STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE	8200 LITCHFORD ROAD RALEIGH, NC 27615

(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 The survey team entered the facility on 5/10/21 to conduct a recertification and complaint survey. The survey team was onsite 5/10/21 through 5/13/21. Additional information was obtained offsite 5/13/21 through 5/14/21. Therefore, the exit date was 5/14/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# DWUJ11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 5/10/21 to conduct a recertification and complaint survey. The survey team was onsite 5/10/21 through 5/13/21. Additional information was obtained offsite 5/13/21 through 5/14/21. Therefore, the exit date was 5/14/21. 1 of 5 complaint allegations was substantiated with a deficiency. Event ID: DWUJ11	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		6/11/21

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

Electronically Signed | 06/10/2021

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, family, resident, and staff interview the facility failed to provide a dependent resident with incontinence care (Resident #3) for 1 of 3 residents reviewed for dignity. Resident #3 waited for 3 hours to be changed and his feelings were hurt, he felt bad and didn't like it. Finding included: Resident #3 was admitted to the facility on	F 550	This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts or alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirement under state and federal law	

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F 550	Continued From page 2 01/19/21 with diagnoses that included hemiplegia following cerebral stroke, type 2 diabetes mellitus without complications, and dysphasia. Review of Resident #3's quarterly Minimum Date Set (MDS) dated 04/24/21 revealed Resident #3 had no memory issues. He was able to communicate his needs to staff and required extensive assistance to total dependence with all his activities of daily living. Resident #3 was always incontinent of bowel and bladder. During an interview with Resident #3 on 05/11/21 at 8:10am he indicated it took staff a long time before they changed his brief. Resident #3 also indicated sometimes he had to call his family and ask them to call the facility to let them know he needed to be changed. Resident #3 indicated he had waited 3 hours for his brief to get changed this am. He added the staff would not change him during mealtimes at all. Resident #3 indicated that it's a bad feeling to setting around wet for long period of time. "It's not a good feeling at all." Incontinence care for Resident #3 was observed on 05/11/21 at 9:15 am and the odor of urine was noted. The bottom sheet on the bed was noted to be wet and stained with a yellow ring that was under Resident #3's lower back. The lift sheet under Resident #3 was wet. The incontinence brief was saturated, and the odor of urine was present during care. An interview with Nursing Assistant (NA) #13 on 05/11/21 at 9:30 am revealed she performed her round at the start of her shift and Resident #3 was not wet. NA #13 also stated Resident #3 did not inform her that he was wet prior to or when she delivered his breakfast tray.	F 550	and to demonstrate the good faith attempts by the provider to improve the quality of life of each resident. IMMEDIATE ACTION On 5/11/2021, Resident #3 was provided incontinence care after breakfast. He was also encouraged to voice any concerns he has or report any delays in care. Any reported concerns will be incorporated into community's grievance process for further modification of this plan. By 6/11/2021, Nursing Assistant #13 was re-educated by the facility Staff Development Coordinator on the importance of ensuring residents are provided incontinent care timely. This includes physically checking residents who sometimes do not voice to their caregiver that they are soiled and need incontinent care. Nursing Assistant #13 voiced understanding of this expectation. IDENTIFICATION OF OTHERS All residents who need incontinent care have the potential to be affected by this alleged deficient practice. By 6/11/2021 the Director of Nursing and/or Staff development Coordinator completed an audit of current residents in the facility that need incontinent care. No other resident was identified receiving delayed incontinent care. Findings of this audit are documented on the Initial Dignity Audit Tool maintained in the facility's compliance binder.	

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F 550	Continued From page 3 During an interview with Resident #3's family member (FM) on 05/12/21 at 11:30am, the FM indicated Resident #3 would call them during the week and most of the time during the weekend. Resident #3 would tell the FM that he had his call bell on for two or more hours because he needed to be changed. The FM indicated it was both bowel movements and/or urine. The FM also stated he had called the facility several times and asked that someone go to Resident #3's room and provide the care he needed. The FM indicated a complaint had been filed several times during his stay. FM also indicated that she knew Resident #3 felt bad about his situation and feeling were hurt. During an interview with the Director of Nursing (DON) on 05/13/21 at 2:15pm, the DON indicated she expected staff to provide dignity and respect to all residents and no resident should wait over 15 minutes for care and treatment to be provided. The DON expected all residents to be treated with dignity and respect.	F 550	SYSTEMIC CHANGES Effective 6/11/2021 and moving forward, nursing staff will complete incontinence rounds timely and provide said care at the point of identification to ensure resident dignity. Starting 6/11/2021, the Director of Nursing and/or the Staff Development Coordinator will complete education for all current nursing staff and care givers, to include full time, part time, and as needed employees on completing incontinence rounds timely and providing said care at the point of identification. This includes physically checking residents who sometimes do not voice to their caregiver that they are soiled and need incontinent care. The education will put an emphasis on the importance of maintaining residents' dignity by completing incontinence rounds timely and providing said care at the point of identification. This education will be completed by 6/11/2021. This education will also be added on new hires orientation process for all new nursing staff and care givers effective 6/11/2021. MONITORING PROCESS Effective 6/11/2021, the Administrator, Director of Nursing, Staff Development Coordinator, Unit Coordinators, Weekend Supervisors and/or Charge nurses will make observations throughout the day to include the observance of incontinent rounds and incontinent care and ensure nursing staff and care givers are maintaining resident dignity by providing	

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F 550	Continued From page 4	F 550	timely care. Findings from this monitoring process will be documented on a Dignity Audit Tool maintained in the facility compliance binder. This monitoring process will take place daily for 2 weeks, then 3x/week for two more weeks, then weekly for 4 weeks, and then monthly until the pattern of compliance is maintained. Effective 6/11/2021, the Administrator, Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		6/11/21

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F 561	Continued From page 5 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to provide showers for 1 of 24 residents (Resident #60) reviewed for choices. Findings included: Resident #60 was admitted to the facility on 4-23-21 with multiple diagnoses that included end stage renal disease, cellulitis of bilateral extremities and diabetes. There was no Minimum Data Set (MDS) available but Resident #60 was documented as being alert and oriented to person, place and time and needed total assist with 2 people for bed mobility, transfers, toileting, and personal hygiene. There was no care plan for assistance with activities of daily living. During an interview with Resident #60 on 5-11-21 at 12:10pm, the resident stated she was not	F 561	IMMEDIATE ACTION By 6/11/2021, Nursing Assistant #1 and Nursing Assistant #2 were re-educated by the facility Staff Development Coordinator on the importance of ensuring residents have the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including the choice of when to bath. Nursing Assistants #1 and #2 voiced understanding of this expectation. On 5/13/2021, Resident #60 was asked by her CNA about her time preference for getting a shower. Resident prefers early evening showers on her current assigned days. Resident #60 was observed by Unit Coordinator receiving her shower during her preferred bathing time. Leg wraps were also replaced post her bathing. On 6/09/2021, Resident was successfully	

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F 561	Continued From page 6	F 561		

receiving a shower twice a week as she was scheduled. She explained she was to receive a shower on 2nd shift (3:00pm to 11:00pm) on Monday's and Wednesday's.

Review of the shower documentation for the month of April and May revealed the resident had received a shower on 5-3-21 and 5-5-21.

The Director of Nursing (DON) was interviewed on 5-12-21 at 1:41pm. The DON stated there were no shower logs for the month of April and no further documentation that Resident #60 had received a shower past 5-5-21.

Nursing Assistant (NA #1) was interviewed on 5-12-21 at 2:50pm. NA #1 stated she had offered a shower to Resident #60 on 5-10-21 but the resident refused. She explained she could not offer a shower to Resident #60 until 8:30pm or 9:00pm so the resident would refuse a shower. NA #1 stated she had discussed the time issue with the head nursing assistant but there had not been any changes made.

During an interview with NA #2 on 5-12-21 at 2:55pm, NA #2 stated he was aware Resident #60 was not being offered a shower until 8:30pm or 9:00pm and that the resident did not want to get a shower at that time. He also stated Resident #60 would refuse a shower if she felt her wound care would not be completed by the evening nurse. NA #2 stated he had not discussed the issue with the DON or the Administrator, but he stated he had spoken with Resident #60 today (5-12-21) to confirm a more suitable time for her to receive her showers.

The Administrator was interviewed on 5-13-21 at

discharged home with her husband.

IDENTIFICATION OF OTHERS
All residents have the potential to be affected by this alleged deficient practice.

By 6/11/2021 the Director of Nursing and/or Staff development Coordinator completed an audit of current residents in the facility to determine their time preference for bathing. Findings of this audit are documented on the Initial Preferred Bathing Times Audit Tool maintained in the facility's compliance binder and each resident's care card was updated.

SYSTEMIC CHANGES
In May 2021, the community purchased an extra shower gurney to meet the current preference demand of the community's resident population and to allow more flexibility to meet the preferences of our resident population.

Starting 6/11/2021, the Director of Nursing and/or the Staff Development Coordinator will complete education for all current nursing staff and caregivers, to include full time, part time, and as needed employees on the importance of ensuring residents have the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including their choice of when to bath. The education will put an emphasis on the importance of maintaining residents' self-determination and empower all staff with the ability to

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F 561	Continued From page 7 12:15pm. The Administrator stated he was not aware showers were offered late in the evening. He also stated he expected and taught staff the customer came first and that the staff needed to provide the resident what she needed.	F 561	update the residents' care cards to reflect resident's current preferences. Education will also include how to document resident bathing and or refusals. This education will be completed by 6/11/2021. This education will also be added to the new hire orientation process for all new nursing staff and care givers effective 6/11/2021. MONITORING PROCESS Effective 6/11/2021, the Administrator, Director of Nursing, Staff Development Coordinator, Unit Coordinators, Weekend Supervisors and/or Charge nurses will make observations throughout the day to include the observed preferences of resident bathing times and ensure bathing was completed or refusal documented. Findings from this monitoring process will be documented on a Self-determination/Preferred Bathing Times Audit Tool maintained in the facility compliance binder. This monitoring process will take place daily for 2 weeks, then 3x/week for two more weeks, then weekly for 4 weeks, and then monthly until the pattern of compliance is maintained. Effective 6/11/2021, the Administrator, Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can	

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F 561	Continued From page 8	F 561	modify this plan to ensure the facility remains in substantial compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the special treatments and program section (Section O) on the Minimum Data Set (MDS) assessment for 1 of 4 residents (Resident #68) reviewed for MDS accuracy. Findings included: Resident #68 was readmitted to the facility on 2-12-21 with multiple diagnosis that included dementia, chronic obstructive pulmonary disease and diabetes. Review of Resident #68's Flu and Pneumonia documentation revealed the resident had a consent form signed 9-30-20 to receive the Flu and Pneumonia vaccines. The documentation also revealed Resident #68 had received the Flu and pneumonia vaccine on 10-15-20. The quarterly Minimum Data Set (MDS) dated 4-7-21 revealed Resident #68 was cognitively intact. Section O0030 Pneumococcal Vaccine was coded the resident's pneumococcal vaccine was not up to date and not offered. Nurse #6 was interviewed by telephone on	F 641	IMMEDIATE ACTION The quarterly MDS assessment for resident #68 dated 4/7/2021 was modified on 6/8/2021 to reflect the resident□s Pneumococcal Vaccine was offered and up to date. The modified assessment will be transmitted on 6/9/2021 by MDS Nurse #4. IDENTIFICATION OF OTHERS All residents have the potential to be affected by this alleged deficient practice. On 6/8/2021, the MDS Nurse #4 and Staff Development Coordinator completed an audit of current residents□ most recent MDS assessment, specifically Section O0250 and Section O0030 to ensure the MDS accurately reflects the Vaccination Status of the residents. The results of the audit indicate two other resident□s Section O0250 or Section OO0030 were coded incorrectly. Findings of this audit are documented on the Initial MDS Accuracy of Vaccination Status Audit Tool maintained in the facility□s compliance binder.	6/11/21

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F 641	Continued From page 9 5-13-21 at 11:30am. The nurse explained she worked part time in the evenings and weekends. She stated she would look for documentation in the medical record if the vaccines had been offered and/or provided. Nurse #6 explained if she did not see any documentation then she would document "not offered" under O0030. She further explained due to her schedule there was not anyone available to assist her in verifying the information. Nurse #6 stated she would leave notes for the full time MDS nurse if she felt information needed verified but stated she could not remember if she had left a note regarding Resident #68's MDS information. The Administrator was interviewed on 5-13-21 at 12:15pm. The Administrator confirmed Nurse #6 worked part time and that there was not someone available for her to speak with to verify information. He also stated Nurse #6 would leave notes for the full time MDS nurse if there was a need for follow up. The Administrator said he expected the information in the resident's medical record to be accurate. An interview with Nurse #4 occurred on 5-13-21 at 1:30pm. Nurse #4 verified Nurse #6 was a part time MDS nurse and worked mostly evenings and weekends. She stated Nurse #6 would leave her notes if she needed to verify information or complete any paperwork but said she could not remember if Nurse #6 had left her any notes for Resident #68 to verify if he had received his pneumonia vaccine.	F 641	SYSTEMIC CHANGES On 6/8/2021, the Corporate Reimbursement Consultant conducted reeducation for all current MDS nursing staff on accurate coding of MDS using Resident Assessment Instruments (RAI) guidelines. This education covers coding requirements and supportive documentation for each item coded in MDS, specifically related to Section O0250 and Section O0030 of the MDS. This education will also be added to the new hire orientation process for all new MDS nursing staff effective 6/11/2021. MONITORING PROCESS Effective 6/11/2021, prior to submission, MDS Nurse #4 will review section O of the MDS completed by MDS Nurse #6 (and vice versa) to ensure that Section O0030 is coded accurately per RAI guidelines. Findings from this monitoring process will be documented Monday through Friday, prior to submission for 2 weeks on all completed MDS assessments, 50% of all completed MDS assessments weekly for 2 weeks, then 25% of all completed MDS assessments monthly for 2 months or until the pattern of compliance is achieved. Any inaccurate coding identified will be noted and corrected before submission by MDS nurse #4 or #6 (whoever is completing the audit). Findings of this monitoring process will be documented on MDS Accuracy of Vaccination Status Audit Tool maintained in the facility□s compliance binder. Effective 6/11/2021, the MDS Nurse #4 or	

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F 641	Continued From page 10	F 641	#6 will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	
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 observations, record reviews, resident and staff interview the facility failed to provide a dependent resident with incontinence care for 1 of 5 residents reviewed for activities of daily living. (Resident #3) Finding included: Resident #3 was admitted to the facility on 01/19/21 with diagnoses that included hemiplegia following cerebral stroke, type 2 diabetes mellitus without complications, and dysphasia. Review of Resident #3's quarterly Minimum Date Set (MDS) dated 04/24/21 revealed Resident #3 had no memory issues. He was able to communicate his needs to staff and required extensive assistance to total dependence with all his activities of daily living. Resident #3 was	F 677	IMMEDIATE ACTION On 5/11/2021, Resident #3 was provided incontinence care after breakfast. He was also encouraged to voice any concerns he has or report any delays in care. Any reported concerns will be incorporated into community's grievance process for further modification of this plan. By 6/11/2021, Nursing Assistant #13 was re-educated by the facility Staff Development Coordinator on the importance of ensuring residents are provided incontinent care timely. This includes physically checking residents who sometimes do not voice to their caregiver that they are soiled and need incontinent care. Nursing Assistant #13 voiced understanding of this expectation.	6/11/21

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LITCHFORD FALLS HEALTHCARE	8200 LITCHFORD ROAD RALEIGH, NC 27615

(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 677	Continued From page 11 always incontinent of bowel and bladder. During an interview with Resident #3 05/11/21 at 8:10am he indicated it took staff a long time before they changed his brief. Resident #3 also indicated sometimes he had to call his family and ask them to call the facility to let them know he needed to be changed. Resident #3 indicated he had waited 3 hours for his brief to get changed this am. He added the staff would not change him during mealtimes at all. Incontinence care for Resident #3 was observed on 05/11/21 at 9:15 am. the odor of urine was noted. The bottom sheet on the bed was noted to be wet and stained with a yellow ring that was under Resident #3's lower back. The lift sheet under Resident #3 was wet. The incontinence brief was saturated, and the odor of urine was present during care. An interview with Nursing Assistant (NA) #13 on 05/11/21 at 9:30 am revealed she performed her round at the start of her shift and Resident #3 was not wet. NA #13 also stated Resident #3 did not inform her that he was wet prior to or when she delivered his breakfast tray. During an interview with Resident #3's family member (FM) on 05/12/21 at 11:30am, the FM indicated Resident #3 would call them during the week and most of the time during the weekend. Resident #3 would tell the FM that he had his call bell on for two or more hours because he needed to be changed. The FM indicated it was both bowel movements and/or urine. The FM also stated he had called the facility several times and asked that someone go to Resident #3's room and provide the care he needed. The FM	F 677	IDENTIFICATION OF OTHERS All residents who need incontinent care have the potential to be affected by this alleged deficient practice. By 6/11/2021 the Director of Nursing and/or Staff development Coordinator completed an audit of current residents in the facility that need incontinent care. No other resident was identified receiving delayed incontinent care. Findings of this audit are documented on the Initial Dignity Audit Tool maintained in the facility's compliance binder. SYSTEMIC CHANGES Effective 6/1/2021 and moving forward, nursing staff will complete incontinence rounds timely and provide said care at the point of identification to ensure resident dignity. By 6/11/2021, the Director of Nursing and/or the Staff Development Coordinator will complete education for current nursing staff and care givers, to include full time, part time, and as needed employees on completing incontinence rounds timely and providing said care at the point of identification. This includes physically checking residents who sometimes do not voice to their caregiver that they are soiled and need incontinent care. The education will put an emphasis on the importance of maintaining residents' dignity by completing incontinence rounds timely and providing said care at the point of identification. This education will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 05/14/2021

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F 677	Continued From page 12 indicated a complaint had been filed several times during his stay. During an interview with the Director of Nursing (DON) on 05/13/21 at 2:15pm, the DON indicated she expected staff to provide incontinence care for all residents in a timely manner. The DON indicated within 15 minutes of the residents needing to be changed.	F 677	completed by 6/11/2021. This education will also be added on new hires orientation process for all new nursing staff and care givers effective 6/11/2021. MONITORING PROCESS Effective 6/11/2021, the Administrator, Director of Nursing, Staff Development Coordinator, Unit Coordinators, Weekend Supervisors and/or Charge nurses will make observations throughout the day to include the observance of incontinent rounds and incontinent care and ensure nursing staff and care givers are maintaining resident dignity by providing timely care. Findings from this monitoring process will be documented on a Dignity Audit Tool maintained in the facility compliance binder. This monitoring process will take place daily for 2 weeks, then 3x/week for two more weeks, then weekly for 4 weeks, and then monthly until the pattern of compliance is maintained. Effective 6/11/2021, the Administrator, Director of Nursing, and/or Staff Development Coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	