STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING ______ B. WING ______	C 03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	**915 PEE DEE ROAD ABERDEEN, NC 28315**

(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 000	INITIAL COMMENTS An unnaounced complaint investigation and focused infection control survey was conducted 2/22/23 to 3/6/23. Two of the 21 complaint allegations resulted in deficiencies. See #YDSJ11. Intakes investigated: NC00192068, NC00198063, NC00196719, NC00197119 and NC00198721.	F 000		
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. §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	F 561		3/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/16/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561

Continued From page 1

interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff, resident and responsible party (RP) interviews and record review, the facility failed to honor a resident request for showers. This was for 1 resident (Resident #4) reviewed for choices. The finding included:

Resident #4 was admitted on 10/12/22 with a diagnosis of Congestive Heart Failure (CHF).

The quarterly Minimum Data Set dated 2/10/23 indicated Resident #4 was cognitively intact, exhibited no behaviors and was coded as independent with bathing.

Review of Resident #4's comprehensive care plan included one care area for assistance with his activities of daily living (ADLs). The care plan did not include any bathing/showering assistance. He was not care planned for noncompliance, rejection or refusal of care or staff assistance.
An interview and observation was completed with Resident #4 on 2/23/23 at 9:00 AM. He was in his room eating breakfast, clean, groomed and dressed for the day. He voiced no complaints with the facility except for not getting his showers as scheduled. Resident #4 stated at one time, he received his showers as scheduled but it stopped and now the staff did not even offer him a shower. He stated he mentioned it to his RP yesterday when he did not get his scheduled shower on Monday.
Review of Resident #4's shower documentation from 1/24/23 to 2/23/23 did not include any documentation that he received a shower.

F 561

F561

1. On February 23, 2023, the Director of Nursing, scheduled showers per resident #4 request, for his shower be on Monday and Thursday in the electronic record.

2. All residents receiving showers have the potential to be affected. The Director of Nursing has completed an audit of all current residents and scheduled showers per residents per request, in the electronic record on February 23, 2023.

3. The Director of Nursing educated Nursing staffing on February 23,2023 regarding entry of shower schedules per resident's choice in the electronic record for new admissions and readmissions. This education will be added to orientation for new hires. Any nurse that has not received education will not be able to work until doing so.

The Director of Nursing and/or Unit Managers review shower sheets during the morning clinical meeting to ensure scheduled showers were completed.

4. The Director of Nursing and/or designee will review 5 residents per week for 4 weeks, then 3 residents per week times 4 weeks, then 2 residents per week times 4 weeks to validate showers were completed. In addition, the Director of

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F 561	Continued From page 2 A telephone interview was completed with Resident #4's RP on 2/22/23 at 11:30 AM. She stated Resident #4 reported to her on 2/18/23 that he was not getting his scheduled showers. She stated she discussed her concern with the Director of Nursing (DON) recently and arrangements were made to change his shower days from Wednesdays and Saturdays to Mondays and Thursdays. She did not expand on the reason for the change in his shower days. An interview was completed with Nursing Assistant (NA) #1 on 2/23/23 at 10:30 AM. She stated Resident #4 preferred female assistance with his showers and that was why his shower days were recently changed. She stated there was a male aide that worked on Saturdays and Resident #4 would not allow the male aide to assist him with his showers. An interview was completed with the Unit Manager (UM) on 2/23/23 at 10:40 AM. She stated Resident #4 did receive his showers, but the days had to be changed because he did not want the male aide who worked every Saturday to assist him. The UM stated the DON spoke with him and his RP about his shower days and they were changed to Mondays and Thursdays on first shift. An interview was completed with the DON on 2/23/23 at 3:15 PM. She stated she spoke to Resident #4's RP on Saturday, she completed a grievance at that time, and she was still working on a resolution. She stated Resident #4 recently stated he did not want a male aide to assist him with his ADLs, but he offered no explanation. The DON stated she recently identified a problem with	F 561	Nursing or designee will observe 3 residents per week for 4 weeks while receiving showers. 5. The Director of Nursing will report the results of these audits monthly to QAPI committee and the committee will make recommendations as needed.	

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F 561	Continued From page 3 staff providing showers as scheduled so she reintroduced the use of the written shower sheets that required review and oversight.	F 561		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification to the	F 625	F625:	3/16/23

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F 625

Continued From page 4

resident regarding bed hold when the resident was sent to the hospital for an evaluation for 1 of 1 resident (Resident #6) reviewed for hospitalization.

The findings included:

Resident #6 was admitted to the facility on 2/2/23.

Resident #6's admission Minimum Data Set (MDS) assessment dated 2/7/23 identified Resident #6 as cognitively intact. Her most recent MDS assessment on 2/11/23 was coded as discharge return anticipated.

Resident #6's medical record revealed on 2/11/23 she was transferred to the hospital for a change in condition and did not return.

Review of nursing notes on 2/11/23 revealed documentation written by Staff Nurse #1 at the time of Resident #6's discharge provided no statements regarding a bed hold notice being provided to the resident.

During an interview with Resident #6 on 3/6/23 at 4:04 PM, she revealed she did not receive a bed hold notice upon transfer to the hospital on 2/11/23.

Staff Nurse #1 was interviewed on 2/22/23 at 3:15 PM, and she revealed she had sent Resident #6 to the hospital on 2/9/23, and she was not aware of a bed hold form included in the transfer folder. She stated the form had never been discussed with her before. On 2/11/23, when Resident #6 was sent to the hospital again, Staff Nurse #1 stated she was helping Staff Nurse #2 with documentation, who was assigned to Resident #6

F 625

1 Resident#6 discharged from the hospital to another skilled nursing facility.

2.All residents requiring transfer have the potential to be affected.

On February 22, 2023, the Director of Nursing conducted an audit of residents discharged to the hospital during the last 30 days.

3.The Director of Nursing educated Licensed Nurses, Social Services, and Medical Records in the regards to bed-hold policy on February 22, 2023. Any nurse, social worker or medical records staff member that has not received education will not be able to work until education is completed. New hired nurses will receive education on bed hold notification during orientation.

4.Medical records and/or social service will complete audits for 5 residents 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 2 times per week for 4 weeks of residents discharged ensuring they received bed hold notification.

5.The Director of nursing will report the results of these audit monthly to QAPI committee and the committee will make recommendations as needed.

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F 625	Continued From page 5 on that date. Attempts were made to contact Staff Nurse #2. She did not return attempted telephone calls and no longer worked at the facility. During an interview with the Director of Nursing (DON) on 2/22/23 at 1:33 PM, she stated medical records made a folder for residents to take with them to the hospital upon discharge, known as the "transfer folder." The Medical Records Director was also present during the interview. The DON stated nursing staff were supposed to document in Resident #6's medical record that the transfer folder, including bed hold, went with her to the hospital on 2/11/23. She indicated she did not have proof that the transfer folder and bed hold document went with Resident #6 when she was discharged on 2/11/23. An interview was conducted with the Administrator on 2/23/23 at 4:26 PM, she stated the issue of Resident #6's bed hold was lack of knowledge with documentation during transfers by nursing staff. The Administrator indicated that nurses were aware of the bed hold documentation, but she was not sure if Resident #6 knew of the bed hold policy. She revealed her expectation was for all bed holds to be documented upon transfer and for Social Services to send written bed hold to the resident.	F 625		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/16/23

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F 689	Continued From page 6 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff and Wound Doctor interviews, record review and observations, the facility failed to safely position a resident in bed without injury when Resident #7 fell from a resident bed raised to the waist high position resulting in a subarachnoid hemorrhage (bleeding in the space that surrounds the brain). This was for 1 (Resident #7) of 3 residents reviewed for accidents. The findings included: Resident #7 was admitted on 9/12/19 with a traumatic brain injury (TBI), seizure disorder, left side hemiplegia, muscle spasms and contractures to his left arm, elbow and leg. Resident #7's comprehensive care plan included a care area dated 4/21/21 for assistance with his activities of daily living (ADLs) because he was dependent on staff to turn and reposition with 2 staff while in the bed for safety. On 10/21/22, the intervention of grabs bars to promote independence was added. The quarterly Minimum Data Set dated 11/9/22 indicated Resident #7 had severe cognitive impairment required extensive assistance of 2 staff for bed mobility and coded for a pressure ulcer. An incident report dated 1/4/23 at 8:29 AM completed by Nurse #2 read Resident #7 fell to the floor next to the bed with a head injury.	F 689	F689: 1.Resident #7 return on January 6, 2023, with no further incidents. Upon return to the facility, nurse completed nursing assessment. 2.All residents have the potential to be affected. A review was conducted by Director of Nursing and MDS coordinator of the transfer status for bed mobility of current residents. Any issues identified were corrected at the time by the Director of Nursing or MDS Coordinator. Upon admission on new residents, bed mobility will be assessed. 3.The Director of Nursing completed education with certified nurse assistants and licensed nurses regarding using the appropriate bed mobility status for residents on 1-4-23. Additional inservice was conducted by Director of Nursing on 2-23-23 with nurses on using the approrpriate bed mobility status for residents. Any licensed nurse or certified nurse aide that has not completed education will be unable to work until doing so. New hires will be provided education in orientation. 4.Director of Nursing and/or designee will discuss will complete observations of residents receiving bed mobility	

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F 689	Continued From page 7 Resident #7 stated "I grabbed the rail while rolling for wound care with my good arm and rolled out of the bed". The report read a staff member was getting ready to do wound care when he turned and repositioned himself by grabbing the rail, extended himself over and fell out of the bed. A nursing note dated 1/4/23 at 8:29 AM completed by Nurse #2 read Resident #7 was using his right arm to turn in bed and fell off the edge to the floor striking his head with an injury. The nurse called emergency medical services (EMS) and controlled the bleeding. Per the hospital report, Resident #7 was admitted with a brain bleed. Both the physician and the responsible party were notified. An interview was completed on 2/23/23 at 12:37 PM with Nurse #2. He stated at the time of Resident #7's fall, he was in the middle of his medication pass so the Unit Manager (UM) assisted the wound nurse with Resident #7 and sent him out to the hospital. An interview was completed on 2/23/23 at 10:40 AM with the Unit Manager (UM). She stated she was under the impression that the Wound Doctor was present in the room when Resident #7 fell from the bed. She stated she assessed Resident #7. The UM recalled seeing the Wound Doctor in the hallway and not the room. She noted a laceration to his right side of his head was bleeding. She got the bleeding stopped, performed neurological checks and contacted EMS to take Resident #7 to the hospital for an evaluation for his injury. The UM stated Resident #7 was not able to turn himself in the bed and she had not known him to regularly use his grab bar to roll himself over with staff assistance.	F 689	assistance on 5 residents a week for 4 weeks, then 3 residents a week for 4 weeks, then 2 residents per week for 4 weeks. In addition, the Director of Nursing and/or MDS nurse will audit 5 residents' kardexs for 4 weeks, then 3 residents' kardexs a week for 4 weeks, and then 2 residents'kardexs a week for 4 weeks to ensure a proper bed mobility status is present. 5.The Director of Nursing will report the results of these audits monthly to the QAPI committee and the committee will make recommendations as needed.	

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F 689	Continued From page 8 An interview was completed on 2/23/23 at 10:00 AM with the wound nurse. She stated she raised the bed to waist level for the Wound Doctor to assess Resident #7's wound. She stated she assisted him onto his right side, and he grabbed the rail and rolled out of the bed. The wound nurse stated it happened so fast when the Wound Doctor came into the room, and she was changing places with him to allow for his wound assessment. She stated she had her hand on Resident #7 until she walked around to the other side of the bed and that was when he grabbed the grab bar and rolled himself out of the bed. The wound nurse stated she thought she positioned Resident #7 in the middle of the be prior to rolling him over. Review of the education dated 1/4/23 provided by the DON to the wound nurse read she was educated that Resident #7 should have 2 staff assisting with bed mobility at all times to ensure safety while doing his wound care. An interview was completed with the DON on 2/23/23 at 9:30 AM. She stated the wound nurse was rounding with the wound Physician. She turned Resident #7, and he grabbed the rail (grab bar) and rolled out of the bed. She stated at the time of the fall, she educated the wound nurse, but she did not provide any staff education, observations, staff interviews or auditing. The hospital discharge summary dated 1/6/23 read Resident #7 was being evaluated by the Wound Doctor for a pressure ulcer to his back when he rolled over to expose the area, Resident #7 rolled off the bed and hit the posterior aspect of his head. He did not lose consciousness. At	F 689		

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F 689	Continued From page 9	F 689		

the time of his admission on 1/4/23 Resident #7 was absent of pain, neck pain, headache, dizziness or changes in his vision. The CT scan completed on 1/4/23 revealed a right frontal and temporal hyper-density reflecting a small volume intraparenchymal hemorrhage (when blood pools in the tissues of the brain). He was consulted by neurosurgery and conservative management was recommended. The repeat CT scan completed on 1/6/23 revealed resolution or redistribution of the subdural blood, stable condition and a return to his baseline. While in the hospital, it was noted that Resident #7's Valproic Acid levels (medication used to treat seizures) were trending downward and adjustments in the dosage were done. His aspirin was held for 2 weeks, and he was discharged back to the facility on 1/6/23 with order to obtain.

A nursing note dated 1/9/23 at 4:10 PM completed by the Director of Nursing (DON) read the interdisciplinary team met to discuss the occurrence on 1/4/23 when Resident #7 had a witnessed fall with an injury to his forehead. He was sent out to the hospital and returned on 1/6/23 with new interventions to ensure Resident #7 was properly positioned while in the bed and to ensure the bed is in the lowest position.

An observation was completed on 2/23/23 at 10:20 AM of Resident #7. He was lying in the with bed a left arm and hand contracture. There was a grab bar (rail) observed at the head level on the right side of his bed and another grab bar in the middle side of his left side of the bed. He recalled falling out of the bed but did not recall the circumstances.

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F 689	Continued From page 10 An interview was completed on 2/23/23 at 10:30 AM with Nursing Assistant (NA) # 1. She stated Resident #7 has grab bars on his bed, but he was not able to roll over by himself and there were supposed to be 2 staff to assist with his bed mobility for safety. An interview was completed on 2/23/23 at 4:20 PM with the DON. The DON stated there should have been 2 staff assisting with Resident #7's turning and positioning prior to the Wound Doctor's assessment. A telephone interview was completed on 2/23/23 at 6:25 PM with the Wound Doctor. He stated he was reading his previous assessment data in the hallway when he heard Resident #7 fall. He stated he had not yet entered the room because the wound nurse was getting Resident #7 prepped by positioning him and removing his old dressing.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732		3/16/23

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F 732	Continued From page 11 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to post total number and actual hours worked per shift for nursing staff for 54 of 54 days reviewed for accuracy. The findings included: Review of the posted nursing hours from January 1, 2023 through February 23, 2023 did not include the daily total number and actual hours	F 732	F732: 1 No resident was affected by the deficient practice 2.Residents are not affected by deficient practice. 3.Staffing Coordinator has been educated on total number and actual staffing hours has been corrected and posted on February 23, 2023, by Director of Nursing.	

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	345509	A. BUILDING ______ B. WING ______	C 03/06/2023

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F 732 Continued From page 12
worked per shift for licensed and unlicensed staff responsible for resident care.

Observation was made of the posted staffing sheet on February 22, 2023 at 10:20 AM during the entry tour. The posted staffing sheet was located on the bulletin at the nursing station hub and it revealed no posting for daily total number and actual hours worked per shift for licensed and unlicensed staff.

In an interview on 2/22/23 at 2:00 PM, the Scheduler stated she was told not to complete the posted staffing sheet in its entirety by her last Administrator. She previously had completed the posted staffing form to include facility name, date, census, total number hours, and actual hours worked of nursing staff per shift. The Scheduler stated it had been months since the change in what she posted. The Scheduler stated she had other duties assigned and the Administrator at that time stated the form did not have to be completed in order to provide the time for her other additional job responsibilities.

Observation of the posted staffing sheet on February 23, 2023 at 8:30 AM located on the bulletin at the nursing station hub revealed no posting for daily total number and actual hours worked per shift for licensed and unlicensed staff.

In an interview on 2/23/22 at 4:00 PM, the current Administrator stated the posted nursing staffing should include the actual daily nursing hours worked along with the total hours worked. The current Administrator stated she had not noticed the posting was incomplete until yesterday when posted staffing was reviewed. The Scheduler reviewed the posted staffing and reported her

F 732

4. Director of Nursing and/or designee will review posting of total number and actual hours on daily staffing forms 5 times per week. Staffing Coordinator will complete an audit 5 times per week times 4 weeks and then monthly times 3 months for completion of daily staffing form. Director of Nursing will ensure that documentation has been completed. Director of Nursing will review audits and make recommendation as necessary to assure compliance is maintained.

5.QAPI committee will review audits and to assure compliance is maintained ongoing. QAPI committee will determine need for further auditing beyond 3 months.

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F 732	Continued From page 13 findings to the Administrator. The Administrator stated she reviewed previous postings, and the data was present, and she had no idea why the Scheduler was told to stop completing the information. She stated the staff would complete the posted staffing sheets in all columns prior to posting for public view in the future.	F 732		
F 867 SS=E	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 §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	F 867		3/18/23

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F 867		F 867		

Continued From page 14
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.

§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

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F 867	Continued From page 15 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 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	F 867		

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F 867	Continued From page 16 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 interview, the facility's Quality Assurance Committee (QA) failed to maintain procedures and monitor interventions that the committee put into to place following complaints dated 10/23/20, 12/2/20 and 1/3/23 and the recertification survey dated 9/30/21. This was for 2 recited deficiencies in the area of Quality of Care at F689 and Nursing Services at F732. The continued failure of the facility during four federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is cross referenced to: F689-Based on staff and Wound Doctor interviews, record review and observations, the facility failed to safely position a resident in bed without injury when Resident #7 fell from a resident bed raised to the waist high position resulting in a subarachnoid hemorrhage (bleeding in the space that surrounds the brain). This was for 1 (Resident #7) of 3 residents reviewed for accidents. F689-cited 9/31/21-Based on record review, observations and staff interview, the facility failed to provide a hazard free environment by utilizing a power strip for a window air conditioner unit for 1 of 14 rooms occupied by residents in the memory care unit (Room #411).	F 867	F867: 1.The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F689 and F732 on 3/16/23. 2. Current residents are affected by these current deficiencies. 3.The Regional Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI committee and the purpose of the Committee to include identifying issues and correct repeat deficiencies related to F689 and F732 on 3/16/23. 4. On 3/17/2023 the Administrator educated the QAPI committee members consisting of the Medical Director, Administrator, Director of Nursing, Unit Support Nurses, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit finds for compliance and/or revision needed. In additon to the QAPI	

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F 867	Continued From page 17 F732-Based on observations, staff interviews and record review, the facility failed to post total number and actual hours worked per shift for nursing staff for 54 of 54 days reviewed for accuracy. F732-cited 12/2/20-Based on review of the facility ' s required posted daily Nurse Staffing forms and staff interview, the facility failed to complete the posting requirements on 22 of 22 days reviewed (11/01/20 through 11/22/20). In an interview on 2/23/23 at 4:40 PM, the Administrator stated she felt the repeat citations were due to the facility's recent staff changes in nursing management. She stated she started 2 weeks ago, and the DON started 3 months ago.	F 867	committee will continue to meet monthly. 5. The Quality Assurance Committee will continue to meet monthly to identify issues related to assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains correct and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility's progress, review corrective actions and date of completion. The administrator will be responsible for ensuring QAPI committee concerns and addressed through further training of other interventions. Compliance date: March 18, 2023.	