STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	**801 PINEHURST AVENUE CARTHAGE, NC 28327**

(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 were conducted on 11/27/23 through 11/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L09O11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted from 11/27/23 through 11/30/23. Event ID# L09O11. Intake number NC00201088 was investigated. One of the 3 complaint allegations resulted in a deficiency at F689.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		12/15/23

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

Electronically Signed | 12/12/2023

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F 623	Continued From page 1	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 2 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party (RP) and staff interviews, the facility failed to notify the resident and/or RP in writing for a transfer to the hospital for 5 (Resident #90, #49, #39, #17, #87) of 6 residents reviewed for hospitalization. The	F 623	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply	

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F 623	Continued From page 3 findings included: 1. Resident #90 was admitted to the facility on 7/14/22. Review of a quarterly Minimum Data Set dated 2/22/23 indicated Resident #90 was coded for moderate cognitive impairment. Resident #90's medical record revealed she was transferred to the hospital on 9/30/22 and readmitted back to the facility on 10/2/22. There was no documentation that a written notice of transfer was provided to the resident and/or RP. Resident #90's medical record revealed she was transferred to the hospital on 3/22/23 and she did not return to the facility. There was no documentation that a written notice of transfer was provided to the resident and/or RP. A telephone interview was completed on 11/27/23 at 2:46 PM with Resident #90's RP. She stated she did not recall receiving anything in writing from the facility about the reason Resident #90 was transferred to the hospital on 9/30/22 and 3/22/23 but was notified in person. An interview on 11/28/23 at 2:20 PM was completed with the Administrator. He stated when a resident was transferred to the hospital the bed hold policy was sent with them, the RP would be notified via phone regarding the transfer and nursing notes would indicate the reason for the transfer. The Administrator stated he was unaware that written notifications regarding the reason for the hospital transfer were required.	F 623	With the requirements and to continue to Provide high quality care. F623 Resident affected by this deficiency: Resident representatives were notified via telephone at time of transfer to the hospital. Unable to retrospectively correct deficiency for these residents. There were no adverse effects to these residents from the alleged deficient practice. Resident #90 was discharged from the facility on 3/22/2023 and did not return. Resident #49 returned to the facility on 09/08/2023. Resident #39 returned to the facility on 11/13/2023. Resident #17 returned to the facility on 7/26/2023 and resident #87 was discharged on 10/22/2023 and did not return to the facility. The Administrator mailed the notice of transfer/discharge to these residents on 12/11/2023. Residents with potential to be affected: On 11/29/2023, a 100% audit of hospital transfers from 10/01/2023 through 11/29/2023 was conducted by the Director of Nursing (DON). Notices of transfer/discharge were not mailed to the resident representatives during this time period. The Business Office Manager mailed out the Notice of Transfer/Discharge to all the resident representatives on 11/29/2023. No resident suffered any adverse effect from the alleged deficient practice.	

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F 623	Continued From page 4 2. Resident #49 was admitted to the facility 7/21/22. Review of the quarterly Minimum Data Set dated 9/22/23 indicated Resident #49 was coded for severe cognitive impairment. Resident #49's medical record revealed she was transferred to the hospital on 9/4/22 and readmitted back to the facility on 9/8/23. There was no documentation that a written notice of transfer was provided to the resident and/or RP. A telephone interview was completed on 11/29/23 at 9:50 AM with Resident #49's Responsible Party (RP). She stated she did not recall receiving anything in writing from the facility about the reason Resident #49 was transferred to the hospital on 9/4/23 but the facility did call her. An interview on 11/28/23 at 2:20 PM was completed with the Administrator. He stated when a resident was transferred to the hospital the bed hold policy was sent with them, the RP would be notified via phone regarding the transfer and nursing notes would indicate the reason for the transfer. The Administrator stated he was unaware that written notifications regarding the reason for the hospital transfer were required. 3. Resident #39 was admitted to the facility on 4/8/23. Review of the quarterly Minimum Data Set dated 11/18/23 indicated Resident #39 was coded for severe cognitive impairment. Resident #39's medical record revealed she was transferred to the hospital on 11/12/23 and	F 623	Systemic Changes: On 11/29/2023, the DON educated all licensed nursing staff that when a resident is transferred to the hospital a copy of the hospital transfer event (notice of transfer/discharge) will be completed and a copy sent with the resident to the hospital. A copy of the notice will be provided to the Business Office Manager. Any licensed nursing staff out on leave or PRN status will be educated on this process by the Staff Development Coordinator or DON prior to returning to duty. This process is part of the education provided to all newly hired licensed nursing staff during orientation by SDC/DON. The Business Office Manager was educated by the Administrator on 11/29/2023 on the following: • The BOM will mail the notice of transfer/discharge on the next business day following a resident transfer to the hospital. • This will be documented in the resident notes section of the medical record by the Business Office Manager. Monitoring An audit tool was developed to monitor for compliance with this plan of correction. Nursing administration will audit all hospital transfers daily in morning clinical meeting Monday through Friday to ensure that the hospital transfer event was completed on any resident transferred to	

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F 623	Continued From page 5 readmitted to the facility on 11/13/23. There was no documentation that a written notice of transfer was provided to the resident and/or RP. A telephone interview was completed on 11/29/23 at 11:55 AM with Resident #39's Responsible Party (RP). He stated he did not recall receiving anything in writing from the facility about the reason Resident #39 was transferred to the hospital on 11/12/23 but the facility did call him. An interview on 11/28/23 at 2:20 PM was completed with the Administrator. He stated when a resident was transferred to the hospital the bed hold policy was sent with them, the RP would be notified via phone regarding the transfer and nursing notes would indicate the reason for the transfer. The Administrator stated he was unaware that written notifications regarding the reason for the hospital transfer were required. 4. Resident #17 was admitted to the facility on 3/8/16. A quarterly Minimum Data Set (MDS) assessment dated 5/5/23 indicated Resident #17 had moderately impaired cognition. Resident #17's medical record revealed she was transferred to the hospital on 7/20/23 and was readmitted back to the facility on 7/26/23. There was no documentation that a written notice of transfer was provided to the resident and/or responsible party (RP). The Administrator was interviewed on 11/28/23 at 2:20 PM and stated when a resident was transferred to the hospital the bed hold policy was	F 623	the hospital and to ensure that the BOM received a copy of the notice of transfer/discharge. Nursing Administration will audit the resident medical record to ensure that the BOM has documented that the notice was mailed to the resident representative. This will be done daily x 3 months, then ongoing as part of standard practice. The results of these audits will determine the need for further monitoring. All results will be brought to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly x 3 months by the DON for review and further recommendations. Completion date: 12-15-23	

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F 623	Continued From page 6 sent with them, the RP would be notified via phone regarding the transfer and nursing notes would indicate the reason for the transfer. He indicated he was unaware that written notifications regarding the reason for the hospital transfer was required. 5. Resident #87 was admitted to the facility on 9/15/23. The admission Minimum Data Set (MDS) assessment dated 9/17/23 indicated Resident #87 had severe cognitive impairment. Resident #87's medical record revealed she was transferred to the hospital on 10/22/23 and did not return to the facility. There was no documentation that a written notice of transfer was provided to the resident and/or responsible party (RP). The Administrator was interviewed on 11/28/23 at 2:20 PM and stated when a resident was transferred to the hospital the bed hold policy was sent with them, the RP would be notified via phone regarding the transfer and nursing notes would indicate the reason for the transfer. He indicated he was unaware that written notifications regarding the reason for the hospital transfer was required.	F 623		
F 641 SS=B	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	F 641		12/15/23

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F 641	Continued From page 7 by: Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 2 of 5 residents reviewed for unnecessary medications (Residents #22 and #73). The findings included: 1. Resident #22 was admitted to the facility on 10/6/23 with diagnoses that included type 2 diabetes. The admission MDS assessment dated 10/11/23 indicated Resident #22 had received 5 days of an insulin injection, however the assessment was not coded for hypoglycemic (medications to treat diabetes) medications or an indication present for its use. On 11/29/23 at 1:30 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 10/11/23 and confirmed she should have marked Resident #22 as receiving a hypoglycemic medication and that there was an indication for its use in his medical record. She felt it was an oversight. During an interview with the Administrator on 11/29/23 at 3:30 PM, he indicated he expected the MDS assessment to be coded accurately. 2. Resident #73 was admitted to the facility on 3/23/23 with diagnoses that included type 2 diabetes. A quarterly MDS assessment dated 10/3/23 indicated Resident #73 had received 7 days of an	F 641	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality care. F641 Affected Residents The Minimum Data Set "MDS" Coordinator #1 modified the 10/11/2023 MDS assessment on 11/26/2023 for resident #22. Resident #22 did not suffer any adverse effect from the alleged deficient practice. MDS Coordinator #1 modified the 10/03/2023 MDS assessment on 11/26/2023 for resident #73. Resident #73 did not suffer any adverse effect from the alleged deficient practice. Residents with the potential to be affected MDS Nurse # 1 & MDS Nurse #2 audited 100% of all MDS assessments completed from 10-1-23 to 11-29-23 to ensure that section N of the MDS was completed correctly, This audit was completed on 11-29-23. It was found that 16 assessments had to be modified. All assessments were modified by 12-5-23 by MDS Nurse #1 and MDS Nurse #2. No resident suffered any adverse effect from the alleged deficient practice. Systemic Changes	

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F 641	Continued From page 8 insulin injection, however the assessment was not coded for hypoglycemic (medications to treat diabetes) medications or an indication present for its use. On 11/29/23 at 1:30 PM, an interview occurred with the MDS Nurse. She reviewed the MDS assessment dated 10/11/23 and confirmed she should have marked Resident #22 as receiving a hypoglycemic medication and that there was an indication for its use in his medical record. She felt it was an oversight. During an interview with the Administrator on 11/29/23 at 3:30 PM, he indicated he expected the MDS assessment to be coded accurately.	F 641	Education was provided to MDS Coordinator #1 and MDS Coordinator #2, by the Regional Reimbursement Manager regarding the Resident Assessment Instrument (RAI) assessment process and the importance of coding the MDS accurately. This education was completed on 11-29-23. This education is provided to any newly hired MDS nurse by the Regional Reimbursement Manager during the orientation process. Monitoring An audit tool was developed to monitor MDS assessments for proper coding of section N and proper coding of insulin which includes the diagnosis of hypoglycemic. MDS Nurse #1 will audit MDS assessments completed by MDS Nurse #2 and MDS Nurse #2 will audit MDS assessments completed by MDS Nurse #1. Audits will be completed by the MDS coordinators for 25% of all MDS assessments weekly x 4 weeks, then 25% monthly for 2 months. The results of these audits will determine the need for further monitoring. Results of the audits will be brought to the Quality Assurance and Performance Improvement meeting monthly by the MDS Coordinators for review and further recommendations. Completion Date: 12-15-23	
F 657 SS=B	Care Plan Timing and Revision	F 657		12/15/23

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F 657	Continued From page 9 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the care plan in the area of planned disposition for 1 of 18 resident's (Resident #16) reviewed. The findings included: Resident # 16 was admitted to the facility on	F 657	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 657	Continued From page 10 6/30/2023 with diagnoses that included atrial fibrillation (irregular heart rate) and history of intracerebral hemorrhage (stroke) with hemiparesis (paralysis of one side). The resident's medical record indicated the resident was transitioned to comfort care 11/2/2023. The resident's active physician orders included atropine for terminal secretions, Ativan for terminal agitation, and morphine for pain. Resident #16's care plan was last revised 11/27/2023. The care plan included a focus for comfort measures dated 10/11/2023. The care plan also included a focus for discharge planning dated 10/4/2023 which included the resident was to be discharged from the facility. Interventions included arrange for home modifications, follow up appointment with primary care provider, and make referrals for home care as needed. On 11/29/2023 at 12:45PM an interview was conducted with the Minimum Data Set (MDS) Nurse. She reviewed Resident #16's care plan and stated she should have revised the care plan. The resident was on comfort measures and there was no intention to discharge him home at that time. She stated it was an oversight and she would update the care plan immediately. During an interview with the Administrator on 11/30/2023 at 8:45AM he stated he believed the failure to revise the care plan was and error and had been updated as of that date.	F 657	F-657 How did we correct residents affected? Resident #16 care plan was updated by Minimum data set “MDS” nurse #1 on 11-29-23. How did we ensure no other residents were affected? MDS nurse #1 and MDS nurse #2 completed a 100% audit for all residents to review discharge care plans. 7 (seven) additional resident care plans were updated for discharge plans on 12/6/2023 by MDS Nurse #1 and MDS Nurse #2. No resident was adversely affected by the alleged deficient practice. Systems changes The Administrator educated the Social Worker regarding care plan accuracy for discharge dispositions. This was completed on 12/05/2023. Any newly hired Social Worker will be educated on this during orientation by their instructor. Monitoring An audit tool was developed to monitor the accuracy of care plans for discharge disposition. MDS Nurse #1 and/or MDS Nurse #2 will audit 25% of all care plans for discharge disposition weekly for 4 weeks, then monthly for 2 months. The results of these audits will determine the	

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F 657	Continued From page 11	F 657	need for further monitoring. QAPI The MDS nurse #1 will bring results of the audits to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly x 3 months for review and further recommendations. Completed by 12-15-23.	
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 §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 record review, observations and staff interviews, the facility failed to provide care in a safe manner during incontinence care that resulted in a fall with a right hip fracture (Resident #17). This was for 1 of 6 residents reviewed for accidents. The findings included: Resident #17 was admitted to the facility on 3/8/16 with diagnoses that included vascular dementia, seizure disorder and a history of a stroke resulting in left-sided weakness.	F 689	Past noncompliance: no plan of correction required.	

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The annual Minimum Data Set (MDS) assessment dated 8/4/22 indicated Resident #17 had moderately impaired cognition and was dependent on one staff member for personal hygiene and toileting tasks.

A quarterly MDS assessment dated 5/5/23 indicated Resident #17 was dependent on one staff member for toileting tasks.

Resident #17 was care planned on 7/21/23 for an actual fall. The interventions included:
- Emergency room visit and staff education implemented on 7/21/23.
- Concave mattress implemented on 7/26/23.

A nursing note dated 7/20/23 at 7:22 PM read a Nurse Aide (NA) reported a witnessed fall while doing personal care with Resident #17. The NA attempted to roll Resident #17 as part of care and was observed rolling out of bed and onto the floor. Resident #17 was complaining of right hip and right head pain. She was alert and oriented. The physician was notified and provided an order to send to the Emergency Room (ER) for further evaluation.

Review of the hospital records from 7/20/23 through 7/26/23 indicated that Resident #17 was seen in the ER following a fall from the bed while she was being changed and was found to have a closed fracture of the right hip. Surgical intervention was completed on 7/21/23.

A review of the Summary of Investigation dated 7/21/23 indicated Resident #17's incident occurred at 6:30 PM and that during incontinence care the NA attempted to roll Resident #17 as

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part of care and rolled out of the bed and onto the floor. She had complaints of right hip and head pain. During the assessment the right hip appeared to be externally rotated and her right leg was shortened. The interventions included sending Resident #17 to the ER, staff education on turning and rolling residents in the bed and initiating a two person assist with incontinence care for Resident #17.

On 11/28/23 at 1:23 PM, an interview occurred with Resident #17 who was able to recall the details of the incident on 7/20/23. She verified that prior to the fall from the bed only one NA assisted her with incontinence care. Stated on 7/20/23, the NA was providing incontinence care, rolled her to the right side of her body and she "just kept rolling" and ended up on the floor.

A phone interview occurred with NA #3 on 11/28/23 at 3:24 PM. She explained on 7/20/23 she was providing incontinence care to Resident #17, rolled her to face the window and her back towards the NA. NA #3 stated she had one hand on Resident #17's side and was using the other hand to provide hygiene, when suddenly Resident #17 lunged forward. NA #3 tried to hold onto Resident #17 was but unsuccessful and ended up falling to the floor. NA #3 stated she immediately retrieved the nurse.

A phone interview occurred with Nurse #1 on 11/29/23 at 3:07 PM. She recalled Resident #17's fall on 7/20/23 and explained she was retrieved by the NA. When she entered the room, Resident #17 was lying on the floor beside her bed. She was able to recall the aide and resident both stated incontinence care was being rendered when the fall occurred. During the

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assessment it was noted her leg was turned inwards and appeared shorter than the other one. Resident #17 was complaining of leg pain as well. 911 was called immediately for further evaluation at the ER.

The corrective action for the past non-compliance dated 7/20/23 was as follows:

NA #3 went into Resident #17's room to change her and when turning Resident #17 away from her she rolled out of bed. Nurse #1 was called to the room to assess Resident #17 who was lying on her right side on the floor beside her bed. The nursing staff called 911 for an ER evaluation. Under further assessment by the ER, Resident #17 was found to have a right hip fracture. The physician, Director of Nursing (DON) and Resident #17's responsible party were notified of the fall and being sent to the ER for evaluation.

Identification of Other Residents:

On 7/21/23, the DON, clinical supervisor, staff development coordinator and therapy completed a 100% audit of all the residents in the facility to assess if they need to be a one person or two-person assistance for incontinence care and bed mobility. 26 out of 83 residents were deemed to need two-person assistance with Activities of Daily Living (ADLs).

On 7/21/23 the MDS Nurse updated the care plans and resident profiles to reflect the residents that needed two-person assistance with ADLs. 100% of all care plans were in compliance for the level of needed assistance.

Systemic Changes:

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Education began on 7/20/23 at 6:55 PM by Nurse Supervisor #1 to NA #3, all the current staff working and the on-coming staff for the 7:00 PM shift regarding bed positioning and safe provision of care. Education needed to be completed no later than 7/21/23 for all licensed nurses and aides, or the staff person would not be allowed to work until the training was completed.

Quality Assurance:

The DON, nurse supervisor, staff development coordinator and MDS nurse were responsible for the ongoing monitoring of proper rolling procedures and safe provision of care were completed weekly for four weeks and monthly for two months. The monitoring included observations of 4 or more aides on various shifts to include the weekends. Reports were presented to the monthly quality assurance (QA) committee to ensure compliance and corrective action.

The date of compliance was 7/21/23.

As part of the validation process, the plan of correction was reviewed and verified through review of the audit sheet, the in-service records, and staff interviews. An observation was conducted on 11/29/23 of staff completing incontinence care to Resident #17. Two staff members were present to provide the necessary care. Other observations were conducted on 11/27/23, 11/28/23 and 11/29/23 of staff completing care on residents while they were in the bed. Staff were observed to provide the necessary care with either one or two people as stated in the care plan and resident profiles.

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F 689	Continued From page 16 Interviews with the staff involved with the incident dated 7/20/23 were completed and with current staff. Interviews revealed they had received in-service education on the provision of safe care with incontinence care. The validation process verified the facility's date of compliance of 7/21/23.	F 689		
F 867 SS=B	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,	F 867		12/15/23

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§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;

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consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its 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;

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F 867	Continued From page 19 (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, record review, resident and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following recertification survey dated 4/8/21 for two deficiencies in the area of accurate Minimum Data Set (MDS) coding at F641 and in the supervision to prevent accidents at F689. Also, the recertification survey dated 9/22/22 for one deficiency in the area of care plan revision F657. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This tag is cross referenced to: F641- Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of medications for 2 of 5 residents reviewed for unnecessary medications (Residents #22 and #73). During a recertification survey dated 4/8/21, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the activities of daily living (ADLs), bowel and bladder and medications.	F 867	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F867 To correct this deficiency the following items were completed. o The Administrator was educated by the Corporate Compliance Manager regarding the purpose of the QAPI Program. The education included the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. This was completed on 12/15/2023. o Facility QAPI committee members will then be in-serviced by the Administrator on the following:	

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F 867	Continued From page 20 F657-Based on record review and staff interviews, the facility failed to revise the care plan in the area of planned disposition for 1 of 18 resident's reviewed. During a recertification survey dated 9/22/22, the facility failed to individualize the care plan for a resident reviewed for accidents. F689 - Based on record review, observations and staff interviews, the facility failed to provide care in a safe manner during incontinence care that resulted in a fall with a right hip fracture (Resident #17). This was for 1 of 6 residents reviewed for accidents. During a recertification survey dated 4/8/21, the facility failed to prevent a resident who had cognitive impairment and known wandering behaviors from exiting the facility unsupervised at night. The resident exited the facility unsupervised and self-propelled himself by wheelchair approximately 0.16 miles away from the facility on a roadway that had no sidewalks. An interview was completed on 11/29/23 at 3:20 PM with the Administrator. He was unable to offer any reason for the repeat citation for accurate MDS coding and care plan revision. He also stated the facility completed a complete plan of correction at the time of the incident involving unsafe incontinence care resulting in a fall with injury.	F 867	o The purpose of the QAPI Program o QAPI Committee is responsible for identifying and reviewing issues from past surveys and evaluating the current plan for its effectiveness and change the plan, as necessary. o How the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. o QAPI committee members include the Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment Nurse and Activities Director. A tool will be utilized to assist the QAPI committee. The tool, titled, “QAPI Self-Evaluation”, includes the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible for overseeing the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved? o This tool was developed for a QAPI sub-committee to establish the success of	

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the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will include the Director of Nursing, Staff Development Coordinator and the Administrator.

Monitoring:

o The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings monthly prior to the next scheduled QAPI monthly meeting for
o Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend.
o The Self-Evaluation tool will be utilized for 3 months; ongoing use of the tool will be determined by the recommendations of the QAPI Committee based on results of this tool.

QAPI

The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make changes if necessary.

Completion date: 12-15-23