STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 04/28/24 through 05/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FS8A11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/28/24 through 05/01/24. Event ID# FS8A11. The following intakes were investigated NC00216410, NC00216345, NC00207047, NC00208659, NC00207722, NC00207122, and NC00206839. 3 of the 20 complaint allegations resulted in deficiency.	F 000		
F 689 SS=D	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 and staff interviews the facility failed to transfer the resident with a mechanical lift putting the resident at risk for injury for 1 of 3 residents reviewed for accidents (Resident #270). The findings included:	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/17/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 1	F 689		

Resident # 270 was admitted to the facility on 9/1/23 with diagnoses that included cerebral infarction and cognitive communication deficit.

The care plan dated 3/5/24 revealed a focused area for at risk for falls and required extensive/total assistance for activities of daily living (ADL) positioning, transfers, mobility, and hygiene. Interventions included the use of a mechanical lift with 2-person assistance for out of bed transfers.

The Mminimum Data Set quarterly assessment dated 4/1/24 in Resident #270 was cognitively impaired and was dependent on staff for shower transfers.

An interview was conducted with NA #1 on 4/30/24 at 12:19 pm. She revealed that she and two trainees (NA #2 and NA #3) assisted Resident #270 in taking a shower on 4/9/24. She indicated that she had worked with this resident prior but that she had never had to transfer out of bed so she did not know she required the use of a mechanical lift and forgot to check the care guide to determine her transfer requirements. She further revealed that NA #2 and NA #3 were both in training and each supported the resident under each arm while she supported her feet during the transfer. She indicated that during the time she was taken to the shower, in the shower, and transferred back to bed, there was no observed accident or reason to feel any injury had occurred. NA #1 also indicated that this resident was known to make noises when she was moved.

Multiple attempts were made to interview NA #2 but unable to reach staff member for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 2	F 689		

Multiple attempts were made to interview NA #3 but unable to reach staff member for interview.

A review of a nursing (Nurse #1) progress note dated 4/9/24 indicated that Resident #270 was given a shower on 4/9/24 and was transferred by 3 NAs.The progress note further revealed that at 7:00 pm the responsible party (RP) came back to the nurse's station and requested an x-ray just to make sure there was not an injury. Nurse #1 contacted the NP and ordered a stat x-ray.

A review of the x-ray results dated 4/9/24 revealed there was no radiographic evidence of acute fracture or dislocation.

An interview was conducted with Nurse #1 on 4/30/24 at 12:06 pm and she indicated that the responsible party told her that Resident #270 was complaining of pain in her leg. Nurse #1 went to residents' room with RP present, assessed for pain and Resident #270 reported pain from a headache. Nurse #1 indicated that she medicated her with acetaminophen and had no further reports of pain or injury. Nurse #1 also revealed that Resident #270 was known to not like to be moved for any reason such as turning and repositioning or incontinence care would moan or seem like it bothered her but as soon as staff would stop, she would stop making the noise.

A review of progress note dated 4/10/14 indicated Resident #270 was transferred out of the facility to the emergency room per resident representative's request and that the resident will not return to the facility.

An interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 3	F 689		

Administrator on 5/1/24 at 3:22pm. She indicated that on 4/10/24 she became aware that NA #1 had transferred Resident #270 without the use of a mechanical lift, and she initiated a performance improvement plan.

The facility provided the following corrective action plan with a completion date of 4/12/2024.

On 4/9/2024 the Resident's son stated that her leg stated was hurting, nurse assessed, and resident reported a headache. As needed acetaminophen was administered.

On 4/9/2024 X-Ray was obtained for resident, no acute findings.

On 4/10/2024 Resident #1 was sent to the hospital.

Corrective action for potentially impacted residents:

All residents are at risk of being affected by the deficient practice.

On 4/10/24 the Administrator, Interim Director of Nursing and the Unit Managers initiated education for all nursing staff to look at care guides before providing care and following the resident's care plan for all aspects of care.

On 4/10/24 skin checks were completed on non-alert and oriented residents by the Unit Managers to ensure no other resident was affected by the deficient practice.
Results included: No other residents were identified to be affected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 4	F 689		

On 4/10/24 the Administrator and the Director of Clinical Services identified residents that would be potentially impacted by the alleged deficient practice by completing resident interviews for all current resident with BIMS of 10 or higher and asked if they had any concerns to ensure they had never been transferred with the inappropriate number of staff.
Results included: No new findings were identified.

On 4/10/2024, after concluding investigation, the Quality Assurance Committee convened to discuss the resident care plan not being followed for resident transfer.

There were no additional findings at that time.

Systemic Changes:

On 4/10/24 the Director of Clinical Services educated the Administrator, Interim Director of Nursing, and the Unit Managers that staff must look at care guides before providing care and follow the resident's care plan for all aspects of care.

On 4/11/24 the Administrator, Interim Director of Nursing and the Unit Managers educated all remaining nursing staff to look at care guides before providing care and following the resident's care plan for all aspects of care.

No staff will be allowed to work until the education has been completed, the Administrator will be responsible for keeping a list of who has been trained. The Administrator will be responsible for ensuring all new hires receive this education before being allowed to work their first shift. Staff members expressed verbal understanding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 5	F 689		

Quality Assurance:

Beginning the week of 4/15/2024 the Administrator and the Interim Director of Nursing will conduct observations of 4 residents care at random, 4 times a week for 4 weeks, 3 residents care at random 2 times a week for 4 weeks, then 2 residents at random weekly for 4 weeks to ensure staff look at care guides before providing care and follow the resident's care plan for all aspects of care. Results will be documented on the audit tool titled "Transfer Audit" results will be reported at the monthly Quality Assurance Performance Improvement Committee meetings by the Administrator where they will be reviewed and discussed for 3 months. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.

Date of compliance 04/12/2024

The Corrective Action plan was validated 5/1/24 and concluded the facility had implemented an acceptable corrective action plan on 4/12/24. Interview with current nursing staff revealed they had received education on and training on following the care guide and transfers. The audits conducted starting on 4/15/24 revealed residents were asked about transfer safety. Skin checks were completed for all non-alert and oriented residents on 4/10/24. The audits continued through the validation date. The Quality Assurance Committee convened on 4/10/24 to discuss the resident care plan not being followed for resident transfer. The next QAPI meeting is scheduled for 5/15/24 to discuss the results documented on the transfer audit tool. On 5/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 689	Continued From page 6 there was sufficient evidence to support the facility's Corrective Action Plan that was implemented and carried out by 4/12/24.	F 689		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		5/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 867	Continued From page 7	F 867		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 867	Continued From page 8	F 867		

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

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

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 867	Continued From page 9 Based on staff interviews and record review, the facility's Quality Assurance and Performance Improvement committee(QAPI) failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following a complaint investigation dated 9/16/21 for one deficiency in the area of Quality of Care, F 689. The deficiency was also cited during the recertification and complaint survey dated 11/19/21 and subsequently recited during the recertification and complaint survey dated 05/01/24. 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: F 689: Based on record review and staff interviews the facility failed to transfer the resident with a mechanical lift putting the resident at risk for injury for 1 of 3 residents reviewed for accidents. (Resident #270). During a complaint investigation on 09/16/21,the facility failed to protect a resident from a fall during bed mobility causing the resident to be lowered to the ground which resulted in a nondisplaced radial neck fracture (elbow). This was evident in 1 of 2 residents reviewed for accidents. During the Recertification and complaint survey 11/19/21, the facility failed to implement effective interventions to prevent further burns for a resident that experienced burns while smoking in 1 of 3 residents reviewed for smoking.	F 867	On 5/15/2024, the Medical Director was notified by the Administrator of the repeat notification citation F 689. The plan of correction was initiated on 4/10/2024. On 5/17/24, the Interdisciplinary Team (IDT) conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citations including F tag F689 and the necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. On 5/17/24, the Regional Director of Operations provided education to the Interdisciplinary Team (IDT) on maintaining an effective QAPI program to prevent repeat citations. Effective 5/17/24, the Facility IDT will meet weekly for twelve (12) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if compliance is not maintained. The Regional Director of Operations will attend QAPI meetings weekly for 4 weeks then, monthly for 2 months to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAPI activities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345548	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON HEALTH AND REHABILITATION	5533 BURLINGTON ROAD MCLEANSVILLE, NC 27301

(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 867	Continued From page 10 Interview was conducted with the Administrator on 05/01/24 at 4:25 pm and she indicated that she expected all citations to be monitored through the center's QAPI program. Any repeat citation would require continuous monitoring through monthly QAPI meetings until the deficient practice has been resolved. After resolved, the center would continue to monitor the resolved issue through its quarterly QAPI meetings. Education would be completed to ensure staff are aware of expectations and these expectations would be tracked by way of auditing.	F 867		