STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345209	A. BUILDING _____ B. WING _____	C 01/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKRIDGE RETIREMENT COMMUNITY	1199 HAYES FOREST DRIVE WINSTON-SALEM, NC 27106

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/23/23 through 1/26/23 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ISEC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/23/23 through 1/26/23. Event ID# ISEC11. The following intake was investigated NC00190280. 1 of the 11 complaint allegations was substantiated resulting in a deficiency-F689	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		3/13/23

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

Electronically Signed | 02/10/2023

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F 640	Continued From page 1 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a discharge tracking Minimum Data Set (MDS) assessment for 3 of 6 residents (Resident #35, #16, and #36) reviewed for closed records. Findings included: 1. Resident #35 was admitted to the facility on 8/30/22 to a skilled bed and a comprehensive	F 640	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	

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F 640	Continued From page 2 MDS was completed on 9/6/22. The medical record revealed that Resident #35 was discharged to the assisted living section within the facility on 9/20/22 and a discharge MDS was not done. On 1/26/23 at 2:41 PM an interview was completed with MDS Coordinator had been in that position since December 2022. She stated she the discharge MDS assessment should have been completed by the 14th day after discharge. She added that it was the responsibility of the MDS Coordinator to make sure those assessments completed and should have been done by the previous coordinator. 2. Resident #16 was admitted to the facility on 9/6/22 and a comprehensive MDS was completed on 9/13/22. The medical record revealed that Resident #16 passed away in the facility on 11/10/22 and a discharge MDS was not done. On 1/26/23 at 2:41 PM an interview was completed with MDS Coordinator had been in that position since December 2022. She stated she the discharge MDS assessment should have been completed by the 14th day after discharge. She added that it was the responsibility of the MDS Coordinator to make sure those assessments completed and should have been done by the previous coordinator. 3. Resident #36 was admitted to the facility on 7/29/22 and a comprehensive MDS was completed on 8/5/22.	F 640	deficiencies cited have been or will be corrected by the date or dates indicated. F640 Encoding/Transmitting Resident Assessments During the survey, it was found that residents #35, #16, and #36 did not have a discharge assessment completed when ending their Certified stay. Discharge assessments for Residents #35, #16, and #36 were completed and transmitted on 1/27/2023 and 2/9/2023. A lookback period of 30 days was completed to ensure all residents who had discharged from certified beds to ensure a discharge assessment was completed. The audit was completed on 2/10/2023 and revealed three additional missing assessments. Missing assessments were completed and transmitted appropriately. This was completed on 2/10/2023. Education was provided by the Administrator to the Director of Nursing, Assistant Director of Nursing, and Minimal Data Set Registered Nurse ensuring completion of a discharge assessment when a resident leaves a Medicare/Medicaid stay. Education was completed on 2/8/2023. Moving forward, an audit will be completed by the MDS RN or designee once a week for 4 weeks for all discharges ensuring assessments for the week were completed and transmitted as required. Monitoring will be forwarded to the facility QAPI committee to determine if further oversight is needed. Audits will be reviewed through the facility's routine QAPI meeting.	

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F 640	Continued From page 3 The medical record revealed that Resident #36 was discharged to an out-of-state assisted living facility on 10/19/22. No discharge MDS was done. On 1/26/23 at 2:41 PM an interview was completed with MDS Coordinator had been in that position since December 2022. She stated she the discharge MDS assessment should have been completed by the 14th day after discharge. She added that it was the responsibility of the MDS Coordinator to make sure those assessments completed and should have been done by the previous coordinator.	F 640	Responsible Team Member: MDS RN Date of Compliance: 2/13/2023 Date of Completion: 3/13/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		3/13/23

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F 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to 1) follow the care plan to place floor mats next to the bedside for fall prevention for 1 of 4 residents (Resident #14) reviewed for falls, and 2) failed to implement a care plan for ileostomy care for 1 of 1 resident (Resident #10) reviewed for ileostomy bowel care. Findings included: 1) Resident #14 was admitted to the facility on 2/16/22 with diagnoses that included, in part, dementia, osteoporosis and repeated falls.	F 656	F656 Develop and Implement Comprehensive Care Plan Resident #14 was found in bed without both fall mats on either side of the bed. Resident #14 was care planned appropriately through the investigation. The facility reviewed resident care plan and ensured it stated “fall mat to either side of resident bed while resident is in bed” vs. “fall mats next to bedside while in bed” to assist in clear communication with nursing staff caring for resident. Resident #10 had directions for caring for resident ileostomy special equipment added to the	

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F 656	Continued From page 5 The quarterly Minimum Data Set (MDS) assessment dated 11/23/22 revealed Resident #14 had severe cognitive impairment. She required extensive assistance with transfers and bed mobility. She was coded on the MDS as having one fall with no injury. The care plan, updated 11/24/22, included a focus area of risk for falls. A care plan intervention stated, "Fall mats next to bedside while in bed." On 1/23/23 at 10:10 AM, Resident #14 was observed in bed. The bed was in the low position. A fall mat was observed on the floor to the right of the bed. There was no fall mat on the left side of the bed; however, a fall mat was leaned up against the dresser. Nurse #1 was interviewed on 1/24/23 at 1:49 PM. She reported Resident #14 needed one person to assist her when she got out of bed. She acknowledged the resident was unable to use her call light due to confusion and was at risk for falls. She said fall prevention interventions used for Resident #14 included the use of a low bed and staff placed two floor mats on either side of the bed when the resident was in bed. During an observation on 1/24/23 at 1:53 PM, Resident #14 was asleep in bed. A fall mat was on the floor to the right of the resident's bed. There was no fall mat on the floor to the left of the resident's bed. A second fall mat was leaned up against the clothes closet. Interviews were completed with Nurse Aide (NA) #1 on 1/25/23 at 2:15 PM and 1/26/23 at 10:53	F 656	current care plan. An audit was completed of fall care plans by the Nurse Supervisors for 6th floor and 7th floor North Unit to ensure resident fall care plans matched equipment in the room. The audit revealed one inaccuracy which was corrected immediately on 1/24/2023. An audit was completed by the Director of Nursing for 6th floor and 7th floor North Unit to ensure special equipment needs, such as ileostomy, colostomy, catheter, etc. were all coded correctly for care in the resident care plan. The audit was completed on 1/24/2023 and revealed one inaccuracy which was corrected immediately by the Director of nursing. Education was completed with Nursing Staff to ensure Fall Care Plans are followed for resident care by Director of Nursing. Education was completed by Administrator with Director of Nursing, Assistant Director of Nursing, and Minimal Data Set Registered Nurse to ensure care plans appropriately reflect resident special devices such as ileostomy or like device, when a resident is admitted to our facility. Specific education was completed for nursing staff who care for resident #10 to ensure they are aware of how to care for resident ileostomy. If the facility should begin using agency staff, education would be provided through orientation to ensure care plans are followed. New Hires will be oriented to the MatrixCare system to ensure they know where to find the resident care plan and are trained to follow resident care guide. Education was	

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F 656	Continued From page 6 AM. She shared Resident #14 required assistance with transfers. NA #1 said the resident had at times tried to get up unassisted and fell. She specified staff looked on the computer and accessed the care plan which revealed to them what fall prevention interventions were to be used when staff cared for a resident. She explained current fall prevention interventions for Resident #14 included a fall mat on both sides of the bed, frequent rounds by staff and the bed placed in the low position. NA #1 verified she worked with Resident #14 on 1/23/23 during the day. When asked why there was only one fall mat observed on the floor next to the resident's bed, NA #1 said she forgot to put the second mat down after she fed the resident breakfast. An attempt to interview NA #2 (who worked with Resident #14 on 1/24/23) was unsuccessful. The Director of Nursing was interviewed on 1/25/23 at 9:37 AM and 1/26/23 at 1:23 PM. She stated Resident #14 was at risk for falls and had a history of attempting to get out of bed unassisted. She shared fall prevention interventions included "fall mats at bedside times two," frequent rounding and positioning checks. She added when a new fall prevention intervention was added, the staff were educated to review the care plan and point of care charting system on their tablets and she expected staff to adhere to the interventions listed on the care plan. 2) Resident #10 was admitted to the facility on 8/4/2022 with diagnoses that included a functional intestinal disorder with ileostomy.	F 656	completed on 2/13/2023. Moving forward, 3 times a week for 4 weeks, a resident sample of 5 residents will be audited by the Director of Nursing or designee to ensure resident fall care plans are followed appropriately throughout the day. Once a week for 4 weeks, resident care plans of new admissions will be reviewed to ensure special equipment is captured. Monitoring will be forwarded to the facility QAPI committee to determine if further oversight is needed. Audits will be reviewed through the facility's routine QAPI meeting. Responsible Team Member: Director of Nursing Date of Compliance: 2/13/2023 Date of Completion: 3/13/2023	

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F 656	Continued From page 7	F 656		

A review of the most recent quarterly Minimum Data Set (MDS) dated 11/11/2022 identified Resident #10 was cognitively intact and always incontinent of bowel and bladder. The diagnoses section identified the Resident had an ileostomy.

A review of the most recent care plan dated 11/14/2022 did not include a care plan focused area for ileostomy care.

An observation was conducted on 1/24/2023 at 9:28 a.m. of Resident #10 and she had a bowel elimination bag attached to her abdomen with a red moist stoma (an artificial opening made into a hollow organ, especially one on the surface of the body leading to the gut or trachea). The elimination bag had a small amount of brown stool. There were no lingering odors.

An interview was conducted with Resident #10 on 1/24/2023 at 9:28 a.m. and she stated staff assist her with changing of the ileostomy bag and emptying the bag. She revealed some staff had been hesitant or did not assist quickly, as if they were not aware she had the bag or did not know how to provide the care. She added they always return with someone to assist them.

An interview was conducted with the MDS Nurse Coordinator on 1/26/2023 at 12:28 p.m. and revealed she was responsible for updating the care plan for a resident. She reviewed the most recent MDS for Resident #10 and the diagnoses list. She then reviewed the most recent care plan dated 11/14/2022 and reported she did not see a focused area for ileostomy/bowel elimination. She added this was a care area that she would place on the care plan and would be added

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F 656	Continued From page 8 immediately. An interview was conducted with the Administrator on 1/26/2022 at 12:42 p.m. and she revealed she expected a resident to have a care plan focused area for any diagnoses that required specialized care such as an ileostomy.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide intervention for fall prevention for 1 of 4 residents (Resident #14) reviewed for falls. Findings included: Resident #14 was admitted to the facility on 2/16/22 with diagnoses that included, in part, dementia, osteoporosis and repeated falls. The quarterly Minimum Data Set (MDS) assessment dated 11/23/22 revealed Resident #14 had severe cognitive impairment. She required extensive assistance with transfers and bed mobility. She was coded on the MDS as having one fall with no injury.	F 689	F689 Free of Accident Hazards/Supervision/Devices Resident #14 did not have a fall mat down on both sides of her bed while lying in bed. Resident #14 was care planned appropriately, and no accident occurred for resident to ensure need for immediate intervention. Education completed in regards to ensuring both fall mats were down and fall care plans followed appropriately. Education completed 2/13/2023. An audit was completed of fall care plans for 6th floor and 7th floor North Unit to ensure resident fall care plans matched equipment in the room. The Audit showed one inaccuracy which was corrected immediately. This audit was completed on	3/13/23

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F 689	Continued From page 9 The care plan, updated 11/24/22, included a focus area of risk for falls. A care plan intervention stated, "Fall mats next to bedside while in bed." The monthly physician orders for January 2023 were reviewed and included an order to "ensure floor mat is in place by bedside when resident is in bed." A nurse's note dated 11/23/22 and authored by Nurse #2 read, in part, "Resident's behavior restless. Attempting to get out of bed. Bed lowered as low as it can go. Mats on either side of bed ..." On 1/23/23 at 10:10 AM, Resident #14 was observed in bed. The bed was in the low position. A fall mat was observed on the floor to the right of the bed. There was no fall mat on the left side of the bed; however, a fall mat was leaned up against the dresser. Nurse #1 was interviewed on 1/24/23 at 1:49 PM. She reported Resident #14 needed one person to assist her when she got out of bed. She acknowledged the resident was unable to use her call light due to confusion and was at risk for falls. She said fall prevention interventions used for Resident #14 included the use of a low bed and staff placed two floor mats on either side of the bed when the resident was in bed. During an observation on 1/24/23 at 1:53 PM, Resident #14 was asleep in bed. A fall mat was on the floor to the right of the resident's bed. There was no fall mat on the floor to the left of the resident's bed. A second fall mat was leaned up against the clothes closet.	F 689	1/24/2023. Education to nursing staff completed in regards to ensuring both fall mats were down and fall care plans followed appropriately by Director of Nursing. Education completed 2/13/2023. If the facility should begin using agency staff, education would be provided through orientation to ensure care plans are followed. New Hires will be oriented to the MatrixCare system to ensure they know where to find the resident care plan and are trained to follow resident care guide. Moving forward, 3 times a week for 4 weeks, a resident sample of 5 residents will be audited by the Director of Nursing or designee to ensure resident fall care plans are followed appropriately throughout the day. Monitoring will be forwarded to the facility QAPI committee to determine if further oversight is needed. Audits will be reviewed through the facility's routine QAPI meeting. Responsible Team Member: Director of Nursing Date of Compliance: 2/13/2023 Date of Completion: 3/13/2023	

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F 689	Continued From page 10 Interviews were completed with Nurse Aide (NA) #1 on 1/25/23 at 2:15 PM and 1/26/23 at 10:53 AM. She shared Resident #14 required assistance with transfers. NA #1 said the resident had at times tried to get up unassisted and fell. She explained fall prevention interventions included a fall mat on both sides of the bed, frequent rounds by staff and the bed placed in the low position. NA #1 verified she worked with Resident #14 on 1/23/23 during the day. When asked why there was only one fall mat observed on the floor next to the resident's bed, NA #1 said she forgot to put the second mat down after she fed the resident breakfast. An attempt to interview NA #2 (who worked with Resident #14 on 1/24/23) was unsuccessful. The Director of Nursing was interviewed on 1/25/23 at 9:37 AM and 1/26/23 at 1:23 PM. She stated Resident #14 was at risk for falls and had a history of attempting to get out of bed unassisted. She shared fall prevention interventions included "fall mats at bedside times two," frequent rounding and positioning checks. She added when a new fall prevention intervention was added, the staff were educated and she expected the fall mats be placed down on both sides of the bed when Resident #14 was in the bed and when staff finished providing care.	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	F 867		3/13/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will 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

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	345209	A. BUILDING _____ B. WING _____	C 01/26/2023

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aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

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

§483.75(e) Program activities.

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

§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

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F 867	Continued From page 13 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey completed on 7/11/2019. This was for one deficiency that were cited in the area of Develop/Implement Comprehensive Care Plan (F656) on 7/11/2019 and recited on the current recertification and	F 867	F867 QAPI/QAA Improvement Activities On 2/7/2023 an Ad Hoc QAPI Meeting was held with the Brookridge QAPI team and Regional Director of Operations. To discuss the Care Plan tag from 2019 and again in 2023. Facility QAPI Plan was updated to reflect a focus area of Care Plans for this facility. Regional Director of Operations and Administrator in Training for facility	

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F 867	Continued From page 14 complaint survey of 1/26/23. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The finding included: This citation is cross referred to: F656-- Develop/Implement Comprehensive Care Plan-- Based on observations, staff interviews and record review, the facility failed to 1) follow the care plan to place floor mats next to the bedside for fall prevention for 1 of 4 residents (Resident #14) reviewed for falls, and 2) failed to implement a care plan for ileostomy care for 1 of 1 resident (Resident #10) reviewed for ileostomy bowel care. During the facility's recertification survey on 7/11/19, the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident with an antidepressant for 1 of 1 residents (Resident #29) reviewed for hospitalization. The facility also failed to develop a care plan that addressed discharge goals for 1 of 1 resident (Resident #27) reviewed for discharge to the community. The Director of Nursing (DON) and Administrator were interviewed on 1/26/23 at 1:23 PM. The DON stated she was aware of the current issues with the care plans for Residents #14 and #11. She stated the staff had been educated in the past of the need to implement the interventions in place for each resident. She stated she was unaware of the missed care plan for ileostomy	F 867	reviewed previous 2567□s from 2019 to current to ensure knowledge of previous citations and processes implemented moving forward. Education was provided to the QAPI committee by the Regional Director of Operations to ensure the knowledge of previous citation lookback and ensuring QAPI processes put in place are maintained for ensuring compliant practice. Moving forward, the QAPI committee will continue to meet Monthly (as needed), Quarterly, and hold Ad Hoc QAPIs on an as needed basis to ensure processes to maintain compliant practices are in place. Minutes of the committee meetings will be forwarded to the Regional Director of Operations to determine further monitoring. For the rules around this plan of correction, these minutes will be forwarded on a month basis for 2 months and reviewed by the Regional Director of Operations. Responsible Party: Administrator Date of Compliance: 2/8/2023 Date of Completion: 4/8/2023.	

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F 867	Continued From page 15 care but that the facility would be implementing a plan to ensure focused areas of care are included on the care plan as well. The administrator stated the facility did have an active Quality Assessment and Assurance Committee and they met monthly and sometimes weekly if needed in the past. The administrator further stated that the committee most likely would be meeting weekly to address this and other potential issues going forward.	F 867		