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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 3/10/2024 to 3/13/2024. Event ID# ZK7111. The following intakes were investigated NC00214272 and NC00214282. 2 of the 8 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at CFR 483.25 at tag F689 Immediate Jeopardy was identified at CFR 483.25 at tag F684 after the case was transferred to Centers for Medicare and Medicaid Services (CMS). Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity J CFR 483.25 at tag F689 at a scope and severity J Tags F684 and F689 constituted Substandard Quality of Care. A partial extended survey was conducted. The survey exit date was changed to 4/24/2024 due to notification of the facility of the F684 IJ.	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 record review, observations, resident and staff interviews, the facility failed to assess	F 554	Corrective Action A. Address how corrective action will be	4/25/24

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

Electronically Signed | 04/03/2024

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F 554	Continued From page 1	F 554		

whether the self-administration of medications was clinically appropriate for 1 of 1 resident (Resident #1) who was observed to have a medication at bedside.

The findings included:

Resident #1 was admitted to the facility on 9/19/2023 with diagnoses including acute posthemorrhagic anemia, end stage renal disease, dialysis, peripheral vascular disease, and diabetes. Resident #1 was readmitted to the facility on 12/19/2023 and 2/23/24.
The admission Minimum Data Set (MDS) assessment dated 12/19/2023 assessed Resident #1 to be cognitively intact without behaviors.

Medication orders for Resident #1 revealed the following were ordered to be administered in the morning:
" Calcitriol 0.25 milligrams (mg) daily at 8:00 AM
" Clopidogrel 75 mg daily at 8:00 AM
" Edurant 25 mg daily at 8:00 AM
" Juluca 50/25 mg daily at 8:00 AM
" Nifedipine ER 60 mg daily at 8:00 AM
" Aspirin 81 mg daily at 8:00 AM
" Carvedilol 6.25 mg daily at 8:00 AM
" Cephalexin 500 mg daily at 8:00 AM
" Nortriptyline 10 mg twice daily at 8:00 AM and 8:00 PM
" Sevelamer Carbonate 800 mg daily with meals at 8:00 AM, 12:00 PM, and 5:00 PM

A review of Resident #1's medical record revealed there was no physician order for Resident #1 to self-administer his medications.

accomplished for those residents found to have been affected by the deficient practice.
On 3/10/2024 Resident #1 was observed having medication at bedside.
Nurse #1 went back into the room, Resident #1 had taken medications.
Nurse #1 ensured Resident #1 took medications, Resident #1 is alert and oriented x 3.

B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents on Nurse #1 assignment (rooms 144-161) have the potential to be affected.
On 3/10/2024 a whole house audit was conducted to check if there are any medications at bedside, including rooms 144-161, this resulted with no findings of medications at bedside.
No other residents were affected by this deficient practice.

C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 3/10/24 Director of Nursing (DON) interviewed Nurse #1, Licensed Practical Nurse (LPN) who left medications at bedside, Nurse #1 stated Resident #1 requested medications to be left at bedside as they were eating and Nurse #1 complied. DON educated Nurse #1 that all medications must be observed for consumption to ensure they were

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F 554	Continued From page 2 There was no care plan in place for Resident #1 to self-administer medications. Resident #1 was observed in bed on 3/10/2024 at 9:07 AM. Resident #1 was eating breakfast. A medication cup with 10 medications was noted to be sitting on his over-the-bed table beside his meal tray. Resident #1 explained he didn't want to take his medications when the nurse brought them in, and he told her to leave the medication cup on the table and he would take them later. Resident #1 was observed again at 9:28 AM and the medication cup was gone from his table. Resident #1 reported he had taken his medications. Nurse #1 was interviewed on 3/10/2024 at 9:30 AM. Nurse #1 reported she was assigned to Resident #1 and had administered his medications this morning. Nurse #1 explained that Resident #1 insisted she leave the medications on the table, and he would take them after he ate breakfast. Nurse #1 reported she had returned to Resident #1's room "a few minutes ago" and he had taken the medications. Nurse #1 explained she thought leaving the medications at the beside would be fine because Resident #1 was alert and oriented. Nurse #2 was interviewed on 3/11/2024 at 10:56 AM. Nurse #2 reported he was the charge nurse on day shift (7:00 AM to 3:00 PM) and he assisted the floor nurses. Nurse #2 explained he had not seen medications left at the bedside of residents. An interview was conducted with the Unit Manager on 3/11/2024 at 11:07 AM. The Unit	F 554	swallowed for the safety of the resident. DON also educated Nurse #1 if residents request to have medications left Nurse #1 must take medications back out of room and waste those medications after educating resident on importance of taking medications in a timely manner. On 3/11/2024 all in house nursing staff were educated that all medications must be observed for consumption to ensure they were swallowed for the safety of the resident. On 3/11/2024 All agency nurses who were working at Randolph Gardens were educated that all medications must be observed for consumption to ensure they were swallowed for the safety of the resident. Any agency nurses not working on 3/11/2024 will be educated prior to the start of their shift that all medications must be observed for consumption to ensure they were swallowed for the safety of the resident. All new RN□s, LPN□s, CMA□s starting employment at Randolph Gardens will be educated at the time of employment that all medications must be observed for consumption to ensure they were swallowed for the safety of the resident. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 554	Continued From page 3 Manager reported she monitored the nursing staff for leaving medications at the bedside and had not observed any instances of medications left for residents to self-administer. The Director of Nursing (DON) #2 was interviewed on 3/11/2024 at 11:23 AM. DON #2 reported medications should not be left at the bedside and she was not certain why Nurse #1 left the medications for Resident #1 to self-administer. DON #2reported she talked to Nurse #1 on 3/10/2024 and Nurse #1 reported Resident #1 insisted she leave the medications and Nurse #1 did not want to upset Resident #1. DON #2 explained an assessment would be completed for a resident to self-administer medications and Resident #1 had not been assessed. DON #2 reported she expected no residents to have their medications left at the bedside if they were not assessed to be able to safely self-administer. During an interview with the Nurse Practitioner (NP), she reported she had been told by nursing staff that Resident #1 would refuse his medications at times. The NP explained that missing one dose of medications would not have harmed Resident #1. The Administrator was interviewed on 3/11/2024 at 4:10 PM. The Administrator reported she visited with Resident #1 daily and had not observed medications left at the bedside. The Administrator reported she expected residents to be assessed for the ability to safely self-administer medications and if they were not assessed, no medications to be left at the beside.	F 554	Effective 3/12/2024 Three times per week five rooms will be audited for medications at bedside by Director of Nursing / Designee for twelve weeks to ensure medications are not being left at bedside. Each shift will be monitored at least one audit day to ensure all shifts are compliant. On 3/12/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed. Date of Compliance date is 4/25/24 The Director of Nursing is the individual responsible for compliance with this action plan.	
F 684 SS=J	Quality of Care	F 684		

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F 684	Continued From page 4 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews, Transporter #1 failed to call emergency medical services (EMS) or have a resident assessed by a medical professional before moving Resident #1 after his wheelchair tipped over and he fell to the floor of a transportation van. On 1/19/24 Transporter #1 pulled out of the dialysis center parking lot and Resident #1's wheelchair tipped backwards, and he hit the left occipital region of his head. Transporter #1 pulled the transportation van over to a parking lot and pulled the resident back up into a sitting position and transported Resident #1 8.4 miles back to the facility. The transporter was not qualified to provide a competent physical assessment to determine if there was an adverse outcome for this resident who was on Plavix (anti-platelet medication that can have a side effect of bleeding). Once back at the nursing home, Resident #1 was assessed to have a bump on his head behind his left ear and he reported head pain and nausea. Resident #1 was sent to the hospital for an evaluation and the CT scan of the head completed at the hospital was negative and the resident returned to the hospital the same day. This was for 1 of 3	F 684	Past noncompliance: no plan of correction required.	

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residents reviewed for accidents.

The findings included:

The facility transportation vehicle policy and procedure dated 10/2018 was reviewed. The policy read, in part, " ...drivers are trained to halt any transport that seems unsafe whether because of securing methods ...any ... incident will be reported to the Administrator ... as well as any appropriate authorities or agencies."

Resident #1 was admitted to the facility on 9/19/2023 with diagnoses including acute posthemorrhagic anemia, end stage renal disease, dialysis, peripheral vascular disease, and diabetes.

A physician order dated 12/15/2023 ordered Plavix 75 milligrams to be administered once per day.

The admission Minimum Data Set (MDS) assessment dated 12/19/2023 assessed Resident #1 to be cognitively intact without behaviors. The MDS documented Resident #1 had limited range of motion of one side of his upper body and both sides of his lower body. The MDS documented Resident #1 used a manual wheelchair for mobility and was non-ambulatory. The medical record documented Resident #1 had a below the knee amputation of the right leg.

An incident report dated 1/19/2024 documented the former Director of Nursing (DON) #1 received a phone call from Transporter #1 who reported Resident #1's wheelchair tipped over while she was driving the van. The transporter reported she had pulled over on the side of the road and

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assisted Resident #1 back into his wheelchair and secured the straps. Transporter #1 then notified the facility of the incident. The incident report documented Resident #1's statement "we were driving, and my chair fell backwards, and I hit my head." The actions taken were documented in the incident report: immediately assessed Resident #1 upon his arrival back to the facility; Resident #1 noted to have a small quarter size knot to the right side of the back of his head. Upon palpitation, the resident stated, "It hurts a little bit." Emergency Medical Services (EMS) notified for transportation to the emergency room for evaluation. Vital signs were blood pressure 100/81, pulse 76, respirations 18, temperature 97.8, oxygen saturation 94% and no bleeding was noted from the bump on his head. The incident report noted the family member, and the medical provider were notified of the incident.

The emergency room notes dated 1/19/2024 at 6:06 PM documented Resident #1 was evaluated in the emergency room. The note documented "(Resident #1) was on his way home on the transport van after dialysis where somehow the wheelchair he was residing in bumped and fell back and hit the back of his head. He is on (blood thinner). EMS noted no signs of trauma or injury ... (Resident #1) reported some blurred vision earlier, but denies any complaints currently ..." Vital signs for Resident #1 were blood pressure 120/63, pulse 67, respiration 16, temperature 98.1, and oxygen saturation 96%. His head was assessed to be without obvious abnormalities and atraumatic (no trauma noted). Resident #1 was noted to be alert and oriented with no deficits. A computed tomography (CT) scan (a diagnostic imaging) of his head revealed it was negative for acute findings. Resident #1 was discharged back

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to the facility without new medications.

Resident #1 was interviewed on 3/10/2024 at 11:17 AM. Resident #1 reported he was able to remember the incident on the van. Resident #1 reported he was not certain of the time of day, but he had completed his dialysis treatment. Resident #1 stated he remembered he was in the van, and they had just left the parking lot. Resident #1 reported he did not notice anything unusual about the way Transporter #1 secured his wheelchair straps. Resident #1 explained the van turned to the right and his wheelchair tipped over and went straight back to the floor and he hit the left side of his head behind the ear. Resident #1 was not certain what he hit his head on. Resident #1 reported he yelled for the driver, and she looked back and saw he was on the floor, so she pulled into a parking lot. Resident #1 described how Transporter #1 rushed to his side and pulled his wheelchair back into a sitting position. Resident #1 explained he told her to get him up from the floor of the van. Resident #1 explained Transporter #1 called the facility and they told her to call EMS, but she was already on her way back to the facility. Resident #1 stated EMS came when he got back to the facility, and he was transported to the hospital emergency room. Resident #1 explained he was not in the emergency room for very long, and he returned to the facility without any new medications.

Transporter #1 was interviewed on 3/10/2024 at 1:47 PM. Transporter #1 reported she had been at the facility as a transporter for almost 16 months and she had been a transporter at other facilities for the past 5 years. Transporter #1 reported she was trained when she was hired at the facility and explained she had never had an

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incident or accident transporting residents in the 5 years she had been a transportation aide. Transporter #1 explained she had picked Resident #1 up from dialysis on 1/19/2024 and she had strapped his wheelchair in and made certain the wheels were locked and the straps were secure before she started the van. Transporter #1 explained she pulled out of the dialysis parking lot and onto the road when she heard Resident #1 say her name, and when Transporter #1 looked into the rearview mirror, she couldn't see Resident #1. Transporter #1 described pulling over into a parking lot, stopping the van and going to Resident #1, who said, "Sit me up! Sit me up!" Transporter #1 explained she was so upset by the incident, she forgot she was supposed to call for EMS to assess Resident #1 for injuries before she moved the resident. Transporter #1 reported she had Resident #1 back to a sitting position and she asked if he was doing ok, he told her he was fine. Transporter #1 explained she was talking to Unit Manager #1 on the phone as she got Resident #1 into a sitting position. Transporter #1 reported she started driving back to the facility. Transporter #1 reported she should have called EMS after she pulled the van over and waited for EMS before Resident #1 was sat back up in the wheelchair.

The Unit Manager was interviewed on 3/11/2024 at 11:07 AM. The Unit Manager reported she received a phone call from Transporter #1, who reported Resident #1 had tipped over in the van. The Unit Manager explained she went directly to the Administrator to tell her about the event, and the Administrator said Transporter #1 should have called EMS. Unit Manager reported she had not been present when the transport van, Resident #1, and Transporter #1 returned to the

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facility. The Unit Manager reported Transporter #1 should have called EMS for Resident #1 to be assessed before moving him off the floor of the van.

A phone interview was conducted with DON #1 on 3/10/2024 at 2:25 PM. DON #1 reported she was employed by the facility on 1/19/2024 and she was in the building when Transporter #1 called the Unit Manager to report an incident on the van. DON #1 explained the ADON performed the assessment and DON #1 completed the paperwork related to the incident. DON #1 reported she did not assess Resident #1 after the incident, and he was sent to the hospital emergency room for evaluation.

An interview was conducted with the ADON on 3/10/2024 at 2:31 PM. The ADON explained DON #1 asked her to go outside to assess Resident #1 when he returned in the transporter van after he had experienced a fall. The ADON reported she and the Unit Manager met the van when Transporter #1 arrived with Resident #1 and completed an assessment of him immediately. The ADON reported Resident #1 had a small bump behind his right ear, but he denied pain. Resident #1 told the ADON he did not want to go to the hospital, but the ADON convinced him to go to be evaluated.

The Medical Director (MD) was interviewed by phone on 3/11/2024 at 1:25 PM. He further explained Resident #1 could have sustained a serious injury during a fall on the van due to his medications and medical history. The MD reported Resident #1 should have been assessed by EMS before being moved up off the van floor. The MD explained there would be a concern

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about injury any time a resident had a fall and was taking a blood thinner.

An interview was conducted with the Administrator on 3/11/2024 at 5:40 PM and she described the afternoon of 1/19/2024 when the Unit Manager received a phone call from Transporter #1. The Administrator explained the Unit Manager came into her office and told her Transporter #1 was on the phone and reported Resident #1 had tipped over in his wheelchair in the transport van. The Administrator asked the Unit Manager if Resident #1 was hurt and asked where Transporter #1 was located. The Unit Manager relayed Transporter #1 was enroute back to the facility and the Administrator had stated Transporter #1 should have called EMS and waited for them to assess Resident #1 before moving him up off the floor. The Administrator reported she asked the DON and the ADON to wait outside with the Maintenance Director for Transporter #1 and Resident #1 to arrive. The Administrator reported Resident #1 was assessed by the ADON and transferred to the hospital for evaluation by EMS. The Administrator reported after the incident, the facility conducted an ad hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss the incident and develop a plan of correction. The Administrator explained Transporter #1 returned to her position on 1/23/2024 and completed re-training and was observed for 2 transport trips by the Maintenance Director. The Administrator reported she knew Transporter #1 received training on hire, but was not certain about the annual training, as the facility was under different management at that time. The Administrator reported the facility had their monthly QAPI meeting in February to discuss the incident, the

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audits, and the plan of correction.

The Administrator was notified of immediate jeopardy on 4/24/2024 at 1:10 PM.

The facility provided the following corrective action plan with a completion date of 01/24/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #1 was picked up from dialysis 1/19/24 by Transporter #1 and secured into the van utilizing the securement straps. The Transporter proceeded to pull away, Resident #1's chair tipped backwards causing Resident #1 to fall backward and resulted in Resident #1 hitting the right side of his head on the floor of the van. The transporter failed to call emergency services at time fall.
Transporter #1 pulled over, asked Resident #1 if they were okay and Resident #1 stated he was fine and insisted the Transporter return him to the facility. Transporter #1 assisted Resident #1 back into seated position in the wheelchair, replaced the security straps and began to drive to the facility. Upon return to the facility the Director of Nursing/Assistant Director of Nursing (DON/ADON) assessed Resident #1, He was alert, oriented and able to answer all questions. Resident #1 reported that he hit his head and pointed to a spot on the back right side of his head. ADON/DON assessed a raised area at that location with no other injuries noted.

Resident #1's physician was notified and received orders to send Resident #1 to the Emergency Room (ER) for evaluation and 911 was contacted.

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Resident #1's family was notified. Resident #1 was alert and oriented at the time Emergency Medical Services (EMS) arrived and transported to the ER. The ER evaluation revealed no laceration, no head trauma or other injury from the fall. Resident #1 returned from the ER at 10:14 PM after evaluation from fall.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents being transported by the Facility Transporter have the potential to be affected.

On 1/19/2024 all residents transported by the facility Transporter were interviewed by the DON and ADON to ensure no unreported incidents occurred during facility transportation requiring notification of emergency services.

No other residents were affected by this deficient practice.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The facility currently does not utilize any contracted transportation services.

On 1/19/24 the Nursing Home Administrator provided one on one education to transporter regarding facility policy of the following: In the event of a transportation related incident, resident is not to be moved until a licensed professional can assess for injuries and to contact emergency services immediately.

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The facility suspended the in-house transportation program and outsourced all transports to a contracted vendor from 1/19/24 through 1/23/24. A full Investigation was completed, and a plan of correction was initiated.

On 1/22/2024 the Vice President of Maintenance (VPM) educated the Facility Maintenance Director on the following:

1. Current Policy and Procedure of Facility Transportation Vehicle dated 10/2018, emphasizing.
"Calling 911 with any incidents in the van with a resident, emphasizing "Drivers are trained to halt any transport that seems unsafe whether because of securing methods, behavior or health conditions of a resident, severe weather, or traffic conditions. Driver will contact the facility Administrator/DON/Unit Manager, even if after hours prior to resuming transport to advise of conditions that halted the transport and the reasons the driver feels safe beginning again. If necessary, a second person will be dispatched to assist the driver/transporter."

On 1/23/24 Transporter #1 was re-educated on the following by the Maintenance Director:

1. Current Policy and Procedure of Facility Transportation Vehicle dated 10/2018.
Calling 911 with any incidents in the van with a resident, emphasizing "Drivers are trained to halt any transport that seems unsafe whether because of securing methods, behavior or health conditions of a resident, severe weather, or traffic conditions. Driver will contact the facility Administrator, DON/Unit Manager, even if after hours prior to resuming transport to advise of

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conditions that halted the transport and the reasons the driver feels safe beginning again. If necessary, a second person will be dispatched to assist the driver/transporter.

On 1/22/24 education was provided to all nurse managers by the NHA on the following: In the event that the transport driver notifies the facility regarding a transportation related incident, inform them to contact emergency services and not move resident until a licensed professional can assess them.

Effective 1/23/24 Residents being transported are verbally made aware by transporter/LNHA, DON/Designee prior to transportation that if an incident shall occur, emergency services will be contacted for assessment by licensed professional.

The facility has 2 trained transporters: The Maintenance Director and Transporter#1

Systematic Changes

New Transporters will be trained by the Maintenance Director prior to any transports and all transporters will be trained on an annual basis on the following:

1. Current Policy and Procedure of Facility Transportation Vehicle dated 10/2018.
Calling 911 with any incidents in the van with a resident, emphasizing "Drivers are trained to halt any transport that seems unsafe whether because of securing methods, behavior or health conditions of a resident, severe weather, or traffic conditions. Driver will contact the facility Administrator or his/her designee prior to

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resuming transport to advise of conditions that halted the transport and the reasons the driver feels safe beginning again. If necessary, a second person will be dispatched to assist the driver/transporter.

The Maintenance Director is responsible for tracking and completing annual training.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

On 1/22/2024 an Ad hoc Quality Assurance Performance Improvement (QAPI) meeting was held to review the incident and Plan of Correction. Utilizing the transportation logs NHA / Designee will randomly choose one resident to interview weekly for twelve weeks to ensure if an incident occurred during transportation the policy / procedure related to a resident being assessed by a licensed professional prior to repositioning the resident was followed. These reviews will be reported by the Administrator at the monthly QAPI meeting for 3 months and reviewed by the committee to ensure compliance is maintained.

IJ removal date on 1/24/24.

The Administrator is the individual responsible for compliance with this action plan.

On 3/11/2024 the facility's correction action plan for immediate jeopardy removal was validated by the following:

The facility provided documentation to support their corrective action plan including education provided to the Maintenance Director and

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F 684	Continued From page 16 Transporter #1. The pre-trip inspections were completed prior to any transportation in the van by Transporter #1. The Maintenance Director audited these inspections 3 times per week from 1/23/2024 to 3/11/2024. Transporter #1 and the Maintenance Director were interviewed and were able to state the correct steps for any incident or accident involving the transportation van and a resident(s). Interviews were conducted with DON #2, the ADON, the Unit Manager, and Nurse # 2 who reported if they received a phone call from a transporter reporting an accident with the transportation van, they would instruct the transporter to call EMS and not to move the resident until EMS was able to assess the resident. QAPI meetings were discussed with the Administrator and meeting notes were reviewed. The facility's date of 1/24/2024 for the corrective action plan was validated on 3/11/2024.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews, the facility failed to provide safe transportation for Resident #1 when he was being transported from dialysis back to the facility on 1/19/2024. Transporter #1 pulled out of the	F 689	Past noncompliance: no plan of correction required.	

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parking lot of the dialysis center and Resident #1's wheelchair tipped over, and he hit the left side of his head. Transporter #1 pulled the transportation van over to a parking lot, where Resident #1 insisted upon Transporter #1 sitting him back upright, and Transporter #1 pulled the resident back up into a sitting and upright position. Transporter #1 then transported Resident #1 8.4 miles back to the facility where he was assessed by the Assistant Director of Nursing (ADON) to have a bump on his head behind his left ear and he reported head pain and nausea after the fall. It was determined by the ADON Resident #1 needed to go to the hospital for evaluation. There was a high likelihood of a serious adverse outcome for Resident #1 due to hitting his head when his wheelchair tipped over in the transportation van. Resident #1 was prescribed and received Plavix (a blood thinning medication). The CT scan completed at the hospital was negative for head injury. This was for 1 of 3 residents reviewed for accidents.

The findings included:

The Vehicle Anchorages for the 4-point Wheelchair Securement Systems manual dated 2020 was reviewed. The illustrated manual provided directions for securing wheelchairs for transport in the transportation van. Tracks on the floor of the van (L-track) where the pin connectors of the retractors locked in place and straps connected to the wheelchair by a J-hook (a J-shaped metal hook affixed to the fabric straps that were attached to the connector pins). The manual illustrated the position of the pin connectors indicated two rear connectors were directly behind the wheelchair and the two front pin connectors were secured to the front and side

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of each side of the wheelchair. The instructions directed to follow the tie down angles in the illustration and attached the J-hooks on the wheelchair frame in the proper locations.

Resident #1 was admitted to the facility on 9/19/2023 with diagnoses including acute posthemorrhagic anemia, end stage renal disease, dialysis, peripheral vascular disease, and diabetes.

The admission Minimum Data Set (MDS) assessment dated 12/19/2023 assessed Resident #1 to be cognitively intact without behaviors. The MDS documented Resident #1 had limited range of motion of one side of his upper body and both sides of his lower body. The MDS documented Resident #1 used a manual wheelchair for mobility and was non-ambulatory. The medical record documented Resident #1 had a below the knee amputation of the right leg.

An incident report dated 1/19/2024 at 3:33 PM documented the former Director of Nursing (DON) #1 received a phone call from the Transporter #1 that Resident #1's wheelchair tipped over while she was driving the van. Transporter #1 reported that she had pulled over on the side of the road and assisted Resident #1 back into his wheelchair and secured the straps. Transporter #1 then notified the facility of the incident. The incident report documented Resident #1's statement "we were driving, and my chair fell backwards, and I hit my head." The actions taken were documented in the incident report: immediately assessed Resident #1 upon his arrival back to the facility; Resident #1 noted to have a small quarter size knot to the right side of the back of his head. Upon palpitation, the

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resident stated, "It hurts a little bit." Emergency Medical Services (EMS) notified for transportation to the emergency room for evaluation. No bleeding was noted from the bump on his head. The incident report noted the family member, and the medical provider were notified of the incident.

Resident #1 was interviewed on 3/10/2024 at 11:17 AM. Resident #1 reported he was able to remember the incident on the van. Resident #1 reported he was not certain of the date or time of day, but he had completed his dialysis treatment. Resident #1 stated he remembered he was in the van, and they had just left the parking lot. Resident #1 reported that he did not notice anything unusual about the way Transporter #1 secured his wheelchair straps. Resident #1 explained the van turned to the right and his wheelchair tipped over and went down to the floor and he hit the left side of his head behind the ear. Resident #1 was not certain what he hit his head on. Resident #1 reported he yelled for the driver, and she looked back and saw he was on the floor, so she pulled into a parking lot. Resident #1 described how Transporter #1 rushed to his side and pulled his wheelchair back into a sitting position. Resident #1 explained Transporter #1 called the facility and they told her to call EMS, but she was already on her way back to the facility. Resident #1 explained he had pain in his head from hitting it and he felt queasy after he hit his head and during the ride back to the facility. Resident #1 reported the pain in his head was "8" (out of 10; 0 no pain, 10 most intense pain). EMS came when Resident #1 returned to the facility with Transporter #1, and he was taken to the hospital emergency room. Resident #1 explained he was not in the emergency room for very long, and he returned to the facility without any new

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medications. Resident #1 explained he was mostly pain free by the time he returned to the facility after the evaluation at the hospital and described his head as feeling "tender".

Transporter #1 was interviewed on 3/10/2024 at 1:47 PM. Transporter #1 reported she had been at the facility as a transporter for almost 16 months and she had been a transporter at other facilities for the past 5 years. Transporter #1 reported she was trained when she was hired at the facility and explained she had been at the facility since November 2022, and she had never had an incident or accident transporting residents in the 5 total years she had been a transportation aide. Transporter #1 explained she had arrived at the dialysis center for Resident #1 on the afternoon of 1/19/2024 and she had used the securement straps to secure his wheelchair and made certain the wheels were locked and the securement straps were secure before she started the van and prepared to leave the dialysis parking lot. Transporter #1 explained she pulled out of the dialysis parking lot and onto the road when she heard Resident #1 say her name, and when Transporter #1 looked into the rearview mirror, she couldn't see Resident #1. Transporter #1 described pulling over into a parking lot, stopping the van and going to Resident #1, who said, "Sit me up! Sit me up!" Transporter #1 explained she was so upset by the incident, she forgot that she was supposed to call for EMS before she moved the resident, but the resident kept demanding to sit him up, she repositioned Resident #1 back to a sitting position. Transporter #1 asked if Resident #1 was doing ok, he told her that he was fine. Transporter #1 explained she was talking to Unit Manager #1 on the phone as she got Resident #1 into a sitting position.

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Transporter #1 reported she started driving back to the facility.

An observation of the transportation van was conducted on 3/10/2024 at 2:05 PM with Transporter #1, the Maintenance Director, and the Administrator. Transporter #1 demonstrated how she had secured Resident #1's wheelchair on 1/19/2024 using the securement system. Transporter #1 locked the wheels on the wheelchair and secured the 4 securement straps using the pin connectors in the L-track and the J-hooks connected to the wheelchair as well as the shoulder harness and lap belt and then wiggled the wheelchair back and forth to demonstrate it was secured. The Maintenance Director then explained the right front securement strap was too far to the side and when the wheelchair was moved side to side, the securement strap was not secure, and the wheelchair was able to tip over when Resident #1 was in the wheelchair. The Maintenance Director then moved the wheelchair from side-to-side and the wheelchair was able to move, and the J-hook with the securement strap slid on the wheelchair frame.

An interview was conducted with the ADON on 3/10/2024 at 2:31 PM. The ADON reported she and the Unit Manager met the van when Transporter #1 arrived with Resident #1 and completed an assessment of him immediately. The ADON reported Resident #1 had a small bump behind his right ear, but he denied pain. Resident #1 told the ADON he did not want to go to the hospital, but the ADON convinced him to go be evaluated. The ADON explained the Maintenance Director visually inspected the pin connectors and wheelchair straps, and he was

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able to identify the connector pins were not positioned correctly for one side of the wheelchair.

During an interview with the Maintenance Director on 3/10/2024 at 2:13 PM, he explained when Transporter #1 returned to the facility with Resident #1 on 1/19/2024, he immediately inspected the position of the pin connectors and the J-hooks and discovered the front right pin connector was positioned at an angle that allowed the J-hook securement strap to move on the wheelchair frame, which allowed the side to side movement of the wheelchair. The Maintenance Director reported he provided re-education to Transporter #1 on 1/23/2024 as well as videos about the pin connectors, J-hooks, L-track, and straps and their use. The Maintenance Director reported since the incident he was checking the van daily at different times to monitor the use of the pin connectors and straps.

The Medical Director (MD) was interviewed by phone on 3/11/2024 at 1:25 PM. The MD explained there would be a concern about injury any time a resident would fall and was taking a blood thinner. He further explained Resident #1 could have sustained a serious injury during a fall on the van due to his medications and medical history.

An interview was conducted with the Administrator on 3/11/2024 at 5:40 PM and she described the afternoon of 1/19/2024 when the Unit Manager received a phone call from Transporter #1. The Administrator explained the Unit Manager came into her office and told her Transporter #1 was on the phone and reported Resident #1 had tipped over in his wheelchair in

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the transport van. The Administrator asked the Unit Manager if Resident #1 was hurt and asked where Transporter #1 was located. The Unit Manager relayed that Transporter #1 was enroute back to the facility and the Administrator had stated that Transporter #1 should have called EMS. The Administrator reported she asked the DON and the ADON to wait outside with the Maintenance Director for Transporter #1 and Resident #1 to arrive. The Administrator reported Resident #1 was assessed by the ADON and transferred to the hospital for evaluation by EMS. The Administrator explained after Resident #1 was sent to the hospital, she and the Maintenance Director discussed the issue and Transporter #1 was suspended during the facility investigation. The Administrator explained the issue was identified as the pin connector was placed in the wrong L-track which allowed the wheelchair to tip over. The Administrator reported after the incident, the facility conducted an ad hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss the incident and develop a plan of correction. The Administrator explained Transporter #1 returned to her position on 1/23/2024 and completed re-training and was observed for 2 transport trips by the Maintenance Director. The Administrator reported she knew Transporter #1 received training on hire was not certain about the annual training, as the facility was under different management at that time. The Administrator reported the facility had their monthly QAPI meeting in February to discuss the incident, the audits, and the plan of correction.

The Administrator was notified of immediate jeopardy on 3/10/2024 at 4:15 PM.

The facility provided the following corrective

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action plan with a completion date of 01/24/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #1 was picked up from dialysis 1/19/24 by Transporter #1 and secured into the van utilizing the securement straps. The Transporter proceeded to pull away, Resident #1's chair tipped backwards causing Resident #1 to fall backward and resulted in Resident #1 hitting the right side of his head on the floor of the van.

Transporter #1 pulled over, asked Resident #1 if they were okay and Resident #1 stated he was fine and insisted the Transporter return him to the facility. Transporter #1 assisted Resident #1 back into seated position in the wheelchair, replaced the security straps and began to drive to the facility. Transporter #1 notified the Unit Manager (UM) Resident #1 fell in the van via cell phone. The UM asked if the resident was injured, and Transporter #1 stated he was not injured. The UM reported the incident to the Director of Nursing (DON), she immediately walked into the Nursing Home Administrator's (NHA) office while on the phone with Transporter #1. UM informed the NHA of a fall in the van, NHA asked if resident was injured, and Transporter #1 stated he was not. The UM informed NHA that the transporter was already driving back to the facility after assisting resident back into the seated position in the wheelchair and securing him in the van with the security straps. The UM directed Transporter #1 to return to the facility and remain in the van with the resident until the DON arrived to assess. Transporter #1 pulled up to the facility, the DON/Assistant Director of Nursing

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(ADON)/Maintenance Director were waiting outside to assess Resident #1. The DON/ADON assessed Resident #1, He was alert, oriented and able to answer all questions. Resident #1 reported that he hit his head and pointed to a spot on the back right side of his head. The ADON/DON assessed a raised area at that location with no other injuries noted. While Resident #1 was being assessed by Nursing, the Maintenance Director observed the front securement straps were not secured per the manufacturer's recommendations. Transporter #1 incorrectly connected the securement straps to the wheelchair's side frame bar, therefore allowing the securement straps to slide and not remain taut.

Resident #1's physician was notified and received orders to send Resident #1 to the Emergency Room (ER) for evaluation and 911 was contacted. Resident #1's family was notified. Resident #1 was alert and oriented at the time Emergency Medical Services (EMS) arrived and transported to the ER. The ER evaluation revealed no laceration, no head trauma or other injury from the fall. Resident #1 returned from the ER at 10:14 PM after evaluation from fall.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents being transported by the Facility Transporter have the potential to be affected.

On 1/19/2024 all residents who have been transported in the last 30 days by the facility Transporter were interviewed by the DON and ADON to ensure no unreported incidents have occurred during any facility transportation.

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F 689	Continued From page 26 No other residents were affected by this deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 1/19/24 the NHA interviewed the Maintenance Director and completed a review of the manufacturer securement manual including the placement of securement straps and wheelchair placement. A root cause analysis of the event was completed, and it was determined to be a result of the placement of the front wheel straps. These straps were not placed further to the front of the security track on the floor of the van. Per the manufacturer's securement system manual, the securement straps should be located as far to the front track as possible with the webbing as tight as allowed. Transporter #1 failed to follow the process for securing a resident seated in a wheelchair in the van per the manufacturer's instructions prior to moving the van. The facility suspended the in-house transportation program and outsourced all transports to a contracted vendor from 01/19/24 through 01/23/24. A full Investigation was completed, and a plan of correction was initiated. On 1/22/2024 the Vice President of Maintenance (VPM) educated the Facility Maintenance Director on the following: 1. Van safety includes the use of the lift, use and the placement of securement straps. 2. Current Policy and Procedure of Facility	F 689		

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Transportation Vehicle dated 10/2018, emphasizing.
"Drivers are trained to halt any transport that seems unsafe whether because of securing methods, behavior or health conditions of a resident, severe weather or traffic conditions. Driver will contact the facility Administrator or his/her designee prior to resuming transport to advise of conditions that halted the transport and the reasons the driver feels safe beginning again. If necessary, a second person will be dispatched to assist the driver/transporter."

3. Transportation Driver Skills Assessment- a comprehensive checklist used with return demonstration to validate Transportation Drivers prior to transport.

4. Transportation Safety Observation Report - a review of securing the wheelchair and using the lift, with loading and unloading for transport.

5. Daily Pre-Trip Inspection - a step by step review of key functions of the van and review of securing the wheelchair prior to leaving the facility.

The following videos were viewed:
1. Manufacturer's Commercial Wheelchair Lift Operators Video Part 1 & 2,
2. How to Operate a Wheelchair Lift
3. Manufacturer Restraint System Training Program.

On 1/22/2024 Maintenance Director was trained to manage the Facility Transportation Program and to provide training and complete skills check off with return demonstration for all Transporters by the VPM.

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On 1/23/24 Transporter #1 was re-educated on the following by the Maintenance Director:

1. Van safety including the use of the lift, use and placement of securement straps including a return demonstration.

2. Current Policy and Procedure of Facility Transportation Vehicle dated 10/2018.
Calling 911 with any incidents in the van with a resident, emphasizing "Drivers are trained to halt any transport that seems unsafe whether because of securing methods, behavior or health conditions of a resident, severe weather or traffic conditions. Driver will contact the facility Administrator or his/her designee prior to resuming transport to advise of conditions that halted the transport and the reasons the driver feels safe beginning again. If necessary, a second person will be dispatched to assist the driver/transporter.

3. Transportation Driver Skills Assessment- a comprehensive checklist used with return demonstration to validate Transportation Drivers prior to transport.

4. Transportation Safety Observation Report - a review of securing the wheelchair and using the lift, with loading and unloading for transport.

5. Daily Pre-Trip Inspection - a step by step review of key functions of the van and review of securing the wheelchair prior to leaving the facility.

The following videos were viewed: A Commercial Wheelchair Lift Operators Video Part 1 & 2, How

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to Operate a Wheelchair Lift and a manufacturer's Restraint System Training Program. The viewing of these videos takes place in the facility and is confirmed by skills return demonstration with the Maintenance Director.

The facility has 2 trained transporters: The Maintenance Director and Transporter#1

Systematic Changes

New Transporters will be trained by the Maintenance Director prior to any transports and on an annual basis on the following: re-education on the Facility Van Manual and placement of the securement straps, current Policy and Procedure of Facility transportation Vehicle dated 10/2018, daily pre-trip inspection completion, calling 911 with any incidents in the van with a resident. A Transportation Driver Skills Assessment will be completed, Transportation Safety Observation Report completed, Safety observation report completed. The following videos will be viewed: The Commercial Wheelchair Lift Operators Video Part 1 & 2, How to Operate a Wheelchair Lift and the manufacturers Restraint System Training Program.

The Maintenance Director is responsible for tracking and completing annual training.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

Effective 1/23/2024 the pre-trip inspection will be completed daily by the transporter. The Maintenance Director will review weekly for 12

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weeks to ensure the pre-trip inspection is completed by the transporter.

Effective 1/23/2024 3 times per week for 12 weeks the Maintenance Director will inspect a random resident with their placement in the van to ensure the straps are securely placed with the appropriate placement per the manufacturer's instructions.
On 1/22/2024 an Ad hoc QAPI meeting was held to review the incident and Plan of Correction. These audits will be reported by the Maintenance Director at the monthly QAPI meeting for 3 months and reviewed by the committee for further recommendations as needed.

The date of Completion is 1/24/2024.

The Administrator is the individual responsible for compliance with this action plan.

On 3/11/2024 the facility's correction action plan for immediate jeopardy removal was validated by the following:
The facility provided documentation to support their corrective action plan including education provided to the Maintenance Director and Transporter #1. The pre-trip inspections were completed prior to any transportation in the van by Transporter #1. The Maintenance Director audited these inspections 3 times per week from 1/23/2024 to 3/11/2024. An observation was conducted of Transporter #1 and the Maintenance Director who both demonstrated the correct method to restrain a wheelchair with a resident into the transportation van using the securement straps, the L-track, pin connectors, and J-hooks. QAPI meetings were discussed with the Administrator and meeting notes were

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F 689	Continued From page 31 reviewed. The facility's date of 1/24/2024 for the corrective action plan was validated on 3/11/2024.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		4/25/24

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

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

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

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

§483.75(e) Program activities.

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

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F 867	Continued From page 33 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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F 867	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family member, physician, nurse practitioner, and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor the interventions that the committee put into place in following the recertification survey of 11/22/2021 and 2/28/2023. This was for 2 deficiencies in the areas of F554 Self-Administration of Medications and F689 Supervision to Prevent Accidents. These deficiencies were recited on the current complaint investigation survey of 3/13/2024. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: F554: Based on observations, record review, resident and staff interviews, the facility failed to assess whether the self-administration of medications was clinically appropriate for 1 of 1 resident (Resident #1) who was observed to have a medication at bedside. During the recertification survey of 2/28/2023 the facility failed to assess the ability of a resident to self-administer medications for 1 of 2 residents reviewed for self-administration of medications. F689: Based on record review, observation, resident, and staff interviews, the facility failed to provide safe transportation for Resident #1 when	F 867	Corrective Action A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 03/12/2024 to discuss the recitation of tag F554 and F689. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at the facility have the potential to be affected. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Facility Administrator and Regional Clinical Nurse Consultant re-educated the Interdisciplinary team and members of the Quality Assurance and Performance Improvement Committee on 3/12/24 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. Any Interdisciplinary Team Member that has not received the Quality Assurance and Performance Improvement education on or after 3/12/24 will be unable to work until	

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F 867	Continued From page 35 he was being transported from dialysis back to the facility on 1/19/2024. Transporter #1 pulled out of the parking lot of the dialysis center and Resident #1's wheelchair tipped over, and he hit the left side of his head. Transporter #1 pulled the transportation van over to a parking lot, where Resident #1 insisted upon Transporter #1 sitting him back upright, and Transporter #1 pulled the resident back up into a sitting and upright position. Transporter #1 then transported Resident #1 8.4 miles back to the facility where he was assessed by the Assistant Director of Nursing (ADON) to have a bump on his head behind his left ear and he reported head pain and nausea after the fall. It was determined by the ADON Resident #1 needed to go to the hospital for evaluation. There was a high likelihood of a serious adverse outcome for Resident #1 due to hitting his head when his wheelchair tipped over in the transportation van. Resident #1 was prescribed and received Plavix (a blood thinning medication). The CT scan completed at the hospital was negative for head injury. This was for 1 of 3 residents reviewed for accidents. During the recertification survey of 11/22/2021 the facility failed to provide enteral feedings and pureed pleasure foods only to 1 of 2 sampled residents assessed unsafe to consume fluids by mouth. Staff provided nectar thickened liquids to a resident with a physician order for nothing by mouth and a speech therapy recommendation for up to 4 ounces pureed pleasure foods and no liquids by mouth. Additionally, the facility failed to complete and document quarterly smoking assessments for 2 of 2 sampled residents reviewed for smoking. These failures occurred for 3 of 4 sampled residents reviewed for supervision to prevent accidents.	F 867	he/she has received the Quality Assurance and Performance Improvement education. All new Interdisciplinary Team Members newly hired will be educated on Quality Assurance and Performance Improvement on date of hire. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. The Interdisciplinary Team, including the facility Medical Director, will meet monthly to conduct the facilities Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiencies F554 and F689 as well as the prevention of any new repeat deficiencies. Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to a present action plan or for a need for new action plan in order to maintain compliance in the facility. Quality Assurance monitoring will take place at each QAPI meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and performance	

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F 867	Continued From page 36 During the recertification survey of 2/28/2023 facility failed to supervise 1 of 4 residents reviewed for smoking. An interview was conducted with the Administrator on 3/11/2024 at 4:10 PM. The Administrator explained the QAPI committee met monthly with the physician, Director of Nursing, Assistant Director of Nursing, Minimum Data Set nurse, Business Office Manager, Social Worker, Dietary Manager, Housekeeping/Laundry Supervisor, Activities Director, and Unit Manager, and a quarterly meeting that the Pharmacist attended. The Administrator described the function of the QAPI committee to identify issues, develop a plan of correction or a Performance Improvement Plan, review accidents, staffing issues, hospitalized residents and review any plan of correction that is in place. The Administrator reported an ad hoc QAPI meeting was conducted in January 2024 after the van accident and the plan of correction was developed. The Administrator explained she started in her position in May 2023 and the citations from the survey in 2/2023 were still being discussed and monitored. The Administrator reported the QAPI committee would discuss prior citations up to 6 months after the areas had been corrected to prevent further deficiencies.	F 867	Improvement committee. Date of Compliance date is 4/25/24 F554 and F689 will be reviewed at QAPI for potiential review for 6 months. The Administrator is the individual responsible for compliance with this action plan.	