STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING ______ B. WING ______	C 12/22/2022

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EDGECOMBE HEALTH CENTER BY HARBORVIEW	**1000 WESTERN BOULEVARD TARBORO, NC 27886**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/19/22 through 12/22/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PROT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/19/22 through 12/22/22. Event ID# PROT11. The following intakes were investigated NC00195614, NC00195662, and NC00196209. 1 of the 9 complaint allegations was substantiated resulting in a deficiency. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		1/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 01/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to maintain a resident's dignity when incontinent care for a bowel movement was not provided when requested. This allowed the resident to remain laying in stool and caused the resident to "feel bad" for 1 of 1 resident (Resident # 105) reviewed for dignity. The findings included: Resident #105 was admitted to the facility on	F 550	1. Immediate action(s) taken for the resident(s) found to have been affected include: The resident involved was provided incontinent care immediately by Physical Therapist. 2. Identification of other residents having the potential to be affected was accomplished by: 800 and 900 hall residents were identified and had potential to be affected as	

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F 550 Continued From page 2

11/11/22. Her diagnoses included chronic idiopathic constipation and Alzheimer's disease.

The admission Minimum Data Set assessment dated 11/18/22 revealed Resident #105 was severely cognitively impaired. She required limited assistance for her activities of daily living including transfers and toilet use. She was occasionally incontinent of urine and always continent of bowel.

On 12/20/22 at 9:49 AM Resident #105 was observed in bed leaning to her left side with her head resting on the left bed rail. She was moaning and said, "I wish they would hurry up." Resident #105 said she had a bowel movement and had activated the call light. During the observation Resident #105's roommate said from behind the partially drawn privacy curtain, "they told her they would get to her after they finished giving baths for the residents going to the singing this morning. She has already waited 10 minutes." During this observation the call light was not activated.

A record review revealed Resident #77 (Resident #105's roommate) was assessed as cognitively intact on her most recent MDS assessment dated 11/29/22.

On 12/20/22 at 9:52 AM Resident #105 was heard from outside her room making a moaning sound.

On 12/20/22 at 9:55 AM Resident #105 was again heard moaning and said "Oh, I wish they would hurry up." Upon entering her room Resident #105 was interviewed. The resident was informed her call light was not activated. She responded

F 550

evidence by 900 hall was around the corner from 800 hall and call lights were not visible from the other hall.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The staffing assignment sheet was updated on 12/23/22 to separate 800 and 900 halls with clear view of call lights of halls assigned.

Staffing Development Coordinator inservice Nursing Staff regarding staffing assignment updates by 1/16/23. Staffing Development Coordinator will provide education on orientation to new staff and agency.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The Charge Nurse ensures compliance on staffing assignments are met. The Assistant Director Of Nursing will complete call bell audits 5 times per week for 12 weeks on 5 random residents to ensure call bells are answered timely and resident needs are met. If noncompliance is discovered during the audits the issue will be corrected immediately and further education provided by the Assistant Director Of Nursing.

The audits will be discussed by the ADON weekly in clinical start up with Inter-disciplinary Team and brought to the Quality Assurance Performance

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she could not reach the call light from her current position. The observation revealed she was laying on her left side with her head resting on the left side bed rail. The call light was attached to the right bed rail. Resident #105 indicated she did not want to roll over because she was soiled. After the surveyor exited the room the call light activated.

On 12/20/22 at 9:57 AM the Activities Director was observed to enter Resident #105's room. She exited the room within a few seconds.

On 12/20/22 at 10:05 AM the Rehabilitation Director was observed to enter the room. She spoke to the resident and turned the call light off.

At 10:06 AM on 12/20/22 upon exiting the room the Rehabilitation Director was interviewed. She explained she turned the call light off because she was going to get the Nurse Aide (NA) assigned to the resident.
On 12/20/22 at 10:06 AM Resident # 105 was again heard moaning loudly and could be heard from the hallway.

On 12/20/22 at 10:07 AM the Rehabilitation Director reentered Resident #105's room.

During the observation on 12/20/22 at 10:07 AM the Rehabilitation Director stated she was unable to find the NA assigned to Resident #105. She closed the door to the resident's room.

At 10:26 AM on 12/20/22 the Rehabilitation Director was observed to exit Resident #105's room. She obtained a gown for the resident and returned to the room.

Improvement meeting monthly for 3 months.

Corrective action completion date: 1/16/23

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On 12/20/22 at 10:34 AM the Rehabilitation Director exited the room and was again interviewed. She reported the resident had a bowel movement, so she provided incontinent care for her.

On 12/20/22 at 3:09 PM Resident #105 said being left soiled for so long made her feel bad. She added it felt like a long time to be laying in stool.

A review of the staffing assignment sheet for 12/20/22 revealed NA #2 was assigned to Resident #105.
Attempts to interview NA #2 were unsuccessful.

The Rehabilitation Director was interviewed again on 12/22/22 at 11:03 AM. She reported she responded to Resident #105's room due to the call light being activated on 12/20222. The Rehabilitation Director said Resident #105 had a bowel movement while in bed. She added she went to get NA #2, but she could not find the NA, so she returned to the room and provided incontinent care for the resident.

On 12/22/22 at 11:44 AM the Director of Nursing (DON) said the Rehabilitation Director reported to her that she did not see anyone to help with incontinent care for Resident #105 on 12/20/22, so she provided the care. She said she was unsure of the length of time Resident #105 had to wait to receive incontinent care. The DON said NA #2 was assigned to 2 rooms (4 residents) on the 800 hall and 5 rooms (10 residents) on the 900 hall. (The 900 hall was around the corner from the 800 hall and call lights were not visible from the other hall.)

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F 582	Continued From page 5	F 582		
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the	F 582		1/16/23

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F 582	Continued From page 6 facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a completed Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) (Form CMS-10055) which included the estimated cost prior to discharge from the Medicare Part A skilled services for 3 of 3 residents reviewed for beneficiary protection notification. (Resident # 110, Resident #278, and Resident #280) Findings included: 1. Resident #110 was admitted to the facility on 2/23/22 with Medicare Part A. Review of Resident #110's quarterly Minimum Data Set assessment dated 5/25/22 revealed she had severe cognitive impairment. Review of Resident #110's Advance Beneficiary Notice of Non-coverage (ABN) form dated	F 582	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #110 was informed of payment status as of the resident's last covered day on 5/27/22 and signature of notification was obtained. Resident #278 was informed of payment status and last covered day on 9/25/22. Resident # 280 has been discharged. For resident 110 and 278 Social Worker Assistant used the correct Advanced Beneficiary Notice form with financial amount. These corrections were completed by the Social Worker Assistant. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available	

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F 582 Continued From page 7

5/21/22 revealed the form number being used by the facility was CMS-R-131 instead of CMS-10055. It also revealed that the care section, reason Medicare may not pay section and the estimated cost sections were not completed. There was a check by Option 3 ("I don't want the care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.") The signature section had "spoke with [Responsible Party (RP)] via phone" written in.

Resident #110's Medicare Part A coverage ended on 5/24/22 and the resident remained in the facility.

An interview on 12/21/22 at 8:24 AM with the Social Worker (SW) confirmed she was responsible for completing the ABN forms. She stated she understood that the form should be completed but did not know what was supposed to be put in the Medicare may not pay section or the estimated cost sections of the form.

An interview on 12/22/22 at 8:15 AM with the Administrator revealed she was unaware the form had not been completed correctly.

2. Resident #278 was admitted to the facility on 9/09/22 with Medicare Part A.

Review of Resident #278's admission Minimum Data Set assessment dated 9/16/22 revealed she was cognitively intact.

Review of Resident #278's Advance Beneficiary Notice of Non-coverage (ABN) form dated 9/23/22 revealed the form number being used by the facility was CMS-R-131 instead of

F 582

have the potential to be affected. An audit was conducted by Social Worker Assistant on current residents who were admitted in the past three months, and corrective actions were completed on 1/16/23.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy: Business Office Manager, Social Services Director and Assistant. Copies of the relevant forms were placed in a binder in the Social Work Office. These actions were completed on 1/16/23.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The Social Service Director, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks to verify that notices were issued timely and appropriately.
Findings of this audit will be brought to Quality Assurance Performance Improvement and discussed by the Social Worker Director.
This plan of correction will be monitored at the monthly Quality Assurance meeting for 3 months.

Corrective action completion date: 1/16/23

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CMS-10055. It also revealed that the care section, reason Medicare may not pay section and the estimated cost sections were not completed. There was a check by Option 3 ("I don't want the care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.") The signature section had "spoke with [Responsible Party (RP)] via phone" written in.

Resident #278's Medicare Part A coverage ended on 9/25/22 and the resident was discharged home on 9/26/22.

An interview on 12/21/22 at 8:24 AM with the Social Worker (SW) confirmed she was responsible for completing the ABN forms. She stated she understood that the form should be completed but did not know what was supposed to be put in the Medicare may not pay section or the estimated cost sections of the form.

An interview on 12/22/22 at 8:15 AM with the Administrator revealed she was unaware the form had not been completed correctly.

3. Resident #280 was admitted to the facility on 6/15/22 with Medicare Part A.

Review of Resident #280's admission Minimum Data Set dated 6/20/22 revealed she was cognitively intact.

Review of Resident #280's Advance Beneficiary Notice of Non-coverage (ABN) form undated revealed the form number being used by the facility was CMS-R-131 instead of CMS-10055. It also revealed that the care section, reason Medicare may not pay section and the estimated

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F 582	Continued From page 9	F 582		

cost sections were not completed. There was a check by Option 3 ("I don't want the care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.") The signature section had "spoke with [Responsible Party (RP)] via phone" written in.

Resident #280's Medicare Part A coverage ended on 6/27/22 and the resident was discharged home on 6/28/22.

An interview on 12/21/22 at 8:24 AM with the Social Worker (SW) confirmed she was responsible for completing the ABN forms. She stated she understood that the form should be completed but did not know what was supposed to be put in the Medicare may not pay section or the estimated cost sections of the form.

An interview on 12/22/22 at 8:15 AM with the Administrator revealed she was unaware the form had not been completed correctly.

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		1/16/23

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information

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F 655	Continued From page 10 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and Resident Representative (RP) interviews the facility failed to develop a baseline care plan within 48 hours of admission that included the diagnosis of diabetes mellitus (DM) and insulin administration and failed to provide a written summary of the baseline care plan for 1 of 1	F 655	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #69 was given a summary of their baseline care plan. A copy of the summary, signed by the resident, resident's representative if applicable, and	

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resident (Resident #69) reviewed for baseline care plans.

Findings included:

Resident #69 was admitted to the facility on 11/2/22 with diagnoses of diabetes mellitus (DM) and long term (current) use of insulin.

A review of admission Minimum Data Set (MDS) assessment dated 11/5/22 revealed he was moderately cognitively impaired. He received insulin injections 4 look back days of the assessment.

A physician's order dated 11/2/22 revealed insulin glargine (a long-acting synthetic version of human insulin) inject 10 units (u) subcutaneously (sub-q) at bedtime.

A review of Resident #69's Medication Administration Record (MAR) revealed documentation 10 u of insulin glargine was administered to him sub-q on 11/2/22 at 9:00 PM.

On 12/19/22 at 11:08 AM an interview with Resident #69 indicated he did not recall receiving any written copy of his baseline care plan.

On 12/20/22 at 3:13 PM a telephone interview with Resident #69's RP indicated she did not recall ever receiving any written copy of Resident #69's baseline care plan

A review of Resident #69's medical record revealed a document titled "Nursing Interim Care Plan" dated 11/2/22 signed by Nurse #2. Neither the diagnosis of DM nor insulin administration were included on this document. The section on

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a facility representative was placed in the medical record by the Social Worker Director.

2. Identification of other residents having the potential to be affected was accomplished by:
The facility has determined that all residents have the potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
All interdisciplinary care plan team members inclusive of Admission Nurse and Nurse Managers responsible for writing baseline care plans will be re-educated by Staffing Development Coordinator on the facility's policy and procedure for developing Baseline Care Plans, which includes procedures for providing the resident a written summary of their baseline care plan by 1/16/23. Staffing Development Coordinator will education on orientation to new staff and agency staff.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:
The Director of Nursing will complete random weekly audits of baseline care plans for six (6) consecutive weeks. Random audits of 5 baseline careplans a week will be completed by the Director of Nursing to ensure that baseline care plan summaries are being provided to residents, and that a copy has been

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F 655	Continued From page 12 the form indicating a written copy was provided to Resident #69 and/or his RP was left blank. A further review of Resident #69's medical record did not reveal any evidence he or his RP were provided with a written summary of his baseline care plan. On 12/22/22 at 7:44 AM a telephone interview with Nurse #2 indicated she completed the document titled "Nursing Interim Care Plan" dated 11/2/22. She stated this was Resident #69's baseline care. Nurse #2 went on to say there was not a place on the form to include DM with insulin administration, so she hadn't included it. She stated nurses would have access to this information in Resident #69's physician orders. She further indicated she had not provided Resident #69 or his RP with a written summary. She stated the admitting nurse completed the baseline care plan, but she did not know who was responsible for providing anything in writing. Nurse #2 went on to say maybe the social worker (SW) did that. In an interview on 12/20/22 at 4:04 PM the MDS Director stated MDS did not provide residents or their RPs with a written summary their care plan. She stated the admitting nurse completed the baseline care plan, but she did not know who was responsible for providing anything in writing. On 12/20/22 at 4:14 PM an interview with SW #1 indicated SWs did not ever provide residents or RPs with a written summary of the baseline care plan. On 12/21/22 at 10:46 AM an interview with the Director of Nursing (DON) indicated a written summary of the baseline care plan should be	F 655	placed in the medical record. Audit records will be reviewed by the the Director of Nursing at the Quality Assurance Performance Improvement meeting for 3 months. Corrective action completion date: 1/16/2023	

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F 655	Continued From page 13 provided to resident's and/or their RPs. She stated the document titled Nursing Interim Care Plan dated 11/2/22 signed by Nurse #2 was Resident #69's baseline care plan. She went on to say Nurse #2 would have been responsible for providing the written summary to him and/or his RP. The DON further indicated while the diagnosis of DM and insulin administration would be important information, she did not know if nurses were including it on resident's baseline care plans. She stated nurses would have access to this information in a resident's physician's orders. On 12/22/22 at 8:44 PM an interview with the Administrator indicated residents and/or their RP should be provided with a written summary of their baseline care plan.	F 655		
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 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	F 657		1/16/23

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F 657	Continued From page 14 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 record review and resident, staff and Resident Representative (RP) interviews the facility failed to ensure the timely review and revision of the comprehensive care plan by the interdisciplinary team (IDT) for 2 of 5 (Resident #45 and Resident #37) residents reviewed for care planning. Findings included: 1. Resident #45 was admitted to the facility on 12/11/2018. A review of the annual comprehensive Minimum Data Set (MDS) assessment for Resident #45 dated 10/28/22 revealed she was cognitively intact. A review of Resident #45's current comprehensive care plan revealed 14 goals with a target date of 8/11/22. The interventions for these goals were last revised on 6/14/22. In an interview on 12/19/22 at 2:32 PM Resident #45 indicated she did not recall being invited to or participating in a care plan meeting.	F 657	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #45 and #37 careplan was reviewed with resident and Responsible Party by the Social Worker Assistant. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Social Worker Assistant will audit 3 months to ensure residents careplans are complete with resident and agent informed. Minimum Data Set Assistant will do 3 month audit on quarterly careplans to ensure all goals are updated. Minimum Data Set Assistant and Social Worker Assistant will do education with current staff by 1/16/23. Staff Development	

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F 657	Continued From page 15 On 12/21/22 at 8:29 AM an interview with the MDS Coordinator indicated the Social Worker (SW) scheduled care plan meetings for residents, sent the invitation letter to RPs, and provided MDS staff with a copy of the scheduled care plan meetings. She stated these meetings were arranged to coincide with the timing of the MDS assessments at least quarterly. On 12/21/22 at 8:33 AM an interview with SW #1 indicated Resident #45 had a care plan meeting scheduled for 10/28/22. She stated she had not heard back from Resident #45's RP regarding the invitation to participate so she went to Resident #45's room and had a meeting with her. She went on to say she did not recall the exact date she had done that. She stated she had not documented the meeting anywhere. She went on to say she did not recall what she and Resident #45 discussed at this meeting. SW #1 stated normally the IDT would be involved in a resident's care plan meeting and there would be a sign in sheet documenting which disciplines participated. She went on to say she did not have this for Resident #45's October 2022 care plan meeting. She stated she did not know why. She further indicated she had not updated Resident #45's comprehensive care plan after this meeting because there must not have been any changes. On 12/21/22 at 10:26 AM an interview with the Director of Nursing (DON) indicated the IDT should have been involved in Resident #45's care plan meeting. She went on to say there should have been a sign in sheet indicating which disciplines participated in the meeting and the meeting should have been documented in Resident #45's medical record.	F 657	Coordinator will complete education to new staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Social Worker Director created monthly careplan calendar on one drive to share with Inter-Disciplinarily team to ensure careplans are not missed which will be monitored weekly. Social Worker Director will monitor weekly x 6 weeks of the careplan calendar. Minimum Data Set Director and Inter-Disciplinary Team will continue to monitor 5 careplans weekly to ensure they are updated timely through weekly audits x 6 weeks to ensure compliance. Monitoring will be taken to the Quality Assurance Performance Improvement Committee by the Social Worker Director and Minimum Data Set Director for 3 months. Corrective action completion date: 1/16/2023	

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On 12/22/22 at 8:44 AM an interview with the Administrator indicated care plan meetings should include the participation of the IDT. She went on to say there should have been a sign in sheet to indicate which disciplines participated in Resident #45's October 2022 care plan meeting. She further indicated if a meeting occurred, it should have been documented in Resident #45's medical record.

2. Resident #37 was admitted to the facility on 5/18/2018.

A review of the annual comprehensive Minimum Data Set (MDS) assessment for Resident #37 dated 10/12/22 revealed she was cognitively intact.

A review of the current comprehensive care plan for Resident #37 revealed 22 goals with a target date of 10/26/22. The interventions for these goals were last revised on 7/29/22.

On 12/19/22 at 11:50 AM an interview with Resident #37 revealed she did not recall ever being invited to or participating in a care plan meeting.

On 12/21/22 at 9:21 AM a telephone interview with Resident #37's RP indicated she last received an invitation to participate in a care plan meeting for Resident #37 in July or August 2022. She stated she participated in a care plan meeting in August 2022 via telephone. She went on to say she had not received an invitation to or participated in a care plan meeting since then. She stated it was important to her to participate in these meetings because while some staff would call her with updates, other times she felt she had

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to call herself or visit to remain informed about Resident #37's status.

On 12/21/22 at 8:29 AM an interview with the MDS Coordinator indicated the Social Worker (SW) scheduled care plan meetings for residents, sent the invitation letters, and provided MDS staff with a copy of the scheduled care plan meetings. She stated these meetings were arranged to coincide with the timing of the MDS assessments at least quarterly.

On 12/21/22 at 8:33 AM an interview with SW #1 indicated Resident #37 last had a care plan meeting on 8/18/22. She stated Resident #37 had an annual MDS assessment on 10/12/22 and should have had a care plan meeting around the time of that assessment. She stated it must have gotten missed. She went on to say Resident #37's next care plan meeting was scheduled for January 2023. SW #1 further indicated she was getting ready to send those invitations out. She stated from August until January was too long for Resident #37 to go without a care plan meeting.

On 12/21/22 at 10:26 AM an interview with the Director of Nursing (DON) indicated care plan meetings normally went along with the MDS assessments. She went on to say if Resident #37 had an annual MDS assessment done on 10/12/22, she should have had a care plan meeting around the time of that assessment. The DON stated from August 2022 until January 2022 was too long for Resident #37 to go without having a care plan meeting.

On 12/22/22 at 8:44 AM an interview with the Administrator indicated Resident #37 should have had a care plan meeting that coincided with her

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F 657	Continued From page 18 10/12/22 MDS assessment. She stated from August 2022 until January 2022 was too long for Resident #37 to go without having a care plan meeting.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and facility staff interviews and record review the facility failed to provide incontinent care when requested for 1(Resident #105) of 2 residents reviewed for activities of daily living. The findings included: Resident #105 was admitted to the facility on 11/11/22. Her diagnoses included chronic idiopathic constipation and Alzheimer's disease. The admission Minimum Data Set assessment dated 11/18/22 revealed Resident #105 was severely cognitively impaired. She required limited assistance for her activities of daily living including transfers and toilet use. She was occasionally incontinent of urine and always continent of bowel. The care plan dated 11/29/22 indicated Resident #105 needed assistance with grooming, bathing and personal hygiene related to self-care impairment. The care plan also indicated Resident #105 had a pressure ulcer due to	F 677	1. Immediate action(s) taken for the resident(s) found to have been affected include: The resident involved was provided incontinent care immediately by Physical Therapist. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Staffing Development Coordinator Inserviced Clinical staff on turning and repositioning and timeliness of incontinent care by 1/16/23. Staffing Development Coordinator will educate on orientation to staff and agency staff. 4. How the corrective action(s) will be	1/16/23

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F 677	Continued From page 19 assistance required for bed mobility and bowel incontinence and the pressure injury was dated 12/3/22. On 12/20/22 at 9:49 AM Resident #105 was observed in bed leaning to her left side with her head resting on the left bed rail. She was moaning and said, "I wish they would hurry up." Resident #105 said she had a bowel movement and had activated the call light. During the observation Resident #105's roommate said from behind the partially drawn privacy curtain, "they told her they would get to her after they finished giving baths for the residents going to the singing this morning. She has already waited 10 minutes" During this observation the call light was not activated. A record review revealed Resident #77 (Resident #105's roommate) was assessed as cognitively intact on her most recent MDS assessment dated 11/29/22. On 12/20/22 at 9:55 AM Resident #105 was again heard moaning and said "Oh, I wish they would hurry up." Upon entering her room Resident #105 was interviewed. The resident was informed her call light was not activated. She responded she could not reach the call light from her current position. The observation revealed she was laying on her left side with her head resting on the left side bed rail. The call light was attached to the right bed rail. Resident #105 indicated she did not want to roll over because she was soiled. After the surveyor exited the room the call light activated. On 12/20/22 at 10:05 AM the Rehabilitation Director was observed to enter the room. She	F 677	monitored to ensure the practice will not recur: Nurse Managers will monitor weekly by completing nurse rounds of 5 residents with audit tool to ensure compliance with turning and repositioning and timeliness with incontinent care. The audits will be discussed by the Nurse Managers weekly in clinical start up with Inter-Disciplinary Team if noncompliance Nursing Staff will correct immediately and Nurse Manager will bring to the Quality Assurance Performance Improvement meeting monthly for 3 months. Corrective action completion date: 1/16/23	

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spoke to the resident and turned the call light off.

On 12/20/22 at 10:06 AM Resident # 105 was again heard moaning loudly and could be heard from the hallway.

On 12/20/22 at 10:07 AM the Rehabilitation Director reentered Resident #105's room.

During the observation on 12/20/22 at 10:07 AM the Rehabilitation Director stated she was unable to find the NA assigned to Resident #105. She closed the door to the resident's room.

At 10:26 AM on 12/20/22 the Rehabilitation Director was observed to exit Resident #105's room. She obtained a gown for the resident and returned to the room.

On 12/20/22 at 10:34 AM the Rehabilitation Director exited the room and was again interviewed. She reported the resident had a bowel movement, so she provided incontinent care for her.

A review of the staffing assignment sheet for 12/20/22 revealed NA #2 was assigned to Resident #105. Attempts to interview NA #2 were unsuccessful.

The Rehabilitation Director was interviewed again on 12/22/22 at 11:03 AM. She reported she responded to Resident #105's room due to the call light being activated on 12/20/222. The Rehabilitation Director said Resident #105 had a bowel movement while in bed. She added she went to get NA #2, but she could not find the NA, so she returned to the room and provided incontinent care for the resident. She added

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Resident #105 had a dressing on her buttock, but it was not soiled so she did not change the dressing. The Rehabilitation Director stated Resident #105 was sometimes continent of bowel and would get assistance to get into the bathroom, but at times the resident had leg pain and did not want to get out of bed. She added Resident #105 was less mobile now than when she was in therapy and if she had pain she would not stand.

On 12/22/22 at 11:44 AM the Director of Nursing (DON) said the Rehabilitation Director reported to her that she did not see anyone to help with incontinent care for Resident #105 on 12/20/22, so she provided the care, and the resident had a loose stool. She said she was unsure of the length of time Resident #105 had to wait to receive incontinent care. The DON said NA #2 was assigned to 2 rooms (4 residents) on the 800 hall and 5 rooms (10 residents) on the 900 hall. (The 900 hall was around the corner from the 800 hall and call lights were not visible from the other hall.) The DON said she was aware Resident #105 had a pressure wound on her buttock and was receiving dressing changes. The DON was not able to explain how the assigned NA (NA#2) was able to monitor the call light for Resident #105's room when the call light was not visible from the other hall NA #2 was assigned.

F 689 SS=G Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) F 689

§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

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F 689	Continued From page 22 §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 and staff interviews the facility failed to assess Resident #29's ability to be safely seated in a regular wheelchair prior to transfer from the resident's reclining wheelchair. While receiving service from the Beautician, Resident #29 suddenly moved forward and fell hitting her head on the air conditioning unit. Resident #29 was sent to the hospital for evaluation and was diagnosed with a displaced intertrochanteric fracture of the left femur. This deficient practice affected one of one resident reviewed for accidents (Resident #29). Findings included: Resident #29 was admitted to the facility on 3/22/17. Her diagnoses included Parkinson disease and Alzheimer's disease, and cervical spinal stenosis. Resident #29's care plan dated 3/6/22 revealed she was care planned to be at a risk for falls related to confusion, deconditioning, gait/balance problems, and diseases of musculoskeletal system. The interventions included to anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, and the resident needs prompt response to all requests for assistance. Resident #29's Occupational Therapy Discharge Summary dated 9/1/22 revealed Resident #29 was recommended a specialty chair due to	F 689	Past noncompliance: no plan of correction required.	

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resident becoming uncomfortable in a regular wheelchair and fidgeting resulting in the resident falling from a regular chair. The specialty chair was in place when the resident discharged from occupational therapy on 9/1/22.

Resident #29's Minimum Data Set assessment dated 10/5/22 revealed she was assessed as severely cognitively impaired. She had no behaviors and was totally dependent on staff for bed mobility and transfers only occurred once or twice in the lookback period.

There was no update to the care plan after the occupational therapy discharge summary and the last MDS with regards to the use of the specialty chair prior to 11/2/22.

A nursing note written by Charge Nurse #1 and dated 11/2/22 revealed the Beautician informed this nurse resident fell out of the regular wheelchair. Resident #29 was found on the floor and the Beautician stated resident had appeared to be reaching and slipped out of the wheelchair. The Beautician told the nurse Resident #29 hit her head on the air conditioner unit. Resident #29 was assessed and noted with cut to left eye and no other injuries. Resident #29 was looking around and presented at baseline. Resident #29 was sent to the emergency department for evaluation. The family member, who was in the facility, was notified before the resident left.

Review of the discharge summary from the hospital dated 11/7/22 revealed Resident #29 sustained a displaced intertrochanteric fracture (a type of hip fracture) of the left femur (thigh bone).

During an interview on 12/21/22 at 8:32 AM the

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F 689	Continued From page 24 Therapy Director stated when a resident is recommended customized seating per therapy it was their expectation that the staff not alter the intervention without clinical evaluation. She concluded the nurse aide should have notified a clinician for an evaluation from therapy if changes needed to be made to the resident's seating for the resident to get her hair done. During an interview on 12/21/22 at 8:40 AM Nurse Aide #1 stated the Kardex would inform her what specialty equipment was to be used for each resident and therapy in-services the staff regarding specialty equipment required by residents and this had been done for Resident #29. She stated she knew the resident needed to be in the specialty chair for safety which was why she remained with the resident after she placed the resident in the regular wheelchair until the beautician was ready for the resident. She would then transfer the resident back into her specialty chair after her hair was done. She had done this a few times with the resident due to family request as the beautician could not reach the back of the resident's hair in the specialized chair. She stated she did not check with anyone prior to transferring the resident out of her specialty chair and into a regular wheelchair. On 11/2/22, per family request, she ensured the line was short at the beautician and then transferred the resident to a regular wheelchair from her specialty chair. She then took the resident to the beautician and stayed with the resident until it was the resident's turn. She positioned the resident for the beautician and then sat in front of the resident. The resident reached for something in the air in front of her that did not exist which resulted in her falling forwards out of her chair. It happened so fast the nurse aide was unable to react to prevent	F 689		

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the fall. The resident fell forwards and to the right of the resident, hitting the air-conditioning unit next to her chair, landing on the floor. The resident had a small laceration above the right eye. The resident's mental status was at baseline and did not display signs of pain following the fall. Per facility protocol with a fall with head injury, the resident was sent to the emergency room for evaluation. She stated she was asked to participate in the fall investigation and provided her witness statement. Following the investigation, she was educated about not altering specialty safety equipment without ensuring the resident had been assessed to be safe with the change. She stated she now knew if a family member requests a resident to be placed into a different chair from what the resident was recommended by therapy, she would alert her supervisor to resolve the issue and see what changed could be made to the resident's seating safely.

During an interview on 12/21/22 at 9:05 AM the Beautician stated Resident #29 came to the beauty shop in a regular wheelchair as she always did, and she was unaware of any discussions about which chair should be used for Resident #29. The nurse aide then left the resident in the beauty shop with the beautician, and it was just the two of them in the room. She stated she was curling the resident's hair and the resident started reaching her hands out in front of her. The resident was not verbal, so she thought perhaps the resident was trying to communicate something to her and asked the resident to wait a second as she finished placing a roller in her hair. Then, the resident's body suddenly went forward, and she reached out to the resident, placing her hand behind the resident's head as the resident

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fell. The resident hit the air-conditioning unit with the right side of her head and landed on the floor. She stated it was just her and the resident in the beauty shop at that time. The nurse aide who brought the resident had left the room, but the door was open to the beauty shop, so she yelled for help. Charge Nurse #1 was the first to respond to the fall and took over from there. Resident #29 did not display any signs or symptoms of pain. She concluded by saying she was educated to get help from staff if any resident developed behaviors or was not safe to proceed due to such behaviors and Resident #29 now was to have her hair done in bed.

During an interview on 12/21/22 at 9:21 AM Charge Nurse #1 stated she was the charge nurse on the hall at the time Resident #29 sustained her fall in the beauty shop. She stated on 11/2/22 she was walking in the direction of the nursing station when she heard the beautician yell out for help. She immediately responded to the call for help and found Resident #29 was on the floor and the beautician appeared to have been attempting to prevent the resident from hitting her head. Resident #29 had a laceration above her right eye which indicated to the charge nurse that the resident had hit her head during the fall. She stated when she first got there it was just the beautician and the resident in the room. She asked what happened and if the resident had hit her head. The beautician told her the resident fell forward out of the chair and hit her head on the air-conditioning unit. She stated due to the head injury she immediately called 911 to have the resident sent to the emergency department for evaluation following the fall. She stated the resident was smiling and did not display any signs of pain at that time though she was non-verbal.

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F 689	Continued From page 27 She concluded the resident was sent out for evaluation and found to have sustained a fracture of the left femur from the fall. She stated the chair she observed in the beauty shop was a regular wheelchair and Resident #29 was supposed to be in a specialty chair for safety related to falls. She stated she did not know why the resident was in a regular chair at that time and had been unaware until the fall investigation that Resident #29 had been going to the beautician in a regular wheelchair instead of the specialty chair. She concluded in a situation where a family is requesting a nurse aide alter specialty equipment for the resident, the nurse aide should bring this to her attention so she could address the situation with the family and see what could be done clinically to ensure the resident's safety and accommodate the family request. During a follow up interview on 12/21/22 at 9:37 AM Nurse Aide #1 again stated she was in the beautician's room when the resident sustained her fall and had not left the room until after the fall occurred. During an interview on 12/21/22 at 8:07 AM the Director of Nursing and the Corporate Clinical Director stated on 9/1/22 Resident #29 was discharged from therapy with a recommendation for a specialty chair for comfort. Resident #29 would become uncomfortable in a regular wheelchair which resulted in her fidgeting and ultimately falling from the chair. During the investigation of the fall, it was determined Resident #29 had been transferred to a regular wheelchair from her specialty chair by Nurse Aide #1 per family request to get Resident #29's hair done. Resident #29 had successfully been to the beauty shop a few times without incident in this	F 689		

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way, but the specialty chair was the recommendation for her seating and the nurse aide should not have altered the recommended seating. The facility initiated a plan of correction focused on making sure in the future, residents in customized seating had an evaluation to determine if they were safe to alter their seating to go to the beauty shop. She concluded the nurse aide should not have altered the recommended customized seating per family request without ensuring that a clinician had evaluated the resident as to safety.

During observation on 12/21/22 at 10:34 AM, Resident #29 was observed in her specialty chair. No concerns were identified.

During an interview on 12/21/22 at 11:11 AM Physician #1 stated his understanding was that nurse aides should get an evaluation completed by therapy prior to placing a resident in a chair that was not recommended for them. He concluded falls would be the biggest concern with moving a resident from their recommended chair to a regular wheelchair without getting a clinician to evaluate the resident for safety.

The facility provided the following corrective action plan with a completion date of 11/12/22.

1. Resident was in a specialized chair receiving beautician services. Family requested resident to be put in a regular wheelchair to be able to reach her hair better. Nursing assistant accommodated the family request by putting resident in a regular wheelchair and taking her to the beauty shop and handing her off to the beautician. Nursing assistant never left resident alone in her wheelchair and stayed with her until beautician

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F 689	Continued From page 29 was ready for the resident. Nursing assistant interview revealed resident had completed this task successfully 7-8 times. Today (11/2/22) while beautician was doing the resident's hair resident made a quick and sudden movement by lunging up and fell before the beautician was able to do anything. Root cause: Nursing assistant altered specialized seating per family request without clinical evaluation for safety. 2. All residents that use specialized seating that go to the beauty shop are at risk. 3. Inservice to all nursing staff to not alter specialized seating even if this is a family request without clinician approval. Inservice with beautician to seek assistance if any resident demonstrates restlessness or is not safe to proceed due to such behaviors. Also, in-serviced beautician if resident demonstrates restlessness or is not safe to proceed due to such behaviors. Also, in-serviced beautician if resident in a specialized wheelchair to use extra towels and capes to help keep resident as dry as possible. 4. Facility will monitor resident in specialized seating for four weeks to ensure no alterations or residents receive services in bed. Special Notes: Update Care plans for residents that are in specialized seating and for residents getting hair done in bed. Date of compliance is 11/12/22. This corrective action plan was in place on 11/12/22 by the Administrator.	F 689		

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F 689	Continued From page 30 The corrective action plan was verified through record review of the education and monitoring of residents who required specialized seating while receiving beautician services, interviews with facility staff, and observations of Resident #29. Based on observations, interviews, and record reviews the facility's compliance date of 11/12/22 was verified.	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,	F 867		1/16/23

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and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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

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

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high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or 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

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action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the recertification and complaint investigation survey of 12/02/21. The deficiencies were in the area of Accuracy of Assessments (F641) and Care Plan Timing and Revision (F657). The continued failure during 2 federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross-referenced to:

F641: Based on record review and staff interviews the facility failed to accurately code the Preadmission Screening and Resident Review (PASRR) on an annual minimum data set assessment for 1 of 1 resident reviewed for PASRR (Resident #20).

During the recertification and complaint investigation survey of 12/02/21, the facility was cited for the failure to accurately code the PASRR and the hospice status.

F657: Based on record review and resident, staff and Resident Representative (RP) interviews the

F 867

1. Immediate action(s) taken for the resident(s) found to have been affected include:
On 1/13/23 and ADHOC Quality Assurance Performance Improvement was held by the Administrator with Regional Nurse Consultant, Director Of Nursing, Staffing Development Coordinator, Minimum Data Set Director and Assistant, Social Worker Director and Assistant, Activities Director, Therapy Director, Dietary Director, Environmental Director regarding the repeat tags to ensure the Quality Assurance Performance Improvement Committee has maintained and monitored the interventions put into place.

2. Identification of other residents having the potential to be affected was accomplished by:
All residents have potential to be affected.

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
Administrator held ADHOC on 1/13/23 with Regional Nurse Consultant, Director Of Nursing, Staffing Development Coordinator, Minimum Data Set Director and Assistant, Social Worker Director and

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F 867	Continued From page 34 facility failed to ensure the timely review and revision of the comprehensive care plan by the interdisciplinary team (IDT) for 2 of 5 (Resident #45 and Resident #37) residents reviewed for care planning. During the recertification and complaint investigation survey of 12/02/21, the facility was cited for the failure to invite a moderately cognitively impaired resident to a care plan meeting and failure to revise a care plan. An interview on 12/22/22 at 8:15 AM with the Administrator revealed she did not know what caused the repeat deficiencies with MDS assessments and care planning.	F 867	Assistant, Activities Director, Therapy Director, Dietary Director, Environmental Director regarding on the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to identify trends and root cause issues for correction on repeated deficiencies related to correct coding of PASRR and accuracy and timing of careplans. Staffing Development Coordinator on orientation will educate new staff. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Quality Assurance Performance Improvement Committee will review root cause and trends to identify concerns. The Quality Assurance Performance Improvement Committee will address root cause with corrective actions and further training or other interventions. The Administrator is responsible for ensuring implementation of acceptable plan of correction. Administrator will monitor the process of PASRR and accuracy and timing of comprehensive careplans x 12 weeks for compliance and will report monthly in Quality Assurance Performance Improvement for 3 months. Any deficient practice will be corrected immediately from findings by the Administrator. Administrator increased QAPI meetings from quarterly to monthly to ensure monitoring and corrective	

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F 867	Continued From page 35	F 867	actions completed. Corrective action completion date: 1/16/23	