STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 01/02/2024 to conduct a recertification and complaint investigation survey. The survey team exited on 01/05/2024. Additional information was obtained offsite on 01/08/2024. Therefore, the exit date was changed to 01/08/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID ID #U8SC11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 01/02/2024 to conduct a recertification and complaint investigation survey and exited on 01/05/2024. Additional information was obtained on 01/08/2024. Therefore, the exit date was changed to 01/08/2024. Event ID #U8SC11. The following intakes were investigated: NC00207293 and NC00210505. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 577		1/23/24

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

Electronically Signed | 01/22/2024

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F 577	Continued From page 1 residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews and staff interviews, the facility failed to inform residents (Resident #11, Resident #6 and Resident #22) of the location of the state inspection results and failed to display state inspection results in a location accessible to residents for 3 of 14 residents present in a Resident Council meeting. The findings included: On 1/3/24 at 11:48 am the survey inspection results binder for the facility was observed in a holder across from the 500/600 hall nurse's station, approximately fifty inches from the floor with a sign above which said survey inspection results. The survey inspection binder was chained to the wall with a chain approximately 2 feet long. On 1/4/24 at 11:40 am during a Resident Council meeting, Resident #11, Resident #6, and Resident #22 stated state inspection results were not made available for residents to read and they	F 577	F577 Right to Survey Results/Advocate Agency Information On 1/4/2024, the Maintenance Director under the supervision of the Administrator, lowered the State Inspection Survey Results Book and removed the attached chain to be more assessable to residents who utilize wheelchairs. On 1/22/2024, the Social Worker initiated education of all alert and oriented residents to include resident #6, #11 and #22 regarding State Inspection Survey Results Book with emphasis on right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility, the location of the book containing the most recent survey results and how to obtain assistance with questions regarding survey results. The education will be completed by 1/23/2024.	

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F 577	Continued From page 2 did not know the location of the state inspection results. During observation conducted with Resident #22 on 1/4/24 at 1:34 PM he pulled the survey book out of the holder. Due to the chain attached to the book he was not able to open the book or bring it down to reading level. An interview was conducted with the Administrator, Corporate Nurse Consultant, and Director of Nursing on 1/4/24 at 1:40 PM. The Administrator stated she was unaware the survey inspection results binder should be accessible to residents without assistance. The DON measured the distance from the floor to the top of the holder and it measured 52 inches. The Administrator reported she would have the survey book moved to a lower position so it would be within reach of wheelchair bound residents and remove the chain. The Administrator stated the residents would be educated on the location of the survey inspection results.	F 577	On 1/22/24, the facility consultant initiated an in-service with the Administrator, Director of Nursing, Social Worker, Activities Director and Maintenance Director regarding State Inspection Survey Results Book with emphasis (1) resident right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility (2) ensuring the State Inspection Survey Results Book is placed in a location readily accessible to residents, family members and legal representatives of residents and at a height readily assessable to residents, family members and legal representatives to include people utilizing wheelchairs and (3) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public and (4) ensure residents are informed of the location of the State Inspection Survey Results Book. The In-service will be completed by 1/23/2024. All newly hired Administrators, Director of Nursing, Social Workers, Activity Directors, and Maintenance Directors will be in-service during orientation. The Social Worker will complete 5 resident questionnaires to include residents who utilize a wheelchair weekly x 4 weeks then monthly x 1 month regarding accessibility of State Inspections Results Book. The Social Worker will address all concerns identified during the questionnaire to include but not	

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F 577	Continued From page 3	F 577	limited to education of the resident on how to access the State Inspections Results Book and/or notification of the maintenance staff if book is not at a readily assessable height. The Administrator will review the questionnaires weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the resident questionnaires to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or increased frequency of monitoring.	
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.	F 623		1/23/24

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F 623	Continued From page 4 §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 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	F 623		

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F 623	Continued From page 5 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related 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 staff interviews, interview with the	F 623	F623 Notice Requirements Before	

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F 623	Continued From page 6 Ombudsman and record review, the facility failed to provide a copy of the transfer/discharge notice to the Ombudsman for 1 of 1 resident (Resident #78) reviewed for hospitalization. Findings included: Resident #78 was admitted to the facility on 9/26/22. The medical record demonstrated the resident was transferred to the hospital on 9/4/23 due to a change in condition. Resident #78 returned to the facility on 9/11/23. No written notice of transfer was documented to have been provided to the Ombudsman. On 1/4/24 at 2:05 PM, an interview was completed with the Social Worker. She explained she typically sent electronic mail (e-mail) to the Ombudsman quarterly with a list of residents who transferred or discharged from the facility for the prior three months. The Social Worker reviewed her e-mail history and shared she was unsure if she sent the Ombudsman the list of residents who transferred or discharged from the facility in September 2023. She added she had not sent an e-mail to the Ombudsman "in a while." During an interview with the Administrator on 1/5/24 at 9:47 AM, she stated the Social Worker was responsible for notifying the Ombudsman of residents who transferred/discharged from the facility. The Administrator was not sure if the Social Worker e-mailed the information to the Ombudsman weekly or every other week. She added she didn't typically follow up with the Social Worker but assumed she e-mailed the list of transfers/discharges to the Ombudsman.	F 623	Transfer/Discharge On 1/22/2024, the Administrator provided the Ombudsman notice of discharge for resident #78 for the date of 9/4/23. On 1/22/2024, the Administrator initiated an audit of all resident discharges for the past 30 days to ensure the resident and/or resident representative received written notification indicating the reason for transfer/discharge from the facility and that a copy of the written notification was provided to the Office of the State Long-Term Care Ombudsman. The Social Worker under the supervision of the Administrator provided written notifications to the resident/resident representative and Ombudsman for all identified concerns during the audit. Audit will be completed by 1/23/2024. On 1/22/2024, the Administrator initiated an in-service with the Director of Nursing (DON), Admissions Coordinator and Social Worker regarding Notification of Ombudsman and Resident Representative for Discharges/Transfers with emphasis on providing written notification indicating the reason for transfer/discharge from the facility to the resident/resident representative and the State Long-Term Care Ombudsman. In-service will be completed by 1/23/24. All newly hired DON, Admissions Coordinator and Social Workers will be in-serviced during orientation regarding Notification of Ombudsman and Resident Representative for Discharges/Transfers.	

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F 623	Continued From page 7 A follow up interview with the Social Worker on 1/5/24 at 11:18 AM revealed it had been at least six months since she last sent an e-mail to the Ombudsman notifying her of residents who had transferred/discharged from the facility. A telephone interview was conducted with the Ombudsman on 1/8/24 at 8:38 AM. She reported the facility had not notified her of transfers/discharges since July 2023.	F 623	10% audit of all resident discharges, to include resident #78, will be completed by the Director of Nursing weekly x 4 weeks then monthly x 1 month utilizing the Nursing Home Notice of Transfer Audit Tool to ensure the resident and/or resident representative receives a written notification indicating the reason for transfer/discharge from the facility and that a copy of the written notification was provided to the Office of the State Long-Term Care Ombudsman. All areas of concern will be addressed by the Director of Nursing, to include providing the resident/resident representative or the Office of the State Long-Term Care Ombudsman when indicated and/or re-training of staff. The Administrator will review the Nursing Home Notice of Transfer Audit Tool weekly x 4 weeks, then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the results of the Nursing Home Notice of Transfer Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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	F 732		1/23/24

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F 732	Continued From page 8 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. (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 observation, staff interviews and review of the daily nursing staff postings, the facility failed to post accurate census numbers for	F 732	F732 Posted Nurse Staffing Information On 1/22/2024, the scheduler under the	

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F 732	Continued From page 9 35 of 35 days. Findings included: During the entrance conference with the Administrator and Director of Nursing on 1/2/24 at 9:44 AM, the Administrator reported the resident census for 1/2/24 was 107, which included 98 certified beds and 9 licensed only beds. During a tour of the facility on 1/2/24 at 2:25 PM, the daily nursing staff posting was observed in the front lobby on the windowsill of the reception desk. The posting stated the census was 107. The daily nursing staff postings were reviewed for 12/1/23-1/4/24. On 1/5/24 at 9:14 AM, the Administrator provided additional information to the postings that revealed the certified bed census as follows: 12/1/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 100. 12/2/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 102. 12/3/23- Certified bed census was 94. The daily nursing staff posting indicated the census was 102. 12/4/23- Certified bed census was 95. The daily nursing staff posting indicated the census was 103. 12/5/23- Certified bed census was 95. The daily nursing staff posting indicated the census was 104. 12/6/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 103.	F 732	oversight of the Administrator corrected the Daily Nursing Staff Sheets from 12/1/2023 to 1/8/2024 to accurately reflect the facility census for certified beds only. On 1/22/24, the Director of Nursing initiated an audit of the Daily Staffing Sheets from 1/9/2024 to 1/22/2024 to ensure all sets were completed accurately to include but not limited to resident census for certified beds, and that the current day was posted per facility protocol. The Director of Nursing addressed all concerns identified during the audit to include updating the Daily Staffing sheet when indicated and education of staff. The audit will be completed by 1/23/2024. On 1/22/2024, the Administrator initiated an in-serviced with the Director of Nursing (DON), Weekend Supervisor and Scheduler regarding Posting of Daily Staffing Sheet with complete and accurate information to include but not limited to the census at the beginning of the shift for the facility□s certified beds. In-service will be completed by 1/23/2024. All newly hired DON, Weekend Supervisor, and Scheduler will be in-serviced during orientation regarding Posting of Daily Staffing Sheet. The Director of Nursing will audit the Daily Staffing sheets to include weekends weekly x 4 weeks and monthly x 1 month to ensure daily posting includes complete and accurate information to include but not limited to census for facility□s certified	

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F 732	Continued From page 10 12/7/23- Certified bed census was 97. The daily nursing staff posting indicated the census was 103. 12/8/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 103. 12/9/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 103. 12/10/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 103. 12/11/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 103. 12/12/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 103. 12/13/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 103. 12/14/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 103. 12/15/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 108. 12/16/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 107. 12/17/23- Certified bed census was 97. The daily nursing staff posting indicated the census was 107. 12/18/23- Certified bed census was 97. The daily nursing staff posting indicated the census was 108. 12/19/23- Certified bed census was 97. The daily nursing staff posting indicated the census was 108.	F 732	beds prior to the beginning of the shift utilizing the Daily Staffing Audit Tool. Retraining will be immediately conducted by the Director of Nursing for any identified areas of concern. The Administrator will review the Daily Staffing Audit Tool weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of the Daily Staffing Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 732	Continued From page 11	F 732		

12/20/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 108.
12/21/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 108.
12/22/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 108.
12/23/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 105.
12/24/23- Certified bed census was 95. The daily nursing staff posting indicated the census was 105.
12/25/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 107.
12/26/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 108.
12/27/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 105.
12/28/23- Certified bed census was 99. The daily nursing staff posting indicated the census was 105.
12/29/23- Certified bed census was 98. The daily nursing staff posting indicated the census was 108.
12/30/23- Certified bed census was 97. The daily nursing staff posting indicated the census was 108.
12/31/23- Certified bed census was 96. The daily nursing staff posting indicated the census was 108.
1/1/24- Certified bed census was 99. The daily nursing staff posting indicated the census was 108.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345366	A. BUILDING _____ B. WING _____	C 01/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION CENTER	1304 SE SECOND STREET SNOW HILL, NC 28580

(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 732	Continued From page 12	F 732		

1/2/24- Certified bed census was 98. The daily nursing staff posting indicated the census was 107.
1/3/24- Certified bed census was 99. The daily nursing staff posting indicated the census was 107.
1/4/24- Certified bed census was 99. The daily nursing staff posting indicated the census was 107.

On 1/04/24 at 1:31 PM an interview was conducted with the Scheduler. She reported she scheduled staff for the entire building, both the certified beds and the licensed beds and completed the daily nursing staff postings. The Scheduler explained when she completed the daily staff posting, she included all residents in the census number, both certified beds and licensed only beds. She shared she was unaware that the daily posting should only reflect certified beds.

The Administrator was interviewed on 1/5/24 at 9:38 AM. She confirmed the Scheduler completed the daily nursing staff postings. The Administrator said she didn't know the certified beds needed to be separated from the licensed beds when the census was reported on the posting.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENDALE FOREST NURSING AND REHABILITATION (	1304 SE SECOND STREET SNOW HILL, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	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. (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 resident and staff interviews and record review, the facility failed to document evidence that a summary of the baseline care plan was offered or provided to the resident for 1 of 4 residents (Resident #85) reviewed for baseline care plans. Findings included: Resident #85 was admitted to the facility on 7/12/23. Diagnosis included, in part, end stage renal disease. The medical record was reviewed and revealed a baseline care plan was completed on 7/13/23. There was no

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documented evidence that a summary of the baseline care plan was offered or given to the resident.

The quarterly Minimum Data Set (MDS) assessment dated 12/27/23 revealed Resident #85 had intact cognition.

An interview was conducted with the MDS Nurse on 1/3/24 at 1:11 PM. She explained the baseline care plan was initiated on the day of admission and a copy offered to the resident or Resident Representative (RR) during the initial care plan meeting. She added the facility Social Worker (SW) distributed the baseline care plan to the resident or RR and then documented in the medical record that the baseline care plan was offered or provided.

During an interview with the SW on 1/3/24 at 1:17 PM, she stated the facility reviewed the baseline care plan with the resident and/or family during the initial care plan meeting, typically held 7-14 days after admission. She recalled she gave Resident #85 a summary of the baseline care plan but had not documented in the medical record that the baseline care plan was offered or provided to the resident. The SW explained she was unaware she had to document that a summary of the baseline care plan was offered or provided to the resident.

Resident #85 was interviewed on 1/4/24 at 11:30 AM and stated he did not think he received a list of medications or a summary of the baseline care plan when he was first admitted to the facility.

In an interview with the Administrator on 1/5/24 at 9:42 AM, she reported the SW offered the baseline care plan to the resident or RR during the initial care plan meeting but was unsure if the SW documented in the medical record that the baseline care plan was offered or provided to the resident.

A follow up interview was conducted with the SW on 1/05/24 at 11:20 AM. She provided a care plan conference summary attendance sheet for a care plan meeting held on 10/9/23 that was signed by Resident #85. She reiterated she had not documented that a summary of the baseline care plan was provided or offered to the resident after initial admission or by the 21st day of the resident's stay.

F 867

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

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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.

§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 distinct

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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 record review, resident interview and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the Focused Infection Control and complaint investigation survey of 12/20/2022. This was for a recited deficiency on the current recertification and complaint investigation survey of 1/08/2024 in the area of Baseline Line Care Plan (F655). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

F655: Based on resident and staff interviews and record review, the facility failed to document evidence that a summary of the baseline care plan was offered or provided to the resident for 1 of 4 residents (Resident #85) reviewed for baseline care plans.

During the Focused Infection Control and complaint investigation survey of 12/20/2022, the facility was cited for failure to formulate a baseline care plan within 48 hours after admission.

In an interview with the Administrator on 1/5/2023 at 12:05 p.m., she explained the facility's plan of correction in 2022 for formulation of a baseline care plan within 48 hours after admission included education of the Minimum Data Set (MDS) Coordinator and monitoring new admissions for four weeks for base line care plans. She further stated that the MDS Consultant continued to monitor formulation of the baseline care plan for new admissions monthly, and no concerns had been identified. She explained documentation of offering and providing the resident or resident representative a copy of the baseline care plan was not addressed in the plan of correction because it was not cited as a concern. She stated the Social Worker was responsible for providing a copy of the baseline care plan to the resident or resident representative and she

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F 867	Continued From Page 4 thought the Social Worker knew to document providing the resident or resident representative a copy.