STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING _____ B. WING _____	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS REHABILITATION AND CARE CENTER	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 09/11/23 through 09/14/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # DQK111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 09/11/23 through 09/14/23. Event ID # DQK111. The following intakes were investigated NC00206617, NC00206661, NC00205081 AND NC00205821. 15 of the 15 allegations did not result in a deficiency.	F 000		
F 641 SS=B	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 staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect the use of an antibiotic and the frequency of use for an anticoagulant, antidepressant, and diuretic for 1 of 6 residents (Resident #53) reviewed for unnecessary medications. The findings included: Resident #53 was admitted to the facility on 7/3/20 with reentry from a hospital on 6/16/23. The resident's cumulative diagnoses included hypertension, heart failure, major depressive disorder, and a history of cerebral infarction due	F 641	For the resident affected, a modified Minimal Data Set (MDS) was completed on September 14, 2023. Since all residents have the potential to be affected, the facility's MDS Coordinator was inserviced on September 14, 2023 on the need to ensure the MDS is properly coded. This training was provided by our Vice President of Revenue Management who oversees all MDS activity. To ensure accurate coding of any future MDS, the MDS Coordinator will pull a medication administration record (MAR)	9/14/23

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

Electronically Signed | 09/27/2023

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F 641	Continued From page 1 to an unspecified occlusion or stenosis of a cerebral artery (a stroke which occurred as a result of disrupted blood flow to the brain). The resident's medical record indicated a physician's order was received on 6/16/23 for 5 milligrams (mg) apixaban (an anticoagulant) to be given as one tablet by mouth twice daily. Physician's orders were received on 6/17/23 for 100 mg nitrofurantoin monohydrate / nitrofurantoin macrocrystals (an antibiotic) to be given as one capsule by mouth once daily, 25 mg sertraline (an antidepressant) to be given as one tablet by mouth each morning, 2.5 mg metolazone (a diuretic) to be given as one tablet by mouth each morning, and 25 mg spironolactone (also a diuretic) to be given as one tablet by mouth each morning. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly MDS dated 6/21/23. The Medication section of this MDS assessment reported the resident received an anticoagulant, antidepressant, and diuretic medication each on 7 out of 7 days during the 7-day look back period from 6/15/23 - 6/21/23. The MDS did not report an antibiotic was administered to Resident #53 during this look back period. Review of Resident #53's June 2023 Medication Administration Record (MAR) revealed the resident was documented as having received an anticoagulant on 6 out of 7 days (not 7 out of 7 days), an antidepressant on 5 out of 7 days (not 7 out of 7 days), and a diuretic on 5 out of 7 days (not 7 out of 7 days) from 6/15/23 to 6/21/23. Additionally, the resident did receive an antibiotic on 5 out of 7 days during this same period of	F 641	for the look back period being coded on the MDS. The MDS will be coded to reflect the medication administration record. To ensure on-going compliance, the Corporate MDS Coordinator will audit 5 assessments a week for 4 weeks and then 3 assessments a week for 2 weeks and then as needed. The results of these audits will be taken to the quality assurance committee for monitoring.	

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F 641	Continued From page 2 time. An interview was conducted with the Regional Reimbursement Specialist and the facility's corporate Vice President of the Resource Utilization Group (RUG) Management on 9/14/23 at 12:27 PM. During the interview, the Regional Reimbursement Specialist reviewed both Resident #53's June MAR and her quarterly MDS assessment dated 6/21/23. Upon review, she confirmed the resident was administered an anticoagulant on 6/7 days, an antidepressant on 5 out of 7 days, and a diuretic on 5 out of 7 days during the 7-day look back period. The Regional Reimbursement Specialist also reported Resident #53's MDS dated 6/21/23 should have reported the resident received an antibiotic on 5 out of 7 days from 6/15/23 to 6/21/23.	F 641		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, resident, Physician and staff interviews, the facility failed to schedule an	F 685	For the effected resident, an ophthalmology appointment was	9/27/23

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F 685	Continued From page 3 ophthalmology consult appointment as ordered by the Physician for 1 of 1 resident reviewed for vision (Resident #67). The findings included: Resident #67 was admitted to the facility on 3/9/23. Diagnoses from the diagnoses tab and care plan of the electronic medical record for Resident #67 included glaucoma, unspecified acute bilateral conjunctivitis. A review of the admission orders on 3/9/23 by Physician #2 specified consultation for ophthalmology, and optometry as needed. The Admission Care Plan dated 3/11/23 revealed a focus related to Vision: I have severely impaired vision secondary to Glaucoma, with the goal of no indications of acute eye problems through the review date of 9/14/23. Interventions included: Arrange consultation with an eye care practitioner as required. The Admission Minimum Data Set (MDS) dated 3/15/23 revealed Resident #67 was cognitively intact, had no rejection of care. The Care Area Assessment (CAA) dated 3/20/23 triggered for vision as severely impaired, with care planning. The assessment revealed he came from the hospital related to a fall from his wheelchair as well as impaired vision related to a diagnosis of Glaucoma. The CAA further revealed that a referral to another discipline was not warranted at the time of the admission CAA. A review of the physician progress notes revealed	F 685	scheduled on 9/14/23 for 9/27/23 at 10:30 a.m. with another provider as his provider continues to deny service for past non-compliance. All residents with external consultations or doctor's appointments could be affected. For any residents with the potential of being affected, the facility will encourage providers to not include end dates on any active orders for outside consultations including doctor appointments. This will allow all orders to remain active until the interdisciplinary team can ensure an appointment is made before the order is no longer active. The interdisciplinary team will review all active orders (Monday through Friday) to ensure any external appointments are scheduled and transportation is arranged accordingly. To ensure on-going compliance, the director of nursing or administrator will randomly select up to 3 consultations per week or the maximum amount available, whichever is greater, for 4 weeks to ensure all outside appointments are made timely. If any issues are identified, the audit will continue for an additional 4 weeks until the facility has ensured compliance with this regulation. The results of these audits will be taken to the quality assurance committee for monitoring.	

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F 685	Continued From page 4	F 685		

Resident #67 had four provider assessment notes related to vision:

1. Date of service on 4/28/23 occurred by Physician #1 for a routine regulatory visit and interval concerns related to Resident #67's concern for right eye visual changes that Resident #67 stated were worsening. The physician note continued that Resident #67 had a significant history of Glaucoma, missed his follow-up appointment with ophthalmology and was in the process of changing ophthalmologists to Ophthalmology Practice #1. Physician #1's physical exam notes of the eyes revealed notable changes to the oculus dexter (OD, right eye) iris, pupil, chronic. The Assessment and Plan notes by Physician #1 revealed right eye visual changes with significant history of glaucoma, overdue for an ophthalmology follow-up appointment, and an order for an ophthalmology consult with Ophthalmology Practice #1. The order was not located in the EMR for this provider.

2. Date of service on 5/18/23 occurred by NP #1 for evaluation and management of chronic health problems. NP #1's physical exam of Resident #67's eyes revealed OD redness, chronic, with history of glaucoma. The Assessment and Plan note for Glaucoma documented needs to be seen by ophthalmology, order placed. The order dated 5/20/23 was written Needs appointment - Ophthalmology with Practice #1.

Review of the active orders revealed the 5/20/23 order for the ophthalmology consult was not written with a stop date: "needs appointment--ophthalmology with Ophthalmology Practice #1--glaucoma."

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F 685	Continued From page 5	F 685		

3. Date of service on 7/7/23 occurred by Physician #1 for a regulatory visit and interval concerns. Review of the documentation revealed Resident #67 again inquired about his ophthalmology evaluation with the history of glaucoma. Physician #1 continued that he did not see an ophthalmology consultant note in the electronic medical record for Resident #67. The Assessment and Plan note for Glaucoma documented Resident #67 with considerable history of glaucoma with a previously ordered ophthalmology consult but did not believe it was obtained, with a second request order placed for ophthalmology consult. Glaucoma was listed again, and documented needs to be seen by ophthalmology, order placed. The order dated 7/7/23 was written Ophthalmology eval with Ophthalmology Practice #1, 2nd request, one time only for glaucoma for 1 Day.

Review of the completed orders revealed the Friday, 7/7/23 order for the ophthalmology consult was not written with a specific stop date: "ophthalmology eval with Ophthalmology Practice #1, 2nd request. One time only for glaucoma for 1 day."

4. Date of service 7/13/23 occurred by NP #4 for an evaluation and management visit of chronic health issues. The Assessment and Plan note for Glaucoma documented needs to be seen by ophthalmology, order placed.

A review of the progress notes revealed no documentation of the outcome for an ophthalmology appointment call to Ophthalmology Practice #1 and no documentation that Physician #1 or NP #1 were notified about the inability to complete their

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F 685	Continued From page 6	F 685		

respective orders for an appointment with Ophthalmology Practice #1.

An interview with Nurse #6 on 9/13/23 at 9:03 am revealed that when a new order for a consult was written by the doctor, she would tell the Nurse Manager, or print out the order and slip it under the door of the Transportation office because either the Nurse Manager or Transportation would set up a new consult appointment.

An interview with Nurse Manager #1 on 9/13/23 at 9:17 am revealed that ordered consult appointments to a specialist were made by either the Nurse Managers or Transportation. If a Nurse Manager was notified by nursing of a new order for a consult, the Nurse Manager would make an appointment for the resident. Transportation would make an appointment for a consult order if the nurses put the printed consult order under the door of the Transportation office. Transportation would let the Nurse Managers know that an appointment was made. Nurse Manager #1 revealed there were usually two Nurse Managers for the facility, with one Nurse Manager covering upstairs, and the other Nurse Manager covering downstairs. She continued she covered the entire facility at times. Nurse Manager #1 stated there was a former Nurse Manager #2 from February through August 2023, who no longer works as Nurse Manager.

An interview with Resident #67 on 9/13/23 at 11:22 am revealed he lost his vision in his left eye around 2013 and had cataract surgery with a shunt in his right eye 4/1/2019, with normal, clear vision in his right eye at that time with great ability to see colors. He continued the last time he saw an eye doctor was either April of 2021 or 2022.

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A telephone interview with former Nurse Manager #2 on 9/13/23 at 1:14 pm revealed she was Nurse Manager from February 2023 through the end of August 2023. She recalled Resident #67, and recalled his care person wanted him to see a specialist but did not remember if the information was passed to the provider. She revealed the nurses would let the Nurse Managers or Transportation know if there was an order for a specialist consult and did not recall an order for an ophthalmology appointment for Resident #67. She continued that the Director of Nursing (DON) and the Nurse Managers would run a daily "Order Listing Report" for the morning Clinical Meeting each day to review all the orders in the last 24 hours. On Mondays, the Order Listing Report would be run for the last 72 hours to obtain any orders written over the weekends. Discussion would occur during the morning Clinical Meeting to review the orders. She revealed the DON would typically give a set of tasks to the Nurse Managers that were still outstanding, and at the end of each weekday there would be a stand-down meeting to review what had been accomplished for the day, and what items were still outstanding.

A telephone call to NP #1 was made on 9/13/23 at 3:37 pm, with no return call received.

An interview with the DON on 9/13/23 at 3:42 pm revealed she could not locate ophthalmology notes for Resident #67.

Telephone calls to Nurse #8 and Nurse #1 were made on 9/13/23 at 7:31 pm with no return calls received.

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An interview with Nurse #7 on 9/14/23 at 11:54 am revealed he had administered eye drops for Resident #67. He recalled Resident #67 would ask about his Glaucoma eye drops and did not recall Resident #67 talking about an eye doctor appointment.

A telephone interview with Physician #1 on 9/14/23 at 2:28 pm revealed he saw Resident #67 for a regulatory visit on 4/28/23, and that Resident #67 brought up a complaint about his eyes. Physician #1 continued he put an order at that time in the electronic medical record, but the facility could not explain what happened to that order. He continued the second time he saw Resident #67 was 7/7/23 and Resident #67 asked again about his ophthalmology appointment. There were no notes that Resident #67 had been seen, so Physician #1 revealed he put in a second request for a consult to ophthalmology. He continued that Resident #67 needed to see an ophthalmologist to determine the pressure in his eyes and could not say if Resident #67's decline in vision was related to his eye infection or delay in receiving glaucoma care because he did not have ophthalmology notes to know for sure that Resident #67 had the diagnosis of glaucoma. Physician #1 concluded that he did not write the orders for Resident #67's glaucoma eye drops.

An interview with Transportation on 9/14/23 at 3:48 pm revealed there was one person for Transportation. She continued that once the doctor wrote an order for a consult, the nurse would print it and let her, or the Nurse Managers know to call and schedule an appointment for the resident. If Transportation was out driving a resident, the Nurse Manager would make the consult appointment, or the printout for the order

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F 685	Continued From page 9	F 685		

would be placed under the Transportation office door for Transportation to make the appointment. Transportation revealed she did not recall an ophthalmology appointment was made for Resident #67.

An interview with the DON on 9/14/23 at 4:15 pm revealed the 7/7/23 order for the ophthalmology consult was written on a Friday and the provider put a stop date on it so it did not show up as an active order when the Order Listing Report was run the following Monday for active orders.

An in-person interview on 9/14/23 at 4:49 pm with former Nurse Manager #2 revealed she wanted to clarify what she recalled regarding Resident #67. She continued she recalled she spoke with Ophthalmology Practice #1 to make an appointment for Resident #67 but was told he was blocked from being seen at Ophthalmology Practice #1 because of non-compliance. She continued she didn't recall a specific communication to any staff that Ophthalmology Practice #1 would not see Resident #67, but she would have told a provider that a different referral order was needed. She revealed that no verbal order was provided to obtain a different consult appointment.

An interview with the DON on 9/14/23 at 5:58 pm revealed Resident #67 had an order to be seen at an ophthalmology practice that would not see him, and Physician #1 did not write an order for an alternative provider because he wanted Resident #67 to be seen by Ophthalmology Practice #1.

An interview with the Administrator on 9/14/23 at 6:06 pm revealed he had a concern that Resident

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F 685	Continued From page 10 #67 had noncompliance with the Ophthalmologist Practice #1 before coming to the facility, which led to the facility being unable to get an appointment for the resident at the Ophthalmologist Practice #1 that the doctor wanted.	F 685		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		9/27/23

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F 690	Continued From page 11 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 3 residents (Resident #107) reviewed with indwelling urinary catheters. The findings included: Resident #107 was admitted to the facility on 1/3/23 with re-entry from a hospital on 7/3/23. His cumulative diagnoses included obstructive uropathy (a structural or functional obstruction of the urinary tract that impedes the flow of urine). A review of Resident #107's most recent Minimum Data Set (MDS) was a significant change assessment dated 7/26/23. This MDS indicated the resident had severely impaired cognition. He required extensive assistance for bed mobility, locomotion on the unit, dressing, eating, toileting, and personal hygiene. He was totally dependent on staff for transfers and bathing. The resident was reported as having an indwelling urinary catheter. The resident's care plan included a "Urinary" area of focus noted as reviewed and revised on 8/2/23. This area of focus indicated Resident #107 was at risk for complications related to his urinary catheter placed due to obstructive uropathy.	F 690	Resident #107's catheter bag was changed out on 9/14/2023 when the correct size catheter bags were delivered to the facility. There was no adverse and or negative outcome of Resident #107 due to the alleged deficient practice. All residents with catheter bags would be considered at risk for the alleged deficient practice. Prior to the survey, the facility ordered new catheter bags which arrived on 9/14/2023. All foley catheter bags were replaced on 9/14/2023 -- the day that they arrived at the facility. Changing all catheter bags will ensure no other residents are affected. However, the facility will monitor, at varying times, all catheter bags 4 times a week for 4 weeks and then randomly twice a week for 3 weeks and then as needed. The observations and any recommendations from these audits will be monitored by the quality assurance committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 12	F 690		

An initial observation was made on 9/11/23 at 10:14 AM as Resident #107 was lying in bed asleep. The resident's urinary catheter bag was observed to be hanging from the bed frame on his right side of the bed with approximately two inches (2") of the bag lying on the floor.

On 9/11/23 at 12:45 PM, a staff member was observed to be sitting on the left side of Resident #107's bed assisting him with his noon meal. The resident's urinary catheter bag was observed to be hanging from the bed frame on his right side of the bed with 2 - 3" of the bag lying on the floor.

An observation made on 9/11/23 at 3:15 PM revealed approximately 6" of Resident #107's urinary catheter bag was lying on the floor as the resident laid in his bed.

Upon request and accompanied by Nurse #9, an observation was made of Resident #107's urinary catheter bag as it remained approximately 6" on the floor while the resident laid in his bed. When asked what her thoughts were about the placement of the catheter bag, the nurse stated, "It shouldn't be there." The nurse reported she would tell the resident's Nurse Aide (NA) the catheter bag needed to be fixed so it would be off the floor.

Observations conducted on 9/13/23 at 11:15 AM and on 9/13/23 at 11:50 AM revealed Resident #107's urinary catheter bag was hanging from the bed frame on his right side of the bed with approximately 1" of the bag lying on the floor.

During an interview conducted with Nurse #10 on 9/13/23 at 11:55 AM, the nurse was asked how a urinary catheter bag needed to be positioned. In

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	345186	A. BUILDING _____ B. WING _____	C 09/14/2023

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F 690	Continued From page 13 response, the nurse stated, "below the belly, but off of the floor." Upon request and accompanied by NA #3, an observation was made on 9/13/23 at 12:07 PM of Resident #107's urinary catheter bag touching the floor. When asked what her thoughts were about the positioning of the bag, the NA stated it was okay for the catheter bag to touch the floor if it had a privacy cover. An interview was conducted on 9/14/23 at 8:48 AM with the facility's Director of Nursing (DON). During the interview, the observations of Resident #107's urinary catheter bag lying on the floor were discussed. The DON reported facility staff were taught that a urinary catheter bag needed to be placed below the resident's bladder and off of the floor. She stated, "Anything touching the floor is considered to be dirty." When asked, the DON reported the NA was incorrect when she reported the catheter bag could lay on the floor if it had a privacy bag. The DON stated this was "still an issue."	F 690		
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	F 867		9/22/23

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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, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:

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(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 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

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F 867	Continued From page 16 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 record review and staff interviews and observations, the facility's Quality Assurance and Performance committee (QAPI) failed to maintain implemented procedures and monitor the interventions the committee put into place during the recertification and complaint investigation survey dated 05/16/22 and the recertification and complaint investigation survey dated 09/14/23. F 641 was originally cited during the recertification and complaint investigation survey dated 05/16/22. F 641 was re-cited during the recertification and complaint investigation survey dated 09/14/23. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program.	F 867	The quality assurance committee met on 9/22/2023 to discuss the survey results and the concern for on-going compliance. It was determined to implement a robust monitoring tool for future Minimal Data Set (MDS) assessments. Since all residents have the potential the potential to be affected, the facility□s current MDS Coordinator was inserviced on 9/14/23 on the need to ensure the MDS is properly coded. This training was provided by our Vice President of Revenue Management who oversees all MDS activity for our organization. To ensure accurate coding of any future	

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F 867	Continued From page 17 The findings included: This tag is cross-referenced to: 1.F 641: Based on staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect the use of an antibiotic and the frequency of use for an anticoagulant, antidepressant, and diuretic for 1 of 6 residents (Resident #53) reviewed for unnecessary medications. During the recertification and complaint investigation survey of 05/16/22, the facility failed to correctly code dialysis and range of motion on the Minimum Data Set (MDS) assessments for 2 of 21 residents reviewed for MDS accuracy. An interview was conducted with the Administrator on 09/14/23 at 6:29 PM. The Administrator explained he had only been at the facility for about two months when the facility conducted monthly QAPI meetings, and he believed the monitoring of previous survey citations had been resolved by the QAPI committee since 2022. The Administrator felt it was back in compliance based on previous audits.	F 867	MDS, the MDS Coordinator will pull a medication administration record (MAR) for the look back period being coded on the MDS. The MDS will be coded to reflect the medication administration record. The MDS Coordinator will also ensure accurate coding of the range of motion and if dialysis is utilized prior to completing the assessment. To ensure on-going compliance, the Corporate MDS Coordinator will audit 5 assessments a week for 4 weeks and then 3 assessments a week for 2 weeks and then as needed. The results of these audits will be taken to the quality assurance committee for monitoring.	