STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/10/23 through 07/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 3EIZ11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/10/23 through 07/13/23. Event ID# 3EIZ11. The following intakes were investigated: Intake Numbers: NC00194902, NC00195060, NC00195395, NC00195412, NC00195485, NC00195589, NC00195590, NC00196034, NC00196703, NC00197173, NC00197298, NC00198042, NC00199417, NC00199870, NC00200394, NC00201041, NC00201332, NC00201596, NC00203706 70 of the 70 complaint allegations did not resulted in deficiency.	F 000		
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 staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's most recent weight obtained during the previous 30-day period for 1 of 5 residents (Resident #392) reviewed for Nutrition.	F 641	Corrective Action for those Residents found to have been affected Resident #392 was admitted to the facility on 4/4/22. MDS assessment dated 9/22/22 was modified by MDS Director on 8/4/23 to include accurate weight obtained	8/8/23

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

Electronically Signed | 08/04/2023

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F 641	Continued From page 1 The findings included: Resident #392 was admitted to the facility on 4/4/22 with a cumulative diagnoses which included vascular dementia and dysphagia (difficulty swallowing). The resident's admission Minimum Data Set (MDS) dated 4/11/22 documented her weight as 134 pounds. Resident #392's quarterly MDS dated 5/27/22 indicated her weight was also 134 pounds. Resident #392's weight history reported in the Vital Signs record of the resident's electronic medical record (EMR) included a measurement obtained and documented on 8/24/22 as 121.8 pounds. Resident #392's quarterly MDS assessment dated 8/27/22 reported the resident weighed 122 pounds (using mathematical rounding). The resident's next available weight documented in her EMR was obtained on 9/12/22 and noted as 122.4 pounds. According to Resident #392's EMR, she was again weighed on 9/19/22. The weight on that date was 115.2 pounds. Resident #392's quarterly MDS dated 9/22/22 reported her weight was 122 pounds. The weight documented on this MDS was not the most recent measure obtained in the last 30 days. An interview was conducted with the facility's Director of Nursing (DON) on 7/13/23 at 11:47 AM. During the interview, concern regarding the accuracy of Resident #392's weight recorded in the Swallowing / Nutritional Status section of her MDS assessment was discussed. The DON reported the facility did not currently have an	F 641	on 9/19/22. How the facility will identify other residents having the potential to be affected: The Case Mix Director will review all residents' weights from previous assessment ARD to current assessment ARD and any assessment identified with missing or incorrectly entered weights will be corrected and the MDS assessment will be modified to reflect accuracy and resubmitted by 8/7/23. Systemic changes made to ensure that deficient practice will not recur: The facility has reviewed its MDS Assessment Accuracy Policy with no revisions needed. Clinical Reimbursement Consultant or designee provided education to the Case Mix Director on the MDS Assessment Accuracy Policy on 8/7/23 . The Administrator is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: The Director of Health Services and/or designee will review the accuracy of five assessments per week for four weeks then ten assessments per month for three months to ensure the accuracy of the minimum data set. Monitoring of performance to make sure	

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F 641	Continued From page 2 MDS Nurse in place and relied on assistance from corporate and interim MDS nurses to help with the completion of the resident MDS assessments. An interview was conducted on 7/13/23 at 1:35 PM with the Regional MDS Coordinator. Upon inquiry, the Coordinator reviewed Resident #392's MDS assessments and weight history. When asked about the weight reported on her 9/22/22 MDS, the Coordinator stated she could not be certain the resident's 9/19/22 weight of 115.2 pounds was available for the MDS Nurse at the time she completed the 9/22/22 MDS assessment. She also stated that since both weights (122.4 pounds and 115.2 pounds) were obtained during the preceding 30 days, she thought either one may have been acceptable to report on the resident's MDS assessment.	F 641	that solutions are sustained. Results from monitoring listed will be presented by the Administrator and/or Director of Health Services to the QA team monthly times three months. Findings will be addressed promptly by the QA team. After the completion of monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Dates when the corrective action will be completed. 8/8/23	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		8/8/23

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F 655	Continued From page 3 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop a baseline care plan which included the minimum healthcare information necessary to properly care for 1 of 12 newly admitted residents reviewed (Resident #242). The findings included: Resident #242 was admitted to the facility on 10/31/22. Her cumulative diagnoses included	F 655	Facility failed to develop a baseline care plan for 1 of 12 residents reviewed for baseline care plans. Resident #242 was admitted to the facility on 10/31/22. Resident discharged out of facility to the hospital on 11/7/22. At the time of discharge, the resident□s baseline care plan was incomplete. The facility will conduct a review of all	

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F 655	Continued From page 4 protein-calorie malnutrition, cirrhosis of the liver, and a recent history of severe sepsis with septic shock (the most severe form in which the infection causes low blood pressure and may result in damage to multiple organs). On 7/12/23 at 8:45 AM, the facility provided a copy of Resident #242's baseline care plan dated 11/2/22 for review. The baseline care plan for this resident addressed only three problems as follows: --Advanced Directives (Problem Start Date 11/2/22); --Pain (Problem Start Date 11/2/22); --Falls (Problem Start Date 11/2/22). The baseline care plan did not address the resident's initial goals based on her admission orders, physician orders, dietary orders, therapy services or social services. Resident #242 was discharged from the facility on 11/7/22. A comprehensive care plan was not yet developed or due at the time of her discharge. An interview was conducted on 7/13/23 at 11:47 AM with the facility's Director of Nursing (DON). During the interview, the DON reported completion of a baseline care plan was typically the responsibility of the hall nurse who was assigned to care for a newly admitted resident. She reported both the former Staff Development Coordinator and she herself frequently assisted with this task. Upon further inquiry, the DON stated she would expect a baseline care plan to include areas such as falls, pain, behaviors, psychotropic and anticoagulant medications, plus any other basic care information that would be needed to "get the resident through until the comprehensive care plan" was developed. The	F 655	resident□s care plans to ensure that each resident has a baseline care plan in place within 48 hours of admission. This review will be completed by 8/7/23. The facility has reviewed its□ Care Plan Policy for clarity with no revisions needed. The Administrator and/or Designee provided education to the MDS nurse and Unit Managers re-educating to the policy by 8/7/23. All newly hired MDS personnel and Unit Managers will receive this education during their general orientation to the facility. The Administrator is responsible for the Plan of Correction Implementation. The Director of Health Services and/or Unit Mangers to review all new admissions Monday □ Friday during clinical stand-up meeting ongoing ensuring the baseline care plan is in place within 48 hours. The Director of Health Services and/or Unit Managers will review 3 resident baseline care plans weekly times 4 weeks, and then 2 monthly times 3 months until 3 months of sustained compliance is maintained and then quarterly thereafter. Results will be presented by the Case Mix Director or Administrator to the QA team monthly times 3 months. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring the QA team will determine the frequency of ongoing monitoring. Date of Compliance 8/8/23	

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F 655	Continued From page 5 DON reported about one week ago the facility "re-started" a plan for auditing residents' medical records to ensure both the baseline and comprehensive care plans were accurate. A review of the care plan Performance Improvement Plan (PIP) revealed this plan was initiated on 6/29/23 with a target end date of 9/29/23. The PIP did not include details on the measures the facility would take or the systems it would alter to ensure that the problem would not recur. Audits for the admission baseline care plan review had not yet been initiated.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		8/8/23

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F 656	Continued From page 6 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which addressed the use of an anticoagulant medication for 1 of 6 residents (Resident #78) reviewed for unnecessary medications. The findings included: Resident #78 was admitted to the facility on 1/20/23. Her diagnoses included chronic obstructive pulmonary disease with acute exacerbation. A review of the resident's physician orders included an order dated 2/18/23 for 5 milligrams (mg) apixaban (an anticoagulant medication) to	F 656	Facility failed to develop a comprehensive care plan for 1 of 6 residents reviewed for comprehensive care plans. Resident #78 was admitted to the facility on 1/20/23. The resident□s care plan was revised on 7/13/23 to address the use of anticoagulant medication. The facility will conduct a review of all residents that are receiving anticoagulant medication and ensure that each resident□s care plan accurately reflects their use of anticoagulant medication. This review will be completed by 8/7/23.	

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F 656	Continued From page 7 be given by mouth every 12 hours. The diagnosis of a pulmonary embolism (a sudden blockage in an artery going to the lung) was added to the resident's electronic medical record (EMR) on 2/18/23. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/17/23. The MDS assessment indicated Resident #78 had moderately impaired cognition. This assessment also reported the resident received an anticoagulant medication on 7 out of 7 days during the look back period. A review of Resident #78's current care plan (last reviewed and revised on 6/15/23) revealed the care plan did not address the resident's use of an anticoagulant medication. Documentation in Resident #78's EMR revealed her current medications on the date of the review (7/13/23) continued to include 5 mg apixaban to be given by mouth every 12 hours. An interview was conducted on 7/13/23 at 11:47 AM with the facility's Director of Nursing (DON). During the interview, the DON confirmed the resident's comprehensive care plan did not include an area of focus related to her use of an anticoagulant medication. Upon further inquiry, the DON stated Resident #78's care plan needed to address the use of an anticoagulant. The DON also reported about one week ago the facility "re-started" a plan for auditing residents' medical records to ensure both baseline and comprehensive care plans were accurate. A review of the facility's care plan Performance Improvement Plan (PIP) revealed the plan was initiated on 6/29/23 with a target end date of	F 656	The facility has reviewed its Care Plan policy for clarity with no revisions needed. Administrator and/or designee has provided education to the MDS Nurse and Unit Managers re-educating to the Care Plan policy by 8/7/23. Any newly hired MDS nurses and/or Unit Managers will be oriented to this policy upon hire. The Administrator is responsible for the Plan of Correction implementation. The Director of Health Services and/or Unit Managers to review all new orders for anticoagulants Monday-Friday during the clinical stand-up meeting ensuring that all new orders for anticoagulants are added to the care plan. The Director of Health Services and/or Unit Managers will review 3 resident care plans weekly times 4 weeks, then 2 resident care plans monthly times 3 months ensuring accurate completion of comprehensive care plans. Results will be presented by the Case Mix Director of Administrator to the QA team monthly times 3 months. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring, the QA team will determine the frequency of ongoing monitoring. Date of completion of corrective action 8/8/23	

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F 656	Continued From page 8 9/29/23. However, the PIP did not include details on the measures the facility would take or the systems it would alter to ensure the problem would not recur.	F 656		
F 761 SS=E	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 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, staff interviews and record review, the facility failed to: 1) lock and secure one unattended medication cart for 1 of 2 medication carts observed (300-hall medication	F 761	Facility failed to 1) lock and secure one unattended medication cart for 1 of 2 medication carts observed and 2) label a multi-use medication with resident name	8/8/23

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F 761	Continued From page 9 cart), 2) label a multi-use medication with resident name and opened date on 1 of 2 medication carts observed (500 Hall medication cart). The findings included: 1) a. An observation was conducted on 07/11/23 at 10:03 AM of 300-hall medication cart parked outside of room 304. The lock mechanism was observed popped out in the unlocked position. Nurse #8 was in room 304 from approximately 10:03 AM until 10:06 AM. Confused residents were ambulating and propelling selves in wheelchairs in hall at and around medication cart. No staff were observed in the hall. b. An observation was conducted on 07/11/23 at 10:16 AM of 300-hall medication cart parked outside of room 305. The lock mechanism was observed popped out in the unlocked position. Nurse #8 was in room 305 from approximately 10:16 AM until 10:25 AM. Confused resident was propelling herself in her wheelchair in hall at and around medication cart. No staff were observed in the hall. c. An observation was conducted on 07/11/23 at 10:48 AM of 300-hall medication cart parked outside of room 307. The lock mechanism was observed popped out in the unlocked position. Nurse #8 was in room 305 from approximately 10:48 AM until 10:52 AM. Confused resident was propelling herself in her wheelchair in hall at and around medication cart. No staff were observed in the hall. During an interview with Nurse #8 on 07/11/23 at 10:54 AM, the nurse confirmed that she had forgot to lock the medication cart prior to walking	F 761	and opened date on 1 of 2 medication carts observed. 1.Observation conducted on 7/11/23 of 300 hall medication cart revealed the lock mechanism in unlocked position while the nurse was in a resident□s room leaving the cart parked outside the resident□s room. On 7/11/23 medication cart immediately locked, and nurse re-educated regarding locking medication carts while unattended. Observation conducted on 7/11/23 of 500 hall medication cart revealed one multi-dose medication bottle without resident name and opened date. The nurse immediately discarded the bottle of medication. The nurse re-educated regarding labeling and dating all medications stored on the medication cart. 2.All residents have the potential to be affected by the lock mechanism in an unlocked position. The facility reviewed all medication carts to ensure that all medications stored on the medication carts were labeled and dated correctly. No other medications were identified without labels or dates during this review completed on 7/11/23. 3.The Director of Health Services and/or Unit Managers began education to all nurses on 7/11/23 regarding locking medication carts while unattended and labeling and dating all medications stored on medication carts. Nurses not educated	

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F 761	Continued From page 10 away from it during the medication administration pass. She demonstrated the lock was not engaged by opening a top drawer. She stated the cart should have been locked when she stepped away. During an interview with the Director of Nursing (DON) on 07/12/23 at 2:37 PM she stated the medication carts should be secured when out of the nurse's line of sight. 2) A review of the 500-hall medication cart on 07/11/23 at 11:12 AM in the presence of Nurse # 4. The review revealed one multi-dose bottle of dry eye relief eye drops with no open date or name listed on the bottle. Nurse #4 discarded the bottle of dry eye relief eye drops. During an interview with Nurse #4 on 07/11/23 at 11:13 AM she stated someone brought the bottle of eye drops to her earlier from a resident ' s room. She further stated she forgot to remove them from the medication cart and discard them. During an interview with the Director of Nursing (DON) on 07/12/23 at 2:37 she stated the nursing staff were to label all multi-use medications with the resident ' s name and the date it was opened. She also stated there should not have been unlabeled eye drops on the medication cart.	F 761	by 8/7/23 will be removed from the schedule and education provided prior to the next scheduled shift. This education has been added to general education for all newly hired nurses. Director of Health Services, Unit Managers and/or designee will review 2 medication carts daily for 5 days, 4 medication carts weekly for 4 weeks, and 4 medication carts monthly until three months of sustained compliance is maintained and then quarterly thereafter. Director of Health Services and/or Unit Managers will review 4 medication carts for labeling and dating of medications weekly for four weeks and then 4 medication carts monthly until three months of sustained compliance is maintained and then quarterly thereafter. 4.The Director of Health Services will present the analysis regarding the locking of the medication carts and labeling and dating stored medications to the QA team monthly times 3 months. Findings will be addressed promptly by the QA team. After the conclusion of ongoing monitoring, the QA team will determine the frequency of ongoing monitoring. Date of Compliance 8/8/23	
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	F 867		8/8/23

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	345551	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 11	F 867		

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 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.

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F 867	Continued From page 12 §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 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	F 867		

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F 867	Continued From page 13 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 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint survey in April 2021, recertification and complaint survey in July 2022, complaint survey in June 2023 and subsequently recited in July 2023 on the current	F 867	Corrective action for the resident affected On 8/7/23, the Administrator had an Ad HOC Quality Assurance and Performance Improvement Committee (QAPI) meeting with the interdisciplinary team (IDT) to discuss the 2 repeat tags, F641 and F656. It was determined through Root Cause Analysis, that the facility has gone through	

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F 867	Continued From page 14 recertification and complaint survey. The recited deficiencies were in the areas of 1) develop an accurate assessment (F641) and 2) develop/ implement comprehensive care plan (F656). These deficiencies were recited in the current recertification and complaint survey. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: These tags were cross referenced to: 1. F 641 - Accuracy of Assessment: Based on staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's most recent weight obtained during the previous 30-day period for 1 of 5 residents (Resident #392) reviewed for Nutrition. During a complaint survey on 6/12/23, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area regarding skin conditions for 1 of 1 resident reviewed for wound care. During a recertification and complaint survey on 7/13/22, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 18 residents whose MDS assessments were reviewed. During the recertification survey on 4/29/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the	F 867	increased turnover in leadership in the management positions in these identified areas. Corrective action for residents potentially affected On 8/7/23, The Administrator and Regional Nurse Consultant educated the Interdisciplinary Team on the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during surveys. On 8/7/23, The Administrator reviewed surveys for June 2022 and July 2021 to identify ongoing trends. The areas identified as ongoing trends are to be addressed in the monthly QAPI meetings. Systematic Changes The Area Vice President of Operations for Coastal North Division and or the Regional Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly times 6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI process. Quality Assurance The results of these ongoing survey trend reviews are to be submitted in the QAPI meeting and placed in the QAPI minutes for review. The Quality monitoring	

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F 867	Continued From page 15 Preadmission Screening and Resident Review (PASRR) Level II status for 5 of 18 residents whose MDS assessments were reviewed. 2. F656 - Develop implement comprehensive care plan: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which addressed the use of an anticoagulant medication for 1 of 6 residents (Resident #78) reviewed for unnecessary medications. During the previous recertification survey on 7/13/22, the facility failed to develop a comprehensive care plan for 2 of 18 residents reviewed for comprehensive care plans. An interview with the Administrator was conducted on 7/13/23 at 3:47 PM. The Administrator stated the Quality Assurance (QA) committee does 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. The Administrator further stated that if there were repeated deficiencies that were identified then the area of concern would become a focus area. The old plan would be revisited and analyzed to see where the failures were, and where the breakdown happened. The root cause would be revisited and new interventions, monitoring tools would be put in place. He explained audits/education would be completed as needed and the team would continuously monitor until the deficient area concerns have been resolved.	F 867	schedule will be modified based on the findings of the monitoring review. The QAPI Committee will evaluate and modify the monitoring schedule as needed. Date of Compliance: 8.8.23	