STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 12/13/2023

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ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

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E 000	Initial Comments An unannounced Recertification and complaint survey was conducted from 12/11/23 through 12/13/23 . The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # YWIV11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey were conducted from 12/11/23 through 12/13/23. Event ID # YWIV11. The following intakes were investigated NC00200836, NC00209552, NC00207904, NC00193738, NC00203414, and NC00209967. 23 of the 23 complaint allegations did not result 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 reviews, resident and staff interviews, the facility failed to determine whether the self-administration of medications was clinically appropriate for 1 of 1 sampled residents (Resident #4) observed to have medications bedside. The findings included: 1. Resident #4 was admitted to the facility on 3/3/2021. Her diagnoses included chronic obstructive pulmonary disease (COPD).	F 554	F554 Resident Self-Admin Meds-Clinically Appropriate 1. The medications were removed from the bedside of Resident #4 on 12/12/2023 by the Licensed Nurse. A Self Administration of Medications Evaluation was completed on Resident #4 on 1/6/2024. 2. All residents have the potential to be affected. A 100% audit was performed on	1/10/24

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

Electronically Signed | 01/06/2024

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F 554	Continued From page 1 A review of Resident #4's electronic medical record (EMR) revealed physician orders for the following medications; -Albuterol Sulfate HFA (multidose inhaler) aerosol solution 108 MCG (micrograms) to be administered as 2 puffs inhaled orally one time a day for the treatment of asthma with a start date of 9/15/2023. -Breo Ellipta aerosol powder breath activated 100-25 MCG/INH to be administered 1 inhalation a day for treatment of COPD with a start date of 3/11/2021. -Ipratropium Bromide nasal solution 0.03 % to be administered 2 sprays in both nostrils three times a day for allergies with a start date of 10/13/2022. A review of the resident's EMR revealed there was no assessment for self-administration. The resident's quarterly Minimum Data Set (MDS) dated 10/15/2023 revealed Resident #4 was cognitively intact. An observation and interview were conducted on 12/12/2023 at 11:00AM of Resident #4 as she prepared to receive wound care treatment. The resident was observed to have a clear plastic bag of medications in the bed next to her. Upon inquiry, Resident #4 reported the nurse left her medications for her to administer and would be back around later to get the medications. Observed in the plastic bag were a multidose inhaler of albuterol, a multidose inhaler of Breo Ellipta, and a bottle of ipratropium bromide nasal spray.	F 554	all residents by the Director of Nursing/ Designee to ensure no medications were at the bedside. No medications were found in any residents rooms. This audit was completed on 12/14/2023. 3. Education completed by Director of Nursing/Designee for All Licensed Nurses on the self-administration Policy on or before 1/10/2024. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor all resident rooms to ensure there are no medications at the bedside. This audit will be completed 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. An Ad Hoc QAPI meeting was held on 1/5/2024. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.	

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F 554	Continued From page 2 On 12/12/2023 at 11:15AM an interview was conducted with Nurse #1, who was assigned to Resident #4. Nurse #1 stated Resident #4 did not have a medication self-administration assessment and should not have medications bedside. She stated the night shift nurse may have left the medications in the resident's room. A second interview was conducted with Resident #4 on 12/12/2023 at 12:00PM. The resident stated Nurse #1 had given her the medications to self-administer. She stated she typically self-administered her inhaled medications. Resident #4's current care plan was last revised 10/15/2023. The resident was not care planned for the self-administration of medications. An interview was conducted on 12/12/2023 at 3:12 PM with the facility's Director of Nursing (DON). During this interview, the DON stated the facility had a process for safe self-administration of medications and that process was not followed. He further stated the medications were removed from Resident #4's bedside, the resident would be evaluated for safe self-administration of those medications per the facility's policy, and the nurse would be provided additional education.	F 554	5. Date of compliance: 1/10/2024.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		1/10/24

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F 695	Continued From page 3 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Resident #25). The findings included: Resident #25 was admitted to the facility on 6/15/22 with diagnoses that included congestive heart failure and chronic obstructive pulmonary disease (COPD). A review of the active physician orders revealed an order dated 11/7/23, for oxygen at 2 liters via nasal cannula continuously. A quarterly Minimum Data Set (MDS) assessment dated 11/10/23 indicated Resident #25 was cognitively intact, had shortness of breath when lying flat and used oxygen. A review of Resident #25's active care plan, last reviewed 11/30/23, included a focus area for exhibited or was at risk for respiratory complications related to COPD and history of acute and chronic respiratory failure. One of the approaches was to provide oxygen as ordered via nasal cannula. On 12/11/23 at 10:00 AM, an observation was made of Resident #25 while she was lying in bed. The oxygen regulator on the concentrator was set at 4 liters flow when viewed horizontally, eye level.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. The oxygen for Resident #25 was corrected with the prescribed amount per the Physician orders (2 liters by nasal canula) by the Respiratory Therapist on 12/12/2023. 2. A 100% audit of all residents with Physician orders for oxygen was performed by the Respiratory Therapist/Director of Nursing on 12/13/2023 to ensure orders were current and at the prescribed rate. No issues were identified. 3. Education completed by the Director of Nursing/designee to all licensed nurses and Respiratory Therapists on Oxygen therapy via simple mask will be administered as ordered by a physician and will include correct flow rate, mode of delivery, and frequency on or before 1/10/2024. Any licensed nurse or Respiratory Therapist that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses/Respiratory	

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F 695	Continued From page 4 An observation occurred on 12/12/23 at 10:06 AM of Resident #25, which revealed the oxygen regulator on the concentrator was set at 4 liters flow by nasal cannula when viewed horizontally at eye level. Resident #25 was observed while lying in bed on 12/13/23 at 10:13 AM. The oxygen regulator on the concentrator was set at 4 liters flow when viewed horizontally at eye level. On 12/13/23 at 10:16 AM, an observation of Resident #25 was completed with Nurse #2, who confirmed the oxygen regulator on the concentrator was set at 4 liters when viewed horizontally at eye level. Nurse #2 adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #2 stated that oxygen rates were checked when she provided medications through out the day. During an interview with the Director of Nursing on 12/13/23 at 12:51 PM, he indicated it was his expectation for oxygen to be delivered at the ordered rate.	F 695	Therapists and newly hired licensed nurses/Respiratory Therapists will have this education during their orientation period by the Director of Nursing/designee. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor all residents with Physician orders for oxygen to ensure they are receiving the prescribed amount of oxygen. Monitoring will be done 5 x weekly for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. An Ad Hoc QAPI meeting was held on 1/5/2024. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. 5. Date of compliance: 1/10/2024.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		1/10/24

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F 758	Continued From page 5 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and Medical Director, and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication was time limited in duration for 1 of 5 residents reviewed for unnecessary medications (Resident #2). The findings included: Resident #2 was admitted to the facility on 2/9/2017 with diagnoses that included Alzheimer's disease. A significant change Minimum Data Set (MDS) assessment dated 10/16/2023 indicated Resident #2 was severely cognitively impaired and received hospice services. A review of Resident #2's medical record was completed on 12/12/2023 and revealed Resident #2 had a physician's order dated 10/11/2023 for Lorazepam (a psychotropic used to treat anxiety) 0.5 milligrams (mg) one tablet sublingually every four hours as needed for anxiety. The order for the Lorazepam was entered into the Electronic Medical Record (EMR) by Nurse #3 and did not have a stop date. Additionally, the medical record contained an order for hospice services dated 10/16/2023. A phone interview was conducted with Nurse #3 on 12/13/2023. She stated she was no longer employed by the facility, and she did not recall the resident or the order for lorazepam. Resident #2's progress notes included a monthly	F 758	F758 Free from Unnecessary Psychotropic Meds/PRN Use 1. The Provider was notified for Resident #2 to verify if the use of the PRN psychotropic was still needed and to obtain a 14 day stop date. This was completed on 12/12/2023 by the RN Unit Manager. 2. The Unit Manager performed a 100% audit to verify all PRN psychotropic orders had a 14 day stop date. No issues were identified. This was completed on 12/15/2023. 3. Education completed by the Director of Nursing/designee to all licensed nurses on the expectation that any PRN Psychotropic must contain a 14 day stop date. If the medication continues, the Provider must reevaluate the resident and a new order with a 14 day stop date obtained on or before 1/10/2024. Any licensed nurse that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee.	

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F 758	Continued From page 7 medication review by the pharmacy consultant dated 11/24/2023. The consultation report recommended the "as needed" (PRN) order for lorazepam be discontinued due to the order being greater than 14 days duration without a stop date. A paper copy of the recommendation was provided with the Medical Director's response. The Medical Director responded on 11/29/2023 and declined the recommendation noting the indication for the PRN psychotropic drug was "hospice care", the duration of "until she passes", with rationale for the extended period as "hospice care". An interview occurred with the Medical Director on 12/13/2023 at 11:07 AM, who stated he was aware of the regulation that required all PRN psychotropic medications to be time limited in duration, but he wrote Resident #2's order the way it was because she was on hospice. He wanted the medication to be available if she should need it. He was not aware the regulation extended to residents receiving end of life services.	F 758	4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor in the clinical morning meeting 5x weekly to verify any PRN Psychotropic medication has a 14 day stop date. Monitoring will be done 5 x weekly for 12 weeks. An Ad Hoc QAPI meeting was held on 1/5/2024. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. 5. Date of compliance: 1/10/2024.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		1/10/24

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F 761	Continued From page 8 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to date multi-use medications per manufacturer's recommendations upon opening and failed to discard expired medications in 1 of 2 medication carts (100 Hall medication cart) reviewed for medication storage and labeling. Findings included: An observation was conducted on 12/12/23 at 11:35 AM of the 100 Hall medication cart in the presence of Nurse #1. The observation revealed no open date on the following multi-dose medications: a. One multi-dose Lantus insulin pen with 60 units out of 100 units left in pen. The manufacturer's recommendation was to discard 28 days after opening. b. One multi-dose Victoza insulin pen with 10mg out of 18mg left in pen. The manufacturer's	F 761	F761 Label/Store Drugs and Biologicals 1. No specific residents were identified with the deficient practice. Upon notification, the multi-use medications were discarded and reordered on 12/12/2023, and the expired medications were discarded on 12/12/2023 by the licensed nurse and Unit Manager. 2. All residents have the potential to be affected. Medication Carts and Medication Storage Rooms were audited by the Director of Nursing and Unit Managers to ensure all medications were dated and properly labeled/stored on 12/12/2023. No issues were identified. 3. Education completed by the Director of Nursing/designee to all licensed nurses on the medication storage policy and the expectation that when a medication is opened it must be dated with the	

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F 761	Continued From page 9 recommendation was to discard 30 days after opening. c. One multi-dose Glargine insulin pen with 220 units out of 300 units left in pen. The manufacturer's recommendation was to discard 28 days after opening. d. One multi-dose package of Albuterol Sulfate 0.63mg/3ml nebulizer solution, 1 pouch contains 5 vials, 2 vials left in pouch. The manufacturer's recommendation was to discard 7 days after opening. e. One multi-dose package of Albuterol Sulfate 0.63mg/3ml nebulizer solution, 1 pouch contains 5 vials, 3 vials left in pouch. The manufacturer's recommendation was to discard 7 days after opening. Nurse #1 verified the medications were not dated and she removed them from the medication cart and discarded them. She indicated nurses were to write the date on all multi-dose medications upon opening and check dates on all medications prior to administration to make sure they were not expired. She then stated she did not realize the medications were not dated. She further stated that the nurses should be checking the medication carts daily prior to administration. f. The observation also revealed one box of Loperamide Hydrochloride 2mg tablets with 17 of 24 tabs still in box with an expiration date of 08/2023 labeled on box. Nurse #1 verified the Loperamide had expired on 08/2023 and discarded the item. She then stated she did not realize there were expired	F 761	appropriate date and expired medications need to be discarded when appropriate on or before 1/10/2024. 4. To monitor and maintain ongoing compliance, the Director of Nursing/designee will monitor all medication carts to ensure that any opened medications are dated appropriately, and no expired medications are present on the medication carts. Monitoring will occur 3 x weekly for 4 weeks, then 2 x weekly for 4 weeks then 1 x weekly for 4 weeks. An Ad Hoc QAPI meeting was held on 1/5/2024. The Director of Nursing will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee. 5. Date of compliance: 1/10/2024.	

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F 761	Continued From page 10 medications on the cart. An interview was conducted with the Director of Nursing (DON) on 12/13/23 at 1:40 PM. He stated when the items were initially opened for administration the nurse was to write the open date on the medication. The expired medication should have been caught earlier and discarded. The nurses are to check dates prior to administering multi-use medications (insulins, eye drops, nebulizer treatments etc.). He also stated nurses should check dates daily, unit managers check carts weekly, and the pharmacist checks them monthly.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		1/10/24

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F 867	Continued From page 11 §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. §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.	F 867		

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	345333	A. BUILDING _____ B. WING _____	C 12/13/2023

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F 867	Continued From page 12 §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 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	F 867		

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F 867	Continued From page 13 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 reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey conducted on 02/05/21 and annual recertification and complaint survey on 07/11/22. This was for 3 deficiencies that were cited in the areas of Respiratory/Tracheostomy care and Suctioning and Label/Store Drugs & Biologicals which were previously cited on 02/05/21 and Resident Self-Admin Meds-Clinically Appropriate which was previously cited on 07/11/22. The deficient practice area was recited on the current recertification and complaint survey of 12/13/23. The duplicate citations during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F554-Based on observations, record reviews, resident and staff interviews, the facility failed to	F 867	F867 QAPI/QAA Improvement Activities 1. The facility failed to maintain implemented procedures and monitoring interventions put in place following a recertification and complaint investigation survey completed on 12/13/2023. Revised plans have been developed to address those areas with ongoing monitoring by the Quality Assurance and Performance Improvement Committee (QAPI) for F554 Self-Administration of Medications, F695 Respiratory/Tracheostomy Care and Suctioning, and F761 Label/Store Drugs and Biologicals. 2. All residents have the potential to be affected. A Root Cause Analysis was completed by the interdisciplinary Quality Assurance Team for each deficient practice to determine the systemic break with revised plans developed to address these areas. 3. Education was provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the	

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F 867	Continued From page 14 determine whether the self-administration of medications was clinically appropriate for 1 of 1 sampled residents observed to have medications bedside. During the facility's recertification and complaint survey of 07/11/22 the facility failed to assess a resident whether the self-administration of medications was clinically appropriate for 1 of 1 sampled resident observed to have medications at bedside. 2. F695- Based on record review, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care. During the facility's recertification survey of 02/05/21, the facility failed to obtain oxygen orders for 1 of 1 residents reviewed for oxygen. 3. F761-Based on observations, record review and staff interviews, the facility failed to date multi-use medications per manufacturer's recommendations upon opening and failed to discard expired medications in 1 of 2 medication carts (100 Hall medication cart) reviewed for medication storage and labeling. During the facility's recertification survey of 02/05/21, the facility failed to remove expired medications from 1 of the 2 medication carts, failed to document open dates of medication in 2 of 2 medication carts, and failed to secure and label unidentified loose pills in 2 of the 2 medication carts. An interview was conducted with the Administrator and facility Nurse Consultant on	F 867	Corporate Nurse Consultant on 1/5/2024 regarding the policy for the Center Quality Performance Improvement Process. 4. The Administrator will conduct Quality Assurance and Performance Improvement Meetings weekly x4 weeks, bi-weekly x2 weeks, then monthly x1 month. The QAPI Committee will review all active Performance Plans for compliance. Any deviations noted will be addressed by the QAPI Committee to determine the Root Cause Analysis of non-compliance with revisions to the plan as indicated. The Quality Assurance and performance Improvement Committee can modify this plan to ensure the facility remains in compliance. The Administrator and the Director of Nursing will be responsible for the implementation of this plan. 5. Date of compliance: 1/10/2024.	

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F 867	Continued From page 15 12/13/23 at 3:08 PM. The Administrator stated that she felt the repeat citations were due to the facility's leadership turnover and due to the facility currently having an interim DON.	F 867		