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	345292	A. BUILDING _____ B. WING _____	04/04/2024

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/1/24 through 4/4/24. Event ID#OICI11. The following intake was investigated: NC00215351. 1 of the 3 complaint allegations resulted in deficiency.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582		4/16/24

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

Electronically Signed | 04/17/2024

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F 582	Continued From page 1 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #40). Findings included:	F 582	Resident #40 remain in the facility in stable condition. Form CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) was provided to resident #40. On 4/2/2024, the Director of Nursing (DON) completed a 30-day audit of residents whose Medicare A services have ended to ensure all have been provided with form CMS-10055 SNFABN. No areas of concern were identified.	

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F 582	Continued From page 2 Resident #40 was admitted to the facility on 1/18/24. Review of CMS-R-131 (a form used to indicate Medicare Part B services are ending) revealed Resident #40's Medicare Part A skilled services ended on 2-16-24. She remained in the facility with benefit days remaining. Record review revealed that Resident #40 was not given the CMS-10555 Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). On 4/3/24 at 1:29 PM an interview with the Social Worker (SW) indicated she provided Resident #40 with the CMS-R-131 form dated 2/14/24. She stated she must have just looked at the ABN part and printed the wrong form. On 4/4/24 at 9:57 AM an interview with the Administrator indicated he knew an attempt was made to provide Resident #40 with notices because she was refusing therapy services, but he was not sure what notices were provided.	F 582	On 4/2/2024, the DON completed an inservice with Accounts Receivable (AR) and Social Work (SW) regarding the completion of CMS-10055 SNFABN with emphasis on providing the correct form to residents whose Medicare A Services are coming to end. Any newly hired AR or SW will be inserviced during orientation. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Nursing Home Administrator (NHA) will complete an audit of any residents whose Medicare A services are ending to ensure form CMS-10055 SNFABN is issued to the resident/resident representative. Audit will be completed 5x/week x4 weeks then monthly x2 months. Any areas of concern will be corrected immediately by SW prior to SNFABN being given to resident/resident representative. The NHA will present audit to Quality Assurance Performance Improvement (QAPI) committee for review X3 months. QAPI committee will determine trends and/or issues that may warrant further	

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F 582	Continued From page 3	F 582	monitoring.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for a resident who discharged from hospice services for 1 of 1 resident reviewed for hospice care. (Resident #55) Findings included: Resident #55 was admitted to the facility on 9/29/23 with hospice services in place. Review of Resident #55's hospice discharge order dated 11/2/23 revealed Resident #55 was discharged from hospice services on 11/2/23. Review of Resident #55's electronic health record revealed no significant change in status Minimum Data Set assessment had been completed for	F 637	Resident #55 continues to reside in the facility and remains in stable condition and remains without hospice services. On 4/3/2024, the Minimum Data Set (MDS) Significant Change for 1/25/2024 was modified to reflect the resident's discontinuation from hospice services and was transmitted on 4/3/2024. On 4/3/2024, the Director of Nursing (DON) completed 100% audit of residents who were admitted to hospice since 12/1/2023 and/or has discontinuation of hospice services to ensure MDS Significant Change is completed timely for admission to hospice services and/or discontinuation of hospice services. No areas of concern were identified. On 4/3/2024 the DON educated the MDS nurse regarding capturing a resident's	4/16/24

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F 637	Continued From page 4 Resident #55. During an interview on 4/3/24 at 12:07 PM the MDS Coordinator stated Resident #55 was admitted to the facility on hospice and was then discharged from hospice in November 2023. She stated she did not recall being made aware of this change in status until some point in February 2024 during a morning meeting. She stated by this time Resident #55 had been off hospice longer than the two-week window to complete a significant change in status Minimum Data Set assessment. She further stated the resident had not undergone a significant change in status herself other than the hospice discharge, so a significant change in status Minimum Data Set assessment was not completed as they had missed the window. She concluded when resident discharged from hospice, a significant change in status Minimum Data Set assessment should have been completed. During an interview on 4/3/24 at 12:17 PM the Director of Nursing stated during a morning meeting in November, Resident #55's hospice status was discussed by clinical staff. She stated the MDS Coordinator was in the morning meetings, and this was how staff were made aware of the change in hospice status for residents and the MDS Coordinator should have followed up to complete a significant change in status Minimum Data Set assessment. During an interview on 4/3/24 at 1:58 PM the Administrator stated that a significant change in status Minimum Data Set assessment should be completed when a resident elected to receive or discharge from hospices services.	F 637	significant change of admitting to hospice services and/or discontinuation of hospice services. DON will audit residents who have admitted to hospice services and/or discontinuation of hospice services to ensure MDS nurse completes a Significant Change MDS. Audit will be completed 5x/week x4 weeks then monthly x2 months during Cardinal Interdisciplinary Team meeting. Director of Nursing will present audit to Quality Assurance Performance Improvement (QAPI) committee for review X3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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F 641	Continued From page 5	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the hospice status of a resident on a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care. (Resident #55) Findings included: Resident #55 was admitted to the facility on 9/29/23 with hospice services in place. Review of Resident #55's hospice discharge order dated 11/2/23 revealed Resident #55 was discharged from hospice services on 11/2/23. Review of Resident #55's Minimum Data Set assessment dated 1/13/24 revealed Resident #55 was coded as receiving hospice care. During an interview on 4/3/24 at 12:07 PM the MDS Coordinator stated on Resident #55's Minimum Data Set assessment dated 1/13/24 she had incorrectly coded the resident as receiving hospice services at that time and the resident was not receiving hospice services. During an interview on 4/3/24 at 1:58 PM the Administrator stated hospice status should be accurately reflected in the resident's Minimum Data Set assessments.	F 641	Resident #55 continues to reside in the facility and remains in stable condition and remains without hospice services. On 4/3/2024, the Minimum Data Set (MDS) Significant Change for 1/25/2024 was modified to reflect the resident's discontinuation from hospice services and was transmitted on 4/3/2024. On 4/3/2024 the Director of Nursing (DON) completed 100% audit of residents who were admitted to hospice services since 12/1/2023 and has discontinuation of hospice services to ensure MDS nurse completed a Significant Change timely indicating the discontinuation of hospice services. No further omissions were identified. On 4/3/2024 the DON educated the MDS nurse regarding timely completion of a Significant Change MDS capturing a resident's discontinuation of hospice services. On 4/3/2024 the Nursing Home Administrator (NHA) educated Accounts Receivable (AR) of the responsibility to clarify with hospice the discontinuation of hospice services and to notify the MDS nurse of the discontinuation hospice services. DON will audit hospice residents and discontinuation of hospice services to	4/16/24

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F 641	Continued From page 6	F 641	ensure 1) AR has clarified with hospice of the discontinuation of hospice services and informed MDS nurse of discontinuation and 2) MDS nurse has completed a Significant Change MDS for the discontinuation of hospice services. Audit will be completed 5x/week x4 weeks then monthly x2 months during Cardinal Interdisciplinary Team meeting. Director of Nursing will present audit to Quality Assurance Performance Improvement (QAPI) committee for review X3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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 observations, record review, and resident and staff interviews the facility failed to provide nail care to 1 of 2 dependent residents (Resident #167) reviewed for activities of daily living (ADL) care. Findings included: Resident #167 was admitted to the facility on 3/21/24 with a diagnosis of dementia. A review of Resident #167's comprehensive care plan revealed in part a focus area initiated on 3/22/24 for ADL care. The goal was for Resident	F 677	Resident #167 continues to reside in the facility in stable condition. On 4/2/2024 resident's nails were clipped and filed of any sharp edges. An emery board was provided to the resident, per resident request, in order to file her nails when she feels it is needed. On 4/3/2024 the Nursing Supervisor, Unit Manager (UM), Minimum Data Set (MDS) nurses, Staff Development Coordinator (SDC), and Quality Assurance Nurse (QA) completed 100% audit of resident's nails to ensure nails were clean, trimmed, and filed to eliminate sharp edges. No other	4/16/24

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F 677	Continued From page 7 #167's ADL care to be completed with staff support. An intervention was 1 person assistance with personal hygiene and grooming. A review of Resident #167's admission Minimum Data Set (MDS) assessment dated 3/28/24 revealed she was moderately cognitively impaired. She exhibited no behaviors or rejection of care. Resident #167 required substantial/maximal assistance with personal hygiene. On 4/1/24 at 4:05 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands. In an interview with Resident #167 at that time she stated her fingernails were breaking off and needed to be clipped. She went on to say she didn't have a nail clipper and so there was nothing she could do about it. She further indicated her fingernails had been like that for a while. Resident #167 stated she got a bath every day, but no one ever offered to clip her fingernails. She went on to say she knew she should have asked someone, but she hadn't. On 4/2/24 at 12:02 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands. In an interview at that time Resident #167 stated she had not yet had her bath that day. On 4/2/24 at 2:18 PM an observation of Resident #167 revealed multiple broken and jagged fingernails on both hands. On 4/2/24 at 2:33 PM an interview with Nurse Aide (NA) #1 indicated she was familiar with Resident #167. She stated Resident #167 had	F 677	concerns were identified. On 4/3/2024 SDC initiated 100% education of nursing staff regarding nail care and ensuring residents' nails are cleaned, trimmed, and filed to eliminate sharp edges. Education was completed on 4/4/2024. Any nursing staff who did not receive education after 4/4/2024 will be educated prior to beginning their next scheduled shift. New nursing staff hired will be educated during orientation. SDC/UM will observe nail care for 5 residents per week x4 weeks then 10 residents x2 months to ensure residents' nails are clean, trimmed, and filed to eliminate sharp edges. Staff Development Coordinator will present audit to Quality Assurance Performance Improvement (QAPI) committee for review X3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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F 677	Continued From page 8	F 677		

never refused any care that she was aware of. She went on to say she provided Resident #167 with a complete head to toe bed bath earlier that day which included washing Resident #167's hands. NA #1 stated she had access to nail care supplies. She went on to say she was able to provide nail care to residents as long as the weren't diabetic or on a blood thinner. NA #1 stated in that case, she would ask the nurse. She further indicated if she noticed a resident's fingernails were dirty or had any roughness, she would ask the resident if they wanted nail care because she wouldn't want them to scratch themselves. NA #1 stated Resident #167 had not requested nail care and she had not noticed Resident #167 having any broken or jagged fingernails during her bath that day. She went on to say she had not asked the nurse about Resident #167's fingernails.

On 4/2/24 at 2:47 PM an observation of Resident #167's fingernails with the Director of Nursing (DON) revealed multiple broken and jagged fingernails on both hands. During an interview at that time the DON stated Resident #167's fingernails had a few rough places and looked like they needed to be filed. On 4/4/24 at 8:26 AM in a follow-up interview the DON stated the only thing she could say was that she had not really been able to see the jaggedness of Resident #167's fingernails just standing by her bed, until she got up close. She further indicated if someone had seen Resident #167's fingernails they should have addressed them.

On 4/3/24 at 1:38 PM an interview with Nurse Aide (NA) #2 indicated she provided Resident #167 with a complete bed bath that included washing Resident #167's hands during her shift

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F 677	Continued From page 9 on 4/1/24. She stated Resident #167 had never refused any care that she was aware of. She went on to say if she noticed a resident had broken or jagged fingernails, she had access to a nail file to file or shape them. NA #2 stated she had not noticed Resident #167 having any broken or jagged fingernails on 4/1/24 when she provided her bath around 9:30 AM. She went on to say Resident #167 had not requested nail care.	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove an expired food item stored for use in 1 of 1 refrigerated walk-in storage cooler. This practice had the potential to affect food served to residents.	F 812	On 4/1/24, the Dietary Manager discarded the expired salad dressing immediately. On 4/1/2024 the Dietary Manager and Dietary Consultant completed a 100%	4/16/24

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F 812	Continued From page 10 Findings included: During the initial tour of the kitchen on 4/1/24 at 9:59 am through 10:35 am, the Dietary Manager was present during the inspection the walk-in cooler was observed with a 1-gallon container of salad dressing that was ¾ full dated as opened 8/29/23. The Dietary Manager was interviewed during the initial tour on 4/1/24 at 9:59 am through 10:35 am. She stated that staff were trained on food storage to include dating, labeling, and discarding outdated foods. She further stated that the refrigerated coolers were checked daily for outdated foods and outdated foods should have been discarded at that time. Opened foods were marked with the date opened and should have been discarded 7 days after that date. She disposed of the food item listed above. In a follow-up interview with the Dietary Manager on 4/1/24 3:15 pm she stated that the salad dressing was used to make tomato and cucumber salad and it was last used about 3 months ago. She stated that she was responsible for checking the refrigerated coolers daily and she last checked the cooler this morning and the dressing should have been discarded but she overlooked it. During an interview with the Nutrition Consultant on 4/1/24 at 3:18 PM revealed the salad dressing should have been discarded 7 days after it was opened. In an interview with the Administrator on 4/2/24 at 9:59 am he stated that the salad dressing was too old and should have been discarded prior to now.	F 812	audit of all refrigerated and dry food storage to ensure no expired foods were noted, food containers opened were dated, and foods dated were disposed of after 7 days. On 4/1/24, the Dietary Consultant and Dietary Manager initiated education with all dietary staff regarding the proper procedure for storing foods, labeling opened food with date opened, and discarding expired foods or foods that were dated and past 7 days of opening. Education was completed on 4/2/2024. The Nursing Home Administrator (NHA) and Dietary Manager will conduct audits of food storage areas with focus on food expiration dates, open food having open dates indicated on the container, and the discarding of expired foods or foods that are 7 days past the open date. Audits will be conducted weekly x4 weeks then monthly x2 months. Any areas of concern will be addressed immediately by the Dietary Manager. The NHA will present audit to Quality Assurance Performance Improvement (QAPI) committee for review X3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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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 812	Continued From page 11 He further indicated he did not know how long it could be kept but knew that you could not keep it for months.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		4/16/24

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	345292	A. BUILDING _____ B. WING _____	04/04/2024

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F 867	Continued From page 12	F 867		

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 13 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867	Continued From page 14 Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 10/28/21, and the recertification and complaint investigation survey of and 3/22/23.This was for re-cited deficiencies in the areas of Medicaid/Medicare Coverage/Liability Notices (F582) and Accuracy of Assessments (F641) The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F582: Based on record review and staff interviews the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN) prior to discharge from Medicare Part A skilled services for 1 of 3 residents reviewed for beneficiary protection notification who required the provision of the SNF-ABN form (Resident #40). On the 3/22/23 recertification and complaint investigation survey the facility was cited for failing to provide a completed Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF-ABN) In an interview on 4/4/24 at 10:01 AM the Administrator stated last year the problem was the notices were incomplete. He went on to say	F 867	Resident #40 remain in the facility in stable condition. Form CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) was provided to resident #40 with all areas completed to include care service Medicare A would not cover, reason for Medicare Non-Coverage, and estimated cost. As well as, “Options” section being completed by the resident. On 4/2/2024, the Clinical Consultant completed an audit of surveys completed in the prior 3 years to determine if F582, Medicaid/Medicare Coverage/Liability Notice, was cited to ensure the Quality Assurance Performance Improvement (QAPI) Committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QAPI Committee by QA Nurse for any concerns identified during the audit including but not limited to the education of staff. Except for, recertification survey of 3/22/2023, no other citations were issued for F582. On 3/1/2024, the Facility Consultant completed an inservice with the Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools and length of time for monitoring, the evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include resident rights. Inservice also	

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F 867	Continued From page 15 this year the form was incorrect. He further indicated he felt like these were different issues. F641: Based on staff interviews and record review the facility failed to accurately code the hospice status of a resident on a Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospice care. (Resident #55) On the 10/28/21 recertification and complaint investigation survey the facility was cited for failing to accurately code the Minimum Data Set (MDS) assessment. In an interview on 4/4/24 at 10:01 AM the Administrator stated it was hard to go back 3 years to look at things. He went on to say the while the QAA Committee did track things like this, he felt the situations were different. He further indicated it would be hard to track the whole process.	F 867	included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. All newly hired Administrator, DON, and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include F582 Medicaid/Medicare Coverage/Liability Notice will be taken to the QAPI committee for review monthly x3 months then Quarterly x3 quarters by the Quality Assurance Nurse. The QAPI committee will review the data and determine if the plans of correction are being followed, if changes in plans of policies 3 are required to improve outcomes, if further staff education is needed, and/or if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will review the QA meeting minutes monthly x3months then quarterly x3 quarters to ensure the QA committee has maintained and monitored interventions that were put into place for all current citations to include F582 Medicaid/Medicare Coverage/Liability Notice to ensure the QAPI committee has maintained and monitored interventions that were put in place. The Facility Consultant will immediately retrain the Administrator, DON, and QA nurse for any identified	

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F 867	Continued From page 16	F 867	areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the QA Nurse to the QAPI Committee monthly x3 months then quarterly x3 quarters for review and the identification of trends, development of action plans as indicated, an/or to determine the need and/or frequency of continued monitoring.	