STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 COVID-19 Focused Infection Control Survey was conducted on 10/16/23. The facility was found to be in compliance with 42 CFR 483.73 realted to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 9ICR11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 10/16/23. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# 9ICR11. The following intakes were investigated: NC00207244 and NC00206855. None of the three complaint allegations resulted in a deficiency.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to obtain active physician orders for medications observed at the bedside for 1 of 1 resident reviewed for self-administration of medications (Resident #3). Findings included:	F 658	The three medications were removed from the resident□s room and disposed of on October 16, 2023, by the Director of Nursing. Resident #3 was assessed and the fluticasone, nystatin powder and zinc oxide were previously ordered for the	10/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/20/2023

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 658	Continued From page 1 Resident #3 was admitted to the facility on 08/05/20 with diagnoses including type 2 diabetes mellitus and chronic pulmonary disease. The significant change Minimum Data Set assessment dated 08/05/23 revealed Resident #3 had minimally impaired cognition and needed extensive assistance for activities of daily living. The care plan revised on 08/28/23 revealed Resident #3 was at risk for adverse reactions related to polypharmacy and included interventions to review medications with the Medical Doctor and/or Consulting Pharmacist for duplicate medications or prescriptions, proper dosing, timing and frequency of administration, adverse reactions, and supporting diagnosis. Review of the document, "Self-Medication Assessment" dated 08/01/23 revealed Resident #3 was able to administer oral medications, creams, and inhalers with supervision and cueing. An observation and interview were conducted on 10/16/23 at 10:00 AM with Resident #3. Placed on the overbed table were two 4-ounce tubes of 40 % zinc oxide cream, a bottle of fluticasone nasal spray (a steroid medication), and a bottle of nystatin powder (an antifungal medication). Resident #3 revealed the nasal spray was used once a day, the nystatin powder was applied underneath each breast when getting dressed and the zinc cream was applied after incontinence episodes. Review of the physician orders revealed no active orders for the administration or use of fluticasone, nystatin powder, and zinc oxide.	F 658	resident and are not needed for resident□s current condition. This assessment was conducted on October 16, 2023, by the Assistant Director of Nursing. Nurse Practitioner was notified of resident receiving medications on October 16, 2023. On October 19, 2023, the Director of Nursing and Assistant Director of Nursing provided in-service education to nursing staff regarding having a physician order before giving any medication. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to accepting a resident assignment. On October 19, 2023, an audit was conducted by the Director of Nursing and Assistant Director of Nursing of medication carts to ensure all discontinued medications have been removed from the Medication Carts. Beginning October 20, 2023, a review of discontinued medications will occur in morning clinical meeting and follow-up to ensure medications have been physically removed from the cart following morning meeting. The Director of Nursing or designee will audit 8 residents weekly for 8 weeks to ensure there were no medications administered without an order and that discontinued medications have been removed from the cart. The weekly audits will include room observations to ensure	

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F 658	Continued From page 2 An interview was conducted on 10/16/23 at 10:39 AM with Nurse #1 who confirmed she was assigned to administer medications to Resident #3. Nurse #1 revealed she was not aware Resident #3 was assessed to self-administer medications and kept zinc cream, nystatin powder, and fluticasone nasal spray in the room on the overbed table. Nurse #1 stated a physician order was needed for medications to be administered and after reviewing the orders revealed Resident #3 had no current orders in place for zinc oxide, nystatin powder, and fluticasone and removed them from the room. During an interview on 10/16/23 at 6:43 PM the Director of Nursing (DON) stated an active physician's order would need to be in place for administering zinc oxide, nystatin powder, and fluticasone nasal spray. During an interview on 10/16/23 at 7:00 PM the Administrator stated for Resident #3 to have zinc oxide, nystatin powder, and fluticasone nasal spray administered there would need to be active physician orders.	F 658	no meds are kept at bedside without a physician's order. The Director of Nursing will review the audits to identify patterns and trends and monitor for continued compliance. The results of the audits will be brought to the monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendations will be made as the committee determines. The Administrator is responsible for implementing corrective action. The completion date is 10/19/23.	
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 record review, observations, and interviews with staff, the facility failed to maintain personal hygiene for a resident dependent on	F 677	On October 16, 2023, Assistant Director of Nursing trimmed and cleaned resident #2's fingernails.	10/19/23

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F 677	Continued From page 3 staff to clean and trim fingernails for 1 of 3 residents reviewed for activities of daily living (Resident #2). Findings included: Resident #2 was admitted to the facility on 09/15/21 with diagnoses including cerebrovascular accident, dementia, and Parkinson's disease. Review of the annual Minimum Data Set (MDS) assessment dated 07/12/23 revealed Resident #2 cognition was minimally impaired and extensive assistance was needed for bathing and personal hygiene. The MDS indicated there were no rejection of care behaviors during the lookback period. The care plan in place for activities of daily living revised on 03/07/23 revealed a deficit in Resident #2's ability to perform self-care. Interventions included provide extensive to total assistance with personal hygiene and bathing. Review of the document, "Skin Monitoring: Comprehensive Nurse Aide (NA) Shower Review" revealed on 10/14/23 Resident #2 received a bed bath and was signed by NA #2. The document did not include information fingernail care was provided as part of the bed bath. During an observation and interview on 10/16/23 at 11:09 AM, Resident #2 revealed staff did provide nail care but could not recall when it was last done. Resident #2 showed the fingernails on the right and left hand were long. The right thumb and index fingernails and the left pinky, index, and ring fingernails extended approximately 1.5	F 677	All residents are at risk of this alleged deficient practice. A 100% audit of all residents' fingernails and toenails was conducted on October 18, 2023, by the House Supervisor Registered Nurse and Unit Manager. All residents with nails and/or toenails that needed cleaning and trimming, that were able to be performed by a licensed nurse, was completed by House Supervisor Registered Nurse and Unit Manager on October 18, 2023. Residents in need of podiatry services were referred for scheduling at completion of audit on October 18, 2023. On October 19, 2023, the Assistant Director of Nursing educated all licensed nurses and certified nursing assistants on accuracy of completion of shower sheets, which include condition of nails and with current updated shower sheet, which specifically asks about fingernails and toenails. Education also included accuracy of documentation on completion of shower sheets and the proper chain of command for follow-up on nail care issues that need to be addressed. Newly hired licensed nurses and those contracted through agencies will be educated upon hire and prior to accepting a resident assignment. On October 18, 2023, the Administrator educated Caring Angels on monitoring and proper reporting procedures of resident nail condition during Caring Angel Rounds.	

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F 677	Continued From page 4 to 2 centimeters (cm) past the tips of the fingers. The right thumb and index fingernails appeared dirty with a thick build-up of debris underneath the nails that was black in color. An observation on 10/16/23 at 12:25 PM revealed Resident #2 had been served the lunch meal and was eating the food using silverware. There was no change in the appearance of the fingernails. During an interview on 10/16/23 at 1:14 PM the Unit Manager revealed she kept the Skin Monitoring: Comprehensive Nurse Aide (NA) Shower Review completed by NA staff and reviewed those to ensure bathing was provided as scheduled. She revealed on 10/14/23 NA #2 signed the document for Resident #2 to indicate a bed bath was provided and there was no documentation care was refused during the bath. An observation and interview were conducted on 10/16/23 at 1:31 PM with NA #2. NA #2 confirmed she provided Resident #2 with a bed bath on 10/14/23. NA #2 observed Resident #2's fingernails were long, and the right thumb and index nails were dirty with a thick build-up of black colored debris underneath the nails. NA #2 stated she cleaned Resident #2's fingernails on 10/14/23 and was included as part of the bath but didn't recall if she had cut the nails stating at times Resident #2 would refuse nail care. NA #2 revealed when she did cut resident fingernails, she clipped the nails straight across close to top of the nail to prevent cutting the tip of the finger. NA #2 asked Resident #2 if the fingernails could be clipped and cleaned and he agreed to the care. During an interview on 10/16/23 at 2:46 PM, NA	F 677	A nurse manager will round at least weekly to visualize resident's fingernails. Issues will be addressed at bedside during rounding. The Director of Nursing or designee will audit 10 shower sheets a week with the audit including a physical assessment of the resident's fingernails and toenails to verify accuracy of documentation and follow-up on nail care issues was completed for 8 weeks. The results of the audits will be brought to the monthly Quality Assurance Process Improvement Committee for review and recommendations will be made as the committee determines. The Administrator is responsible for implementing corrective action. The completion date is October 19, 2023	

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F 677	Continued From page 5 #3 confirmed she was assigned to provide personal hygiene care for Resident #3 on 10/16/23. NA #3 revealed she did notice Resident #2's fingernails were long and appeared dirty but did not offer to clean or cut the fingernails because she got busy. NA #2 revealed fingernails were supposed to be cut on bath days and it was not Resident #2's scheduled bath day and she did not serve Resident #2's meal tray and did not offer clean the fingernails prior to the lunch meal. During an interview on 10/16/23 at 6:26 PM the DON revealed Resident #2 was dependent on nursing for personal hygiene including fingernail care. The DON stated education was provided to the nurses and NA staff, the shower sheets were given to the nurse who follow up with the resident to ensure bathing was completed and the resident appeared clean including fingernails were cut and clean. The DON revealed the process failed when the nurse did not follow up to ensure nail care was done on 10/14/23 and when Resident #2's fingernails were observed to have a build-up of thick black debris, she would expect hand hygiene and/or nail care was provided to remove debris before the Resident #2 was served a meal tray. During an interview on 10/16/23 at 7:00 PM the Administrator revealed she expected NA staff provide hand hygiene prior to meal service and fingernails should be cut and cleaned if Resident #2 was accepting of the care. The Administrator revealed if a resident refused, she expected the NA staff to report this to the nurse and nurse would follow up with the resident and report to the Unit Manager.	F 677		
F 808 SS=D	Therapeutic Diet Prescribed by Physician	F 808		10/19/23

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F 808	Continued From page 6 CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to serve fortified foods as directed by the physician's diet order for 2 of 3 sampled residents (Resident #1 and #2). The findings included: 1. Resident #1 was admitted to the facility on 07/08/21 with diagnoses that included diabetes mellitus and dementia. An active diet order dated 09/10/23 for Resident #1 read in part, mechanical soft texture and fortified foods. The significant change Minimum Data Set (MDS) assessment dated 09/15/23 revealed Resident #1 had severe cognitive impairment. He was independent with eating receiving setup help only with meals, received a therapeutic diet and weighed 130 pounds with no significant weight loss or gain during the MDS assessment period. During an observation on 10/16/23 at 12:40 PM, Resident #1 was observed sitting up in bed eating his lunch. Resident #1 received a serving of	F 808	Resident # 2 meal card was corrected to reflect current diet order of fortified foods on October 16, 2023, by the District Dietary Manager. All residents in the facility with orders for therapeutic diets for fortified foods have the potential to be affected by the alleged deficient practice. The Registered Dietitian and District Dietary Manager completed an audit of all residents to ensure that the current diet order matched the Meal Tracker System on October 16, 2023. This audit included orders for fortified foods. Any areas identified through this audit were immediately corrected. The Dietary Manager provided education to all current dietary employees on October 19, 2023. The education included the update to the resident tray tickets with fortified foods now printed in larger print and highlighted. Education will be completed during orientation for all	

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F 808	Continued From page 7 chicken pot pie, mixed vegetables and sliced peaches. The meal card on his lunch tray revealed a diet order for fortified foods and he was to receive fortified creamed soup. There was no soup observed on his meal tray. During an observation and interview on 10/16/23 at 12:50 PM the Administrator confirmed Resident #1 did not receive the fortified cream soup with his lunch as ordered by the physician and should have. The Administrator stated she would check with the kitchen and get the fortified soup for Resident #1. During an interview on 10/16/23 at 1:53 PM the District Dietary Manager revealed for the lunch meal on 10/16/23, residents with diet orders for fortified foods received either mashed potatoes fortified with powdered milk or fortified creamed soup. The District Dietary Manager stated Resident #1 should have received fortified creamed soup with his lunch meal and was not sure why it was overlooked. She explained the dietary aide at the end of the tray line was responsible for ensuring fortified soup was added to the meal tray when indicated on residents' meal tray cards and before the meal trays left the kitchen. During an interview on 10/16/23 at 2:18 PM, Nurse Aide (NA) #1 confirmed she delivered Resident #1 his lunch meal and there was no fortified soup served on his meal tray. NA #1 stated it had just slipped her mind to look at the meal tray card and didn't realize he should have received fortified soup with his lunch. During an interview on 10/16/23 at 7:03 PM, the Administrator stated she was not sure where the	F 808	new hires in the dietary department ongoing prior to beginning their shift. The Dietary Manager or designee will audit meal trays through direct observation for those residents in the facility with physician orders for fortified foods and ensure the meal tray and tray ticket match. Audits will be completed 2 times per week for 8 weeks. The Dietary Manager or designee will audit the Meal Tracker System and Point Click Care System 1 time per week for 8 weeks to ensure that the meal ticket includes all current dietary ordered items. The results of all audits will be brought to the monthly Quality Assurance Process Improvement (QAPI) meeting for review and recommendations will be made as the Committee determines. The Administrator is responsible for implementing corrective action. The completion date is October 19, 2023.	

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F 808	Continued From page 8	F 808		

process broke down during meal service that led to Resident #1 not receiving the fortified soup as indicated on his meal tray card. The Administrator stated she expected for residents to receive fortified foods as instructed on the physician's diet order.

2. Resident #2 was admitted to the facility on 09/15/21 with diagnoses including cerebrovascular accident, dementia, and Parkinson's disease.

The annual Minimum Data Set (MDS) assessment dated 07/12/23 revealed Resident #2 had minimally impaired cognition and required supervision with setup for eating.

The active physician's diet order dated 10/11/22 revealed Resident #2 receive a regular diet and fortified foods for all meals.

An observation and interview were conducted on 10/16/23 at 11:50 AM of the lunch meal tray line with the Dietary Manager. The Dietary Manager revealed she recently started her position approximately one month ago. She revealed the fortified foods for the lunch meal on 10/16/23 included cream of chicken soup and mashed potatoes and showed those were available.

During an observation on 10/16/23 at 12:25 PM Resident #2 was sitting upright in bed eating the lunch meal. The lunch meal consisted of chicken pot pie, mixed vegetables, a biscuit, and a bowl of fruit. The diet card on the plate read in part regular diet with no instructions fortified foods were provided at all meals.

An observation and interview were conducted on

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F 808	Continued From page 9 10/16/23 at 12:40 PM of the lunch meal served to Resident #2 with the Administrator. The Administrator confirmed there were no fortified foods served to Resident #2 and the diet card did not include instructions to provide with all meals. The Administrator stated if a physician's diet order was in place for Resident #2 to have fortified foods it should be served on the plate. An interview was conducted on 10/16/23 at 1:54 PM with the District Dietary Manager. The District Dietary Manager revealed a paper copy of the diet order was needed before it was entered into the meal tracker system. She stated diet orders were not entered without a paper copy of the order and was unsure the correct order was provided that include instructions to serve Resident #2 fortified foods with all meals. An interview was conducted on 10/16/23 at 7:00 PM with the Administrator. The Administrator revealed diet orders were recently audited to verify the order in the medical record matched the meal tracker and she was unsure were the breakdown in communication occurred or why fortified foods with all meals was changed and not included in the meal tracker per the current diet order instructions for Resident #2.	F 808		
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		10/19/23

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345312	A. BUILDING _____ B. WING _____	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT HENDERSONVILLE	1870 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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
F 867	Continued From page 12 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 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 and complaint investigation survey completed on 12/09/21 and the recertification survey completed on 08/04/23. This was for one repeat deficiency in the area of therapeutic diet prescribed by a physician originally cited on 12/09/21 during a recertification and complaint investigation survey, 08/04/23 during a recertification survey, and subsequently	F 867	1) Facility received repeat citations of F 658, F 677 and F 808 during an onsite revisit survey which had been cited on three prior surveys in the last two years. Revised plans have been developed to address Services Provided Meet Professional Standards, ADL Care Provided for Dependent Residents and Therapeutic Diet Prescribed by Physician with ongoing monitoring by the Quality Assurance and Performance Improvement Committee.	

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F 867	Continued From page 13 recited on 10/16/23 during the revisit and complaint investigation survey. In addition, there were two repeat deficiencies in the areas of professional standards and activities of daily living provided to dependent residents originally cited on 08/04/23 during a recertification survey and subsequently recited on 10/16/23 during the revisit and complaint investigation survey. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F658: Based on record review, observations, and staff interviews the facility failed to obtain active physician orders for medications observed at the bedside for 1 of 1 resident reviewed for self-administration of medications (Resident #3). During the recertification survey of 08/04/23, the facility failed to obtain a physician's order prior to administering a medication. F677: Based on record review, observations, and interviews with staff, the facility failed to maintain personal hygiene for a resident dependent on staff to clean and trim fingernails (Resident #2) for 1 of 3 residents reviewed for activities of daily living. During the recertification survey of 08/04/23, the facility failed to maintain residents' personal hygiene by not cleaning and trimming fingernails and not trimming toenails.	F 867	2) All residents have potential to be affected. Root Cause Analysis completed by the Interdisciplinary Quality Assurance Team for F 658, F 677 and F 808 to determine the systemic break that led to the deficient practice with a revised plan to address. 3) Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Regional Director of Operations. Quality Assurance and Performance Improvement Committee (QAPI) Team consists of: Administrator, Director of Nursing, Assistant Director of Nursing/Infection Preventionist, Business Office Manager, Human Resource Manager, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Manager, Activities Director, Minimum Data Set Nurse, Rehabilitation and Marketing Director. Education included review of Quality Assurance and recognizing areas for Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement. 4) The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The Quality Assurance and Performance Improvement (QAPI) Committee to review all active Performance Plans for compliance, any deviations noted will be addressed by the Quality Assurance and Performance Improvement (QAPI)	

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F 867	Continued From page 14 F808: Based on record review, observations, and staff interviews, the facility failed to serve fortified foods as directed by the physician's diet order for 2 of 3 sampled residents (Resident #1 and #2). During the recertification and complaint investigation survey of 12/09/21, the facility failed to provide therapeutic diets as ordered by the Physician for 3 residents. During the recertification survey of 08/04/23, the facility failed to serve fortified foods as directed by the physician's diet order. During an interview on 10/16/23 at 7:03 PM, the Administrator revealed it was hard for her to pinpoint where the breakdown occurred regarding the repeat concerns as they were not the result of the same caring angel who made daily rounds, same resident hall or same staff. The Administrator stated she felt the processes they put into place to address the concerns identified during the recertification survey of August 2023 were working overall as the repeat concerns identified during the revisit survey were far less and not widespread. The Administrator explained they would continue monitoring the processes previously put into place to address the areas of concern as well as review and discuss during QAPI meetings in an effort to achieve and maintain compliance going forward.	F 867	Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 3 months and attend Quality Assurance and Performance Improvement (QAPI) Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The Administrator will be responsible for the implementation of the plan. Date of Compliance October 19, 2023.	