STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R-C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	5000 NANNIE HELEN BURROUGHS AVE. NE WASHINGTON, DC 20019

(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 000}	INITIAL COMMENTS An unannounced Revisit Survey was conducted at Deanwood Rehabilitation and Wellness Center from August 29, 2022 through August 31, 2022. Survey activities consisted of a review of 45 sampled residents. The facility's census on the first day was 219. After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following deficiencies are based on observation, record review, and resident and staff interviews. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C- Discontinue Dl- Deciliter	{F 000}	DEANWOOD REHABILITATION AND WELLNESS CENTER Disclaimer: Facility submits this plan of correction under procedures established by the Department of Health in order to comply with the Department directives to change conditions which the department alleges are deficient under state regulations related to Long term care. This should not be construed as either a waiver of the facility's right to appeal or to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrongdoings.	09/07/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/6/22

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 000}	Continued From page 1	{F 000}		9/07/22

DMH - Department of Mental Health
DOH- Department of Health
EKG - 12 lead Electrocardiogram
EMS - Emergency Medical Services (911)
F - Fahrenheit
FR.- French
G-tube- Gastrostomy tube
HR- Hour
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP- Infection Prevention and Control Program
LPN- Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD- Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M- minute
mL - milliliters (metric system measure of volume)
mg/dl - milligrams per deciliter
mm/Hg - millimeters of mercury
MN midnight
N/C- nasal canula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2- Oxygen
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO- by mouth
POA - Power of Attorney
POS - physician ' s order sheet

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{F 000}	Continued From page 2 Prn - As needed Pt - Patient Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	{F 000}		9/07/22
{F 641} SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 45 sampled residents, facility staff failed to accurately code the Minimum Data Set (MDS) for Residents' #155 and #237. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: "... MDS Coordinators will conduct weekly house wide audit to ensure that MDS staff are coding correctly... resident with desire to return to the community..."	{F 641}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #155 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22.MDS coding will be updated to reflect ongoing discharge planning. Resident #237 was assessed from head to toe by unit manager on 9/2/22.Resident suffered no negative outcome. MD/RP updated on 9/2/22.MDS coding will be modified to reflect discharge plan from the facility by 9/07/22 IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit conducted by MDS team to ensure that residents due for discharge have accurate coding. All findings will be corrected immediately.	

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{F 641}	Continued From page 3 The facility's date of alleged compliance was 08/24/22. 1. Facility staff failed to accurately code Resident #155's MDS dated 07/18/22 to reflect the residents overall expectations to be discharged from the facility. Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder. Review of the medical record showed: 05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in [local skilled nursing facility] on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her." A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to be discharged to another facility; and no active discharge planning already occurring for the resident to return to the community. The evidence showed that facility staff failed to accurately code the MDS to reflect that discharge	{F 641}	MEASURES TO PREVENT RECURRENCE: MDS coordinators will be rein-serviced by staff educator / Designee on the importance of proper coding for residents who are due for discharge. Licensed social services team will be re-educated on the importance of ensuring that their coding reconcile with that of MDS for accuracy purposes. Any discrepancies will be rectified by the Lead MDS coordinator and the social services team House wide audit will be conducted by MDS team and Social services team to reconcile the coding in the MDS and ensure that all residents due for discharge are coded correctly. All findings will be corrected immediately. Social services team will present a list of residents due for discharge to the MDS team during stand up meeting daily to enable the MDS team verify their coding to ensure accuracy. All findings will be corrected immediately. The social services team will read the names of residents who are due for discharge and those who are in the process of discharge daily during morning meeting to alert every department to verify their documentation. All findings will be corrected immediately.	9/07/22

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{F 641}	Continued From page 4 planning was occurring. During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) acknowledged that the MDS should have been coded to show, "expects to be discharged to another facility/institution." 2. Facility staff failed to accurately code the MDS dated 08/15/22 to reflect Resident #237's discharge plan(s) from the facility. Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease. Review of the medical record revealed: 06/16/22 [Social Work Progress Note] "The SW accompanied [Resident #237] to [Facility Name] Assisted Living Facility. The SW and resident took a tour and completed an assessment with the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged." 07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled." 08/01/22 [Social Work Progress Note] "The SW	{F 641}	MDS team and social services team will reconcile coding for residents who are due for discharge or residents who are in the process of discharge every morning during morning meeting to ensure accuracy in coding. All findings will be corrected immediately.	9/07/22

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{F 641}	Continued From page 5 met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive assessment. This is to assist him in locating the most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]." A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community. The evidence showed that facility staff failed to accurately code Resident #237's MDS to reflect that discharge planning was occurring. During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 acknowledged that the MDS was not coded to reflect the residents plan to be discharged to the community.	{F 641}	MONITORING CORRECTIVE ACTION MDS Regional consultant will audit MDS coding for residents due for discharge and those in the process of discharge to ensure codlings are done accurately. This audit will be carried out weekly x4, then monthly x3 and reported to QA Committee All findings will be corrected immediately.	9/07/22
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	{F 656}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #155 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP updated on 9/2/22. Resident #237 was assessed from head to toe by unit manager on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22	

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{F 656}	Continued From page 6 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 45 sampled residents, facility staff failed to develop a comprehensive care plan with measurable goals, timeframes and approaches to address Resident #155's and #237's discharge plans. The findings included:	{F 656}	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected DON/Designee conducted house wide audit to ensure that residents' comprehensive care plans are updated/ revised. All findings will be corrected immediately.	9/07/22

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{F 656}	Continued From page 7 Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: " ... Licensed clinical team members conducted house wide audit on 04/22/22 to ensure that the residents have a person-centered comprehensive care plan ..." " ... Unit Managers and Supervisors will audit resident clinical records ... on a weekly basis. Any issues found will be corrected by 08/24/22 ..." The facility's date of alleged compliance was 08/24/22. Review the facility's policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... It is the policy of [Facility Name] to develop and implement person-centered care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care..." 1. Facility staff failed to develop a care plan to address Resident #155 discharge plan. Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder. Review of the medical record showed: 05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in WDC	{F 656}	MEASURES TO PREVENT RECURRENCE DON/Designee, Unit Managers, Clinical care coordinator, supervisors and social services team members will be rein-serviced by the facility's staff educator / designee on the importance of developing a comprehensive care plan for the residents. Unit managers will audit charts of residents on a weekly basis to ensure residents have their comprehensive care plan in place. AI findings will be corrected immediately. Supervisors will audit charts during their shifts weekly to ensure that residents have all comprehensive care plans in place. All findings will be corrected immediately. Social services team will ensure that they develop a comprehensive care plan for residents who are due for discharge. All findings will be corrected immediately.	9/07/22

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{F 656}	Continued From page 8 (Washington District of Columbia) NE (North East) on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her." A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to be discharged to another facility; and no for active discharge planning already occurring for the resident to return to the community. 08/11/22 [Care Plan Meeting Note] "Care plan meeting held today for [Resident #155] ...The SW answered questions about [Resident #155]'s behavior and why other facilities may continue to reject his transfer ...The family asked how can that be removed and the DON (Director of Nursing) stated that we must report the behaviors so the facility can properly work with [Resident #155]." Review of the comprehensive care plan showed no documented evidence that facility staff developed a discharge care plan with goals and approaches to address Resident #155 and the residents' responsible party's wishes for him to be discharged from the facility. During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) stated, "Once his (Resident #155) family	{F 656}	MONITORING CORRECTIVE ACTION: Clinical team members (DON, Unit manager) Social services, MDS coordinator will audit charts to ensure that comprehensive care plans have been developed by social services team to ensure compliance for residents who are due for discharge. This audit will be done weekly x4, then monthly x3. All findings will be corrected immediately and reported to QAPI Committee.	9/07/22

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{F 656}	Continued From page 9	{F 656}		9/07/22

became involved, they wanted him to go to [Facility Name]. He was not accepted at [Facility Name]. He is not appropriate for housing due to his diagnoses". No further comment was made related to a discharge care plan being created for the resident.

2. Facility staff failed to develop a care plan to address Resident #237 discharge plan.

Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease.

Review of the medical record revealed:

06/16/22 [Social Work Progress Note] "The SW accompanied [Resident #237] to [Facility Name] Assisted Living Facility. The SW and resident took a tour and completed an assessment with the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged."

07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled."

08/01/22 [Social Work Progress Note] "The SW met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive

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{F 656}	Continued From page 10 assessment. This is to assist him in locating the most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]." A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community. During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 acknowledged that no care plan has been developed to address the residents discharge plan.	{F 656}		9/07/22
{F 657} SS=D	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	{F 657}	CORRECTIVE ACTION FOR AFFECTED RESIDENTS: Resident #182 is in the hospital. Resident #134 no longer resides in the facility. Discharged to another facility 9/1/22.	

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{F 657}	Continued From page 11 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 45 sampled residents, the facility staff failed to revise/update the comprehensive care plan with goals and approaches. Residents' #134 and #182. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: " ... Resident #182 ... care plan will be updated to include dialysis perma-cath site on the resident chest immediately, but not later than 08/24/22." " ... House wide audit will be conducted by the ADON (Assistant Director of Nursing), Clinical care coordinator, Unit Managers and Supervisors to ensure that care plans are revised ..." " ...In-service will be provided by staff educator/designee to all licensed nursing staff on the need to ensure that all residents' comprehensive care plans are revised ..." The facility's date of alleged compliance was	{F 657}	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents in the facility have the potential to be affected. Unit managers conducted house wide audit to ensure that residents with permacath for dialysis treatment have revised care plan to include the site of the perma cath and interventions Charge nurses will asses the site of the perma cath prior to and after dialysis. All findings will be addressed immediately. Licensed social worker conducted house wide audit to ensure discharge planning is reflected in care plan. All findings will be corrected immediately.	9/7/22

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{F 657}	Continued From page 12 08/24/22. Review the facility policy entitled, "Interdisciplinary Team Meeting (Care Plan Meeting)" revised 03/2022 documented, "... A comprehensive, individualized care plan will ... be reviewed and revised by the interdisciplinary team..." 1. Facility staff failed to update/revise Resident #134's discharge care plan to reflect discharge plans and goals. Resident #134 was re- admitted to the facility on 02/15/22 with diagnoses that included Eating Disorder and Schizophrenia. Review of the medical record showed: A Quarterly Minimum Data Set (MDS) dated 06/21/22 in which facility staff coded the following: cognitively intact and active discharge planning occurring. Review of the progress notes revealed: 07/15/22 "The out of State Referral was completed and returned to New Jersey today. It was sent via email to [Family representative]. The package has been filed in [Resident #134's] chart." 08/16/22 " ... Text: IDT (interdisciplinary team)/ Care plan meeting held today 8/16/22. The RP (responsible party), [Family Representative] was present via telephone ...The SW (social worker) is working with [Resident #134] towards her transfer to a LTC (long term care) facility in NJ (New Jersey). The SW will continue to work with [Resident #134] until her transition is complete	{F 657}	MEASURES TO PREVENT RECURRENCE: Staff educator / Designee will re in service all licensed nurses to ensure that care plan for resident with perma cath reflect the site of the perma cath and interventions for dialysis treatment. Licensed social services team will be reeducated by staff educator / Designee to always ensure they update the discharge plans and goals of the resident. Unit managers will audit care plans of residents on perma cath weekly to ensure the care plan reflects the site on which the perma cath is located and interventions for dialysis treatment. All findings will be addressed immediately. Licensed social services team will conduct weekly audit to ensure that they update discharge care plan to reflect discharge plans and goals. All findings will be addressed immediately. DON/Designee will audit care plans weekly to ensure that the social services team are updating discharge care plan to reflect discharge plans and goals and that residents with perma cath has a care plan that indicates the site and interventions for dialysis treatment. All findings will be addressed immediately.	9/07/22

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{F 657}	Continued From page 13 ...resident's sister joining via phone ... no concerns at this time Social worker is working with the family regarding transfer to out of state, continues with current plan of care. 08/25/22 "The SW attended another hearing today, 8/25/2022 with [Resident #134] and [Representative's Name] to inform [Judge] that she would like to transfer [Resident #134] to [Facility Name]. The discharge date is September 1, 2022. The SW has submitted the requested information to [Facility Name]'s Admission Coordinator ..." Review of the comprehensive care plan for Resident #134, showed no evidence that facility staff updated the discharge care plan to reflect plans to be discharged from the facility. During a face-to-face interview conducted on 08/31/22 at approximately 1:50 PM, Employee #3 acknowledged the finding. 2. Facilty staff failed to update/revise Resident #182's care plan to address his use of a right chest perm-a-cath for dialysis. Resident #182 was admitted to the facility on 11/30/21 with multiple diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, and Anemia in Chronic Kidney Disease. Review of the Quarterly MDS dated 06/14/22 showed facility staff coded: the resident had a Brief Interview for Mental Status summary score of "14" indicating the resident was cognitively intact and for receiving dialysis while a resident. Review of the resident's medical record showed	{F 657}	IDT team members(clinical team, unit managers, DON, QA/IP director) and other department heads will assist during daily morning meeting to ensure that care plans are updated/ revised to indicate a person centered care. All findings will be addressed immediately. MEASURES TO PREVENT RECURRENCE; Unit manager/Supervisors will audit charts of residents using perma cath for dialysis treatment to ensure the care plan indicates the site of the perma cath and interventions. Licensed social workers will audit charts of residents due for discharge to ensure that their care plans are updated to reflect discharge plans and goals. This audit must be conducted weekly x4, then monthly x3. All findings will be corrected immediately and reported to QA committee.	9/07/22

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{F 657}	Continued From page 14 the following: 08/16/22 [Physician's order] - "Dialysis: Tuesday, Thursday, Saturday every day shift" 08/24/22 [Nursing Note] - "Pre Dialysis Note: Resident alert and verbally responsive. Resident went to dialysis at 5:55 am. Travel by wheelchair. Right PC (perm-a-cath) site intact with dressing no bleeding, no swelling or redness noted." Review of Resident #182's care plan on 08/30/22 at approximately 1:00 PM revealed that the facility staff had not updated the resident's care plan to address his use of a right chest perm-a-cath for dialysis as indicted in their Plan of Correction. During a face-to-face interview on 08/30/22 at approximately 3:00 PM, Employee #4 (2nd Floor Unit Manager) stated that the resident had a right chest perm-a-cath. The Employee could not explain why the resident's right chest perm-a-cath wasn't included in his comprehensive care plan.	{F 657}		9/07/22
{F 660} SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the	{F 660}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident # 134 no longer reside in the facility. was discharged to another facility on 9/1/22. Resident #155 was assessed from head to toe on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22. Discharge care plan will be created by 9/07/22	

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{F 660}	Continued From page 15 development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident	{F 660}	Resident #237 was assessed from head to toe on 9/2/22, resident suffered no negative outcome. MD/RP notified on 9/2/22. Discharge care plan will be created by 9/07/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED; All residents residing in the facility have the potential to be affected, House wide audit conducted by Licensed social worker team to ensure that they create a discharge plan for residents who are due for discharge. Findings will be corrected immediately.	9/07/22

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{F 660}	Continued From page 16 representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for three (3) of 45 sampled residents, facility staff failed to: (1) have a discharge plan for one resident; (2) record/document information related to the resident's discharge plan to the community in the clinical record;(3) ensure the residents discharge needs were adequately identified and the results developed into a discharge plan. Residents' #134, #155 and #237. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated:	{F 660}	MEASURES TO PREVENT RECURRENCE: Licensed social services team will be rein-serviced by staff educator / Designee on the importance of creating discharge planning in a timely manner. Licensed social services team members will read the names of residents due for discharge in the stand up/morning meeting so that the MDS and clinical team members will verify documentation and coding. All findings will be corrected immediately Unit managers will monitor clinical dashboard every morning at stand up meeting to see if any resident is due for discharge. The Unit manager will work with the social services team to ensure discharge planning is taking place timely. All findings will be corrected immediately. During interdisciplinary meetings (nursing, social services, MDS, activities) care plan review will be conducted and members of the team will ensure discharge planning is moving as stipulated. All findings will be corrected immediately.	9/07/22

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{F 660}	Continued From page 17 " ... Licensed Social Worker will ensure that discharge planning for Resident #155 is updated to ensure that there are no delays in discharge process ..." " ... Licensed Social Worker will ensure that the needs for Resident #237 are adequately identified to prevent delays in the discharge process ..." " ... Unit Manager/Supervisor will audit charts of residents due for discharge to ensure the licensed social worker has discharge plan in place ..." The facility's date of alleged compliance was 08/24/22. 1. Facility staff failed to update/revise Resident #134's comprehensive care plan and discharge plan to address the resident's goals for care and treatment preferences and identified needs. Resident #134 was re-admitted to the facility on 02/15/22 with diagnoses that included Eating Disorder and Schizophrenia. Review of the medical record showed: A Quarterly Minimum Data Set (MDS) dated 06/21/22 in which facility staff coded the following: cognitively intact and active discharge planning occurring. Review of the progress notes revealed: 07/15/22 "The out of State Referral was completed and returned to New Jersey today. It was sent via email to [Family representative]. The	{F 660}	MONITORING CORRECTIVE ACTION: Licensed social worker will ensure that they create a discharge plan for the resident upon admission and ensure the discharge goals and plans reflect in the care plan. This audit will be done weekly x4, then monthly x3. All findings will be corrected immediately and reported to QAPI committee.	9/07/22

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{F 660}	Continued From page 18 package has been filed in [Resident #134's] chart." 08/16/22 " ... Text: IDT (interdisciplinary team)/ Care plan meeting held today 8/16/22. The RP (responsible party), [Family Representative] was present via telephone ...The SW (social worker) is working with [Resident #134] towards her transfer to a LTC (long term care) facility in NJ (New Jersey). The SW will continue to work with [Resident #134] until her transition is complete ...resident's sister joining via phone ... no concerns at this time Social worker is working with the family regarding transfer to out of state, continues with current plan of care. 08/25/22 "The SW attended another hearing today, 8/25/2022 with [Resident #134] and [Family Representative] to inform [Judge] that she would like to transfer [Resident #134] to [Facility Name]. The discharge date is September 1, 2022. The SW has submitted the requested information to [Facility Name]'s Admission Coordinator ..." There was no documented evidence that facility staff updated/revised Resident #134's discharge plan and care plan to address: goals for care; treatment preferences; resident and caregiver support and education that must be addressed prior to discharge. During face-to-face interview conducted on 08/30/22 at 3:37 PM, Employee #5(Social Worker) stated, "I sent the 'Interstate Compact' form to the nursing facility. There were a few things that were not answered and it was sent back the next day. Maybe I didn't look carefully enough [at the form]."	{F 660}		9/07//22

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{F 660}	Continued From page 19	{F 660}		9/07/22

2. Facility staff failed to create a discharge plan for Resident #155.

Resident #155 was admitted to the facility on 11/18/19, with diagnoses that included: Chronic Pancreatitis, Hypertension and Major Depressive Disorder.

Review of the medical record showed:

05/19/22 [Social Work Progress Note] "The SW (social worker) submitted a transition packet to [Facility Name] nursing home in WDC (Washington District of Columbia) NE (North East) on 5/12/22. The SW received a call from [facility representative] the admissions coordinator from [Facility Name] because she needed more information regarding [Resident #155]. The SW called and left a voicemail as well as sent an email requesting that she be specific with what documentation she needs so the SW can send it to her."

A Quarterly MDS dated 07/18/22, revealed that facility staff coded the following: In Section C (Cognitive Patterns), severe cognitive impairment; in Section Q (Participation in Assessment and Goal Setting), not expected to be discharged to another facility; and no for active discharge planning already occurring for the resident to return to the community.

08/11/22 [Care Plan Meeting Note] "Care plan meeting held today for [Resident #155] ...The SW answered questions about [Resident #155]'s behavior and why other facilities may continue to reject his transfer ...The family asked how can that be removed and the DON (Director of

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{F 660}	Continued From page 20 Nursing) stated that we must report the behaviors so the facility can properly work with [Resident #155]." There was no evidence in Resident #155's medical record that facility staff documented a discharge plan that included: the discharge destination; ensuring the location met the resident's health and safety needs; addressing the resident's goals for care and treatment preferences; and identifying resident education and rehabilitation needs that must be addressed prior to discharge. During a face-to-face interview conducted on 08/31/22 at 11:50 AM, Employee #3 (Social Worker) stated, "Once his (Resident #155) family became involved the wanted him to go to [Facility Name]. He was not accepted at [Facility Name]. He is not appropriate for housing due to his diagnoses." No further comment was made related to a discharge plan being created for the resident. 3. Facility staff failed to create a discharge plan for Resident #237. Resident #237 was admitted to the facility on 07/19/19 with multiple diagnoses that included: Gastro Esophageal Reflux Disease without Esophagitis, Gout, and Human Immunodeficiency Virus (HIV) Disease. Review of the medical record revealed: 06/16/22 [Social Work Progress Note] "The SW accompanied [Resident #237] to [Facility Name] Assisted Living Facility. The SW and resident took a tour and completed an assessment with	{F 660}		9/07//22

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{F 660}	Continued From page 21 the DON ...He was very happy about the placement and after the assessment it appeared to be a very good fit. The SW took information needed to continue and complete the application process and will continue to work with [Facility Name] until [Resident #237] is successfully discharged." 07/28/22 [Social Work Progress Note] "Met with patient and SW, discharge planning in progress but no specific paperwork needed now. Patient is otherwise stable and is in no distress, Vitals stable and cough/emphysema controlled." 08/01/22 [Social Work Progress Note] "The SW met with [Resident #237] and [Transition Worker] via telephone to complete his comprehensive assessment. This is to assist him in locating the most appropriate placement. The SW's will work together to assist him in transitioning him to [Facility Name]." A Quarterly MDS dated 08/15/22, showed that facility staff coded the following: In Section C (Cognitive Patterns), cognitively intact; in Section Q (Participation in Assessment and Goal Setting), no active discharge planning already occurring for the resident to return to the community. There was no documented evidence that facility staff completed Resident #237's discharge paperwork in a timely manner for the resident's placement at an assisted living facility. There is also no evidence that facility staff documented: the discharge plan; timely completion of the comprehensive assessment; the resident's goals for care and treatment preferences; or the resident's education and rehabilitation needs that must be addressed prior to discharge.	{F 660}		9/07/22

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{F 660}	Continued From page 22 During a face-to-face interview conducted on 08/31/22 at approximately 1:41 PM, Employee #3 stated, "He (Resident #237) is too advanced for [Facility Name]. I am contacting [Facility Name] to get an assessment ...He has a case worker in the community."	{F 660}		9/07/22
{F 726} SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	{F 726}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS: Resident #126 was assessed by Unit manager on 9/2/22 for adverse reaction to medication. Resident suffered no negative outcome. MD/RP updated on 9/2/22. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. House wide audit conducted by Unit manager to ensure Licensed nurses are administering medication via inhaler correctly.	

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{F 726}	Continued From page 23 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, for one (1) of 45 sampled residents, facility staff failed to ensure the facility's nurse was competent on how to administer Tiotropium Bromide Aerosol (anticholinergic) Inhaler for Resident #126. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: " ... Clinical Care Coordinator, DON (Director of Nursing) and Unit Managers will conduct house wide audit to ensure that the nurses are administering inhalers correctly to the residents... Also, they will ensure that licensed nurses are competent in administering medications via inhaler..." The facility's date of alleged compliance was 08/24/22. Review of the facility's policy, "Proper Administration Medication-Metered Dose Inhaler", requires staff to "instruct residents/patients to rinse their mouths [after using inhalers]..." According to the Mayo Clinic, Ipratropium and Albuterol (anticholinergic) (Inhalation Route) Proper Use ...When you have finished all your doses, rinse your mouth with water ..." (Last updated 08/01/22).	{F 726}	MEASURES TO PREVENT RECURRENCE: Targeted in service was provided to employee #6 on 8/31/22 by Unit Manager on the importance of accurately following the steps when administering medication. Coaching and counseling was provide to employee #6 on 8/31/22 All Licensed nurses will be rein-serviced by staff educator / Designee on the importance of following all steps of the process when administering medication via inhaler to the residents. Unit managers will conduct rounds on their units during their shifts to ensure medication via inhaler is administered correctly. All findings will be corrected immediately. Supervisors will conduct random rounds during their shift, to monitor Licensed nurses to ensure they are administering medication via inhaler correctly. All findings will be corrected immediately. Another in-service will be provided by Pharmscript to re-educate licensed nurses on proper medication administration including metered dose inhaler. The education started 9/6/22 and will be ongoing.	9/07/22

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{F 726}	Continued From page 24 https://www.mayoclinic.org/drugs-supplements/ipratropium-and-albuterol-inhalation-route/proper-use/drg-20062048 Resident #126 was admitted to the facility on 11/16/21 with multiple diagnoses including Chronic Obstructive Pulmonary Disease, Asthma, and Cardiomegaly. During an observation on 08/30/22 at approximately 11:00 AM, Employee #6 (Licensed Practical Nurse) failed to have Resident #126 rinse her mouth after administering two puffs of Ipratropium Albuterol [Aerosol] Solution (metered dose inhaler). The employee instead gave the resident water and instructed her to rinse her mouth but neglected to tell her not to swallow and spit it out. Also, the employee failed to provide a container for the resident to spit into after cleaning her mouth. Review of the Quarterly Minimum Data Set dated 06/17/22 showed facility staff coded the resident with a Brief Interview Mental Status summary score of "9", indicating moderately impaired cognition. Review of the medical record showed a physician's order dated 05/11/22 that instructed staff to administer, "Ipratropium -Albuterol [Aerosol] Solution 20-100 MCG/ACT (micrograms/actuation) 2 puffs inhale orally every 4 hours for SOB (shortness of breath)". During a face-to-face interview conducted at the time of the observation, Employee #6 was asked why he failed to instruct Resident #126 not to swallow the water after rinsing her mouth and not	{F 726}	MONITORING CORRECTIVE ACTION: DON/Designee will conduct random rounds ,to monitor Licensed nurses to ensure they are administering medication via inhaler correctly to the residents. This audit will will be done weekly x4 then monthly x3. All findings will be corrected immediately and reported to QAPI Committee.	9/07/22

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{F 726}	Continued From page 25 providing her with a container to spit the water into. The employee failed to provide an answer. During a face-to-face interview on 08/30/22 at approximately 11:15 AM, Employee #7 (Staff Educator) stated that Employee #6 was educated on 06/21/22 about how to correctly administer metered-dose inhalers to patients, including rinsing their mouths afterwards.	{F 726}	CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this deficient practice.	9/07/22
{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	{F 755}	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this deficient practice. MEASURES TO PREVENT RECURRENCE: Targeted in service provided on 8/29/22 to employee #8 and employee #2 on the importance to accurately reconcile controlled substance by staff educator. Coaching and counseling provided to employee #8 on 8/29/22. All Licensed nurses will be rein-serviced on the importance to accurately reconcile controlled medication by staff educator /Designee.	

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{F 755}	Continued From page 26 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, facility staff failed to accurately reconcile controlled medications in one (1) of 16 medication carts. The findings included: Review of the facility's Plan of Correction in response to the statement of deficiencies from the recertification survey that ended on 04/20/22, stipulated: "...The Director of Nursing will create a new control substance form that will enable accurate reconciliation and accounting of all controlled substances..." The facility's date of alleged compliance was 08/24/22. The facility's policy and procedures for the storage of controlled substances revised on 08/2020 documented, "... At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and...documented on a Control Count Sheet (or similar form) or in accordance with facility policy..." During an observation on 08/29/22 at approximately 10:50 AM of unit 5 North's	{F 755}	Unit managers will ensure that Licensed nursed are accurately reconciling controlled medications daily. All findings will be corrected immediately. Supervisors will ensure during their shifts that Licensed nurses are accurately reconciling controlled medication. All findings will be corrected immediately. DON/Designee will conduct weekly random rounds to ensure that Licensed nurses are accurately reconciling controlled substance. All findings will be corrected immediately.	9/07/22

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{F 755}	Continued From page 27 Medication Cart #2, a blister packet of Oxycodone-APAP (Acetaminophen) (narcotic pain reliever) 5-325 mg (milligrams) was observed with 15 tablets remaining. However, review of the "Controlled Drug Administration Record" showed, "Drug: Oxycodone; amount received 30 on 8/20/22"; amount remaining, "14." During a face-to-face interview conducted at the time of the observation, Employee #2 (Director of Nursing) and Employee #8 (Licensed Practical Nurse) were unable to explain the discrepancy in the amount of Oxycodone on hand and the amount recorded on the Controlled Drug Administration Record.	{F 755}	MONITORING CORRECTIVE ACTION: DON/Designee will conduct rounds and audit carts to ensure Licensed nurses are accurately reconciling controlled medication. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee.	9/0722
{F 867} SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to ensure that the comprehensive quality assurance and performance improvement (QAPI) plan was implemented to correct identified quality deficiencies. The resident census on the first day of the survey was 219. The findings included:	{F 867}	F 867 CORRECTIVE ACTION FOR THE AFFECTED RESIDENT: No resident was affected by this deficient practice. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected by this deficient practice. MEASURES TO PREVENT RECURRENCE: QAPI / QAA will ensure that the facility staff maintain and implement an effective comprehensive quality assurance and performance program that will show that areas of deficiencies are adequately addressed. All findings will be corrected immediately. QA committee will ensure that the staff are implementing plans that are put in place to address deficiencies. Any findings will be corrected immediately.	

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{F 867}	Continued From page 28 A review of the facility's previous survey dated 03/26/22 to 04/20/22 showed that the facility was cited for the following deficiencies: F641 - Accuracy of Assessments F656 - Develop/Implement Comprehensive Care Plan F657 - Care Plan Timing and Revision F660 - Discharge Planning and Process F726 - Competent Nurse Staffing F755 - Pharmacy Services/Procedures/Pharmacist/Records F867 - QAPI Program/Plan, Disclosure/ Good Faith Attempt The aforementioned deficiencies were cited again during the Revisit Survey that ended on 08/31/22. Review of the Plan of Correction with a compliance date of 08/24/22, revealed that facility staff would continuously monitor their deficient practices from the prior survey and failed to implement the corrective actions as indicated below: Under F641 - "Monitoring Corrective Actions - Rehab Director and MDS (Minimum Data Set) lead will conduct audits to ensure that all coding is done accurately. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately, and report presented to the QAPI committee." Under F656 - Monitoring Corrective Actions not addressed Under F657 - "Monitoring Corrective Actions - DON (Director of Nursing)/Designee will conduct house wide audit MDS nurses will complete	{F 867}	Re-inservice will be provided to the Administration, DON, Unit managers, MDS, QA, Social Services, and other IDT on the Quality Assurance and Performance Improvement process by the Staff Educator by 9/7/22 Re-inservice and education will be provided to the MDS, Social Services and Rehab Director on accuracy of coding the MDS by the Staff Educator by 9/722. QA Director will ensure that the audit tools are collected, analyzed and discussed during the QA meeting on the following audit tools: Accuracy of Assessments Audit tool, Developing and Implementing Comprehensive Care Plan Audit tool, Care Plan Timing and Revision Audit tool, Discharge planning and Process Audit tool, Competent Nurse Staffing Audit tool, Pharmacy Services/Procedures/Records audit tool as part of the QAPI program to improve resident care and facility systems and processes. All findings will be completed immediately. MONITORING AND CORRECTIVE ACTIONS Facility staff will continuously monitor the deficient practices and implement the corrective actions as indicated below: Under Accuracy of Assessments Monitoring the Rehab Director and MDS (Minimum Data Set) lead will conduct audits to ensure that all coding is done accurately. This audit will be conducted weekly x4, then monthly x3. All findings will be corrected immediately and report presented to the QAPI committee by 9/7/22. Under Development/Implement Comprehensive Care Plan, the DON/Designee will do a house wide monthly audit to ensure Comprehensive Care plans are developed and implemented. This audit will take place weekly x 4, and monthly x 3. Any negative findings will be corrected immediately and reported to the QAPI committee.	9/7/22

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{F 867}	Continued From page 29 monthly audit to validate that all residents have person-entered comprehensive care plan in place, that are revised ... This audit will take place weekly x4, then monthly x3. Findings will be corrected immediately and reported to QAPI committee." Under F660 - "Monitoring Corrective Actions - Licensed Social Services Director will audit residents' chart to ensure that there are no delays in discharge planning, that there is adequate documentation about resident's discharge plans. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected, and report presented to QAPI." Under 726 - "Monitoring Corrective Actions - DON/Designee will conduct random rounds to ensure that nurses are administering medication correctly ... This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to the QAPI committee." Under 755 - "Monitoring Corrective Actions - DON/Designee will conduct audits on all units to ensure that the nurses are using the controlled medication sheet accurately and that all control substances are always accounted for. This audit will be conducted weekly x4, then monthly x3. Findings will be corrected immediately and reported to the QAPI committee." According to Employee #1 (Administrator), the QAPI team last met on 07/26/22. During the exit conference on 08/31/22 at 3:00 PM, Employee #1 (Administrator) acknowledged the findings.	{F 867}	Under Care Plan Timing and Revision, the DON (Director of Nursing)/Designee will conduct random audit to validate that all residents have person-centered comprehensive care plan in place, that are revised. This audit will take place weekly x4, then monthly x3.All Findings will be corrected immediately and reported to QAPI committee. Under Discharge Planning and Process the Licensed Social Services Director will audit residents' chart to ensure that there are no delays in discharge planning, that there is adequate documentation about resident's discharge plans. This audit will be conducted weekly x4, then monthly x3. All findings will be corrected, and report presented to QAPI committee. Under Competent Nursing Staff, the DON/Designee will conduct random rounds to ensure that nurses are administering medication correctly. This audit will be conducted weekly x4, then monthly x3. All findings will be corrected immediately and reported to the QAPI committee . Under Pharmacy, the DON/Designee will conduct audits on all units to ensure that the nurses are using the controlled medication sheet accurately and that all control substances are always accounted for. This audit will be conducted weekly x4, then monthly x3. All findings will be corrected immediately and reported to the QAPI committee. These corrective actions and planned audits will be monitored, tracked and trended by the QA Director, and discussed with the IDT during the QAPI meeting to improve systems and processes. Continued deficient practice identified will be corrected immediately and placed on a performance improvement plan.	9/7/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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