STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345050	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACOB'S CREEK NURSING AND REHABILITATION CENTER	1721 BALD HILL LOOP MADISON, NC 27025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 04/24/23 through 04/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #J4M711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 04/24/23 through 04/27/23. Event ID# J4M711. The following intakes were investigated NC00195661, NC00196161, NC00197012, NC00197591, NC00197943, NC00198955, NC00200889, and NC00201282. 4 of the 17 complaint allegations resulted in deficiencies.	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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		5/25/23

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

Electronically Signed | 05/15/2023

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F 550	Continued From page 1 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, record review, and staff and resident interviews the facility failed to maintain a resident's dignity by dressing a resident (Resident #54) in a facility gown. This occurred for 1 of 3 residents reviewed for dignity. The findings included: Resident #54 was admitted 5/24/2021. A review of the quarterly Minimum Data Set dated 3/28/2023 revealed Resident #54 had severe cognitive impairment and required extensive assistance of one staff member with dressing.	F 550	Resident #54 was offered by the Certified Nursing Assistant (CNA) to change out of the facility gown, and to put on personal clothing. Resident was changed from the facility gown into his personal clothing on 4/26/23. Resident #54 care plan will be updated to reflect his refusal to put on personal clothing at times and remain in the facility gown. On 5/1/23 the Director of Nursing (DON) initiated an audit of all residents that prefer to be dressed in their personal clothes daily, to ensure they are dressed. The Director of Nursing (DON) and/or	

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F 550	Continued From page 2 A review of Resident #54's care plan dated 3/28/2023, identified focused areas; 1) Resident was at risk for activities of daily living decline related to the disease process. The interventions included, to provide clothing that promotes dignity and allows resident choices. An observation was conducted on 4/24/2023 at 10:35 a.m. of Resident #54. He was lying in bed wearing a facility gown. An interview was conducted on 4/24/2023 at 10:35 a.m. with Resident #54 and he stated he did not like to wear a gown. An observation was conducted on 4/25/2023 at 12:16 p.m. of the Resident and he was lying in bed wearing a facility gown. During the observation, the Resident asked where his pants were located? An observation was conducted on 4/26/2023 at 11:11 a.m. and the Resident was lying in bed wearing a facility gown. Personal clothing with Resident #54's name written on the garments were hanging inside the room closet. He was the only Resident residing in the room. An interview was conducted on 4/26/2023 at 11:11 a.m. with the Resident and he stated he would like to get dressed in his clothes but the only thing he had was the gown. An interview was conducted with Nursing Assistant (NA) #05 on 4/26/2023 at 11:13 a.m. and she revealed she was not assigned to Resident #54 on this date but was frequently assigned to the Resident. She stated the Resident likes to wear clothing and will share with	F 550	Assistant Director (ADON) of Nursing will address all concerns identified through the audit. On 5/12/23 the DON/ADON/Staff development coordinator (SDC) initiated an in-service with all nurses, and nursing assistants, to include agency and contract staff on dressing residents in personal clothes daily as residents' requests. In-service will be completed by 5/19/23. After, 5/19/23 any nurses, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding dressing or assisting in dressing residents who want to wear their personal clothes. An audit of all residents that request to be dressed daily in their personal clothes will be completed by the DON/ADON and/or Unit Manager (UM) 1-time weekly x 4 weeks, then monthly x 2 month utilizing the audit tool. This audit is to ensure all residents who desire to be dressed daily in their personal clothes are dressed appropriately. The DON will address all concerns identified during the audit to include re-training of nursing staff. The Director of Nursing will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly	

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F 550	Continued From page 3 the staff what he prefers to wear. An interview was conducted with NA #06 on 4/26/2023 at 11:42 a.m. and she revealed she was the caregiver for Resident #54. She stated she had not tried to dress the Resident on 4/26/2023. She added the Resident did not refuse to get dressed and she had not previously had problems dressing the Resident in his clothing. An interview was conducted with the Director of Nursing on 4/26/2023 at 3:52 p.m. and she revealed Resident #54 should be provided with the clothing of his choice and she would ensure the NAs provide the opportunity to get dressed.	F 550	for 2 months and review the Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 5/25/23	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		5/25/23

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F 609	Continued From page 4 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, resident representative interview and record review, the facility failed to submit an Initial Allegation Report and an Investigation Report to the State Survey Agency for 1 of 3 residents (Resident #129) reviewed for abuse. Findings included: Resident #129 was admitted to the facility (Skilled Nursing Facility (SNF) #1) on 7/15/21. Diagnoses included, in part, pressure ulcer, schizophrenia and bipolar disorder. Resident #129 discharged to the hospital on 9/6/22. She transferred from the hospital to a different skilled nursing facility (SNF #2, date unknown) where she expired on 2/22/23. The quarterly Minimum Data Set assessment dated 6/8/22 revealed Resident #129 was cognitively intact. The facility's abuse investigations were reviewed and no reports were completed or sent to the State Agency for Resident #129 for the time period of 5/1/22-4/26/23. A phone interview was completed on 4/25/23 at 3:14 PM with a resident representative who	F 609	F609 Reporting of Alleged Violations Resident #129 no longer resides in the facility. Initial report was submitted to the Healthcare Personal Registry (HCPR) agency on 4/26/23 at 4:45pm, the 5-day report was submitted to Healthcare Personal Registry on 5/2/23 and was unsubstantiated. Following the 24-hour report sent for resident #129 safe surveys were conducted on residents with a BIMS of 13 or above and full body skin checks on residents with a BIMS of 12 or below, with no negative findings. On 4/27/23 the Director of Nursing (DON) and Nursing Home Administrator (NHA) initiated an audit of all events that meet criteria for reporting to the Health Care Personnel Investigations (HCPI) state regulatory agency for the past 30 days to include but not limited to injury of unknown origin, misappropriation and/or abuse. This audit was to ensure all reportable events were reported within the two-hour time frame when indicated and that the facility submitted an accurate investigation report within 5 days per the HCPI requirements.	

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F 609	Continued From page 5 visited with Resident #129 when she was at SNF #2. The representative reported he visited Resident #129 in February 2023 at SNF #2 (unsure of exact date of visit) and she reported to him an allegation of abuse that occurred when she was at SNF #1. He stated the resident had some confusion and was unable to provide any details such as the identity of the perpetrator, when the alleged abuse happened, where it happened or what occurred. The representative said he contacted the police and an investigation was completed but he was not aware of the outcome of the investigation. During interviews with the Director of Nursing (DON) on 4/25/23 at 11:15 AM and 4/26/23 at 10:26 AM, she explained a police officer came to the facility sometime in February 2023 (unable to recall exact date) and said he was investigating a complaint for Resident #129 who used to live at the facility. Resident #129 had made an allegation of abuse. The police officer reported to the DON he had spoken to Resident #129 several times and each time he interviewed the resident, she changed the details of her allegation and police were unable to substantiate the allegation. The DON stated the facility did not submit an investigation to the State Agency because, "we felt we had nothing to report, no details, and didn't know what happened." In an interview with the Administrator on 4/26/23 at 10:35 AM, she stated she had been at the facility for two weeks. She explained when an allegation of abuse was made, the protocol was the facility submitted a report to the State Agency.	F 609	The DON/NHA will address all concerns identified during the audit to include but not limited completion of initial and investigative reports when indicated and education of staff. The audit will be completed by 4/28/23. Results of the audit showed no other residents were affected and there were no negative findings that required reporting to the HCPR. On 4/27/23, Facility Consultant and Clinical Director initiated an in-service with the NHA and DON regarding Health Care Personnel Investigation Reportable Requirements with emphasis on reporting allegations to include but not limited to injury of unknown, misappropriation and abuse within 2 hours when indicated and completion of an accurate investigation report within 5 days per HCPI requirements. If the NHA and DON are not available there will be a trained designated person to cover the facility for any reportable incidents. All newly hired Administrators and/or Director of Nursing will be in-serviced during orientation regarding Health Care Personnel Investigation Reportable Requirements. 100% of all staff to include nurse, C.N.A. both agency and contracted, housekeeping, dietary, administration, therapy, and maintenance were in-serviced on timely reporting of allegations of abuse, neglect, misappropriation or injury of unknown origin. On 5/12/23 the DON/Assistant Director of Nursing (ADON) will review all	

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F 609	Continued From page 6	F 609	investigative folders 1 time a week x 4 weeks then monthly x 2 month utilizing the Audit Tool. This audit is to ensure all HCPI reportable events to include injury of unknown origin, misappropriation and/or abuse are reported timely and an accurate investigative report completed within 5 days per HCPI requirements. The NHA will address all areas of concern identified during the audit to include reporting initial and investigative reports when indicated and re-training of staff. The NHA will review and initial the Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The NHA will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 5/25/23	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 626		5/25/23

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F 626	Continued From page 7 following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with facility staff, the hospital's social worker and the hospital's psychiatric nurse practitioner, the facility failed to permit 1 of 4 sampled residents (Resident #96) to return to the facility following a facility-initiated transfer to the hospital. Findings included:	F 626	F626 Permitting Residents to Return to Facility On 4/26/23 at 1:07 pm the Social Worker/Behavioral Therapist #3 was telephoned by the facility Social Worker #1 to inform them that the Interdisciplinary Team (IDT) reviewed the hospital□s	

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F 626	Continued From page 8 Resident #96 was originally admitted to the facility on 6/2/21 and re-admitted on 1/21/23 with diagnoses which included: epilepsy, depressive episodes, mild dementia with other behavioral disturbance, conversion disorder with seizures or convulsions, bipolar disorder, psychosis, and insomnia. The quarterly minimum data set (MDS) assessment dated 4/6/23 indicated Resident #96 was cognitively intact and demonstrated verbal behavior symptoms towards others. Nurse's notes dated 4/7/23 indicated that while ambulating in the residential hallway, Resident #96 yelled at two female residents in wheelchairs "I wish you would get out of the damn way!" The resident proceeded to the social worker's office, where he laid down on the floor. Resident got back up and walked back towards his room, stating "I wish I was dead". Supervisors were made aware. The resident also telephoned 911 multiple times and when nursing staff offered to assist the resident, he began yelling "you only do it for the money". The facility's nurse practitioner was notified of the resident's behaviors and a new order was given for a one-time dose of Ativan (antianxiety medication) 0.5mg (milligrams) which was administered intramuscularly in the resident's left arm. The resident's responsible party was also made aware of the resident's behaviors. Resident #96 was sent to the local hospital #1 for evaluation due to his aggressive behaviors. Review of the nurse's note dated 4/8/23, Resident #96 returned from hospital #1 via his family member's vehicle. The family member reported to	F 626	discharge summary and considered the resident to remain a danger to himself and others based on the documentation in the discharge summary from hospital #3. Resident #96 was discharged to the hospital and was unable to return to the facility prior to being discharged to another facility. Resident #96, will be able to return to the facility with medical clearance from psychiatry and acceptance of the facility Medical Director. Resident #96 was discharged from the hospital to his home on 5/01/2023. Resident #96 is at home with his Financial / Medical POA and is independent with ADLs and has no gate abnormalities. Resident #96 is alert and orientated and displays no memory defects. Home health was not required, and he no longer meets criteria for skilled placement. This information was obtained directly from the discharging hospital's discharge plan and Summary. If resident #96 seeks long term placement at the facility in the future, he will be evaluated as all referrals are for offer of placement. On 4/27/23 The Regional Vice President (RVP) in-serviced the Nursing Home Administrator (NHA) on the policy regarding permitting residents to the facility after the hospitalization. On 5/12/23, the NHA provided education to Admissions Coordinator, Social Services Director and Business Office Director regarding policy related to permitting residents to return to facility after hospitalization. Education will be provided to any new hires in the	

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F 626	Continued From page 9 the supervisor's office that on their journey back to the nursing home, the resident attempted to jump out of her car and attempted to break her hand. The family member reported she had to call the sheriff's office for assistance. The sheriff placed the resident in the backseat of her car and put the child safety locks on the doors enabling a safe return to the facility. The family member also reported after assisting Resident #96 to his room, the resident tried to strike her with his cane. Resident #96 was placed on 1:1 (an assigned sitter with the resident). The resident was observed in the hallway, standing over a resident yelling, using profanity. The floor nurse then removed Resident #96 and redirected him to his room. The other resident reported that he was sitting in his wheelchair talking to another resident when Resident #96 came out of his room, charging at him and grabbed his shirt collar and mask that was around his neck. The Director of Nursing, the On-Call Nurse Practitioner, and the Police were immediately notified. The Nurse Practitioner gave new orders to send Resident #96 to Hospital #2 for evaluation. The resident also threatened staff members, grabbing the assigned sitter by the neck and threatened to kill the two sheriff deputies, when they arrived. Resident #96 was transported to hospital #2 with 2 nurses and another staff member by the facility's contracted transport service. The discharged MDS dated 4/8/23 indicated Resident #96 was an unplanned discharged to a psychiatric hospital with return anticipated. Review of nurse's note dated 4/20/23 indicated Resident #96's responsible party (RP) was informed of the facility's interdisciplinary (IDT) team's decision to not re-admit the resident to the	F 626	Admissions Coordinator, Social Services Director and Business Office Director moving forward to assure continued compliance regarding policy related to permitting residents to return to facility after hospitalization. The Admissions Coordinator, Social Services Director and/or Business Office Director will visit the hospital, when necessary, to evaluate if a resident is appropriate to return to the facility if there are concerns related to safety or ability to provide the appropriate level of care. On 5/12/23, The Admissions Coordinator initiated an audit of all residents discharged in the last 30 days to determine compliance with Permitting Residents to Return to Facility by use of the Unplanned Discharge/Transfer Audit Tool. The DON/ADON will audit 1 times weekly x 4 weeks, 1-time monthly x 2 months utilizing the Audit Tool. This audit is to ensure all resident discharged to the hospital are permitted to return to the first available bed when discharged from hospital. The Director of Nursing (DON) will address all concerns identified during the audit to include re-training of nurses. The DON/NHA will present the results of the Unplanned Discharge/Transfer Audit Tool for 3 months at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to determine trends and/or issues that may	

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F 626	Continued From page 10 facility. This nurse informed the RP the facility did not have adequate resources to keep the resident as well as other residents and staff safe due to the resident's continued aggressive behaviors. On 4/26/23 at 12:16 p.m., an interview was conducted with the Director of Nursing (DON). The DON revealed Resident #96 was discharged to hospital #1 on 4/7/23 due to increased behaviors and aggression. The hospital also tested the resident for a urinary tract infection which was negative. On 4/8/23 the resident's RP reported that while driving the resident back to the facility, Resident #96 attempted to exit the moving car. With the assistance of the sheriff's deputy, the RP returned the resident to the facility and was assigned a sitter due to his aggressive behaviors and for safety. The DON stated that the resident was observed standing in front of another resident yelling expletives and drew back his fist but the nurse and assigned sitter intervened. The sitter returned Resident #96 to his room, but the nurse supervisor heard the sitter calling out and along with two other staff, observed the resident had "pinned" the sitter to the wall by the neck. The staff nurse stayed with the resident while the nurse supervisor notified her (DON) and instructed the nurse to notify police while she (DON) obtained transportation to take the resident to hospital #2's Behavior Health. The DON stated that when the sheriff deputies arrived, the resident threatened to kill the two sheriff deputies, was handcuffed and removed from the facility to the sheriff's car. The transport van arrived, and the sheriff transferred Resident #96 to the transport van and along with two nurses the resident was transported to hospital #2. The DON revealed she telephoned hospital #2 on 4/11 and was informed the resident had	F 626	need further interventions put into place and to determine the need for further frequency of monitoring. The alleged date of compliance is 5/25/23.	

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	345050	A. BUILDING _____ B. WING _____	C 04/27/2023

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been transferred to hospital #3. The DON stated that she telephoned hospital #3 on 4/11/23 and was informed by the hospital's Social Worker/Behavioral Therapist the resident was receiving therapy and medication adjustments. The DON stated during this conversation she requested a summary of Resident #96's hospital visit before he returned to the facility, to review if the resident was safe for return. The DON revealed the hospital's Social Worker/Behavioral Therapist left a voicemail message on 4/20/23 stating the resident was ready for discharge; she also faxed the hospital's discharge summary. The DON stated the IDT team reviewed the discharge summary which included the resident was still a danger, imminent rehospitalization likely. The IDT made the decision not to have Resident #96 return to the facility based on documentation of hospital #3's discharge summary indicating the resident was a danger to himself and/or others.

During an interview on 4/26/23 at 1:07 p.m., Social Worker (SW#1) revealed she telephoned the hospital #3 on 4/20/23 and informed the Social Worker/Behavioral Therapist that the facility's IDT team reviewed the hospital's discharge summary and considered the resident remained a danger to himself and others based on documentation in the discharge summary from hospital #3. SW#1 stated the hospital's Social Worker/Behavioral Therapist response was "they have to put that in there", referring to the statement in the discharge summary about the resident being a danger and rehospitalization likely.

During an interview on 4/27/23 at 11:00 a.m., the Administrator stated the facility would not accept the return of Resident #96 to facility due to

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F 626	Continued From page 12 concerns for the safety of other residents and staff. When questioned, the Administrator indicated no one from the facility went to hospital #3 to evaluate if the resident was safe to return to the facility. On 4/27/23 at 12:41 p.m., via telephone, hospital #3's Psychiatrist was not available for interview. A telephone interview was conducted on 4/27/23 at 12:42 p.m. with hospital #3's Psychiatric Nurse Practitioner (NP) who stated that Resident #96 was admitted to the hospital with diagnoses which included Bipolar II and mood disorder and received Depakote (antiepileptic medication) and Seroquel (antipsychotic medication). She revealed the resident had requested to return to (name of nursing home), but she was informed the facility would not be able to take him back. She stated the resident had been at the hospital for 17 days, was stable, at baseline and ready for discharge for 3 days, no behaviors in the past week. The NP stated the resident attended group meetings, talked to others appropriately, did not require any special precautions, or special monitoring. The NP stated she did not think the resident was a danger to himself or anybody if he remained on his medications.	F 626		
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	F 867		5/25/23

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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 aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that

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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 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and

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F 867	Continued From page 15 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 and staff interviews 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 1/11/22. This was for one deficiency that was cited in the area of Resident Rights/Exercise of Rights (F550) on 1/11/22 and recited on the current recertification and complaint survey of 4/27/23. 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	F 867	F867 QAPI/QAA Improvement Activities Resident #54 was offered by the Certified Nursing Assistant (CNA) to change out of the facility gown, and to put on personal clothing. Resident was changed from the facility gown into his personal clothing on 4/26/23. Resident #54 care plan will be updated to reflect his refusal to put on personal clothing at times and remain in the facility gown. On 5/1/23 the Director of Nursing (DON)	

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F 867	Continued From page 16 Assurance Program. The finding included: This citation is cross referred to: F550-- Resident Rights/Exercise of Rights -- Based on observations, record review, and staff and resident interviews the facility failed to maintain a resident's dignity by dressing a resident (Resident #54) in a facility gown. This occurred for 1 of 3 residents reviewed for dignity. During the facility's recertification survey on 1/11/22, the facility failed to provide a dignified dining experience by standing while providing assistance with feeding for 1of 8 residents reviewed for assistance with dining. The Director of Nursing (DON) and Administrator were interviewed on 4/27/23 at 1:23 PM. The DON stated the staff had been educated on the importance of following a resident's wishes as part of their on-boarding process. She had stated she was unaware Resident #54 was not being dressed as requested but would be implementing a plan to ensure that all residents' needs are met. The administrator, who was new to the facility, stated the facility did have an active Quality Assessment and Assurance Committee and they meet monthly. The administrator further stated she felt like the large amount of agency staff contributed to this issue and is in the process of hiring permanent staff members.	F 867	initiated an audit of all residents that prefer to be dressed in their personal clothes daily, to ensure they are dressed. The Director of Nursing (DON) and/or Assistant Director (ADON) of Nursing will address all concerns identified through the audit. On 5/12/23 the DON/ADON/Staff development coordinator (SDC) initiated an in-service with all nurses, and nursing assistants, to include agency and contract staff on dressing residents in personal clothes daily as residents' requests. In-service will be completed by 5/19/23. After, 5/19/23 any nurses, nursing assistants, agency and contract staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, agency and contract staff will be in-serviced during orientation regarding dressing or assisting in dressing residents who want to wear their personal clothes. On 5//15/23 an audit of all residents that request to be dressed daily in their personal clothes will be completed by the DON/ADON and/or Unit Manager (UM) by visual observation 1-time weekly x 4 weeks, then monthly x 2 month utilizing the audit tool. This audit is to ensure all residents who desire to be dressed daily in their personal clothes are dressed appropriately. The DON will address all concerns identified during the audit to include re-training of nursing staff.	

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F 867	Continued From page 17	F 867	The Facility Consultant/Corporate Clinical Director will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings, to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes, and the Performance Improvement Plans once a month for 2 months. The Nursing Home Administrator will hold monthly Quality Assurance Performance Improvement Committee (QAPI) meetings with the QAPI committee. The meeting agenda will include review of all Performance Improvement Plans (PIP) to include the PIP for residents as requested are dressing in personal clothing daily. The Audit Tool will be reviewed monthly to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 5/25/23	