STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345385	A. BUILDING ______ B. WING ______	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

(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 03/11/24 through 03/14/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2XM411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/11/24 through 03/14/24. The following intakes were investigated NC00197653, NC00201361, NC00201538, NC00202509, NC00203505, NC00214245, NC00214542, NC00214638, NC00214639. 28 of the 28 complaint allegations did not result in deficiency. Event ID# 2XM411.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		4/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/05/2024

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

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F 553	Continued From page 1	F 553		

right to sign after significant changes to the plan of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and resident, resident representative and staff interviews the facility failed to afford the resident and/or resident representative the right to participate in the care plan process for 2 of 3 (Resident #7 and Resident #22) residents reviewed for care plans.

The findings included:

1. Resident #7 was admitted to the facility on 07/11/22.

Review of Resident #7's quarterly Minimum Dat Set (MDS) dated 02/16/24 revealed the resident was severely cognitively impaired.

Review of resident #7's care plan revealed it was last revised on 01/19/24.

Review of Resident #7's record review revealed no documentation a care plan meeting had been completed with Resident #7 and resident representative (RR).

1. Resident # 7 was provided a Care Plan invite on 3/26/24. Resident # 22 was provided a Care Plan invite on 4/3/24.

2. From 3/27/24 to 4/5/24 the Social Worker (SW) reviewed Care Plan invites. The completion date was 4/5/24. Any issues identified were addressed.

3. On 4/5/24 the Administrator provided education to the Social Worker (SW) and MDS Nurse on the importance of establishing a system of scheduling resident's care plan meetings with documentation of invitation sent to resident / Power of Attorney (POA) and /or responsible party. Care Plan invitations are given to the residents in their room or sent to the responsible party by the Social Worker (SW) at least two weeks prior to the scheduled care plan meeting. Social Worker (SW) will put a copy of the invitation with postmark or date given to the resident in the chart when invitations

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Continued From page 2

An interview conducted with Resident #7's RR on 03/11/24 at 10:15 AM revealed they had not been invited to any care plan meetings in several months. The RR further revealed she wanted to be invited to care plan meetings to discuss Resident #7.

An interview conducted with the Social Worker (SW) on 03/13/24 at 2:45 PM revealed she was hired as the facility SW in November 2023. It was further revealed she had just recently received training for conducting care plan meetings but only a couple of meetings had been completed since November 2023. The SW stated she was aware Resident #7 did not have a care plan meeting this past quarter and did not notify Resident #7's RR that a care plan meeting would not be completed.

2. Resident #22 was admitted to the facility on 03/16/23.

Review of Resident #22's annual MDS dated 02/28/24 revealed the resident was cognitively intact.

Review of Resident #22's care plan revealed it was last revised on 02/12/24.

Review of Resident #22's record review revealed no documentation that a care plan meeting had been completed with Resident #22 and resident representative (RR).

An interview conducted with Resident #22 on 03/11/24 at 3:15 PM revealed she had not been invited to her care plan meetings in several months. Resident #22 further revealed she wanted to attend care plan meetings to discuss

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have been dispensed. Newly hired staff will be educated upon hire.

4. The Executive Director to perform Quality Improvement Monitoring of scheduling care plan meeting three times a week per week for 12 weeks. The Executive Director introduced the plan of correction to the Quality Assurance performance Committee on 4/3/24. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Medical Director, Maintenance Director, Human Resources, Housekeeping Services, Pharmacist, Dietary Manager and Minimum Data Set Nurse and a minimum of one direct care giver. The Executive Director will report findings Quality Assurance Performance Improvement Committee monthly for three months.

Date of Compliance is 4/10/24.

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F 553	Continued From page 3 her care. Resident #22 indicated she was not aware why she had not been notified. An interview conducted with the Social Worker (SW) on 03/13/24 at 2:45 PM revealed she was hired as the facility SW in November 2023. It was further revealed she had just recently received training for conducting care plan meetings but only a couple of meetings had been completed since November. The SW stated she was aware Resident #22's had not received a care plan meeting due to the SW not being trained. The SW indicated she did not notify Resident #22 that her care plan meeting would not be completed. An interview conducted with the Administrator on 03/14/24 at 5:40 PM revealed he was not aware of Resident #7 and Resident #22 had not received a care plan meeting timely. It was indicated that the Administrator expected care plan meetings to be completed and the resident representative/responsible party notified if changes were made.	F 553		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		4/10/24

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F 561	Continued From page 4 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview the facility failed to honor resident preference and requests to eat dinner in the dining room (Resident #46, Resident #47, and Resident #39) for 3 of 3 residents reviewed for choices. The findings included: a. Resident #46 was admitted to the facility on 4/25/22. Review of the quarterly Minimum Data Set (MDS) dated 08/07/23 revealed Resident #46 was cognitively intact and was assessed as independent requiring no assistance for eating. An interview conducted with Resident #46 on 03/12/24 at 3:10 PM revealed she has always preferred to eat lunch and dinner in the dining room and staff have been aware of that since her	F 561	1. On 4/5/24 resident #46 was invited to go to the dining room for all meals including weekends 7 days a week. Resident #46 preference is to attend lunch and dinner meals in the dining room including weekends 7 days a week. 1a. On 4/5/24 resident #47 was invited to go to the dining room for all meals including weekends 7 days a week. Resident #47 preference is to attend lunch and dinner meals in the dining room including weekends 7 days a week. 1b. On 4/5/24 resident #39 was invited to go to the dining room for all meals including weekends 7 days a week. Resident #39 preference is to attend lunch and dinner meals in the dining room including weekends 7 days a week.	

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F 561	Continued From page 5 admission. She stated for a minimum of the last four months, she and other residents have not been allowed to eat their dinner in the dining room and have had to eat in their rooms. She revealed when she asked staff why she and other residents were not able to eat their dinner in the dining room, staff would say they didn't have time to take residents to the dining room or they were short staffed although she would see multiple staff on the hall. Resident #46 stated although she participated in facility activities and would sit on the outside porch to read, eating lunch and dinner in the dining room was important to her because it allowed her to socialize with other residents and have a break from being in her room and not being able to eat her dinner in the dining room aggravated her and made her feel isolated. b. Resident #47 was admitted to the facility on 12/29/22. Review of annual Minimum Data Set (MDS) dated 12/26/23 revealed Resident #47 was cognitively intact and required set-up and clean-up assistance for eating. An interview conducted with Resident #47 on 03/14/24 at 11:10 AM revealed she preferred to eat lunch and dinner in the dining room and over the past few months she had been served dinner in her room and was not allowed to eat dinner in the dining room. She stated when she would ask staff why she could not eat her dinner in the dining room they would tell her because she had to eat in her room, or they did not have enough staff to go to the dining room. Resident #47 revealed she participated in facility activities but the reason she preferred eating lunch and dinner	F 561	2. On 4/5/24 residents and/or responsible party were questioned regarding eating three meals in the dining room per their preference by the Director of Nursing. On 4/5/24 a dining room schedule was developed by the Director of Nursing to reflect resident's preference going to the dining room for all meals. 3. On 3/15/24 The Director of Nursing and/or designee will re-educate Licensed Nurse/Certified Nursing Assistants/Medication Aides regarding resident rights to choose to go the dining room per meal preference. 4. Starting on 4/8/24 the Director of Nursing and/or designee will conduct Quality Improvement monitoring of resident preference on attending going to the dining room 3 times a week for twelve weeks and then one time monthly for three months. 5. The Executive Director to perform Quality Improvement Monitoring of resident preferences on going to the dining room three times a week for twelve weeks and then one time monthly for three months. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 4/3/24. The Executive Director is responsible for implementing this plan. The Quality Assurance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Assistant Director of Nursing, Social	

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F 561	Continued From page 6 in the dining room and why it was important to her was because it allowed her time to socialize with other residents and having to eat dinner in her room made her feel like she was stuck. c. Resident #39 was admitted to the facility on 07/22/22. Review of quarterly Minimum Data Set (MDS) dated 03/05/24 revealed Resident #39 to be cognitively intact and required supervision for eating. An interview conducted with Resident #39 on 03/14/24 at 2:45 PM revealed he preferred to eat lunch and dinner in the dining room and over the past several months he had not been allowed to eat dinner in the dining room and was made to eat in his room. He stated he when he asked staff about going to the dining room for dinner, they would say they did not have the time to take him. He revealed eating lunch and dinner in the dining room was important to him because it allowed him to be in a different setting besides his room and able to socialize with other residents. Resident #39 stated he also was able to participate in some facility activities but not being able to eat dinner in the dining room bothered him and made him feel left out. An interview conducted with Dietary Aide #1 on 03/13/24 at 8:48 AM revealed she had observed over the past few months they had been sending resident trays to the halls and residents were not being brought into the dining room for dinner. She stated they typically had a big turnout in the dining room for lunch and she had wondered why residents were no longer coming to the dining room for dinner but when she asked staff about it,	F 561	Worker, Medical Director, Pharmacist, Maintenance Director, Housekeeping Services, Dietary Manager and Minimum of One direct Care giver. The Executive Director will report findings Quality Assurance performance Committee monthly for every three months. Date of compliance is 4/10/24.	

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F 561 Continued From page 7
she never received an answer as to why.

An interview conducted on 03/13/24 at 5:11 PM with Nursing Assistant (NA) #1 revealed she had been employed at the facility for the past 6 years and worked both 1st and 2nd shift. She stated she was aware of residents being served their dinner meal in their rooms during the week and on the weekends instead of going to the dining room. When asked why residents were being served their dinner meals in their rooms instead of the dining room, NA #1 stated staff did not always have the time to leave the hall and assist certain residents in the dining room, so it was easier for the residents to be served their dinner meal on the hall. NA #1 stated she had a few residents that would ask her from time to time about eating their dinner in the dining room and she would explain to them about not having the time or staff to assist them to the dining room.

An interview conducted on 03/14/24 at 11:17 AM with Nurse #1 revealed she had been employed at the facility for the past 10 years and worked 12-hour shifts from 7AM to 7PM. She stated over the past few months she had observed residents being served their dinner meals in their rooms instead of being taken to the dining room. She revealed she was not aware of why staff were not taking residents to the dining room for dinner because there had been no issues with the halls being short-staffed or with staff not being able to complete their tasks. Nurse #1 stated that she had not reported the issue to anyone because she assumed administration was aware.

An interview conducted on 03/14/24 at 5:07 PM with the Administrator, Director of Nursing (DON), and Vice-President of Clinical Services revealed

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F 561	Continued From page 8 they had not been aware of staff not honoring resident mealtime preference of being able to eat their dinner meal in the dining room. When asked why they had not been aware of residents not being served their dinner meals in the dining room, they stated no residents or staff had come to them with any issues or concerns of not eating their dinner meal in the dining room until this week and they had not noticed residents not being in the dining room in the evenings when dinner was being served. They also stated there had been no staffing issues at the facility that would attribute to staff not being able to take residents to the dining room for their meals. They revealed staff should always honor resident's mealtime preference of being able to eat their meals in the dining room.	F 561		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		4/10/24

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F 644	Continued From page 9 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for resident with mental health diagnosis upon admission and resident with new mental health diagnoses for 2 of 3 residents (Resident #9 and Resident #15) reviewed for PASRR. The findings include: 1. Review of Resident #9's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 03/10/23. The resident had been diagnosed with paranoid schizophrenia as part of her admission. No PASRR level II had been completed per Resident # 9 medical records. During an interview on 03/14/24 at 4:20 PM with the Social Worker (SW) revealed she had been employed as the facility SW since November 2023 and was still receiving training on how to complete PASRR paperwork for residents. She stated she was not aware of Resident #9 mental health diagnosis or that a Level II PASRR had not been completed. The SW revealed that based on the PASRR training she had received a Level II PASRR should be completed upon resident admission with a mental health diagnosis, when there was a change in condition or behavior, and when a resident had received a new mental health diagnosis. She also revealed that based on Resident #9 admission diagnosis of paranoid schizophrenia and the preadmission PASRR level I, paperwork for a PASRR level II should have	F 644	1. On 4/5/24 a Level 2 PASRR was initiated on resident #9. On 4/3/24 a Level 2 PASRR was initiated on resident #15. 2. All residents are being assessed for psych diagnosis to determine need for significant change and initiation of referral for a Level 2 PASRR. 3. On the beginning of 4/8/24 the Social Worker and/or the Assistant Business Office Manager were notified for the responsibility for submitting the level 2 PASRR. On the beginning of 4/8/24 the Social Worker and/or Assistant Business Office Manager, Director of Nursing/MDS Nurse were notified for the responsibility to review medical records for new psych diagnosis, change in condition, change in behaviors and new psych. medications including new admissions in the department head morning meeting. 4. On 4/5/24 the Director of Nursing, MDS Nurse, Asst. Business Office Manager, Admissions Director and Social Worker were educated by Vice President Clinical / MDS regarding process of initiating significant change in mental health or change in diagnosis for mental health as defined by the MDS manual. 5. Starting on 4/8/24 the Administrator will conduct Quality Improvement monitoring to ensure that any resident identified with new psych diagnosis has significant change and Level 2 PASRR referral initiated daily x 5 days a week for 12 weeks. The Administrator introduced the plan of correction to the Quality Assurance	

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been completed.

During an interview on 03/14/24 at 5:05 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #9 admission diagnosis of paranoid schizophrenia, a PASRR level II should have been completed.

2. Review of Resident #15's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 03/23/22. The resident was diagnosed with bipolar disorder, depressed, with mild or moderate severity on 02/08/23 and major depressive disorder on 12/01/23. No PASRR level II had been completed per Resident #15 medical records.

During an interview on 03/14/24 at 4:20 PM with the Social Worker (SW) revealed she had been employed as the facility SW since November 2023 and was still receiving training on how to complete PASRR paperwork for residents. She stated she was not aware of Resident #15 newly added mental health diagnosis or that a Level II PASRR had not been completed. The SW revealed that based on the PASRR training she had received a Level II PASRR should be completed upon resident admission with a mental health diagnosis, when there was a change in condition or behavior, and when a resident had received a new mental health diagnosis. She also revealed that based on Resident #15 new mental health diagnosis of bipolar disorder, depressed with mild or moderate severity and major

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Performance Committee on 4/3/24. The Administrator is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Administrator, Director of Nursing, Assistant Director of Nursing, Social Worker, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records and MDS Nurse. The Administrator will report findings to the Quality Assurance Performance Improvement Committee monthly for three months.

Date of Compliance 4/10/24.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HEALTHCARE AND REHAB	**931 N ASPEN STREET LINCOLNTON, NC 28092**

(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 644	Continued From page 11 depressive disorder and the preadmission PASRR level I, paperwork for a PASRR level II should have been completed. During an interview on 03/14/24 at 5:05 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. He stated based on Resident #15 new mental health diagnosis of bipolar disorder, depressed with mild or moderate severity and major depressive disorder, a PASRR level II should have been completed.	F 644		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		

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F 867	Continued From page 12	F 867		

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

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F 867	Continued From page 13 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 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)	F 867		

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F 867	Continued From page 14 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, record reviews, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation surveys that occurred on 10/28/21. This was for one deficiency in the area of Self Determination that was originally cited on 10/28/21 recertification and complaint investigation survey and cited again during the recertification and complaint investigation survey completed on 3/14/24. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: F561: Based on record review, resident and staff interview the facility failed to honor resident preference and requests to eat dinner in the dining room for 3 of 3 residents reviewed for choices.	F 867	Past noncompliance: no plan of correction required.	

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F 867	Continued From page 15 During the recertification and complaint investigation survey completed on 10/28/21 the facility failed to provide showers for 1 resident at least 2 times per week as scheduled for 1 of 3 residents reviewed for choices. During an interview on 10/14/24 at 5:30 PM with the Administrator, he revealed the QAPI committee meets monthly with department heads, administrative staff, the Medical Director, and at least quarterly the Pharmacist and Registered Dietician attend and monthly attend by phone. He reported they currently had Process Improvement Plans (PIPs) addressing some of the issues he and the corporate advisors had identified at the facility. Some of the PIPs currently being addressed included grievances, care plan meetings, and he also reported they would be putting PIPs into place to address the current concerns addressed during the current recertification and complaint survey. The Administrator stated the PIPs would be ongoing and monitored to ensure ongoing and future compliance.	F 867		