	7348 NORTH WEST STREET FALCON, NC 28342

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/31/23 through 08/03/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Z21211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/31/23 through 08/03/23. Event ID# Z21211. The following intakes were investigated NC00201674, NC00201597, and NC00195124. 15 of the 15 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		8/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/24/2023

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F 623	Continued From page 1	F 623		

(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;

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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 staff and resident interviews and record review, the facility failed to provide a written notice of transfer/discharge to the hospital	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 to the resident and regional ombudsman for 1 of 1 resident (Resident #18) reviewed for hospitalization. Findings included: Resident #18 was initially admitted to the facility on 4/5/23. Her quarterly Minimum Data Set (MDS) dated 5/10/23 indicated she was cognitively intact. A nursing progress note dated 7/15/23 completed by Nurse #2 indicated Resident #18 was complaining of abdominal pain and was sent to the hospital for evaluation. The progress note did not indicate if Resident #18 was provided written notice of reason for transfer. A nursing progress note dated 7/19/23 indicated Resident #18 returned to the facility from the hospital. During an interview on 8/1/23 at 2:25 PM, Nurse #1 revealed when a resident was discharged to the hospital an Interact Transfer Form was filled out and sent to hospital staff but not provided to the resident. During an interview on 7/31/23 at 2:10 PM, Resident #18 revealed she was not provided written notice that included the reason for transfer to the hospital. During an interview on 8/2/23 at 10:20 AM, the Director of Nursing (DON) revealed written notice of reason for transfer to the hospital was not provided because they were anticipated to return. The DON revealed the regional ombudsman was not notified of transfers or discharges because	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 facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F623 Corrective action for resident(s) affected by the alleged deficient practice. Residents discharged to the hospital for the month of June 2023-July 2023 were included on the discharge listing report and faxed to the Ombudsman by the Director of Nursing on 8/21 /2023. On 8/03/2023 a transfer/discharge notice was given to resident #18. Corrective action for residents with the potential to be affected by the deficient practice On 8/21 /2023, the list of residents discharged to the hospital was reviewed by the Administrator for the months of June and July 2023 to monitor that all residents who had been discharged that month, were present on the report that was faxed to the ombudsman on by the Director of Nursing. On 8/21/2023 the Director of Nurses/Administrator audited all residents transferred/discharged 8/1/2023 through 8/18/2023 for written notification of the transfer/discharge to the resident/responsible party. As of 8/22/2023 all transfer/discharges identified above were in compliance with the transfer/discharge process.	

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F 623	Continued From page 4 the facility did not have a social worker, and no one had taken over submitting since she started three months ago. During an interview on 8/3/23 at 10:00 AM, the Administrator revealed he was not aware of the requirement to provide a resident a written notice that included reason for transfer to the hospital. He was not aware no one was contacting the ombudsman of discharges and transfers.	F 623	Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/3/2023 the Regional Clinical Nurse Consultant educated the Administrator, Director of Nurses on the transfer/discharge notification process. On 8/3/2023, the Administrator educated the director of nursing on the requirement to include all residents discharged to the hospital on the list of discharged residents provided to the Ombudsman monthly and on giving the resident or their responsible party notice of discharge in writing. Contact was made to the local ombudsman and she stated that the discharge report from Point Click Care was sufficient for the monthly report and this is all that she required once at the end of the month. On 8/3/2023 the Director of Nurses educated all licensed nurses including agency on the transfer/discharge notification process. As of 9/10/2023 any of the above staff who have not completed the education will not be allowed to work until the education is complete. This will be monitored by the Director of Nurses for compliance. 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/designee will monitor compliance utilizing the F623 Quality Assurance Tool for compliance with inclusion of residents discharged to the hospital and faxing of the Discharged Resident Report monthly to the	

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F 623	Continued From page 5	F 623	Ombudsman and written notification of the resident/responsible party of transfer/discharge. This will be monitored weekly x 2 and monthly x 3 o0r until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of compliance will be 9/11/2023.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge location (Resident #42) and tracheostomy care (Resident #145) for 2 of 12 residents reviewed for MDS accuracy. The findings included: 1. Resident #145 was admitted to the facility on	F 641	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	8/24/23

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F 641	Continued From page 6 10/06/2008 with diagnoses that inclued laryngectomy (surgical removal of the larnyx) and tracheostomy (a breathing tube). The 5-day Minimum Data Set (MDS) dated 10/17/2022 had Resident #145 was moderately cognitively. He was coded for suctioning and as not having a tracheostomy. The care plan dated 10/11/2022 had a focus of laryngectomy, tracheal suctioning as needed (PRN) for congestion or unable to clear secretions, change tracheostomy ties weekly and PRN. Monitor skin and document concerns in nursing notes as needed for laryngectomy stoma, and laryngectomy care everyday shift and PRN. An interview with the MDS Coordinator was conducted on 08/01/2023 at 10:11 AM. The MDS Coordinator stated she completed Resident #145's MDS and he did have a tracheostomy. The MDS also stated the MDS was coded incorrectly due to oversite. An interview with the Director of Nursing was conducted on 08/01/2023 at 12:03 PM. The DON stated Resident #145 did have a tracheostomy and it was coded incorrectly on the MDS due to oversite. 2. Resident #42 was admitted to the facility on 5/22/2023. Review of Nursing Progress Note written by Nurse #1 on 6/28/23 read: "Resident discharged home with daughter." The Discharge MDS dated 6/28/2023 was coded in Section A as discharge to hospital.	F 641	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 8/04/23, the facility□s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 3/18/22. This was for 1 deficiency that was cited for accuracy of assessments (F641). The duplicate citation during the two federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program. 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: accuracy of assessments (F641) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 08/15 /2023 to review the deficiencies from the July 31- August 4 annual recertification survey, CI survey, and reviewed the citations. On 08/14 /2023, the Regional Director of Operations and Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning	

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F 641	Continued From page 7 An interview with the Director of Nursing was conducted on 08/02/2023 at 12:35 PM. The DON stated Resident #42 discharged to home on 6/28/23 and the Discharge MDS was coded incorrectly due to oversite. An interview with the MDS Coordinator was conducted on 08/02/2023 at 1:23 PM. The MDS Coordinator verified Resident #42 was discharged home on 6/28/23. She stated she completed Resident #42's Discharge MDS and it was coded incorrectly due to oversite.	F 641	of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 8/15/2023 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. 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 Committee 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 9 /11/2023. 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 weekly x 4 weeks and monthly x 6 months. The tool will monitor facility identified concerns that need to be	

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F 641	Continued From page 8	F 641	addressed by the QA Committee. Reports will be presented to the weekly 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 weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/11/2023	
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to schedule a Registered Nurse	F 727	The statements made on this plan of correction are not an admission to and do	8/24/23

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F 727	Continued From page 9 (RN) for at least 8 consecutive hours a day for 5 of 90 days reviewed (dates 1/07/23, 1/08/23, 2/18/23, 3/04/23, and 3/05/23). The findings included: A review of the facility's Daily Schedules and the Daily Nursing staff posting dated January 2023 through March 2023 was conducted on 8/03/23. The Daily Schedules and the Nursing Staff Postings indicated a Registered Nurse (RN) was not scheduled for at least 8 consecutive hours a day on the following dates: 1/07/23, 1/08/23, 2/18/23, 3/04/23, and 3/05/23. A review of the Payroll Based Journal Report dated Quarter 2 (January 1-March 2023). It triggered no RN hours for four or more days withing the quarter. Those dates included 1/07/23, 1/08/23, 2/18/23, 3/04/23 and 3/05/23. An interview was conducted on 8/03/23 at 10:45 AM with the Director of Nursing (DON). During the interview, the DON stated that she was not employed at the facility during that time. She confirmed with the facility human resource staff there was no RN on shift during 1/07/23, 1/08/23, 2/18/23, 3/04/23, and 3/05/23. She stated there should have been RN coverage for at least 8 consecutive hours 7 days a week. An interview was conducted on 8/03/23 at 11:15 AM with the Administrator. He explained he had been made aware of the Payroll Based Journal Report (PBJ Report) and the staffing issues when he took over as Administrator in late April 2023. He stated he did not know what happened prior to his employment. He stated his expectations are for the current DON to cover if there are any call outs.	F 727	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. F727 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to staff Registered Nurse coverage for 8 consecutive hours daily. 1. Corrective action for resident(s) affected by the alleged deficient practice: At least eight consecutive hours of registered nurse staffing will be maintained daily by 8/15/2023 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. 8/15/2023, staffing sheets were reviewed by the Director of Nurses for the last 30 days to monitor that at least eight consecutive hours of registered nurse staffing was in place daily. 30 out of 30 days had at least 8 consecutive hours of registered nurse hours in place. An oncall process to maintain eight consecutive hours of registered nurse staffing daily and use of a contracted agency for	

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F 727	Continued From page 10	F 727	registered nurses will be developed and in use by 8/15/2023 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 08/15/2023, the Nurse Consultant educated the Administrator and Director of Nurses on the requirement of the facility to staff Registered Nurse Coverage for at least consecutive hours daily. Coverage by a Registered nurse for a least eight consecutive hours will be maintained by 8/16/2023. 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 Director of Nurses will monitor compliance utilizing the F272 Quality Assurance Tool weekly for staffing of registered nurse hours daily x 2 weeks then monthly x 3 months. The Director of Nursing will monitor staffing for compliance with the requirement for at least 8 hours of registered nurse staffing daily. Reports will be presented to the weekly 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 weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy	

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F 727	Continued From page 11	F 727	Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/11/23	
F 867 SS=D	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 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,	F 867		8/24/23

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	345367	A. BUILDING _____ B. WING _____	C 08/03/2023

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LIBERTY HC SVCS OF GOLDEN YEARS NSG CTR, LLC	7348 NORTH WEST STREET FALCON, NC 28342

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F 867	Continued From page 12	F 867		

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.

§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.

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F 867	Continued From page 13 §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 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.	F 867		

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F 867	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 3/18/22 recertification survey. This was for a recited deficiency in the area of Accuracy of Assessments (F641). This deficiency was cited again on the current recertification survey of 8/3/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F641: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of discharge location (Resident #42) and tracheostomy care (Resident #145) for 2 of 12 residents reviewed for MDS accuracy. During the recertification survey of 3/18/22, the facility was cited at F641 for failing to accurately code the MDS in the areas of Preadmission Screening and Resident Review level II and personal hygiene. During an interview on 8/3/23 at 12:00 PM, the Director of Nursing (DON) revealed she completed chart audits monthly to review for accuracy of MDS assessments. She addressed findings in QAA meetings monthly. She had not found any issues with accuracy of MDS	F 867	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 8/04/23, the facility□s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 3/18/22. This was for 1 deficiency that was cited for accuracy of assessments (F641). The duplicate citation during the two federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program. 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:	

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F 867	Continued From page 15 assessments. During an interview on 8/3/23 at 12:05 PM, the Administrator revealed that monitoring for accuracy of assessments was an ongoing project. He was not aware of any issues with MDS coding accuracy but will be working with a corporate consultant to address the issues found.	F 867	accuracy of assessments (F641) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 8/15/2023 to review the deficiencies from the July 31- August 4 annual recertification survey, CI survey, and reviewed the citations. On 8/14/2023, the Regional Director of Operations and Regional Clinical Consultant 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. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 8/15/2023 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. 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 Committee 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	

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F 867	Continued From page 16	F 867	9 /11/2023. 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 weekly x 4 weeks and monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly 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 weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/11/2023	