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STODDARD BAPTIST NURSING HOME	**1818 NEWTON ST. NW WASHINGTON, DC 20010**

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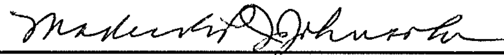
{F 000}	INITIAL COMMENTS A Revisit Survey was conducted at this facility on January 23-25, 2023, as a follow up to the recertification survey of November 9, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 91 and the survey sample included 22 residents. 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 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 DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department	{F 000}	Stoddard Baptist Nursing Home makes its best effort to operate in substantial compliance with both Federal and State laws. Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged of the validity of the conditions set forth of the Statement of Deficiencies. This POC is prepared and/or executed solely because it is required by Federal and State laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1-9-23

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 EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources Hrs - Hours HS - hour of sleep 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 cannula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2 - Oxygen PA - Physician's Assistant PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO - by mouth POA - Power of Attorney	{F 000}		

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{F 000}	Continued From page 2 POS - physician's order sheet Prn - As needed Pt - Patient Q - Every 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 SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	{F 000}		
{F 610} SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	{F 610}		

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{F 610}	Continued From page 3 Based on record review and staff interview, for one (1) of 22 sampled residents, facility staff failed to conduct a thorough investigation that included statements from witnesses, and employees who worked when a resident fell from his wheelchair. In addition, the facility failed to forward the investigation results to the State Agency within five (5) working days of the incident. Resident #12. The findings included: Review of the facility's Plan of Corrections with a compliance date of 01/09/23 stipulated, stipulated, "3. The Administrator provided the Social Services staff, DON, Nursing Supervisors and Charge Nurses and in-service on the process for conducting an investigation of facility reported incidents, including abuse and elopement on 12/14/22. 4. Any resident complaint or reported incidents of abuse will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of event ...completion date: January9, 2023." On 01/15/23 at 12:03 AM, the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "Writer was called by the charge nurse to see [the] Resident who was sitting on [the] wheelchair but was observed sitting on the floor between his bed and his wheelchair. He is (was) alert and verbally responsive. He stated that he wanted to sit down on his bed, but he still sit (sat) down on the floor on (in) a sitting position ...no swelling, bruises or any injury was noted ..." Resident #12 was admitted to the facility on	{F 610}	1. The DON met with Resident #12 on 1/30/23 who acknowledged that the incident on 1/14/23 was a fall. The charge nurse and the CNA providing care for resident on 1/14/23 provided a written statement. Unable to retrospectively send completed investigation within required 5-day window. 2. All complaint allegations were reviewed and there were no other allegations identified that would rise to the level of abuse or neglect. 3. The nursing supervisors were provided re-inservice on the process for completing an investigation including the process following the investigation and timely re-submission after follow up completed on 2/1/23. 4. Any resident complaint or reported incident of abuse will be monitored to ensure a thorough investigation is conducted with written statements from persons who may have knowledge of the event. Any findings from the audit conducted will be discussed monthly at QAPI meeting. 5. Completion date: 2/8/23 6. Director of Social Services	

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{F 610}	Continued From page 4 10/21/22 with diagnoses including malignant neoplasm of the prostate, Retention of urine, Difficulty in walking, and Cognitive communication deficit. Review of Resident #12's medicalrecord revealed the following: 10/30/22 [Significant Change Minimum Data Set] documented: Brief Interview for Mental Status Summary Score: "08" indicating mildly impaired cognition, required extensive assistance for bed mobility, transfers, locomotion on the unit, toilet use, dressing, and personal hygiene, and uses a wheelchair for mobility. 11/25/22 [Care Plan]: "Problem: [Resident #12] had a fall without injury. Goal(s): Resident's fall/injuries will be minimized ...Approach: Remind Resident to always call for assistance. Monitor when out of bed ..." 01/14/23 [Progress Note]: "Resident received OOB (out of bed) on w/c (wheelchair) in day area this shift ...Around 8:20 PM Resident call(ed) for help, noted on the floor in a sitting position beside his w/c, per resident, he slid out of his chair trying to transfer himself to bed. Writer educated Resident to use his call light when (in) need assistant (assistance), s/p (status post) fall, no apparent injury noted ...denied any pain ...Neuro checks in progress ..." 01/14/23 [Care Plan]: "Problem: [Resident #12] had a fall without injury related to failure to call for assistance during transfer ...Goal(s): Resident's fall/injuries will be minimized ...Approach: Hourly monitor for falls ..." 01/16/23 [Investigation Report Form]	{F 610}		

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{F 610}	Continued From page 5 documented: " ...Incident witnessed by: unwitnessed ...Type of Incident: ...Fall ...Resident Injured: "No" ...Location of Incident: Resident Room ...Statements: Summary of Resident's statements: Stated he wanted to sit on his bed but sat on the floor ... Under the Section of the form with the heading, "List of Staff working in the area at the time of the incident" were the following: [Licensed Practical Nurse (LPN), assigned to Resident #12, [Certified Nurse Aide (CNA) assigned to Resident #7] and [Second CNA working on the unit when the incident occurred] ... The following written statements from two (2) facility staff were attached to the form: 01/14/23 [Statement from CNA assigned to Resident #12] that read: 'Dear Sir/Ma, I was called by the Charge Nurse that the resident slide (slid) down from his wheelchair.' 01/25/23- Last day of the State Agency survey [Statement from Administrator] that read: 'Resident sustained a fall without injury. No indication of abuse (was) noted. Statements obtained from staff care plan (were) updated .... ' Of note, there were no written statements from the second CNA working on the unit when the incident occurred, and the Charge Nurse assigned to Resident #12. In the last section of the facility's Investigative Report Form, under the heading, 'Signatures of person completing the investigation,' were the following facility staff signatures: Director of Nursing, Human Resources Staff, Director of Quality Improvement, Director of Staff	{F 610}		

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{F 610}	Continued From page 6 Development, and the Administrator. Next to all the signatures was a date entry of 01/25/23. Of note, this was 11 working days after Resident #12's fall on 01/14/23. A review of Resident #12's medical record and review of the facility's investigation documents lacked documented evidence that the facility conducted a thorough investigation for the Resident's fall on 01/14/23 by failing to obtain written statements from the Charge Nurse, and the second CNA working on the unit when the incident occurred. In addition, the facility failed to provide its findings of the investigation for Resident #12's fall within five (5) working days of the incident to the State Agency. The Administrator's written statement, the facility employees' signatures, and date entries show documented evidence that the facility completed its investigation and provided its findings to the State Agency surveyors on 01/25/23, 11 working days after the incident. On 01/25/23 at approximately 6:00 PM, Employee #1 (Administrator) and Employee #2 (Director of Nursing) acknowledged the findings and made no further comment.	{F 610}		
{F 657} SS=E	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--	{F 657}		

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{F 657}	Continued From page 7 (A) The attending physician. (B) Aregistered nurse with responsibility for the resident. (C) Anurse 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 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 22 sampled residents, facility staff failed to update a resident's comprehensive care plan to include progression from a Stage 3 sacral pressure ulcer to an unstageable sacral pressure ulcer, upon the Resident's re-admission to the facility on 01/18/23. Resident #10 The findings included: On 01/18/23 at 9:06 PM, the facility submitted a Department of Health (DOH) Complaint/ Incident Report Form that documented the following: "...re-admit from [Name of Local Hospital] with multiple diagnose including altered mental status, Stroke, Sepsis, UTI (Urinary Tract Infection). On assessment ...unstageable sacral ulcer	{F 657}	1. Resident #10 was reassessed, and care plan was updated on 1/25/23. 2. A review of residents returning from the hospital with pressure ulcers was conducted. There were no other resident identified. 3. A meeting was held on 2/1/23 with the licensed staff regarding the updating of care plan. The nursing supervisor will review new admissions records to ensure care plan is updated. 4. The nursing supervisor will review the care plans developed for residents with skin condition monthly and report to QAPI monthly. 5. Completion date 2/8/23 6. Director of Nursing.	

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{F 657}	Continued From page 8	{F 657}		

measuring 7.5cm x 6.3cm with slough and eschar ...Orders given by MD: Cleanse sacral ulcer with Dakin's solution, pat dry, apply Santyl ointment, and cover with gauze two (2) times a day..... "

Resident #10 was re-admitted to the facility on 01/18/23 with the following diagnoses: Cerebral Infarction, Personal History of COVID-19, Pressure Ulcer Sacral Region, Stage 3, Colostomy Status, and Other Artificial Openings of Urinary Tract Status.

Review of Resident #10 medical record showed the following:

06/09/21[Care plan]: "Focus area: "[Resident #10] has a pressure ulcer to sacrum ... Goal: Resident's ulcer will heal without complications through the next 90 days. Approach: Keep clean and dry as possible. Apply dressings as ordered ... Assess the pressure ulcer for stage, size (length, width, and depth), presence/absence of granulation tissue, and epithelization. Weekly rounds by wound specialist ... Edited 10/19/22 ...Eval Notes ... Sacral ulcer stable. Tx (treat) as ordered. Seen by surgeon weekly." Of note, Resident #10's sacral pressure ulcer was not included in any other area on the Resident's comprehensive care plan.

10/12/22 [Quarterly Minimum Data Set] documented: Brief Interview for Mental Status Summary Score: "11" indicating the residents' cognition is moderately impaired, required extensive assistance for bed mobility, transfers, toilet use, dressing, and personal hygiene, and had one (1) Stage 3 pressure ulcer.

01/11/23 [Nursing Progress Note]: "... while

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{F 657}	Continued From page 9 serving lunch at1pm resident was noted not responding to verbal communication ...MD (Medical Doctor) made aware of the above and ordered to send Resident to the nearest ER (Emergency Room) via 911 for further evaluation ..." 01/18/23 at 8:05 PM [Nursing Progress Note]: " ... [Name of Resident #10] re-admitted from [Local Hospital] ... Skin is warm, dry to touch, multiple bruises to the bilateral upper extremity, red discoloration to bilateral heel, bilateral leg weakness, and an unstageable sacral pressure ulcer ..." 01/18/23 [Physician's Order]: "Cleanse sacral ulcer with Darkin's [Dakin's]solution, pat dry, apply Santyl ointment, and cover with dry gauze two (2) times a day." 01/18/23 [Physician's Order]: "Weekly skin assessment, once a day on Wednesdays 07:00 AM- 03:00 PM." There was no evidence that facility staff updated the Resident's comprehensive care plan to address the care and treatment of the residents' unstageable sacral pressure ulcer that facility staff observed when she was re-admitted to the facility on 01/18/23. During a face-to-face interview on 01/25/23 at 4:28 PM, Employee #2 acknowledged that Resident #10's comprehensive care plan had not been updated or revised to include the unstageable sacral ulcer that facility staff observed upon the Resident's re-admission to the facility on 01/18/23.	{F 657}		

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{F 756}	Continued From page 10	{F 756}	1. The Drug Regimen Review for resident #8 was conducted. The LFT order was done on 1/24/23 and completed on 1/25/23 and results were documented. 2. A review of Drug Regimen Review was conducted. There were no other residents identified. 3. The process for addressing MMRs was revised on 2/3/23. The nursing supervisor will review the Drug Regimen Review folder on each unit. Any follow up action necessary will be initiated by the supervisor and the manager for the unit will ensure its completed. 4. The nursing manager will review the Drug Regimen Review folder daily and report results monthly to QAPI. 5. Completion date: 2/8/23 6. Director of Nursing	
{F 756} SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	{F 756}		

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{F 756}	Continued From page 11	{F 756}		

when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, for one (1) of 22 residents, facility staff failed to take the action of ordering liver function tests for a resident in response to a monthly MRR (medication regimen review). Resident #8.

The findings included:

Facility staff failed to take the action of ordering liver function tests (LFTs) for Resident #8 in response to the monthly MRR (medication regimen review) with the Physician Prescriber Response of "Agree" dated and signed by the Physician on 01/18/2023.

Resident #8 was admitted to the facility on 01/13/22 with multiple diagnoses including Chronic Kidney Disease Stage 4, Urinary retention, a History of COVID-19 infection, and Dementia.

Review of Resident #8's medical record revealed the following:

A Quarterly Minimum Data Set (MDS) dated 11/03/22 showed facility staff coded: severely impaired cognitive response and as having Acute Kidney Failure and Chronic Kidney Disease Stage 4.

Care plan focus area "[Resident #8] is on nine (9) or more medications" last reviewed/revised on 11/10/22 had the following approach, "...Review medications at least monthly ...Monitor labs and

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{F 756}	Continued From page 12 report abnormal to Physician." 01/16/2023 at 7:04 PM [Pharmacist Note] "MRR completed. Recommendation check LFTs with next labs. Thank you." Review of Resident #8's medical record and physical chart on 01/24/23 at 11:02 AM showed no documented evidence that facility staff had ordered the liver function tests (LFTs) for Resident #8. During a face-to-face interview conducted on 01/24/23 at 2:20 PM, Employee #2 (Director of Nursing) reviewed the 01/16/23 [Pharmacist's Note] and acknowledged that there was no documented evidence of a physician's order for the Resident's liver function tests. On 01/25/22 at approximately 4:30 PM, Employee #2 presented a copy of the following Physician's order: Other Test: (LFT) [DX (diagnosis): Chronic kidney disease, Stage 4 (severe)] once-one time; 12:30 AM-08:30 AM."	{F 756}		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	{F 842}		

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	095020	A. BUILDING ______ B. WING ______	R-C 01/25/2023

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{F 842}	Continued From page 13 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	{F 842}	1. A review of Resident #7 was conducted. An order was obtained on 1/26/23 to address no blood pressure on the left arm. The care plan was updated to reflect the order. 2. A review of residents on dialysis was conducted. There were no other residents impacted by this practice. 3. The nursing staff on the unit were where residents on dialysis reside were re-educated on 2/7/23 on the importance of documenting which arm the blood pressure was taken. This education includes not taking the blood pressure in arms with AV graft/fistula site. Staff were advised that documentation errors may result in additional corrective actions. 4. The Director of Nursing/designee will review blood pressure documentation for residents on dialysis. The information will be reported to QAPI monthly. 5. Completion date: 2/8/23 6. Director of Nursing	

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{F 842}	Continued From page 14 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 22 sampled residents, facility staff failed to accurately document the location where Resident #7's blood pressure was being taken. The findings included: Review of the facility's Plan of Corrections with a compliance date of 01/09/23 stipulated, "3. The Administrator provided an re-education on accuracy of documentation..." Resident #7 was admitted to the facility on 05/02/19 with diagnoses including Acute Kidney Failure, Pleural Effusion, Chronic Obstructive Pulmonary Disease, and Combined Systolic (congestive) and Diastolic (congestive) Heart Failure. Review of Resident #7's medical record showed the following: 09/22/22 at 10:04 PM [Nursing Note] "[Resident	{F 842}		

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{F 842}	Continued From page 15 #7] ... re-admitted from [Hospital Name] ... at 1:35 PM..." 09/22/22 [Physician's order] "Resident is for dialysis every Monday, Wednesday, and Friday." A Significant Change MDS dated 09/27/22 showed facility staff coded: severe cognitive impairment and received dialysis while a resident. 10/27/22 at 7:10 AM [Nursing Note] "...Left for surgery appointment ... AV (arteriovenous) graft placement..." 10/27/22 at 11:34 PM [Nursing Note] "Resident wheeled back onto the unit at 7:10 PM...Left arm surgical site [new AV graft site] observed with transparent pressure dressing. No signs of bleeding noted..." Review of Resident #7's vital signs showed that on the following dates and times, facility staff documented taking the Resident's blood pressure on the left arm: 01/14/23 at 3:47 AM 01/19/23 at 5:31 AM 01/20/23 at 5:19 AM A total of three (3) days, facility staff recorded obtaining Resident #7's blood pressure on the left arm. During a face-to-face interview conducted on 01/25/23 at 11:30 AM, Employee #2 (Director of Nursing/DON) stated, "It's the night shift-the nurses know not to take the blood pressure in the arm with the dialysis site. They should not be documenting that they are taking any blood	{F 842}		

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{F 842}	Continued From page 16 pressure on his left [arm]."	{F 842}		
{F 867} SS=F	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	{F 867}	F867 1. A review of the Quality Improvement Program was conducted to ensure repeat findings have correction actions in place. 2. The QAPI plan affects all residents, staff and facility. 3. A meeting was held with the individuals identified in the plan of correction who will be monitoring specific areas and how the plan of correction is sustained. These individuals were re-educated on QAPI on 1/31/23. 4. The identified areas in the statement of deficiency will be reviewed by the QAPI Director monthly. The findings will be presented to the QAPI committee monthly. 5. Completed date: 2/8/23 6. Administrator	

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{F 867}	Continued From page 17 adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approachto 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 theeffectiveness 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	{F 867}		

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{F 867}	Continued From page 18	{F 867}		

resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

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

§483.75(g) Quality assessment and assurance.

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

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to continuously monitor identified

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{F 867}	Continued From page 19	{F 867}		

deficient practices from the prior survey and implemented the corrective actions through their Quality Assurance and Performance Improvement (QAPI) process as indicated in their Plan of Correction from the Revisit survey that ended on 01/25/2023 with a compliance date of 01/09/2023. The resident census on the first day of the survey was 91.

The findings included:

Review of the facility's Plan of Corrections with a compliance date of 01/09/23 stipulated, "3.The QAPI members were provided an in-service plan on the Quality Assurance and Performance Improvement process by the Executive Clinical Director on 12/22/22. Training on QAPI will be provided to all staff across all departments . 4. The identified areas in the statement of deficiency will be reviewed at each QA (Quality Assurance) meeting. The Quality Council will evaluate findings to determine effectiveness of actions for each aspect of care and services to determine how long to monitor each aspect of care."

A review of the facility's previous survey (Federal Recertification Survey) dates of 10/31/2022 to 11/09/2022 showed that the facility was cited for the following deficiencies:

F610 Investigate/Prevent/Correct Alleged Violations
F842 - Resident Records-Identifiable Information
F867 - QAPI Program/Plan, Disclosure/Good faith Attempt

The aforementioned deficiencies were cited again during the Revisit Survey that ended on 01/25/2023.

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{F 867}	Continued From page 20 Facility staff failed to continuously monitor their deficient practices from the prior survey and implemented the corrective actions as they indicated in their Plan of Correction from the Revisit survey that ended on 01/25/2023 with a compliance date of 01/09/2023. On 01/25/23 at 5:00 PM, a face-to-face interview was conducted with Employees #1 (Administrator), Employee 2 (DON), and #3 (Director of Quality Improvement) regarding the Quality Assurance and Performance Improvement plan for the development and implementation of appropriate corrective and preventive actions. Employee #3 stated, " We work so hard educating our staff to accomplish our QAPI plan and provide our residents with quality care." Employee #1 presented the staff education information along with staff attendance signatures used during the training sessions and stated, "We will have to reeducate staff."	{F 867}		