STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 11/18/19 through 11/21/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZDYS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/19 through 11/21/19. Event ID# ZDYS11 0 of the 9 complaint allegations was not substantiated.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to recommend a Level 2	F 644	Franklin Oaks Nursing and Rehabilitation Center acknowledges receipt of the	12/16/19

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

Electronically Signed | 12/06/2019

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F 644	Continued From page 1 Pre-Admission Screening and Resident Review (PASRR) for 2 of 4 residents (Resident #5 and #137) reviewed for PASRR. The findings included: 1. A review of Resident #5's Pre-Admission Screening and Resident Review (PASRR) dated 1/8/2015 revealed a level 1 category. Review of a Hospital history and physical report dated 3/30/2018 revealed Resident #5 had a diagnosis of schizophrenia. Resident #5 was admitted to the facility on 5/30/2018 with diagnoses to include residual schizophrenia, and unspecified intellectual disabilities. A Physician order dated 5/30/2018 for Risperidone (an antipsychotic) was ordered for schizophrenia. Resident #5's annual Minimum Data Set (MDS) assessment dated 5/4/2019 revealed his cognition to be severely impaired, and he required extensive assistance from staff for activities of daily living. The assessment included a diagnosis of schizophrenia and no level II PASRR. On 11/20/2019 at 10:41 AM, an interview was conducted with the Social Worker (SW), who stated Resident #5 had come to the facility with the diagnosis of schizophrenia and a PASRR level I in place, and she had not submitted him for a rescreening. The SW stated in reviewing the PASRR screening submitted in 2015, no mental health or intellectual disability diagnoses had	F 644	Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Franklin Oaks Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the deficiency is accurate. Further, Franklin Oaks Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 644 Resident #5 and Resident #137 were reviewed and a request was submitted on 12/4/2019 for a rescreening PASARR evaluation. A 100% audit of all residents was completed on 12/4/2019 by the Director of Nursing, Assistant Director of Nursing, Social Worker, MDS Nurses and RN Unit Managers, specifically looking for diagnosis of serious mental disorder and/or intellectual disability to determine the necessity of screening for a Level II PASARR. If a resident was found to have a diagnosis of a serious mental disorder	

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F 644	Continued From page 2 been included, nor any antipsychotic medication. The SW stated it looked like the previous PASRR had been submitted inaccurately and she would request a rescreening for Resident #5. On 11/20/2019 at 4:02 PM, an interview was conducted with the Administrator who stated it was her expectation they followed the requirement and had started a performance improvement plan regarding the issue. 2. Resident #137 was admitted to the facility on 6/18/15 and had diagnoses that included cerebrovascular accident (stroke), chronic obstructive pulmonary disease aphasia, depression and anemia. Review of the Pre-admission Screening and Resident Review (PASRR) revealed the screening was done on 4/24/2006 and the resident was screened as a Level I PASRR. The resident's current Care Plan contained an entry dated 10/22/15 and was last reviewed on 8/1/19 that noted a problematic manner in which the resident acts characterized by ineffective coping with paranoid, suspiciousness behavior, hallucinations and delusions related to cognitive impairment. Has psychosis diagnosis. Be careful not to invade the resident's personal space. Behavior management/psych consult. The Care Plan revealed the resident received psychotropic drugs with the potential for side effects. Review of the clinical record revealed a pharmacist note to the attending physician dated 6/26/15 that noted the resident received Risperdal (antipsychotic medication) that required	F 644	and/or intellectual disability and did not have a Level II PASARR, then the resident was resubmitted by the SW for a new screening. All new residents will be reviewed on admission, by the Director of Nursing, Assistant Director of Nursing, Social Worker, MDS Nurses and RN Unit Managers to check for accuracy of the hospital PASARR submission. All new Resident Diagnoses, MD notes, Psychiatric Notes, Nursing progress notes and significant changes will be reviewed in the daily Interdisciplinary Team Meeting, by the Director of Nursing, Assistant Director of Nursing, Social Worker, MDS Nurses and RN Unit Managers, to identify any serious mental disorder and/or intellectual disability diagnosis. If a diagnosis is identified, the Social Worker and/or designee will resubmit for a new PASARR screening. A PASARR tracking tool will be initiated by the Director of Nursing and/or Assistant Director of Nursing to ensure timely and accurate communication of identified residents and completion of submission for a new PASARR screening. The Administrator will review each tracking form for completion. MDS nurses will update the care plan for any PASRR level changes as indicated. On 12/3/2019 an in-service on PASARRs was completed by the Administrator with Medical Records staff, Minimum Data Set Nurse (MDS), Director of Nursing, Assistant Director of Nursing, Social	

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F 644	Continued From page 3 a diagnosis to support its use. The physician responded on 7/8/15 with the diagnosis of Psychosis in the absence of dementia. The Annual Minimum Data Set (MDS) Assessment dated 5/5/19 noted the resident was not a level II PASRR. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 10/25/19 revealed the resident had moderate cognitive impairment, no behaviors and required extensive to total assistance with activities of daily living except was independent with eating with tray set up and supervision. The MDS noted the resident received an anti-depressant for 7 days of the 7 day assessment period. The MDS noted a diagnosis of psychosis. On 11/21/19 at 10:33 AM an interview was conducted with the Social Worker and revealed she had worked in the facility since 1999. The Social Worker stated she tried to find the document listing the diagnoses at the time the PASRR screening was done but the screening was so old, the information was not accessible. The Social Worker further stated she had not been getting the information regarding new psychiatric diagnoses and had not requested a PASRR screening for this resident since admission to the facility. The Social Worker continued and stated this resident should have been submitted for a re-screening for the PASRR. On 11/21/19 at 11:32 AM the Administrator stated in an interview they had started a performance improvement plan regarding the PASRR.	F 644	Worker, and RN Unit Managers in regards to identification of any serious mental disorder and/or intellectual disability diagnosis to include: 1. Review of all new admissions history and physical and discharge summaries. 2. Review of all Diagnoses, MD notes, Psychiatric notes, Nursing Progress Notes and significant changes for any serious mental disorder and/or intellectual disability condition or diagnosis. 3. Initiation of PASARR Tracking Tool and submission for a new PASARR screening. 4. MDS nurse will update care plan for any PASARR level changes as indicated. All newly hired Medical Records, Minimum Data Set Nurse (MDS), Director of Nursing, Assistant Director of Nursing and RN Unit Managers will be in-serviced during orientation on PASARRs in regards to identification of any serious mental disorder and/or intellectual disability diagnosis to include: 1. Review of all new admissions, history and physical and discharge summaries. 2. Review of all Diagnoses, MD notes, Psychiatric notes, Nursing Progress Notes and significant changes for any serious mental disorder and/or intellectual disability condition or diagnosis. 3. Initiation of PASARR Tracking Tool and submission for a new PASARR screening. 4. MDS nurse will update care plan for any PASARR level changes as indicated. A 25% audit of all new admissions,	

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F 644	Continued From page 4	F 644	Diagnoses, MD notes, Psychiatric notes, progress notes and significant changes for any serious mental disorder and/or intellectual disability diagnosis will be completed by the Director of Nursing and Administrator weekly x 8 weeks, then monthly x 1 month utilizing the PASARR Audit Tool to ensure all areas of concern were addressed. The Quality Improvement (QI) Nurse will forward the results of the PASARR Audit Tool to the Quality Assurance and Performance Improvement Committee monthly x 3 months. The Quality Assurance and Performance Improvement Committee will meet monthly x 3 months and review the results of the PASARR 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 Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		12/16/19

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F 657	Continued From page 5 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to update a care plan for 1 of 2 residents (Resident # 125) reviewed for splints. The findings included: Resident#125 was admitted to the facility on 12/7/18 with diagnoses that included hemiplegia following a cardiovascular accident. Review of nursing note dated 10/9/19 revealed Resident #125 was screened by therapy for left hand splint and increased right hand pain. Review of physician order dated 10/11/19 for	F 657	F657 Resident #125 Care Plan was reviewed and revised on 11/21/2019 to reflect a hand splint identified by the Director of Nursing. A 100% audit of all resident care plans was completed on 12/4/2019 by the Director of Nursing, Assistant Director of Nursing, MDS Nurses, and RN Unit Managers to include Resident #125 to ensure that all areas of the care plan reflect the resident□s individual needs. Any care plans with areas of concerns will be updated to reflect the resident□s individual needs by the MDS Nurses with	

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F 657	Continued From page 6 resident to be seen by occupational therapy for 5 days a week for 4 weeks due to muscle weakness. Further review revealed an order to apply right arm splint daily in the morning. Remove right arm splint daily in PM. Review of the most recent Minimum Data Set (MDS) dated 10/21/19 revealed Resident #125 adequate vision and hearing with severe cognitive impairment. She required extensive assistance to for activities of daily living (ADLS) and had functional limitations of range of motion to the left side. Review of the most recent care plan last updated 11/8/19 did not address the limited mobility and splint to hand. An observation of Resident #125 on 11/18/19 at 03:52 PM revealed the resident was sitting up in chair at bedside alert with hand splint off and laying in lap. Resident #125 stated that she had taken splint off to stretch her hand. An observation of Resident #125 on 11/20/19 at 08:48 AM revealed the resident was sitting up in chair at the bedside. There was no splint on the residents' right hand. An interview was conducted on 11/20/19 at 8:50 AM with Nurse #2 who stated the resident had an order on the Medication Administration Record (MAR) dated 11/12/19 for hand splint to be placed in the morning and taken off in the evening. She further stated that the splint was placed on after the breakfast meal. An interview was conducted on 11/21/19 09:05 AM with the MDS nurse and she stated that there	F 657	oversight from the Director of Nursing. An in-service was completed on 12/3/2019 by the Registered Nurse Consultant with the Interdisciplinary Care Plan Team members: MDS Coordinator, MDS Nurse, Director of Nursing, Assistant Director of Nursing, RN Unit Managers, Dietary Manager. Social Worker, Activities Director and Therapy Manager on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed. All newly hired MDS Nurses will be in-serviced during orientation on updating the resident care plan. An audit will be completed of 10% of all residents care plans to include the care plan for resident #125 X 8 weeks, then monthly X 1 month by the Director of Nursing, Assistant Director of Nursing or RN Unit Managers to ensure that the care plans accurately reflect the resident utilizing the QI Care Plan Audit Tool. The Interdisciplinary Care Plan Team members will be retrained and the care plan will be revised immediately by the Director of Nursing for any identified area of concern. The Administrator will review and initial the QI Care Plan Audit Tool weekly X 8 weeks, then monthly X 1 month for compliance and to ensure all areas of concern have been addressed. The Quality Improvement (QI) Nurse will forward the results of the QI Care Plan	

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F 657	Continued From page 7 was no care plan update for the hand splint that was ordered on 11/12/19. The MDS nurse further stated the nurse that transcribed the order for hand splint was responsible for making sure the care plan was updated. During an interview with the Director of Nursing (DON) on 11/22/19 at 11:57 AM she stated that the MDS nurse was supposed to enter any new diagnoses and update the care plan. She further stated that the splint should have been included on Resident #125's care plan.	F 657	Audit Tool to the Quality Assurance and Performance Improvement Committee monthly x 3 months. The Quality Assurance and Performance Improvement Committee will meet monthly x 3 months and review the results of the QI Care Plan 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 Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		12/16/19

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F 761	Continued From page 8 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to lock an unattended medication cart for 1 of 8 carts observed. The findings included: On 11/20/2019 at 8:25 AM, an observation of a medication pass was conducted on the Alzheimer's Unit with nurse #1, with the medication cart parked outside the dining area. At 8:28 AM on 11/20/2019 Nurse #1 stated she would have to go to the main medication room to get a correct dosage of medication. The nurse left the cart unlocked where it remained parked outside the dining area and left the locked unit. One resident walked past the unlocked cart shortly after Nurse #1 left the unit. 2 residents were sitting in chairs in the TV viewing area of the hallway approximately 10 feet from the unlocked cart. On 11/20/2019 at 8:31 AM, 2 residents left the dining area and walked past the unlocked cart to the TV viewing area. On 11/20/2019 at 8:33 AM, 2 additional residents walked past the unlocked medication cart to the TV viewing area. On 11/20/2019 at 8:35 AM, Nurse #1 returned to the cart and stated she did not know she had left her medication cart unlocked when she was off the unit. The nurse further stated that it was not her practice to leave the cart unlocked.	F 761	F761 Nurse #1 was immediately provided with retraining on 11/20/2019 by the Director of Nursing on locking the medication cart when leaving it unattended or out of site at all times. A 100% audit was completed on 11/20/2019 of all medication and treatment carts in facility were checked to ensure every cart was locked when attended. 100% Licensed nurses and Medication Aides were in serviced, beginning on 11/20/2019 and completed on 12/5/2019 by the Staff Facilitator, on maintaining a locked medication cart when out of sight and unattended. Medication carts will be monitored using a Medication Cart Security QI tool, to ensure all medication carts are locked when left unattended by the Administrator, Director of Nursing, Assistant Director of Nursing, RN Unit Managers to include nights & weekends, 3X a week for 4 weeks, then monthly for 1 month. The licensed nurse will be immediately retrained by the Staff Facilitator for any identified areas of concern. The DON will	

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F 761	Continued From page 9 On 11/20/2019 at 4:13 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected nurses to lock their medication carts anytime they turned their back to the cart.	F 761	review and initial the Medication Cart Security Audit Tool for completion and to ensure all areas of concerns were addressed Weekly X 4 Weeks and Monthly X 1 Month. The Quality Improvement (QI) Nurse will forward the results of the Medication Cart Security QI Audit Tool to the Quality Assurance and Performance Improvement Committee monthly x 3 months. The Quality Assurance and Performance Improvement Committee will meet monthly x 3 months and review the results of the Medication Cart Security 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 Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
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	F 812		12/16/19

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F 812	Continued From page 10 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 observations and staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the steam table under shelf for one of one steam tables observed. The findings included: A review of the Weekly Cleaning Assignment sheet the second line read as: "Clean and polish steam table". The tenth line read as: "Clean and polish work tables including legs." A review of the Weekly Cleaning Assignment sheet documented the steam table was last cleaned on 11/8/19. During an observation on 11/19/19 at 8:40 AM the 6 well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles. A second observation on 11/21/19 at 10:24 AM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles and sticky to touch. In an interview on 11/21/19 at 10:26 AM the Certified Dietary Manager stated the steam table	F 812	F812 The steam table in the dietary department was immediately cleaned on 11/21/2019. The Dietary Manager was immediately provided with retraining on 11/21/2019 by the Administrator on maintaining kitchen equipment in a clean and sanitary condition to include cleaning the shelf under the steam table. 100% of all Dietary Staff were in serviced on 12/2/2019 on maintaining kitchen equipment in a clean and sanitary condition to prevent cross contamination to include the shelf under the steam table. All kitchen equipment to include the shelf under the steam table, will be monitored by the Dietary Manager 5 days a week, 2X a day for 4 weeks, then monthly X 3 months using a Dietary Audit Tool to ensure kitchen equipment and the shelf under the steam table are clean and free of debris. The dietary staff and Dietary Manager will be immediately retrained by the Administrator for any identified areas of concern.	

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	345335	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	1704 NC HIGHWAY 39 N LOUISBURG, NC 27549

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F 812	Continued From page 11 was cleaned on a weekly basis. He stated where the cleaning schedule listed to clean and polish all the tables, his staff knew to clean the undersides of tables. In an interview on 11/21/19 at 10:28 AM the assistant dietary aide indicated they would clean the steam table right away.	F 812	The Dietary Manager and Administrator will review and initial the Dietary Audit Tool for completion and to ensure all areas of concerns were addressed weekly for 4 weeks, and monthly for 3 months. The Quality Improvement (QI) Nurse will forward the results of the Dietary QI Audit Tool to the Quality Assurance and Performance Improvement Committee monthly x 3 months. The Quality Assurance and Performance Improvement Committee will meet monthly x 3 months and review the results of the Dietary 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 Administrator and Dietary Manager will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 867	F867	12/16/19

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F 867	Continued From page 12 facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor interventions that the committee put in place November 2018. This was for a deficiency originally cited on 11/8/2018 and was subsequently recited on the current recertification survey 11/21/2019. The repeated deficiency was for care plan timing and revision. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 657 Care Plan Timing and Revision. Based on observation, record review and staff interview the facility failed to update a care plan for 1 of 2 residents (Resident #125) reviewed for splints. During the previous certification survey on 11/8/2018 the facility was cited for a deficiency at F657 for failure to update a resident's care plan to reflect weight loss and increased behaviors for 1 of 2 residents with a significant change in status. The facility also failed to update the care plan for care of a peripherally inserted central catheter (PICC) for 2 of 2 residents reviewed with PICC lines. The facility was recited during the current 11/21/2019 annual recertification and complaint investigation survey for the same issue of care plan timing and revision. During an interview with the Administrator on 11/21/2019 at 12:00 PM she stated the care plan timing and revision process worked but felt that	F 867	On 11/21/2019, the Administrator, Director Of Nursing (DON) and Assistant Director Of Nursing (ADON) were educated by the Facility Nurse Consultant on the Quality Assurance and Performance Improvement (QAPI) process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the Quality Assurance and Performance Improvement process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include care plan timing and revision. In-service also 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 Quality Assurance and Performance Improvement process. On 12/3/2019, a 100% audit was completed by the Administrator and Director of Nursing of previous citations and action plans within the past year to include updating of care plans to ensure that the QAPI committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the Quality Assurance and Performance Improvement Committee on 12/4/2019 by the Administrator for any concerns identified. All data collected for identified areas of concerns to include updating care plans will be taken to the Quality Assurance and	

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F 867	Continued From page 13 this one just slipped through the cracks. The Administrator further stated the staff who usually updated the care plan was absent at this time and a less familiar employee was filling in.	F 867	Performance Improvement Committee for review monthly for six (6) months by the QI Nurse. The Quality Assurance and Performance Improvement Committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Improvement and Performance Improvement Committee will be documented monthly at each meeting by the QI Nurse. The facility nurse consultant will ensure the facility is maintaining an effective Quality Assurance and Performance Improvement program by reviewing and initialing the Quarterly Quality Assurance and Performance Improvement Committee meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include updating care plans and all current citations and Quality Assurance and Performance Improvement plans are followed and maintained Quarterly for six (6) months. The facility consultant will immediately retrain the Administrator, DON and QI Nurse for any identified areas of concern. The results of the monthly Quality Assurance and Performance Improvement Committee meeting minutes will be presented by the Administrator and/or DON to the Quarterly Quality Assurance and Performance	

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F 867	Continued From page 14	F 867	Improvement Committee for 6 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	