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	345134	A. BUILDING _____ B. WING _____	C 05/03/2024

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted from 04/30/24 through 05/01/24. Additional information was obtained offsite through 05/03/24. Therefore, the exit date was changed to 05/03/24. Event ID #0DMN11. The following intake was investigated NC00215700. Four of the four complaint allegations did not result in deficiencies.	F 000		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		5/4/24

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

Electronically Signed | 05/22/2024

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F 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to update the comprehensive person-centered individualized care plan to reflect an assessment to self-administer medications. This failure occurred for 1 of 1 sampled resident reviewed for self-administration of medications (Resident #3). The findings included: Resident #3 was admitted to the facility on 10/4/23 with diagnoses that included neuralgia and neuritis (nerve pain caused by inflammation of the nerves). A 1/10/24 quarterly Minimum Data Set (MDS) assessment evaluated Resident #3 with adequate hearing and vision, clear speech, made self-understood, able to understand others, intact cognition, no upper extremity impairment, and no behavior symptoms. A review of the care plan revised on 2/28/24 for Resident #3 revealed it did not reflect that Resident#3 was approved to self-administer medication. A 3/11/24 Self Administration of Medications assessment, completed by the Assistant Director of Nursing (ADON) recorded that Resident #3 was assessed by the interdisciplinary team (IDT) as approved to self-administer pain relief creams. A 3/11/24 nurse progress note written by the ADON recorded Nurse Practitioner (NP) was aware and approved of pain relief creams that	F 657	A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #3 did not experience any adverse effects related to revision of care plan. Care plan for resident #3 was updated to reflect self-administration of medications on 4/30/2024 by MDS LPN. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. MDS LPN completed a 100% audit of all residents who self-administer medications to ensure all care plans appropriately reflected to self-administer medications on resident care plan. All other residents who self-administer medications care plans and profiles were noted to reflect ability to self-administer medication. No additional modifications to care plans needed. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Education was provided to MDS LPN and MDS RN by the Administrator on 5/3/24 to state all residents who self-administer medication should be reflected on the care plan. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. A MDS audit tool was developed to ensure the care plan accurately reflects	

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F 657	Continued From page 2 Resident #3 had ordered and requested to use. An observation on 4/30/24 at 12:01 PM of Resident #3's room revealed two pain relief creams were both stored on the over-bed table. During an interview with Resident #3 on 4/30/24 at 1:27 PM, he stated that he ordered pain relief creams that he administered to himself during the night and early in the morning for the relief of neuropathy pain (a condition that causes weakness, numbness, and pain) in his legs. The ADON stated in an interview on 4/30/24 at 4:42 PM that she completed the 3/11/24 Self Administration of Medications assessment for Resident #3 at his request to apply pain relief creams. The ADON stated that she educated Resident #3 on the process of administering medications to himself, but that she did not update the care plan. During a follow up phone interview on 5/3/24 at 12:14 PM, the ADON stated that the Self Administration of Medications assessment for Resident #3 was discussed during a clinical morning meeting, but that it was up to the MDS Nurse to decide whether or not to update the care plan as she was not the MDS Nurse and was not sure if the care plan should reflect Resident #3's Self Administration of Medications assessment. During a phone interview on 5/3/24 at 11:10 AM, the MDS Nurse stated that she was in the second week as the MDS Nurse for facility, this was her first position as a MDS Nurse and that she was training in her role. She stated that she had not yet been trained in the process to complete care plans, but that she would receive training on how	F 657	self-administration of medications for those residents who are safe to self-administer their medication. MDS Director or designee will utilize the monitoring tool and audit 5 random resident care plans for accuracy weekly for 12 weeks, including new admission care plans. The MDS Director will report the findings of the audits to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 3 months. The QAPI team will evaluate the need for additional monitoring and/or modification of this requirement.	

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F 657	Continued From page 3 to complete care plans later that day (5/3/24). The MDS Nurse stated that care plans were the responsibility of the IDT. An interview with the Director of Nursing (DON) occurred on 5/1/24 at 6:30 PM, the DON stated that the IDT, which included the DON, ADON, and MDS Nurse, discussed Resident #3's ability to self-administer medications and that he independently completed most of his activities of daily living (ADL). The DON stated his ADL care plan could have included the task that he was able to administer medications, but it did not and that he did not have a care plan to self-administer medications. She stated she could not say if the task to self-administer medications should have been added to the Resident's care plan. The NP stated during a phone interview on 5/2/24 at 11:26 PM that Resident #3 was competent and assessed to administer pain relief creams to himself. The NP stated that Resident #3 should have a care plan to address his ability to safely administer pain relief cream medications. The Administrator stated during a phone interview on 5/3/24 at 1:35 PM that the facility was not required to develop a care plan for Resident #3 to self administer medication, but rather the facility was required to complete an IDT assessment which was completed. The Administrator futher stated that the NP was not the person to ask about the requirement to develop care plans.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		5/4/24

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F 690	Continued From page 4 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to keep a urinary catheter drainage bag off the floor to reduce the risk of infection for 1 of 2 residents reviewed with urinary catheters (Resident 2).	F 690	A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/30/2024 Resident #2 was observed	

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F 690	Continued From page 5 The findings included: Resident #2 was admitted to the facility on 12/8/20. Her cumulative diagnoses included obstructive and reflux uropathy (blockage in the urinary tract), overactive bladder, severe chronic kidney disease, stage 4, and a history of urinary tract infections (UTIs). Resident #2's catheter care plan revised 7/3/23 included the use of a suprapubic catheter related to her diagnosis of obstructive uropathy and history of UTIs. Staff interventions included monitoring for conditions and complications that may contribute to urinary infections. A 3/12/24 quarterly Minimum Data Set (MDS) assessment, indicated Resident #2 had adequate hearing/vision, able to understand and be understood, clear speech, intact cognition, and no impairment in upper body range of motion. The MDS recorded that Resident #2 required partial/moderate staff assistance with upper/lower body dressing, toileting, transfers, and personal hygiene. The MDS assessed Resident #2 with an indwelling urinary catheter. A continuous observation of Resident #2 occurred on 4/30/24 from 1:05 PM until 1:12 PM. During the continuous observation, Resident #2 propelled independently from the dining room to her room. While Resident #2 propelled from the dining room to her room, the catheter drainage bag was observed attached to the center section of her wheelchair underneath the seat, with approximately one inch of the bottom portion of the catheter drainage bag dragging on the floor as she propelled herself to her room.	F 690	with foley catheter privacy bag dragging on the ground while she was self propelling. Assistant Director of Nursing (ADON) obtained a urinary drain bag holder and attached to resident #1's wheel chair. Resident #1 demonstrated she was able to manipulate the catheter bag independently utilizing the urinary drain bag holder which prevents the privacy bag over the catheter from dragging on the ground. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with a urinary catheter bag have the potential to be affected. On 4/30/2024 ADON completed a whole house audit of all residents with a urinary incontinence bag. No other residents were affected by this deficient practice. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 4/30/24 all in house Certified Nursing Assistants (CNA), Certified Medication Aides (CMA), Registered Nurses (RN) and all Licensed Practical Nurses (LPN) were educated on Foley catheter drainage bags are to be placed below level of the bladder and are never to touch the ground, including the privacy bag by ADON. On 4/30/2024 All agency CNAs and LPNs	

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F 690	Continued From page 6 On 4/30/24 at 1:15 PM, the Rehab Director measured the distance from the dining room to Resident #2's room at the surveyor's request and stated the distance was 226 feet. Resident #2 was observed and interviewed in her room on 4/30/24 at 1:16 PM while seated in her wheelchair. Resident #2 stated that she was not aware that her catheter drainage bag was touching the floor because she could not see underneath her wheelchair. She further stated that sometimes in the past, staff have repositioned the catheter drainage bag because staff have said it was on the floor. Resident #2 said she was fine with her catheter drainage bag positioned underneath her wheelchair and stated, "As long as it is not on the floor, I don't want to get an infection." She stated that sometimes staff positioned the catheter drainage bag to the side of her wheelchair to keep it off the floor, but when staff position it next to the wheel of her wheelchair, it gets caught in the wheel and she moves it. She also stated that sometimes, "I move it to the side of my wheelchair when I need to get in bed or go to the bathroom, but I did not move it today, it's been in the same place since I got in my chair this morning." An observation of Resident #2 in her wheelchair in her room and an interview with Nurse #1 occurred on 4/30/24 at 1:20 PM. Nurse #1 stated that she worked at the facility through a staffing agency, and it was her first day as the Nurse for Resident #2. Nurse #1 observed the catheter drainage bag for Resident #2 and stated that she had not observed Resident #2 that day in her wheelchair with the catheter drainage bag touching floor. When asked by the surveyor to	F 690	who were working at Randolph Gardens were educated on Foley catheter drainage bags are to be placed below level of the bladder and are never to touch the ground, including the privacy bag by ADON. Any agency CNAs and LPNs not working on 4/30/2024 will be educated prior to the start of their shift on Foley catheter drainage bags are to be placed below level of the bladder and are never to touch the ground, including the privacy bag by ADON or designee. All new RN's, LPN's, CMA's and CNA's starting employment at Randolph Gardens will be educated at the time of employment on Foley catheter drainage bags are to be placed below level of the bladder and are never to touch the ground, including the privacy bag by ADON. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 4/30/2024 Three times per week two residents with a foley catheter bag will be checked by Director of Nursing / Designee for twelve weeks to ensure to ensure catheter bag or privacy cover is not dragging on the ground. On 4/30/2024 an Ad hoc QAPI meeting was held to review the deficiency and Plan of Correction. These audits will be reported by the Assistant Director of Nursing at the monthly QAPI meeting for 3 months and reviewed by the committee	

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F 690	Continued From page 7 describe what she saw, Nurse #1 stated that the catheter drainage bag was positioned in the center section of the Resident's wheelchair underneath the seat and that it was touching the floor. Nurse #1 said that the drainage bag should be "positioned below the bladder but not touching the floor for infection control prevention to prevent UTIs." An observation of Resident #2 in her wheelchair in her room and an interview with Nurse Aide (NA) #1 occurred on 4/30/24 at 1:22 PM. NA #1 stated she was the assigned NA to care for Resident #2 that day. She observed Resident #2 and stated that "The catheter drainage bag is touching the floor, but it should not be on the floor." NA #1 further stated "I put it in the middle of the chair underneath her seat at the cross bars, that's where I usually put it, she propels all around the facility and sometimes it will shift to the left or the right, when it does it will touch the floor at times, and I have to reposition it." NA #1 stated that the catheter drainage bag was still in the same position where she attached it that morning around 11:00 AM when she assisted Resident #2 to her wheelchair. NA #1 stated that she did not realize that the catheter drainage bag was touching the floor when she attached it to the wheelchair. NA #1 stated she received a recent in-service on catheters related to infection control and to keep them off the floor. An interview with the Infection Control Preventionist (ICP)/Assistant Director of Nursing (ADON) on 4/30/24 at 4:45 PM revealed that Resident #2 at times repositioned her catheter drainage bag because she did not like it to touch the floor or the wheels of her wheelchair. The ICP/ADON also stated that Resident #2 moved	F 690	for further recommendations as needed. Date of Compliance date is 4/30/2024 The Assistant Director of Nursing is the individual responsible for compliance with this action plan.	

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F 690	Continued From page 8	F 690		

the catheter drainage bag when she transferred herself to her bed or to the commode. The ICP/ADON stated that the catheter drainage bag should be positioned below the Resident's bladder but not on the floor. She stated that "the floor is an infection control issue because the floor is very dirty." The ICP/ADON stated that she provided a staff in-service on 2/21/24 on infection control related to catheters and reminded staff that the catheter drainage bag should not be on the floor. The ICP/ADON provided a copy of the 2/21/24 staff in-service and record of staff attendance which included NA #1's signature.

Resident #2 was observed in her wheelchair in her room with the Director of Nursing (DON) on 4/30/24 at 1:25 PM. During the observation the DON stated that regarding the positioning of the catheter drainage bag, "It should be higher than that and not on the floor to prevent infections or UTIs for this resident and for other residents." The DON repositioned the drainage bag to left side of the wheelchair underneath the seat, near the wheel and stated to Nurse #1, "If it stays positioned there, it will not move." Resident #2 asked the DON where she positioned the catheter drainage bag and the DON stated, "next to your wheel." The DON stated that Resident #2 rolled herself around the facility and when the catheter drainage bag was positioned in the center section underneath the wheelchair seat at the cross bars, "it will move around." During a follow up interview with the DON on 4/30/24 at 1:45 PM, the DON stated that Resident #2 at times repositioned the catheter drainage bag when she transferred to the commode or to her bed or if it was attached next to the wheel of her wheelchair because she did not like for it to touch her wheels. The DON stated that Resident #2

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F 690	Continued From page 9 had just moved her catheter drainage bag after the DON moved it because the DON positioned it near the wheel of her wheelchair.	F 690		
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 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	F 732		5/4/24

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F 732	Continued From page 10	F 732		

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 observations, staff interviews and record review, the facility failed to post nurse staffing data at the beginning of each shift for 2 of 2 days of the survey.

The findings included:

On 4/30/24 at 11:00 AM nurse staffing data was observed posted for 4/28/24 and recorded the census of 85. The first shift staff was recorded as 1 Registered Nurse (RN), 5 Licensed Practical Nurses (LPN), and 9 Nurse Aides (NA). The second shift staff was recorded as 0 RN, 5 LPN, and 8 NA. The third shift staff was recorded as 0 RN, 3 LPN, and 5 NA.

On 5/1/24 at 10:37 AM nurse staffing data was observed posted for 4/30/24 and recorded the census of 82. The first shift staff was recorded as 0 RN, 5 LPN, and 9 NA. The second shift staff was recorded as 1 RN, 5 LPN, and 8 NA. Third shift staff was recorded as 1 RN, 2 LPN, and 5 NA.

An interview on 5/1/24 at 5:45 PM with the Scheduler revealed she typically worked from 8:30 AM or 9:00 AM until 4:30 PM or 5:00 PM. The Scheduler stated she was responsible for posting nurse staffing data daily once she arrived at work. She stated she was aware that the nurse staffing data was to be posted daily but that she was not aware of the requirement to post it at the beginning of each shift. She said she only posted

A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
The Customer Service Liaison (CSL) immediately posted an accurate nurse staffing information in a prominent place at the beginning of the next shift on 5/1/2024. This ensured residents, visitors and staff had access to the required nurse staffing information.
B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All residents, visitors and staff have the potential to be affected by the lack of posting of required nurse staffing information.
A comprehensive review of nurse staffing postings for the past three months was conducted to verify that all postings were made accurately and on time. All other sheets had been updated and in compliance.
C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
The Administrator conducted an in-service training session with the Director of Nursing (DON), Assistant Director of Nursing (ADON) and CSL regarding the regulatory requirements for posting nurse

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PELICAN HEALTH RANDOLPH LLC	4801 RANDOLPH ROAD CHARLOTTE, NC 28211

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F 732	Continued From page 11 the nurse staffing data once daily each day and that if there were any staffing changes, she did not adjust the data per shift on the nurse staff posting once it was posted. The Scheduler stated that she did not arrive at work until after the first shift started and usually left during the second shift. The Scheduler stated that she was on vacation Saturday 4/20/24 through Monday 4/29/24. When she returned to work on Monday (4/29/24) she arrived at work about 11:45 AM and stated that she did not remember if she paid attention to the nurse staff posting because she arrived to work so late that day. She stated, "I did not pay it any attention." She stated that on Tuesday (4/30/24), she was off that morning for an appointment, so she printed the nurse staffing data for 4/30/24, the day before (4/29/24), and placed it in the sign placard behind the other postings. The Scheduler stated that when she was off or on vacation, she communicated via an email to the Receptionist, the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the Administrator to let them know she would be off and that someone would need to post the nurse staffing data in her absence. The Scheduler stated that when she came to work on 5/1/24, the nurse staffing data for 4/30/24 was posted and that she posted the nurse staffing data for 5/1/24 sometime after "10:00 AM or so" that morning. The Receptionist was interviewed on 5/1/24 at 5:50 PM and stated that she would post nurse staffing data if she was asked to, but that she had not been asked. She stated she did not realize it was not posted correctly that morning (5/1/24) until she saw the Surveyor look at it. The ADON stated in an interview on 5/1/24 at	F 732	staffing information at the beginning of each shift. The training covered the specific data requirements and the importance of maintaining compliance. This training was completed on 5/1/2024. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator or designee will audit the posting of nurse staffing data for each shift 3 times per week for 12 weeks. Audit findings will be reviewed by the Quality Assurance Performance Improvement committee monthly until 3 months of continued compliance is achieved. Any discrepancies or failures to post staffing information will be addressed immediately, and corrective actions will be documented. Date of Compliance: 5/1/2024 The Administrator is the individual responsible for compliance with this action plan.	

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6:00 PM the Scheduler sent an email that included the ADON when she was off or absent regarding posting of the daily nurse staffing data in her absence. The ADON stated the email was sent to all the managers and that the manager who arrived at work first should post the nurse staffing data. The ADON stated that she did not typically check the posting of nurse staffing data to make sure it was posted unless she was responsible for putting the nursing assignment sheets out. The ADON stated she was aware of the requirement to post nurse staffing data at the beginning of each shift. The nursing shifts were identified as 7A to 3P, 3P to 11P, and 11P to 7A.

The DON stated in an interview on 5/1/24 at 6:30 PM that nurse staffing data was usually posted daily by the Scheduler. The DON said she was not sure who was responsible to post the nurse staffing data in the Scheduler's absence. The DON stated that the Scheduler communicated vacation plans to the Administrator, and that staff vacations were posted on a calendar so the managers could see when staff were on vacation. The DON stated that she was not sure why the nurse staffing data was not posted daily and up to date.

The Administrator stated on 5/1/24 at 5:37 PM in an interview that the nurse staffing data should be posted daily. The Administrator stated that the Scheduler was responsible for posting nurse staffing data daily. The Administrator reviewed the regulatory requirement during the interview and stated that she saw the requirement to post nurse staffing data at the beginning of the shift, but her expectation was for her staff to post it daily, not necessarily at the beginning of the shift.

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F 867	Continued From page 13	F 867		
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 systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	F 867		5/4/24

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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

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F 867	Continued From page 15 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: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to	F 867	A. Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 867	Continued From page 16 maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 11/22/21, the complaint investigation survey of 2/17/22, and the current complaint investigation survey of 5/3/24. This failure occurred for three repeat deficiencies originally cited in the areas of comprehensive resident centered care plan, quality of care, and nursing services that were subsequently recited on the current complaint investigation survey of 5/3/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F657: Based on observation, staff interviews and record review, the facility failed to update the comprehensive person-centered individualized care plan to reflect an assessment to self-administer medications. This failure occurred for 1 of 1 sampled resident reviewed for self-administration of medications (Resident #3). During the complaint investigation survey of 2/17/22, the facility failed to update the care plan to reflect pressure ulcer care for a resident. F690: Based on observations, resident and staff interviews, and record review, the facility failed to keep a urinary catheter drainage bag off the floor to reduce the risk of infection for 1 of 2 residents reviewed with urinary catheters (Resident 2). During the recertification and complaint	F 867	practice. Facility Administrator conducted a Quality Assurance and Improvement Committee meeting on 5/3/2024 to discuss the recitation of tags F657, F690, F732. B. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at the facility have the potential to be affected. C. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Facility Administrator re-educated the Interdisciplinary team and members of the Quality Assurance and Performance Improvement Committee on 5/3/24 regarding accurately reporting and revising current action plans as well as developing and implementing new action plans to assure state and federal compliance in the facility. Any Interdisciplinary Team Member that has not received the Quality Assurance and Performance Improvement education on or after 5/3/24 will be unable to work until he/she has received the Quality Assurance and Performance Improvement education. All new Interdisciplinary Team Members newly hired will be educated on Quality Assurance and Performance	

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F 867	Continued From page 17 investigation survey of 11/22/21, the facility failed to change a resident's indwelling urinary catheter as ordered by the physician and failed to anchor the resident's indwelling urinary catheter to prevent discomfort. F732: Based on observations, staff interviews and record review, the facility failed to post nurse staffing data at the beginning of each shift for two of two days observed. This failure had the potential to affect a resident census of 82 residents. During the complaint investigation survey of 2/17/22, the facility failed to post complete and accurate nurse staffing data for 12 of 15 days of nurse staffing data reviewed. The Administrator stated in an interview on 5/1/24 at 5:39 PM that the facility's QAPI committee met monthly with department managers and reviewed repeat deficiencies. The Administrator stated that the facility looked terrible on paper with all the deficiencies, but that the staff worked hard at the facility to provide care to residents to meet their needs. The Administrator stated that she could not speak about what happened in the facility before she became the Administrator, but since she became the Administrator, staff have worked hard to provide care for the residents. She stated that when staff identified an issue, it was brought to QAPI for review. She stated that repeat deficiencies for the last three years was reviewed and discussed at each QAPI meeting. The Administrator stated that although some of the same deficiencies were cited previously, the citations were about different issues than the current issues being cited.	F 867	Improvement on date of hire. D. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. The Interdisciplinary Team, including the facility Medical Director, will meet monthly to conduct the facility's Quality Assurance and Performance Improvement meeting. Special attention will be given to assessing the effectiveness of the monitoring of repeat deficiencies F657, F690 and F732 as well as the prevention of any new repeat deficiencies. Should any interdisciplinary team member find that the facility may need an Impromptu Quality Assurance and Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order for a revision to a present action plan or for a need for new action plan in order to maintain compliance in the facility. Quality Assurance monitoring will take place at each QAPI meeting monthly and any impromptu meetings held. This monitoring tool will be signed off by each Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and performance Improvement committee. F657, F690 and F732 will be reviewed by the QAPI committee for 6 months. Date of Compliance date is 5/3/24 The Administrator is the individual responsible for compliance with this action	

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