STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 8-29-23 through 8-30-23. Event ID# JSEV11. The following intakes were investigated: NC00206453, NC00206080, NC00205834, and NC00205021. 6 of the 12 complaint allegations resulted in deficiency.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		9/21/23

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

Electronically Signed | 09/14/2023

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview and staff interview the facility failed to clean and prevent water damage such as warped and splintering of wood vanities in 9 of 57 resident rooms (Rooms # 109, 301, 308, 309, 312, 314, 316, 319, 320, 401 and 403) and prevent leaking water from hand sinks and toilet plumbing. They also failed to clean a flat, black substance on walls near toilet plumbing and behind raised wallpaper behind toilet and to fix wallpaper that was wet to touch and separating from the wall behind toilets in 7 of 50 bathrooms (Rooms # 105, 111, 201, 209, 213, 215 and 312). The findings included: A. Observations of resident's rooms on 8/29/23 at 10:15 am revealed 3 of 6 room (Room # 109, 401 and 403) hand sinks were leaking and were wet to touch underneath the vanities. The vanity was observed to have warped wood with splintering, bowing and separation of the layers of particle board. Underneath the vanity in room #109 there was a dark substance surrounding the	F 584	Corrective Action for the residents affected The wood vanities for all cited rooms (109, 301, 308, 309, 312, 314, 316, 319, 320, 401 and 403) were removed and plumbing repaired or replaced for the hand sinks and toilets by the Maintenance Director and/or Maintenance Assistant by September 20th, 2023. The walls near the toilet plumbing and behind the raised wallpaper behind the toilet were cleaned and the wallpaper removed, treated, and repaired by the Maintenance Director and/or Maintenance Assistant for all cited rooms (105, 111, 201, 209, 213, 215, and 312) by September 20, 2023. Corrective action for residents potentially affected	

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F 584	Continued From page 2 area in which water was pooling. An observation of resident rooms on 8/30/23 at 11:00 am revealed an additional 7 of 57 rooms (Room # 301, 308, 312, 314, 316, 319, 320) with vanity hand sinks were leaking and were wet to touch underneath the vanities had water leaking underneath resulting in wet, warped wood with splintering, bowing and separation of the layers of particle board. An interview with the family of Resident #1 (Room #109) on 8/29/23 at 10:45 am revealed he had reported Resident #1's hand sink had been leaking under the vanity in her room. He also indicated there was a dark substance around the wet area that he believed was mold. He was unable to name the staff he had told about the leaking sink. Resident #1's admission Minimum Data Set dated 8/7/23 revealed Resident #1 was cognitively intact. In an interview with Resident #1 (Room #109) on 8/29/23 at 1:15 pm, she indicated she had reported the leak under the sink vanity several times to unnamed staff. She further reported Maintenance had not been in to assess the water leak. An interview and observation with the Maintenance Manager on 8/30/23 at 9:35 am, revealed he received work orders from staff through the building management computer system , a call on the radio, by report in person, or by paper request. Maintenance Manager kept a list of work that was completed that he later entered into the building management computer	F 584	All residents have the potential to be affected. On 09/11/2023, the Maintenance Director assessed the remaining rooms to ensure the vanities, sinks and toilet plumbing were in proper working order. Of the 59 rooms assessed, 37 rooms were in need of repairs and or replacement of the vanities. On September 14, 2023 maintenance staff assessed the remaining rooms to check the walls near the toilet plumbing; if an area was noted to have raised wallpaper behind the toilet it is scheduled to be cleaned and repaired. Of the 59 rooms assessed, 37 needed repairs. Work orders and repairs needed to all areas of concern have been placed in the facility□s Electronic Maintenance Software program and a schedule of all areas noted to be prioritized according to urgency. " During the week of September 18th vanities will be removed and plumbing repaired or replaced in resident rooms: 101, 102, 103, 105, 107, 108, 110, 111 and 112. " During the week of September 25th vanities will be removed and plumbing repaired or replaced in resident rooms: 201, 204, 205, 206, 207, 208, 209, 210, 212, 213 and 215. " During the week of October 2nd vanities will be removed and plumbing	

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F 584	Continued From page 3 system . It was difficult for him to access the building management computer system reliably as the facility network was overwhelmed after 8:30 AM. During the observation of Room # 109 and 401 the Maintenance Manager stated he believed the black substance under hand sink vanities was mold. He had been aware there were leaking hand sinks in the building since he started the position 3 months ago. He stated he could only fix one plumbing issue at a time and must turn the water off to the whole building, making it difficult to schedule plumbing maintenance. He stated he had contacted the Administrator and Corporate regarding hiring a contractor to fix the plumbing. B. Observations of resident's rooms on 8/29/23 at 10:15 am revealed 1 of 6 rooms (Room # 213/215 shared) had wallpaper that was wet to touch behind the toilet in the shared bathroom. An observation on 8/30/23 at 11:00 am revealed an additional 5 toilets (Room # 111, 201/203 shared, 209/211 shared, 213/215 shared and 312) had wallpaper that was wet to touch behind toilets and had a black substance behind and on top of the wallpaper. In an interview with Housekeeping staff #1 on 8/29/23 at 1:10 pm revealed she cleaned rooms daily. She further stated in the instance she saw a leak in the bathroom or residents' room, she would clean any spills and report it to Maintenance through the building management computer system . She further stated housekeeping was to let Maintenance know of any substance that they perceived as mold. In an interview and observation with the	F 584	repaired or replaced in resident rooms: 303, 306, 310, 311, 313, 318 and 325. Systemic Changes On September 15, 2023, the Administrator in-serviced IDT on compliance rounds to include but not limited to identifying any concerns of resident□s rooms to and including, warped, and splintering of wood vanities, water leaking from hand sinks and toilet plumbing. The IDT will also assess the residents□ rooms for black substances on the walls, including the toilet plumbing and behind any wallpaper that is raised and or wet. Quality Assurance Resident□s rooms will be monitored by Interdisciplinary team (IDT) to include but not limited to Social Worker, Activities Director, Financial Counselor, Medical Records, Director of Healthcare Service, Dietary Manager, Housekeeping Supervisor, and Maintenance Director during facility compliance rounds. Concerns to be discussed in morning and or afternoon meetings and action taken to ensure residents□ rooms are safe, clean, comfortable and a homelike environment. The Housekeeping Supervisor will monitor 3 residents□ rooms, 3 times a week for 2 weeks, then 3 residents□ rooms weekly, times 4 weeks, then 3 residents□ rooms monthly to ensure their rooms are safe/clean/comfortable and a homelike environment, utilizing the Quality Assurance monitoring tool for	

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F 584	Continued From page 4 Housekeeping Manager at 8/30/23 11:15 am, revealed rooms were cleaned daily. Housekeeping staff were trained to put maintenance requests into the building management computer system when they observed a maintenance issue. If they saw a substance they believed to be mold, they would alert maintenance to assess it. Resident #1's (Room #109) vanity hand sink was observed with the housekeeping manager who stated she was surprised at the extent of the water damage. In an interview and observation with the Maintenance Assistant on 8/28/23 at 2:10 pm, he stated staff would enter maintenance requests into the building management computer system , call on the radio, report in person, or put in a paper request. He had both a paper log and an electronic log of maintenance requests. The two logs did not have the same information. There are only a few identifying keywords on the lists such as "paint" or "toilet". He stated he remembered the exact maintenance request when he went into a room. If he observed a substance that appeared to be mold, he would make the Maintenance Manager aware. An interview and observation was conducted on 8/30/23 at 9:35 am with the Maintenance Manager. During the observation of Room # 105, 111, 201, 209, 213 and 215, the Maintenance Manager stated he believed the black substance behind and on top of wallpaper was mold. He further revealed the wallpaper was wet to touch. Housekeeping kept a spray on their carts he would use to clean what he suspected was mold. Upon observation of the cleaning agent, it was not labeled for cleaning mold. The Maintenance Manager stated he did not have a kit to test for	F 584	safe/clean/comfortable/homelike environment. Any concerns will be identified, and corrections made. The results of these reviews will be submitted to the Quality Assurance Performance Improvement Committee by Administrator and or AIT and reviewed by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. Compliance Date: September 21, 2023	

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F 584	Continued From page 5 mold and he did not know he could ask to have an outside company come into the facility and test. The Maintenance Manager indicated that what appeared to be mold behind toilets and under vanities was not a reason to ask for mold testing. In a continued interview with the Maintenance Manager on 8/30/23 at 1:30 pm, indicated he was only responsible for fixing maintenance issues such as leaks, and housekeeping staff were responsible for cleaning. He provided two cleaning agents and neither were labeled to kill mold spores. He had seen a black substance near leaking areas under the hand sink vanity and behind toilets but did not think it appeared to be mold. The Maintenance Manager stated he would have to shut the water off to the entire building to fix any water leaks. He also stated the toilet shut off valves needed to be replaced. The pipes would crumble when he attempted to replace the plumbing. He contacted the Administrator and Corporate regarding hiring a contractor to fix the plumbing. The Director of Nursing was interviewed on 8/28/23 at 3:15 pm. She stated she was unaware of leaking plumbing or black substance under vanities or behind toilets. She indicated ongoing water leaks could affect the health of residents with respiratory issues. In an interview with the Administrator on 8/29/23 at 2:15 pm she indicated she was not aware of leaking plumbing or a black substance in resident vanities and bathrooms.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		9/21/23

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F 677	Continued From page 6 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #3) dependent on staff for activities of daily living (ADL) care. Findings included: Resident #3 was admitted to the facility on 4-20-23 with multiple diagnoses that included respiratory failure. The quarterly Minimum Data Set (MDS) dated 7-4-23 revealed Resident #3 was cognitively intact and required total assistance with 2 people for toileting. Resident #3 was also documented as always incontinent of bowl and bladder. Review of weekly skin assessments from 8-1-23 through 8-29-23 did not reveal any open areas to Resident #3's skin but did indicate redness to her buttocks. Resident #3's care plan last reviewed on 8-24-23 revealed Resident #3 was at risk for ADL decline due to muscle weakness and respiratory failure. The goal for Resident #3 was her ADL needs would be met. The interventions for the goal included to set Resident #3 up for ADL care and encourage her to participate as much as possible.	F 677	Corrective Action for the Resident Affected On August 30, 2023 the Director of Healthcare Services, (DHS), ensured that resident #3 had incontinence care. Action for the Residents Potentially Affected On September 11, 2023 the Administrator and DHS met with the Case Mix Director (MDS Nurse) to review residents with incontinence care. Of the 89 residents in house, 61 residents require incontinence care. Systemic Changes On September 14, 2023 the DHS and other clinical managers re-educated the licensed nursing and unlicensed staff on providing incontinence care in a timely manner. Any staff member not re-educated by September 18, 2023 will receive the education prior to their next shift worked or removed from the schedule until they receive the education. Education on incontinence care in a timely manner will be reviewed with new licensed and unlicensed staff during their orientation process.	

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F 677	Continued From page 7 Resident #3 was interviewed on 8-29-23 at 10:10am. The resident stated she was not receiving incontinence care as she should. She explained when she would ask a staff member for incontinence care, she would have to wait for an hour or longer until the staff member was able to provide the incontinence care. Resident #3 discussed the staff telling her they were short staffed, and they would provide the care as soon as they could. The resident also explained she knew how long it took to receive care because she had looked at the clock on her wall. Resident #3 explained the last time she received incontinence care today (8-29-23) was around 6:00am. The resident stated she had placed her call light on at 8:30am for incontinence care but said staff came in and turned off her light and was informed by the staff (she could not remember who) that breakfast was being served and she would need to wait. Resident #3 stated she was still waiting. There were no odors observed. Observation of incontinence care with Resident #3 occurred on 8-29-23 at 10:58am with Nursing Assistant (NA) #1. Resident #3's brief was observed to be wet but had not leaked through to the under pad and there were no signs of dried urine. The resident's skin was observed to be free of any open areas. However, the lower part of her buttocks and upper part of her thighs were observed to be bright red and the resident was observed to tell the NA the area was sore when the NA cleaned her lower buttocks and upper thigh areas. NA #1 was observed to apply a barrier cream to the bright red areas. NA #1 was interviewed on 8-29-23 at 11:19am. The NA stated she was supposed to check on her assigned residents every 2 hours but stated due	F 677	Quality Assurance The DHS and/or the Administrative Nurses will randomly select 5 residents weekly, times 4 weeks, then 5 residents monthly, times 3 months to ensure they have received incontinence care in a timely manner, utilizing the QA Monitoring Tool for ADL Care Provided for Dependent Residents. Any concerns will be addressed. The results of these audits will be reported to the Quality Assurance Performance Improvement, (QAPI) Committee, by the DHS for review by the Interdisciplinary Teams members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 21, 2023	

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F 677	Continued From page 8	F 677		

to staffing issues she was not able to provide 2-hour rounds on her residents and said she had not checked on or provided Resident #3 any incontinence care prior to 10:58am. NA #1 explained she had been busy this morning (8-29-23) with other residents and had not had time to provide care to Resident #3. She also explained she was unaware Resident #3 had her light on earlier in the morning. The NA stated she had reported the concerns to the Director of Nursing (DON) but had not received any help. NA #1 discussed Resident #3 having to wait "probably an hour or more" for incontinence care due to the lack of staff. NA #1 also discussed Resident #3's redness to her bottom and upper thighs had been present "for the last couple months."

An interview with NA #2 occurred on 8-29-23 at 4:47pm. NA #2 discussed being assigned to Resident #3 on the 3:00pm to 11:00pm shift on 8-29-23. She stated she "tried" to check for incontinence care on her assigned residents every 2 hours. The NA explained Resident #3 would trigger her call light when she needed incontinence care but stated Resident #3 has had to wait over an hour for incontinence care due to lack of staff. NA #2 was unable to recall specific dates as to when Resident #3 had to wait over an hour for incontinence care but stated it happened "at least 3-4 times a week." She explained she had discussed her concerns with DON but had not received any help.

During an interview with NA #3 on 8-30-23 at 8:15am, the NA discussed being assigned to Resident #3 on the 7:00am to 3:00pm shift on 8-30-23. She discussed trying to check on her assigned residents every 2 hours for incontinence

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F 677	Continued From page 9 care. The NA stated Resident #3 would "sometimes" trigger her call light for incontinence care but explained most of the time she had to ask Resident #3 if she needed incontinence care. NA #3 stated Resident #3 has had to wait over an hour for incontinence care when the facility was short on staff. She stated she could not recall exact dates but that it occurred "4-5 times a week." The NA also stated she had voiced her concerns to DON but had not received any help. The Director of Nursing (DON) was interviewed on 8-30-23 at 9:05am. The DON explained the NAs were assigned 17-20 residents per shift. She stated the NAs had brought to her attention the difficulty they were having providing care to their assigned residents and stated the NAs were educated on asking for assistance if they were not able to complete their assignments. The DON stated she had not heard that Resident #3 had to wait an hour or more for incontinence care. She stated she expected staff to inform management of any difficulties, provide timely care and ask for help. The DON also said she would expect the call light to remain on until care had been completed. During an interview with the Administrator on 8-30-23 at 9:55am, the Administrator discussed the NAs being assigned 17-20 residents per shift. She stated if the NAs voiced any concerns completing their tasks, management staff would assist. The Administrator discussed not hearing any concerns of Resident #3 having to wait an hour or more for incontinence care but said she would expect staff to ask for help if they were unable to provide care in a timely manner.	F 677		
F 725 SS=D	Sufficient Nursing Staff	F 725		9/21/23

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F 725	Continued From page 10 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to provide sufficient nurse staff to ensure 1 of 2 residents (Resident #3) who was dependent on staff received incontinence care. Findings included:	F 725	Corrective Action for the residents affected On August 31, 2023, the Director of Healthcare Services, (DHS), met with Resident # 33 and discussed their concerns, including the call-light response time.	

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F 725	Continued From page 11 This tag is cross referenced to: F677: Based on record review, observation, resident, and staff interviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #3) dependent on staff for activities of daily living (ADL) care. A review of the facility's working schedules from 7-1-23 through 8-29-23 revealed the average census for the facility was 92 residents with 5 Nursing Assistants scheduled for the facility. Nursing Assistant (NA) #1 was interviewed on 8-29-23 at 11:19am. The NA discussed not being able to provide care to her assigned residents due to the lack of staff. She explained she typically was assigned 18-20 residents and was not able to provide incontinence care to all her assigned residents in under an hour. NA #1 discussed management being aware of the problem but not helping. During an interview with NA #2 on 8-29-23 at 4:47pm, the NA explained she would be assigned up to 20 residents during her shift and stated she was not able to complete all her assigned tasks. She also discussed residents having to wait an hour or more for care due to the lack of available staff. NA #2 explained she had informed management of the issues and stated she was told to ask management for help, but NA #2 discussed lack of management on the 3:00pm to 11:00pm shift to assist. The Director of Nursing (DON) was interviewed on 8-30-23 at 9:05am. The DON explained the facility did not currently have a scheduler and that she had been helping with the scheduling of	F 725	Corrective action for residents potentially affected On September 6, 2023, the facility received approval for the Regional Vice President of Operations, (RVPO), to delay admissions until the facility was able to increase their staffing needs. On August 31, 2023, the Administrator met with the DHS, Staffing Coordinator and Human Resources and reviewed the open positions for the facility. Systemic Changes On September 1, 2023, the RVPO approved sign-on bonuses for newly hired licensed and unlicensed staff until the facility can fill the open positions. On September 1, 2023, the RVPO approved increasing incentive pay for licensed and unlicensed staff until the facility can fill the open positions. The Administrator meets weekly with the Talent Acquisition Department, DHS, Staffing Coordinator and Human Resources to review the immediate staffing needs of the facility. On September 14, 2023, the Human Resources Director in-serviced facility staff and reviewed the referral program and encouraged input for referring qualified licensed and unlicensed staff. Quality Assurance	

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	345357	A. BUILDING _____ B. WING _____	C 08/30/2023

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F 725	Continued From page 12 nursing staff. She discussed if there was a call out, she would ask staff to work over and if she was unable to find a replacement she would fill in and assist the staff wherever possible. The DON stated the NAs were assigned 17-20 residents per shift and said she had heard from the NAs that they were having difficulty completing their assignments and providing care in a timely manner. She stated she had educated the NAs in asking nursing staff or management for help when needed. The DON explained the normal staffing pattern should be 12 to 13 residents per NA. During an interview with the Administrator on 8-30-23 at 9:55am, the Administrator discussed scheduling by acuity of the facility and stated she had been made aware by staff that they were having difficulty completing their assignments and providing care in a timely manner. The Administrator discussed that most of the residents in the facility were high acuity (residents who require extensive to total assistance) residents, and she explained the NAs had been educated in asking for help when needed. The Administrator confirmed the NAs were assigned 17-20 residents per shift and stated she felt the assignments were appropriate since the NAs were able to ask for help.	F 725	The Administrator, DHS, Staff Coordinator, Human Resource Director, and Talent Acquisition will meet weekly to review the staffing needs of the facility, review upcoming interviews, offers made and onboarding. The Administrator will meet and review the staffing schedule with the DHS, Staffing Coordinator and Human Resources Director 3 times a week times 4 weeks, then 2 times a week times 4 weeks, then weekly utilizing the QA Monitoring Tool for Sufficient Nurse Staffing. The results of these meetings will be reported to the Quality Assurance Performance Improvement, (QAPI) Committee, by the Human Resources Director for review by the Interdisciplinary Teams members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: September 21, 2023	
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	F 867		9/21/23

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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, 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,

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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.

§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

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F 867	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 4-21-22 recertification and complaint survey and the 7-13-23 recertification and complaint survey. This was for 1 recited deficiency in F677 Activities of Daily Living. The deficiency was cited again in a follow-up and complaint survey on 8-30-23. The continued failure of the facility during three federal surveys	F 867	Corrective action for the resident affected On September 15, 2023 the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT)to discuss the F- 677, Activities of Daily Living, cited on 4-21-22, recertification and complaint survey, 7-13-23 recertification and complaint survey, and the follow-up and complaint survey on 08-30-23. It was determined	

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F 867	Continued From page 16 of record shows a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to: F677: Based on record review, observation, resident, and staff interviews the facility failed to provide incontinence care for 1 of 3 residents (Resident #3) dependent on staff for activities of daily living (ADL) care. During the complaint and recertification survey on 7-13-23 the facility was cited for failing to provide nail care. During the complaint and recertification survey on 4-21-22 the facility was cited for failing to provide incontinence care. The Administrator was interviewed on 8-30-23 at 2:23pm. The Administrator discussed not being sure what the root cause was for the continued failure for F677 and stated she had not heard of any concerns relating to incontinence care. She discussed education being completed with staff to ask for help and stated the facility managers needed to be more proactive in asking staff if assistance was needed to complete resident care.	F 867	through the Root Cause Analysis that staff attrition from full-time to PRN staffing exceeded the pace of hiring new full-time staff. Corrective action for residents potentially affected On August 30, 2023 the Regional Nurse Consultant re-educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocols for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys. Systemic Changes The Area Vice President of Operations for Coastal North Division and or the Regional Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly times 6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI process. Quality Assurance The results of these ongoing survey trend reviews are to be submitted in the QAPI meeting and placed in the QAPI minutes for review. The Quality monitoring schedule will be modified based on the findings of the monitoring review. The QAPI Committee will evaluate and modify the monitoring schedule as needed.	

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