STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345568	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HEALTH & WELLNESS CTR AT CAMBRIDGE VILLAG	83 CAVALIER DRIVE, STE 200 WILMINGTON, NC 28405

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/27/2023 through 11/30/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T1N511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/27/2023 through 11/30/2023. Event ID #T1N511. The following intakes were investigated NC00202219, NC00201096, NC00198673, and NC00196025. 2 of the 7 complaint allegations resulted in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, and Physician interviews the facility failed to assess a resident's ability to self-administer medications. This deficient practice occurred for 1 of 1 resident (Resident #3) reviewed for medication self-administration. Findings included: Resident #3 was admitted to the facility on 4/25/2023 with diagnoses to include hypertension and major depressive disorder, recurrent, moderate.	F 554	Davis Health and Wellness Center of Cambridge Village acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Davis Health and Wellness Center of Cambridge Village□s response to this Statement of Deficiencies does not	1/5/24

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

Electronically Signed | 12/21/2023

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F 554	Continued From page 1 The quarterly Minimum Data Set (MDS) assessment 10/27/2023 for Resident #3 revealed she was cognitively intact and required extensive assistance of 1 staff for activities of daily living (ADL) care. The Care Plan for Resident #3 last reviewed on 11/16/2023, revealed a plan of care with a start date of 5/16/2023 which read in part, "She has history of pocketing medications and then reporting that nurse didn't give to her, and reporting being given prn medications without asking for them." Interventions included administering medications as ordered and to document refusals. There was no plan of care for self-administration of medications. Review of the electronic medical record (EMR) for Resident #3 did not reveal an assessment for medication self-administration. The physician's orders for Resident #3 did not reveal an order for Resident #3 to self-administer her oral medications. An observation and interview with Resident #3 were completed on 11/27/2023 at 11:33 AM. A medication cup containing several pills was observed sitting on Resident #3's overbed table. Resident #3 stated the nurse must have left the pills in the room while she was sleeping. Resident #3 was observed immediately swallowing the medications. The November 2023 Medication Administration Record (MAR) for Resident #3 revealed she was administered aspirin 81milligrams (mg) tablet by mouth, vitamin D3 1000 units 1 capsule by mouth, duloxetine 20mg 1 capsule by mouth,	F 554	denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Health and Wellness Center of Cambridge Village reserves the right to refute any of the deficiencies on this Statement of Deficiencies through the Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. 1) Resident assessed by MD on 11/30/23 for ability to self administer medication. 2) Order was written on 11/30/23 for resident to self administer medications 3) Staff education initiated for resident ability to self administer medications. Agency staff to be educated upon arrival to facility. 100% nursing education on this topic to be completed by 1/05/24. 4) Audit conducted of all residents in facility with BIMS score over 8 to be assessed for ability to self administer medication by nurse completed 12/29/23. Should resident have ability to and request to self-administer medication(s), education will be provided and order will be written immediately. 5) Director of Nursing and/or designee will continue audit on weekly basis in IDT meeting using audit tool. This audit tool will be reviewed at monthly QA meeting for 3 months and re-evaluated in quarterly QA meeting.	

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fexofenadine 60 mg take 1 ½ tablets to equal 90 mg by mouth, tizanidine 4mg 1 pill by mouth, potassium chloride 20 milliequivalents (meq) 1 tablet by mouth, vitamin B complex 1 capsule by mouth, multivitamin 1 tablet by mouth, and fluticasone propionate 1 spray each nostril on 11/27/2023 by Nurse #3.

An interview was completed with Nurse #3 on 11/28/2023 at 3:12 PM. Nurse #3 stated that she was the nurse that left Resident #3's morning medications on her bedside table on 11/27/2023. She further stated that Resident #3 would not take her medications before she eats, so she left them on the bedside table. Nurse #3 indicated Resident #3 was allowed to self-administer some of her medications.

An interview was conducted with the Physician on 11/28/2023 at 3:14 PM. The Physician stated that she trusted Resident #3's judgment for self-administration of most of her medications, just not her fentanyl pain patch. She further stated that she wanted to allow Resident #3 some autonomy in her care.

An interview with Nurse #4 was completed on 11/29/2023 at 09:33 AM. Nurse #4 stated she always observed Resident #3 taking her oral medications. She further stated Resident #3 did not have an order to self-administer her oral medications.

An interview was conducted with the Director of Nursing (DON) on 11/30/2023 at 07:42 AM. The DON stated that she could not find any assessments for medication self-administration for Resident #3. She further stated that Resident #3 did not have a physician's order for

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F 554	Continued From page 3 self-administration of oral medications. The DON indicated that pills should not be left in resident's rooms without the resident being assessed and a physician's order for self-administration. An interview was conducted with the Clinical Nurse Administrator on 11/30/2023 at 3:14 PM. The Clinical Nurse Administrator stated that she was unable to find any evidence to support that any Medication Self Administration Assessments were completed for Resident #3. She further stated that there was not a physician's order for Resident #3 to self-administer her oral medications.	F 554		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		1/5/24

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F 692	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide a nutritional supplement ordered by the physician for 1 of 9 sampled residents (Resident #10) reviewed for nutrition. The Findings included: Resident #10 was admitted to the facility on 10/31/23 and had diagnoses of protein malnutrition, chronic kidney disease, and dysphagia. A review of Resident #10's diet orders dated 11/03/23 revealed the resident to receive a fortified nutritional supplement 237 milliliters (ml) once a day in the morning, with a start date of 11/03/23. A review of Resident #10's November/2023 Medication Administration Record (MAR) was conducted on 11/30/23. The MAR revealed from 11/04/23 through 11/30/23 nurses checked off the morning fortified nutritional supplement was given to the resident. The Admission Minimum Data Set (MDS) dated 11/06/23 revealed Resident #10 had a memory problem and was severely impaired in cognitive skills for daily decision making. Resident #10 needed set up help and supervision for meals. A review of Resident #10's weight record revealed that on 10/31/23 her weight was 116.8 pounds and on 11/21/23 her weight was 111 pounds, a weight loss of 5.8 lbs. in 10-days.	F 692	1) Staff education conducted for when to offer supplement for identified patient and educated on where to locate supplements, will have 100% education completed by 01/05/24. Agency staff to be educated upon arrival to facility as needed. 2) New order written on 12/5/23 for resident to receive supplement(s) at bed time and leave at bedside if identified resident would like. 3) New order written on 12/18/23 for resident to receive magic cup once in the evening 4) New order written on 12/18/23 for resident to receive a mighty shake twice a day (AM/PM) 5) Facility completed audit on 12/29/23 to review all resident weights with RD, identify all residents with order to receive a nutritional supplement and ensure that residents are receiving the supplements as ordered. Administrator and Director of Nursing/designee to review this audit on a weekly basis during IDT meeting using audit tool, will bring audit tool to monthly QA for review for 3 months, and to be re-evaluated in quarterly QA meeting.	

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Resident #10's most recent Care Plan dated 11/03/23 revealed she was at risk for potential alteration of nutrition and/or weight status related to cognitive decline and poor appetite. Interventions included monitoring by mouth (PO) intake of meals, offering alternates/substitutes and snacks as needed, and providing diet and supplement per physician order.

An interview was conducted on 11/27/23 at 1:10 PM with Resident #10 and visitor #1. The resident was in her room with her sitter and had just finished lunch. Both the resident and her visitor #1 said they knew what the fortified nutritional supplement looked like and had not received fortified nutritional supplement on her breakfast tray or lunch tray that day (11/27/23), or at any time during resident's stay at the facility. A review of resident's meal card, served with this resident's breakfast and lunch meal trays, did not list a fortified nutritional supplement as something that needed to be provided with the breakfast or lunch meal.

An interview was conducted on 11/30/23 at 1:00 PM with Nurse #1. The nurse said she passed out morning medications to Resident #10 that morning (11/30/23). The nurse said she did not know where they kept nutritional supplements like the fortified nutritional supplement ordered and did not provide Resident #10 her morning fortified nutritional supplement per Physician order because she was new and did not know where supplements were kept and did not think to ask the Director of Nursing (DON). She said she signed off in the resident's MAR that she gave the fortified nutritional supplement to the resident, but she had not, saying she signed in error.

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An interview was conducted on 11/30/23 at 1:20 PM. with Resident #10's Physician. She said she ordered fortified nutritional supplement one time per day in the morning for Resident #10 and expected the facility to follow that order to provide the supplement daily in the morning and did not. She said she also expected the facility to document the amount of fortified nutritional supplement the resident drank or refused, so she wound know if additional supplements were needed or type of supplement needed changing per resident preference. The Physician indicated that she did not feel that Resident #10's five-pound weight loss was detrimental to her. She indicated that Resident #10 was very old and that some weight loss was expected.

An interview was conducted on 11/30/23 at 1:50 PM with the Administrator. She said Resident #10 had a Physician order for fortified nutritional supplement to be given to the resident once a day in the morning. She said the facility should have provided the fortified nutritional supplement as ordered, and then document in the resident's chart amount consumed or refused. The Administrator said she expected nursing staff to follow the Physician's order for fortified nutritional supplement as given, which they did not.

An interview was conducted on 11/30/23 at 2:35 PM with the Registered Dietician (RD). She stated that she had been working in the facility and had assessed Resident #10 on 11/03/23, who reported that she had had poor appetite for a while, so she recommended fortified nutritional supplements every day related to poor appetite. She indicated she had not been contacted regarding Resident #10's nutritional status. She indicated that if a supplement, such as fortified

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F 692	Continued From page 7 nutritional supplements, was ordered it needed to be given to the resident. The RD indicated that the facility should have provided the Physician ordered fortified nutritional supplement and did not. In an interview on 11/30/23 at 3:40 PM the Director of Nurses (DON) stated that Resident #10's ordered morning fortified nutritional supplement to be given during the morning medication pass, was never ordered to be delivered, and none were ever in stock to provide to the resident. She said she had reviewed resident's current Medication Administration Record (MAR), which revealed nursing had checked off that resident's fortified nutritional supplement was given, but she said the nurses shouldn't have because no fortified nutritional supplements were ever ordered to be delivered, and none were in stock. Also, she indicated that if nursing was not providing the supplement to the resident, then no one, including kitchen staff or Nursing Aides (NAs) would know the resident was supposed to be given the RD ordered fortified nutritional supplement, and by whom. The DON stated no one ordered Resident #10's fortified nutritional supplement to be delivered, and that she expected all residents to receive nutritional supplements if ordered by the RD or Physician, especially if there was a weight loss.	F 692		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 727		1/3/24

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F 727	Continued From page 8 §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours per day, 7 days a week for 17 of 332 days reviewed for sufficient staffing 8/27/22, 9/17/22, 9/18/22, 10/30/22, 12/10/22, 12/24/22, 12/25/22, 2/19/23, 3/4/23, 4/1/23, 4/2/23, 4/15/23, 4/16/23, 5/27/23, 5/28/23, 6/10/23, and 6/24/23. This deficient practice had the potential to affect all facility residents. The findings included: The Payroll Based Journal (PBJ) data report for fiscal year 2022 Quarter 4 from August 1 to September 30, 2022, was reviewed. The report indicated that the facility had 3 days within the quarter with no registered nurse (RN) hours. The dates were 8/27/22, 9/17/22, and 9/18/22. Review of the facility's nursing schedule revealed no RN was scheduled to work on 8/27/22, 9/17/22, and 9/18/22. The time sheets revealed no RN, including the Director of Nursing (DON), had worked any shift on 8/27/22, 9/17/22, and 9/18/22. The PBJ data report for fiscal year 2023 Quarter	F 727	1) Director of Nursing creates schedule 5 weeks in advance to ensure RN hours are covered and reviewed by administrator. 2) Daily RN coverage hours reviewed via daily staffing sheet by administrator, Director of nursing and/or designee. 3) If unable to procure minimum of 8 RN hours, Director of Nursing or RN designee will report to work effective immediately. 4) Administrator and Director of nursing educated by clinical compliance administrator on regulation regarding required RN coverage. 5) Administrator and Director of Nursing/designee to audit schedule weekly during IDT meeting using audit tool. RN coverage audit tool to be reviewed at monthly QA for three months and re-evaluated in quarterly QA meeting.	

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1 from October 1 to December 31, 2022, was reviewed. The report indicated that the facility had 4 days within the quarter with no RN hours. The dates were 10/30/22, 12/10/22, 12/24/22 and 12/25/22.

Review of the facility's nursing schedule revealed the RN called out on 10/30/22 and 12/10/22 and was replaced with a Licensed Practical Nurse (LPN). There was no RN scheduled on 12/24/22 and 12/25/22. Review of the time sheets revealed no RN, including the DON, had worked any shift on 10/30/22, 12/10/22, 12/24/22, and 12/25/22.

The PBJ data report for fiscal year 2023 Quarter 2 from January 1 to March 31, 2023, was reviewed. The report indicated that the facility had 2 days within the quarter with no RN hours. The dates were 2/19/23 and 3/14/23.

Review of the facility's nursing schedule revealed no RN was scheduled to work on 3/4/23 and the RN scheduled on 2/19/23 called out and was replaced with a LPN. The time sheets revealed no RN, including the DON, had worked any shift on 2/19/23 and 3/14/23.

The PBJ data report for fiscal year 2023 Quarter 3 from April 1 to June 30, 2023, was reviewed. The report indicated that the facility had 8 days within the quarter with no RN hours. The dates were 4/1/23, 4/2/23, 4/15/23, 4/16/23, 5/27/23, 5/28/23, 6/10/23, and 6/24/23.

Review of the facility's nursing schedule revealed no RN was scheduled to work on 4/1/23, 4/2/23, 4/15/23, 4/16/23, 5/27/23, 5/28/23, 6/10/23, and 6/24/23. The times sheets revealed no RN, including the DON, had worked any shift on

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4/1/23, 4/2/23, 4/15/23, 4/16/23, 5/27/23, 5/28/23, 6/10/23, and 6/24/23.

An interview was completed with the Clinical Nurse Administrator on 11/29/2023 at 1:01 PM. The Clinical Nurse Administrator stated that she had worked for the facility as the Director of Nursing (DON) until the current DON was hired in August 2023. She further stated that since the facility was small and only had 20 beds, the DON could be counted as the RN hours for the day. The Clinical Nurse Administrator stated that weekend staffing was always a challenge, and all of dates listed were on the weekend. She indicated that an RN was always available on-call for the nursing staff.

An interview was conducted with the Director of Nursing (DON) on 11/30/2023 at 7:33 AM. The DON stated she had only been the DON since August 2023. She further stated that the facility had no days without RN coverage for 8 hours a day since she had been the DON. The DON indicated that she was available by phone for the nursing staff if they had questions or concerns when she was not in the facility.

An interview was conducted with the Administrator on 11/30/2023 at 1:58 PM. The Administrator stated that the dates listed were days that the facility did not have any RN coverage for 8 hours a day. She further stated that she had only been the Administrator since September 2023, and did not know why the facility did not have RN coverage for the days listed. The Administrator stated that getting a consistent staff for the facility was one of the first things she did when she started working at the facility. She indicated that there had not been any

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F 727	Continued From page 11 days without RN coverage for 8 hours a day since she became the Administrator.	F 727		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		1/5/24

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F 842	Continued From page 12 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of fortified nutritional supplement for 1 of 1 resident reviewed (Resident #10). The Findings included:	F 842	1) Staff educated for when to offer supplement for identified patient and educated on where to locate supplements, will have 100% education completed by 01/05/24 2) New order written on 12/18/23 for	

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F 842	Continued From page 13 Resident #10 was admitted to the facility on 10/31/23. The Admission Minimum Data Set (MDS) dated 11/06/23 revealed Resident #10 had a memory problem and was severely impaired in cognitive skills for daily decision making. A review of Resident #10's diet orders dated 11/03/23 revealed the resident to receive a fortified nutritional supplement 237 milliliters (ml) once a day in the morning, with a start date of 11/03/23. A review of Resident #10's November/2023 Medication Administration Record (MAR) was conducted on 11/30/23. The MAR revealed from 11/04/23 through 11/30/23 nurses checked off the morning fortified nutritional supplement was given to the resident. An interview was conducted on 11/27/23 at 1:10 PM with Resident #10 and visitor #1. The resident was in her room with Visitor #1 and had just finished lunch. Both the resident and her visitor #1 said they knew what the fortified nutritional supplement looked like and had not received fortified nutritional supplement on her breakfast tray or lunch tray that day (11/27/23), or at any time during resident's stay at the facility. An interview was conducted on 11/30/23 at 1:00 PM with Nurse #1. The nurse said she passed out morning medications to Resident #10 that morning (11/30/23). She said she signed off in the resident's MAR that she gave the fortified nutritional supplement to the resident, but she had not, saying she signed in error.	F 842	resident to receive magic cup once in the evening 3) New order written on 12/18/23 for resident to receive a mighty shake twice a day (AM/PM) 4) Director of Nursing or designee to audit the inventory of nutritional supplements at beginning of each day effective immediately. Will utilize list of all residents that are ordered to receive nutritional supplements and review inventory again at end of day to ensure supplements are received. Audit will be reviewed at a weekly basis during IDT meeting with Administrator and DON/designee, reviewed at monthly QA for 3 months, and re-evaluated at quarterly QA meeting. 5) Facility to complete an audit on 12/29/23 to review all resident weights, identify all residents with order to receive a therapeutic supplement and ensure that residents are receiving the supplements as ordered. NHA and DON/designee to review this audit on a weekly basis during IDT meeting utilizing audit tool, will review audit tool at monthly QA for 3 months, and re-evaluate in quarterly QA meeting.	

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F 842	Continued From page 14 An interview was conducted on 11/30/23 at 1:50 PM with the Administrator. She said the facility should have provided the fortified nutritional supplement as ordered, and then document in the resident's chart amount consumed or refused. In an interview on 11/30/23 at 3:40 PM the Director of Nurses (DON) stated that Resident #10's ordered morning fortified nutritional supplement to be given during the morning medication pass, was never ordered to be delivered, and none were ever in stock to provide to the resident. She said she had reviewed resident's current Medication Administration Record (MAR), which revealed nursing had checked off that resident's fortified nutritional supplement was given, but she said the nurses shouldn't have because no fortified nutritional supplements were ever ordered to be delivered, and none were in stock. Also, the DON revealed nursing staff were expected to accurately document on a resident's MAR that medications, treatments, or nutritional supplements were completed per the physician order only when they were the ones who administered the medication, treatment, or nutritional supplement.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		1/3/24

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F 867	Continued From page 15 §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 improvements are realized and sustained.	F 867		

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§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 available resources, as reflected in the facility

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F 867	Continued From page 17 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 record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee previously put in place. This was for one repeat deficiency in the area of Resident Records (F842) originally cited on 3/26/2021 during the recertification and complaint investigation survey and subsequently recited on 11/30/2023 during the recertification and complaint survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA.	F 867	1) The facility, in conjunction with the main campus has restructured the monthly QA meeting with facility administrators and led by clinical compliance officer as of 12/14/23. Binders formulated and minutes recorded. Administrators will meet on a monthly basis in addition to quarterly QA meetings. 2) Education provided by clinical compliance administrator to nursing home administrator on 01/03/2024. 3) Administrator and/or Director of nursing	

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F 867	Continued From page 18 Findings included: This tag cross referenced to: F842 Based on record review and staff interview the facility failed to maintain an accurate Medication Administration Record (MAR) for the administration of fortified nutritional supplement for 1 of 1 resident reviewed (Resident #10). During the recertification and complaint investigation survey of 3/26/2021, the facility failed to provide consistent information regarding a resident's code status. An interview was completed with the Administrator on 11/30/2023 at 4:15 PM. The Administrator stated that she did not know why the QAA committee had failed to maintain compliance because she was not the Administrator 2021.	F 867	will ensure that all QA PIPs are in place and reported in monthly and quarterly QA minutes beginning 12/14/23. 4) PIPs will be reviewed at monthly QA meeting and re-evaluated in 3 months.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/3/24

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F 880	Continued From page 19 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 20 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to have a documented water management program and failed to develop a program to assess/identify where legionella and other opportunistic waterborne pathogens could grow and spread, and measures to prevent the growth of opportunistic waterborne pathogens and how to monitor them that could affect 9 of 9 residents. The findings included: Review of the facility's Emergency Preparedness Plan (effective 11/29/23) and Infection Prevention and Control Program Policy dated 02/27/23; revealed no information related to a facility water safety management program. An interview was conducted on 11/29/23 at 11:30 AM with the Maintenance Technician. He said a water safety management program was not in place to monitor legionella or other waterborne pathogens, and that they needed to develop a program.	F 880	1) Facility had an outside company (Enviornchem) come to facility and test water for Legionella on 11/30/23, results were negative for legionella. 2) The facility has employed a new director of maintenance who will ensure testing and tracking is completed on a monthly basis. Contract company to test water annually and/or as needed. 3) Facility has developed and implemented a policy for assessing and tracking for opportunistic waterborne pathogens throughout facility which was reviewed and accepted at monthly QA meeting 12/14/23 4) Results of testing water for opportunistic pathogens will be reviewed in monthly QA meeting for 3 months and re-evaluated in quarterly QA meeting.	

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F 880	Continued From page 21 An interview was conducted on 11/29/23 at 1:15 PM with the Administrator. She stated she was unaware of the requirement to develop a water management program. She stated that she spoke with the facility Maintenance Technician, and he was also unaware of the requirement. The Administrator said they should have had a water management policy and program in place and didn't. A follow-up interview was conducted on 11/29/23 at 2:25 PM with the Administrator and Clinical Compliance Administrator. They both said the facility did not have a water management policy or had a water management program in place and should have. The Administrator said she and the Maintenance Technician would develop a water management policy and water safety management program.	F 880		