STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/4/24 through 3/7/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# JY1G11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/4/24 through 3/7/24. Event ID# JY1G11. The following intakes were investigated: NC00206505, NC00206512, NC00207197, NC00207716, NC00207843, NC00208255, NC00209484, NC00209678, NC00209943, NC00210144, NC00212013 and NC00212437. 1 of the 29 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident reviewed for medications at bedside (Resident #67). The findings included: Resident # 67 was admitted to the facility on 7/30/23 with diagnosis that included type 2 diabetes mellitus with hyperglycemia and congestive heart failure.	F 554	1. Facility failed to assess a resident's ability to self-administer medications for 1 of 1 resident reviewed for medications at the bedside. Resident #67 was found to have a cup of pills at bedside, left unattended by Nurse #1. Resident #67 took medication by mouth, independently, after returning from the restroom. Resident #67 was assessed for adverse effects of self-administration with none identified. Resident #67 does not wish to self-administer medications.	3/27/24

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

Electronically Signed | 03/23/2024

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F 554	Continued From page 1 Review of the quarterly Minimum Data Set (MDS) assessment dated 1/5/24 revealed that Resident #67 was cognitively intact. Review of Resident #67's medical record revealed no documentation that Resident #67 had been assessed to self-administer medications at bedside. An in-room observation and interview with Resident #67 on 3/4/24 at 11:17 AM revealed a medication cup sitting on Resident #67's overbed table containing 11 pills. Resident #67 stated the nurse had brought her medication to her about 30 minutes prior for her to take. Resident #67 said she told the nurse she would take the pills after she used the bathroom, and the nurse had left the pills for her to take. Resident #67 said she left the pills on her overbed table while she used the restroom and was going to take them soon. On 3/4/24 at 11:45 AM the Administrator was brought to the resident's room. Resident #67 stated to the Administrator she had just taken her medications and the nurse had left the medications for her to take after she used the restroom. The Administrator stated to Resident #67 her medications should have been taken with the nurse present in her room. Nurse #1 was interviewed on 3/4/24 at 3:29 PM and confirmed he had given Resident # 67 her medications but did not watch her take the medications. Nurse #1 stated Resident #67 should have taken her medications before he had left her room. The Director of Nursing (DON) was interviewed	F 554	2. Current facility residents are at risk of being affected by the deficient practice. The Director of Nursing (DON) completed an audit of all residents to ensure there were no medications left at bedside for self-administration. No other areas of concern identified. Audit was completed on 3/18/2024. 3. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: All facility and agency licensed nurses and Certified Medication Aides will be re-educated on the Resident Self-Administration Medication policy and not leaving medication at bedside, visually ensuring residents have taken their medications before leaving the resident. The Director of Nursing completed this education with facility and agency licensed nurses and Medication Aides. Newly hired facility and agency licensed nurses and Certified Medication Aides will be educated upon hire and prior to working their first shift. 4. The Director of Nursing or Regional Director of Clinical Services will complete an audit of 10 resident’s rooms twice weekly for four (4) weeks, then weekly x four (4) weeks, then bi-weekly x four (4) weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement	

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F 554	Continued From page 2 on 3/07/24 at 10:44 AM and stated Nurse #1 should have watched the resident take her medications prior to leaving Resident #67's room.	F 554	Committee. Data will be brought by the Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance. 5. Completion Date: 3/27/2024	
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the regulated time frames for 3 of 3 residents reviewed for completion of quarterly Minimum Data Set (MDS) assessments (Residents # 34, #15, #69). The findings included: 1. Resident #34 was admitted to the facility 8/29/18. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 2/8/24 was reviewed and revealed the assessment was still in progress on 3/6/24. The MDS Coordinator was interviewed on 3/6/24	F 638	1.The facility failed to complete quarterly Minimum Data Set assessments within regulated time frame for 3 of 3 residents reviewed for completion of Quarterly Minimum Data Set Assessments. Resident #34, #15, and #69 all showed quarterly assessments that were still in progress on 3/6/2024 and were not completed within the appropriate time frame. Assessments were completed and transmitted by the Minimum Data Set (MDS) Coordinator on 3/11/2024. 2. Current facility residents have the potential to be affected by this deficient practice. An audit was completed on 3/11/2024 by the Minimum Data Set (MDS)coordinator on quarterly MDS assessments with ARD dates between 1/1/2024 and 3/1/2024 to ensure all were	3/27/24

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F 638	Continued From page 3 at 9:25 AM and stated she had been working at the facility for one month and was aware of the late quarterly MDS assessment. The MDS Coordinator stated the facility had been without a MDS Coordinator and had a plan to complete late assessments. The Interim Administrator stated on 3/7/24 at 11:32 AM the MDS quarterly assessments should have been completed on time. The facility was working on a plan to catch up on the late MDS assessments. 2. Resident #15 was admitted to the facility on 10/1/23. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 2/12/24 was reviewed and revealed the assessment still in progress on 3/6/24. The MDS Coordinator was interviewed on 3/6/24 at 9:25 AM and stated she had been working at the facility for one month and was aware of the late quarterly MDS assessment. The MDS Coordinator stated the facility had been without a MDS Coordinator and had a plan to complete late assessments. The Interim Administrator stated on 3/7/24 at 11:32 AM the MDS quarterly assessments should have been completed on time. The facility was working on a plan to catch up on the late MDS assessments. 3. Resident # 69 was admitted to the facility on	F 638	completed. Late quarterly assessments were completed and submitted as identified. 3. The measures that have been put into place to ensure the deficient practice does not recur are as follows: Education was provided to the Minimum Data Set (MDS) coordinator and the Interdisciplinary Team (Administrator, Director of Nursing, Dietary Manager, Activities Coordinator, Therapy Director, and Social Worker) by the Regional Director of Clinical Reimbursement on timely completion of quarterly MDS per Resident Assessment Instrument (RAI) guidelines. The education was completed by the Regional Director of Clinical Reimbursement on 3/11/2024. New facility Minimum Data Set (MDS) nurses and Interdisciplinary Team (IDT) members will be educated upon hire and prior to working their first shift. 4. The MDS coordinator and/or DON will monitor 5 random residents for timely completion of quarterly MDS assessments. Monitoring will be completed twice weekly for 4 weeks, then weekly for 8 weeks. The facility will monitor the corrective actions to ensure that the deficient practice is corrected and does not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing (DON) monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary.	

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F 638	Continued From page 4 9/15/23. The quarterly MDS assessment with an assessment reference date (the last day of the assessment period) of 2/16/24 was reviewed and revealed the assessment was still in progress on 3/6/24. The MDS Coordinator was interviewed on 3/6/24 at 9:25 AM and stated she had been working at the facility for one month and was aware of the late quarterly MDS assessment. The MDS Coordinator stated the facility had been without a MDS Coordinator and had a plan to complete late assessments. The Interim Administrator stated on 3/7/24 at 11:32 AM the MDS quarterly assessments should have been completed on time. The facility was working on a plan to catch up on the late MDS assessments.	F 638	5. Completion Date: 3/27/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		3/27/24

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F 644	Continued From page 5 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for a resident with new mental health diagnoses for 1 of 2 residents reviewed for PASRR (Resident #23). The findings included: Review of Resident #23's medical record revealed the resident had a PASRR level I completed prior to his admission dated 8/3/17. He was admitted to the facility on 10/26/22 with diagnoses of bipolar disorder and anxiety disorder. A diagnosis of major depressive disorder was added on 8/29/23. Review of Resident #23's medical records revealed no PASRR level II had been completed. Review of Resident #23's annual Minimum Data Set (MDS) dated 9/20/23 revealed he had not been evaluated by Level II PASRR. During an interview on 3/6/24 at 2:25 pm, the Interim Administrator and the Social Worker (SW) explained the facility's PASRR process. The SW stated all residents had PASRR when they got to the facility. Their diagnoses determined what kind of PASRR they had. The SW sent resident information to a state contracted vendor to conduct PASRR if they needed one. The SW	F 644	1. The Facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for a new mental health diagnosis for 1 of 2 residents reviewed for PASRR (Resident # 23). PASRR Level II review was initiated and submitted for resident #23 on 3/6/2024. When the PASRR evaluator came to visit resident #23, he was on a Leave of Absence with family, therefore another PASRR Level II review was requested on 3/19/2024. 2. Current facility residents with a new mental health diagnosis are at risk of being affected by the same deficient practice. The Social Worker (SW) audited current facility residents to ensure all residents with new mental health diagnosis have a completed PASRR. This was completed on 3/22/24. No further concerns identified. 3. To ensure the same deficient practice does not recur, the facility has put the following in place: the Social Worker and Interdisciplinary team (IDT) was educated by the Regional Director of Clinical Services on ensuring a resident with a new mental illness is submitted to the North Carolina Medicaid Uniform Screening Tool (NCMUST) user interface for review of change in diagnosis. This education was completed on 3/7/2024.	

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F 644	Continued From page 6 stated the contractors came and assessed the resident. They determined what level of PASRR the residents would be. This was done to everyone that came in. SW would send another referral if there was a change in condition or if PASRR was getting ready to expire. The contractors came and did another assessment. They also determined expiration dates. There would be expiration dates on the PASRR if a resident was admitted short term such as for rehabilitation, or if resident was scheduled to be discharged to an assisted living facility. The SW sent PASRR referral for any residents with new mental health diagnoses after admission. During a follow up interview on 3/6/23 at 3:02 pm, the SW revealed Resident #23 was not referred for Level II when his diagnosis of major depressive disorder was added on 8/29/23. She stated she missed sending a referral for Level II PASRR for the resident because she was busy trying to orient in her new role as SW, learning care plans and was training on PASRR. She stated she will send in a referral for Resident #23 as soon as possible. During a follow up interview on 3/7/24 at 12:20 pm, the Interim Administrator stated there should have been a referral sent for level II PASRR for Resident #23 when he had a new mental health diagnosis on 8/29/23.	F 644	Newly hired Social Workers and IDT members will be educated upon hire or prior to working their next scheduled shift by the Administrator or RCDR. 4. The Director of Nursing (DON) or Administrator will audit 5 residents for new mental health diagnosis and need for PASRR review, twice weekly for four (4) weeks, then weekly x four (4) weeks, then bi-weekly x four (4) weeks. Deficient practice identified in these audits will be corrected immediately. The results of this audit will be presented by the Director of Nursing at the monthly Quality Assurance Process Improvement (QAPI) meeting. This will continue for a period of 3 months or longer if deemed necessary by the QAPI team. The QAPI team may adjust this plan if deemed necessary to achieve compliance. 5. Date of Compliance: 3/27/2024	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		3/27/24

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F 658	Continued From page 7 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility administered a medicated powder without a physician's order for 1 of 1 resident reviewed for professional standards of practice (Resident #21). The findings included: Resident #21 was admitted to the facility on 2/22/24. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/19/24 revealed that Resident #21 was cognitively intact. A review of Resident #21's active physician orders for March 2024 revealed that there was not an order for nystatin powder. An in-room observation and interview with Resident #21 occurred on 3/04/24 at 11:08 AM. A bottle labeled nystatin topical powder was observed on Resident #21's overbed table. She stated it was brought to her the previous night and left on the table and the bottle was left in her room often. Resident # 21 stated the nursing assistants applied the powder on to her. Resident # 21's Unit Manager who was Resident #21's assigned nurse was interviewed on 3/04/24 at 11:11 AM and stated he had not noticed the nystatin medication bottle in the resident's room earlier when Resident #21's medications were brought to her. The Unit Manager stated he was	F 658	1. The facility failed to uphold professional standards of practice, when a medicated powder was administered without a physician's order for 1 of 1 resident reviewed. Resident #21 had a bottle of nystatin topical powder at bedside on the morning of 3/4/2024, in which she stated nursing had applied to her the night before. Resident #21 did not have an active order for this medication. Medication was removed from the room by the Registered Nurse/Unit Manager on 3/4/2024, and the Medical Director was notified and did not wish to reinstate the previous order. 2. All residents are at risk for this deficient practice. On 3/7/2024, the Director of Nursing audited the facility's two treatment carts for medications that have been discontinued. Any discontinued medications identified were discarded appropriately or returned to the pharmacy. On 3/7/2024, the Director of Nursing and Administrator visually audited all rooms for medications at bedside that did not have appropriate physicians' orders. No other medications were found. 3. The measures that have been put into place to ensure the deficient practice does not recur, are as follows: All facility and agency licensed nurses, Certified Medication Aides, and Certified Nursing Aides will be re-educated on verifying physicians' orders, applying medication per orders, as well as not leaving medication at the bedside for unlicensed	

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F 658	Continued From page 8 not sure how the nystatin powder bottle had gotten into the resident's room, and he did not think Resident #21 had an active order for the medication. The Director of Nursing (DON) was interviewed on 3/07/24 at 10:44 AM and stated the nystatin powder should not have been left with the resident. The DON said Resident #21 needed the nystatin powder on and off again when she developed a rash.	F 658	personnel or residents to administer. The Director of Nursing completed this education with facility and agency licensed nurses, Certified Medication Aides, Certified Nursing Aides. Newly hired facility and agency licensed nurses and Certified Medication Aides will be educated upon hire and prior to working their first shift. 4. The Director of Nursing or Regional Director of Clinical Services will complete an audit of 10 resident's rooms and the Treatment Cart for Discontinued Medication, twice weekly for four (4) weeks, then weekly x four (4) weeks, then bi-weekly x four (4) weeks. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement Committee. Data will be brought by the Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance. 5. 3/27/2024	
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	F 867		3/27/24

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F 867	Continued From page 9	F 867		

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, 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

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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.

§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

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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

(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 867	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, 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 surveys conducted on 1/28/22 and 12/16/22. This was for a repeat deficiency in the area of quarterly assessments that was originally cited on 1/28/22 during the recertification survey, and subsequently recited during the recertification survey on 12/16/22 and	F 867	1) Facility failed to ensure compliance with Quality Assurance and Performance Improvement prevention of previous facility citations. Facility has had previous Minimum Data Set (MDS) related citations within the last 3 years. During this recertification survey completed on 3/7/2024, the facility was found to be out of compliance in Minimum Data Set (MDS) quarterly assessment timely completion and submission.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 12 the recertification survey completed on 3/7/24. The continued failure of the facility during three 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: F638 - Based on record review and staff interviews, the facility failed to complete quarterly assessments within the regulated time frames for 3 of 3 residents reviewed for completion of quarterly Minimum Data Set (MDS) assessments (Residents # 34, #15, #69). During the recertification survey on 1/28/22, the facility failed to complete quarterly Minimum Data Set assessments within 14 days of the Assessment Reference Date for 3 of 30 sampled residents. During the recertification survey on 12/16/22, the facility failed to complete quarterly Minimum Data Set assessments within 14 days of the Assessment Reference Date for 6 of 9 residents reviewed for resident assessments. An interview with the Interim Administrator on 3/7/24 at 11:40 AM revealed they held ad hoc QAA meetings all the time to address various issues which included MDS assessments. She stated that one of the reasons why they continued to have issues with MDS assessments was because they weren't strategic with hiring MDS nurses, and they hired whoever applied for the position. She also stated that the other disciplines needed education too in completing	F 867	2) Residents currently residing in the facility are at risk. Therefore, on 3/8/2024, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by facility Interdisciplinary Team (IDT) including the Medical Director, Regional Director of Clinical Reimbursement and Regional Director of Clinical Services, to review the root cause of repeat citations and put a plan in place to ensure stricter oversight of this area by the Quality Assurance and Performance Improvement committee. 3) The following measures have been put into place to ensure the deficient practice does not recur. On 3/7/2024, the Regional Director of Clinical Services provided education to the Administrator and Director of Nursing on the importance of maintaining an effective QAPI program and the necessary components, to prevent repeat citations. On 3/8/2024, the Administrator and Director of Nursing provided education to the interdisciplinary team on maintaining an effective QAPI program to prevent repeat citations. Effective 3/8/2024, the facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not being maintained per corrective plan. 4) The Vice President of Clinical and QAPI or a Director of Clinical Services will attend QAPI meetings monthly for three (3) months to validate the effectiveness of the facility QAPI program and its ongoing	

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F 867	Continued From page 13 their sections on the MDS assessments, and this contributed to the assessments being late. The Interim Administrator stated the current MDS Coordinator had been receiving lots of instruction and education on completing the MDS assessments, and she was positive that she would improve with more time and experience.	F 867	compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAA improvement activities. Completion Date: 3/27/2024	