STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155494	A. BUILDING 00 B. WING	12/12/2023

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WATERS OF SCOTTSBURG, THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00420651, IN00423014 and IN00423115. This visit resulted in a Partially Extended Survey - Immediate Jeopardy. Complaint IN00420651 - Federal/State deficiency related to the allegation is cited at F550. Complaint IN00423014 - Federal/State deficiency related to the allegations is cited at F684. Complaint IN00423115 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited Survey dates: December 8, 11, and 12, 2023 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 6 Medicaid: 42 Other: 16 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 19, 2023.	F 0000	**F000** Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is January 1, 2024. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure a staff member did not post photos of a resident on their personal social media account for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed on 12/8/23 at 9:56 a.m. The diagnoses included, but were not limited to, dementia and cognitive communication deficit. The quarterly MDS (Minimum Data Set) assessment indicated the resident's cognition was severely impaired. Review of Resident B's guardianship paperwork indicated the guardian was appointed for the resident on 7/24/15. On 12/8//23 at 10:00 a.m., seven pictures of Resident B were observed on the Dietary Manager's personal social media page with a posted date of 10/26/23. The pictures were of the resident inside the facility, throughout her time at the facility. The resident's clinical record lacked documentation of consent from Resident B's guardian to post picture on social media. During an interview on 12/8/23 at 10:25 a.m., the Executive Director (ED) indicated per the facility policy, staff are not allowed to post any pictures of residents on social media. Staff are not to take pictures of residents at all. The ED viewed the personal social media post for the Dietary Manager and was unaware the post was out there.	F 0550	**F 550 Residents Rights / Exercise of Rights** It is the policy of this facility that only residents who have an appropriate release/consent to photograph should have their photo shared on the facility's social media pages. Staff members are not to share photos or videos of any resident on their personal social media page. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The affected resident passed away on 10/25/23, the day before the Dietary Manager posted the resident's photos on her personal social media page in remembrance of the resident's life. The Dietary Manager has since deleted all the resident's photos from her personal social media page. The affected resident's guardian did sign a photo consent form in 2016, but that document was not discovered until after the survey was completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	01/01/2024

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	During an interview on 12/8/23 at 10:38 a.m., the Dietary Manager indicated the resident had a signed consent for the facility social media. She thought since the resident was no longer a resident at the facility that it would be ok. It was a bad judgement call. On 12/8/23 at 10:30 a.m., the Executive Director provided a current copy of the document titled "Social Media Policy" dated 7/15/17. It included, but was not limited to, "Procedures...What You Should Never Disclose...Photographs...of Residents...." This Citation relates to Complaint IN00420651 3.1-3(a)		**action(s) will be taken?** All residents have the potential to be affected. An audit was conducted on 12/27/23 of all residents that have a consent to photograph on file, to ensure that the consent was signed by an appropriate party such as a resident with a BIMS of 13, 14, or 15, a guardian if the resident has a guardian, or the responsible party for any resident with a BIMS of 12 or less. For any resident that does not have a consent on file, or whose consent was not signed by the correct party, the Activity Director will complete a new consent form by 1/1/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The photograph consent form will be reviewed with each new admission to ensure that the person signing the consent has the capacity to sign the form. The Activity Director of designee will be responsible for this task. All staff will be re-educated on the Social Media Policy and will complete a test to demonstrate understanding of the policy. Staff education will be complete by 1/1/24. Any current staff member that is not able to complete education by 1/1/24 will complete	

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			education at the beginning of the next shift they work. All newly hired staff will receive education on the Social Media Policy during orientation. Any staff that fails to adhere to the facility policy for Social Media will be re-educated and may face progressive discipline, which could include termination of employment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Activity Director or designee will complete the Photo-Video Consent Audit for each new admission to ensure the appropriate person has signed the consent form. This audit will be conducted for a period of not less than 6 months. The Photo-Video Consent Audit will be reviewed during the monthly QAPI meeting to ensure compliance. Any concerns will have been addressed. However, any patterns will be identified. Any needed action plan will be written by the QAPI committee. Any written action plan will be monitored by the administrator weekly until resolved. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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			stopped. **By what date the systemic change for the deficiency will be completed?** Date of completion 1/1/24.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a resident's (Resident C) fall intervention was in place, per the resident's plan of care, for 1 of 3 residents reviewed for quality of care. Findings include: The clinical record for Resident C was reviewed on 12/8/23 at 12:06 p.m. The diagnosis included, but was not limited to, history of falls. The care plan, dated 4/13/21, indicated the resident was at risk for falls. The interventions included, but were not limited to, non-skid strips to the bathroom floor. During an observation on 12/8/23 at 2:01 p.m., Resident C's bathroom floor did not have non-skid strips in place.	F 0684	**F684 Quality of Care** It is the policy of this facility to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The affected resident had a fall intervention for non-skid strips on the bathroom floor. The non-skid strips were replaced on 12/8/23. **How other residents having the potential to be affected by the**	01/01/2024

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	During an interview on 12/8/23 at 2:04 p.m., the Director of Nursing indicated they would ensure non-skid strips were placed to the bathroom floor. During an interview on 12/11/23 at 10:05 a.m., the Executive Director indicated the non-skid strips were put down on Friday. She believed that the old strips were scraped up by housekeeping and the maintenance department was not informed to replace them. This Citation relates to Complaint IN00423014 3.1-37		**same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected. The Director of Nursing or designee will review the fall care plan for each resident and will ensure that interventions are in place. This will be completed by 1/1/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** A fall interventions audit will be conducted weekly for 10 residents weekly x 8 weeks, then 10 residents monthly x 4 months to ensure that interventions are in place. Interventions not in place will be immediately corrected. All staff will be re-educated on facility policy Guidelines for Incidents/Accidents/Falls with emphasis given to notify maintenance if non-skid strips are removed from the floor, or if a resident requiring non-skid strips moves to a different room. Staff education will be completed by 1/1/24. Additionally, any staff that fails to comply with the point of this in-service will be further educated and/or disciplined as indicated. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e. what quality assurance program will be put into place? A fall interventions audit will be conducted for 10 residents weekly x 8 weeks, then 10 residents monthly x 4 months to ensure that interventions are in place. Interventions not in place will be immediately corrected. The fall interventions audit will be reviewed in the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action plan will be written by the QAPI committee. Any written action plan will be monitored by the administrator weekly until resolved. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. **By what date the systemic change for the deficiency will be completed?** Date of completion 1/1/24.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure adequate supervision was in place when a resident (Resident G) with impaired cognition and risk for elopement exited the front doors without staff supervision. This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 12/7/23. Resident G is a 69-year-old male with severely impaired cognition and risk for elopement that had resided on the dementia unit since 7/12/23. The resident was admitted to a psychiatric hospital on 11/22/23. He readmitted to the facility on 12/7/23 at 11:30 a.m., off the dementia unit, as a trial for the safety of the other residents on the dementia unit. The resident exited the facility through the front doors on 12/7/23 between 5:20 p.m. and 5:30 p.m. when a visitor exited the facility. At 5:43 p.m. on 12/7/23, the visitor returned and informed the facility she thought she had let a resident out of the facility. The resident was found by the maintenance director 0.8 miles from the facility. The path the resident took was a busy highway without sidewalks. The resident was returned to the facility and placed on the secured unit. The resident had an abrasion to his right knee and a hematoma to his right hand from a fall while out of the facility unsupervised. The resident was not placed on any increased supervision upon behavioral hospital return until after the elopement. The Executive Director (ED) and Director of Nursing (DON) and Regional Nurse Consultant were notified of the Immediate Jeopardy on 12/11/23 at 4:00 p.m. The Immediate Jeopardy was removed on 12/12/23 at 4:35 p.m., but noncompliance remained at the lower scope	F 0689	**F689 Accident Hazards/Supervision/Devices** It is the policy of the facility to provide a safe and secure environment for all residents. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice-** The affected resident was moved back to the secured unit on 12/7/2023. His elopement risk assessment was updated, and his elopement care plan was reviewed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken-** Residents who reside in the facility have the potential to have been affected by the findings cited in the IJ. The facility has reviewed the current elopement risk assessment for every resident as of 12/8/23. New elopement risk assessments were completed for residents who had a quarterly assessment due, as well as for	01/01/2024

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	and severity level of no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy. On 12/11/23 at 11:30 a.m., Resident G was observed sitting at a table in the dining room of the dementia unit. His right hand was observed to be extremely swollen. The clinical record for Resident G was reviewed on 12/11/23 at 10:11 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance, anxiety, violent behavior, wandering, impulsiveness and glaucoma. The quarterly MDS (Minimum Data Set) Assessment, dated 11/22/23, indicated the resident's cognition was severely impaired. Resident G's hospital admission record, dated 5/10/23, indicated the resident admitted from home with a previous diagnosis of dementia, aggressiveness towards his spouse, and eloped from his home. During an interview of 12/11/23 at 9:29 a.m., the ED indicated she had an incident occur last Thursday evening and reported it. Resident G was readmitted back to the facility after a hospital stay from the behavioral hospital. The resident was placed off the dementia unit due to a positive COVID result. There were a lot of things going on as well as the Christmas dinner for the residents. Resident G exited the facility when Visitor 22 let him out the front doors. Visitor 22 notified the building and the maintenance director found him up by the highway. The facility should have placed him on the secured unit, or the resident should have had a wanderguard (alarm bracelet) on.		those residents who have had a medical or psychosocial change in condition that may affect their elopement risk. The care plans for residents identified to be at risk were reviewed and updated as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur-** The DON, IP, and Administrator received re-training on the Dementia policy and the Hope Springs Unit policy, with attention to re-admission risk assessment and putting safety measures into place immediately upon identification of risk. Maintenance contacted Safe-Care on 12/8/23 and ordered a wander guard monitor for the front door. All other exit doors have a wander guard present. The front door was attended by a staff member to prevent elopement until the wander guard device was installed on 12/20/23. On 12/8/23, All resident family contacts were educated to check with nursing before letting anyone out the exit door. When the facility hosts events, the facility will have a greeter	

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	The care plan, dated 6/9/23 and last reviewed on 9/11/23, indicated the resident was a risk for elopement related to a previous elopement from home. The interventions included, but were not limited to, activities per the calendar, check and maintain code device if applicable, elopement risk assessment quarterly and as needed, and secure with a code device and/or secured unit. The progress note, dated 7/6/23 at 12:00 p.m., indicated the staff were alerted that Resident G was naked outside in the courtyard. The resident was then redirected to the shower room and assisted by a CNA in taking a shower. The progress note, dated 7/12/23 at 10:09 a.m., indicated the family member gave consent for the resident to be moved back to the secured unit related to being intrusive, using the bathroom outdoors, disrobing outdoors and more confused. The physician's order, dated 7/12/23, indicated the resident may reside on the secured unit. Review of the resident's census report indicated Resident G had resided on the dementia unit since 7/12/23. The progress note, dated 11/22/23 at 9:29 a.m., indicated the resident had an altercation with another resident and was placed on one staff member to one resident supervision. The progress note, dated 11/22/23 at 2:00 p.m., indicated the resident had been transported to a behavioral hospital. The IDT (Interdisciplinary Team) note, dated 12/7/23 at 9:30 a.m. (created as a late entry on 12/8/23 at 5:52 p.m.) indicated the IDT team met to		stationed at the front door to monitor for residents attempting to exit the facility with visitors. The Regional Nurse Consultant conducted training with the Administrator, DON, and IP on 12/8/23 on the following policies: 1.Elopement Policy- Missing Resident 2.Guidelines for Alarms 3.Admission/Re-admission Checklist At an in-service held for all staff on 12/8/23 through 12/12/23, and conducted by the Administrator with input from RNC (Regional Nurse Consultant), the following was reviewed: 1.Elopement Policy- Missing Resident 2.Guidelines for Alarms 3.Admission/Re-admission Checklist 4.Handling and Addressing Behavioral Emergencies Knowledge of the in-servicing was measured by a POST TEST that required 100% accuracy of answers to “pass.” No staff will work after 12/12/23 until they are educated. This includes all staff on vacation or any type of leave, newly hired staff, prn staff, agency staff and any other staff. Any staff who fail to comply with the points of the in-service will be further educated and/or	

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	review Resident G's placement upon return to the facility from the behavioral hospital. The resident had not had exit seeking behaviors prior to placement on the dementia unit or while on the dementia unit. IDT determined to trial the resident on an open unit upon hospital return related to the safety of the residents on the memory care unit as well as not having a history of exit seeking. The admission elopement risk review assessment, dated 12/7/23 at 11:27 a.m., indicated the resident was an elopement risk. The progress noted, dated 12/7/23 at 11:30 a.m., indicated the resident readmitted from the behavioral health hospital, alert to self, recognized the facility, but not the name of the facility. The progress note, dated 12/7/23 at 12:30 p.m., indicated the resident tested positive for COVID-19 and was moved to another room. The police report, dated 12/7/23 at 5:52 p.m., indicated the police responded to the area at a grocery store parking lot in reference to an elderly man lying face down in the roadway. Dispatch advised they had received two to three calls about the male. Upon arrival, the police spoke with the facility Maintenance Director. He advised the police Resident G was a resident at the facility and should have had a device on to alert staff when a resident wandered away. The Maintenance man indicated Resident G did not have an alert device on. The dispatch narrative on the police report indicated on 12/7/23 at 5:53 p.m. included, but was not limited to, "Face down...elderly man...in roadway...had to swerve...adv [advised] people were with him... [the resident was wearing] Blue		progressively disciplined as indicated. All staff will have been educated by 1/1/24. **How the corrective actions will be monitored to ensure the deficient practice does not recur-(i.e., what quality assurance program will be put into place and by what date the systemic changes for the deficiency will be completed.** An Ad Hoc QAPI meeting was conducted on 12/8/23 to discuss this action plan and will take place weekly to review the Exit Seeking Compliance Audit and the facilities progress toward compliance. After the facility is put back into compliance, these meetings will be held monthly. Any concerns found will be addressed. However, any patterns will be identified. If needed, an Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored weekly by the Administrator until resolved. The Director of Nursing / designee will complete the Exit Seeking Compliance Audit with each new admission / re-admission for a period of at least 6 months to ensure compliance. Any identified concerns will be addressed immediately. Additional staff education will be given.	

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	jeans and a dark sweatshirt...5:56 p.m ... employee adv that ...the male left...and wondered [sic] off...." The progress note, dated 12/7/23 at 6:57 p.m., indicated at 5:40 p.m. Visitor 22 approached LPN (Licensed Practical Nurse) 3 at the nurse's station to report a person had exited out of the facility at the time she did earlier. When she returned to the building, she had seen the same person walking up by the new pharmacy. At that point, the visitor thought it may have been a resident. A Code Silver (missing resident) was called at that time. The Maintenance Director left the facility to see if he could locate the resident in the area where he was last seen by the visitor. Staff searched the building and perimeter of the building. The resident was unable to be located. The LPN 3 received a call from the Maintenance Director and informed LPN 3 that the resident had been located. The resident was brought back to the facility by the Maintenance Director. The progress note, dated 12/7/23 at 10:46 p.m., indicated Resident G had a small abrasion to his right knee and a hematoma to top of his right hand, approximately 3 cm (centimeters) in diameter. Ice was applied and his hand elevated on a pillow. The physician was notified with a new order to x ray the right hand. The progress note, dated 12/7/23 at 10:52 p.m., indicated Resident G was moved to the dementia unit. The physician's order, dated 12/8/23, indicated the resident may reside on the secured unit. During an interview on 12/11/23 at 11:24 a.m., the Maintenance Director indicated he was told a		The Exit Seeking Compliance Audit will be presented monthly to the QAPI Committee. If compliance is maintained over the 6-month period, the QAPI Committee may elect to discontinue use of the Exit Seeking Compliance Audit. A member of the Regional Team will attend all QAPI meetings either in person or remotely for not less than 3 months to ensure on-going compliance and to offer any guidance or feedback on findings. This will serve as corporate oversight. **By what date the systemic change for the deficiency will be completed?** Date of completion 1/1/24.	

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	resident was missing. He got in his truck, sometime between 5:45 p.m. and 6:00 p.m., to go and look for the resident. It was dark outside. He found the resident at the entrance of a grocery store parking lot. When he got there, two other people were talking to the resident and informed the Maintenance Director that the resident had fallen. After that, the police came to find out what was going on. The police then called EMS (emergency medical services) to check Resident G out before he took the resident back to the facility. During an interview on 12/11/23 at 11:26 a.m., LPN 3 indicated he worked Resident G's Hall on 12/7/23. The resident was originally on another hall, tested positive for COVID-19 and was then moved to LPN 3's hall. He had not realized the resident had vanished. A visitor approached him at the desk and told him a gentleman had walked out the front doors with her when she left, and she thought maybe it was a resident. He called a Code Silver and found Resident G was missing. The Maintenance Director went out and found the resident and he was place on the dementia unit. Resident G was not on 15-minute checks until after the elopement. During an interview on 12/11/23 at 3:20 p.m., Visitor 22 indicated she had left the facility between 5:20 p.m. and 5:30 p.m. As she was leaving, the resident was standing off to the side of the door keypad. He did not look like a resident. She opened the door, and he followed her out. She assumed he was going to smoke out front. She left the parking lot to go back home to pick up her kids. She only lived 5 minutes from the facility. On her way back, she noticed the same guy in front of the new pharmacy. She called her mother who recommended that she let someone know at the facility. She got back to the facility at 5:43 p.m.			

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	and told the front desk what had happened, and they started to try and figure out who was missing. On 12/12/23 at 2:43 p.m., Visitor 22 indicated there were no staff down the hallway where the front doors were located on the day Resident G exited out the doors behind her. During an interview on 12/12/23 at 3:25 p.m., the Director of Nursing indicated a wanderguard should have been implemented upon readmission. She was unaware there was not a code alert system on the front doors. If known, she would have implemented 15-minute checks. On 12/11/23 at 4:21 p.m., the ED provided a current, undated copy of the document titled "Policy and Procedure Regarding Missing Residents and Elopement". It included, but was not limited to, "It is the policy of this facility that all residents are provided adequate supervision...Prevention of Missing Residents and Elopements...Resident that are at risk for elopement will be provided at least one of the following safety precautions...staff supervision of facility exits either directly or by video camera...door alarms on facility exits...a personal safety device that notifies facility staff when the resident attempts to or has left the facility without supervision...." The Immediate Jeopardy, that began on 12/7/23, was removed on 12/12/23 when the facility conducted the following: The facility reviewed the current elopement risk assessment for every resident; the care plans for at risk residents were reviewed; the Director of Nursing, Infection Preventionist and Administrator were re-trained on the Dementia policy and the Dementia Unit policy with attention to re-admission risk assessment and putting safety measures in place			

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	immediately upon identification risk; a wanderguard monitor had been ordered for the front door and staff placed at the front door to prevent elopement until the wander guard device is put in place; all families were contacted and educated to check with nursing prior to letting anyone out the exit door; a greeter will be placed at the front door during events to monitor for residents attempting to exit the facility with visitors; the Regional Nurse conducted training with the Administrator, Director of Nursing and Infection Preventionist on the elopement policy, guidelines for alarms, and admission/readmission checklist; and all staff were educated on the elopement policy-missing resident, guidelines for alarms, admission/readmission checklist, and handling and addressing behavioral emergencies. The Immediate Jeopardy was removed on 12/12/23 but remained at the lower scope and severity level of no actual harm with potential for more than minimal harm, that is not Immediate Jeopardy, because not all staff had been educated on the elopement policy-missing resident, guidelines for alarms, admission/readmission checklist, and handling and addressing behavioral emergencies. 3.1-45(a)(2)			
F 0867 SS=E Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §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			

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	effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the 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			

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	that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and 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			

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	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.			
	Based on record review and interview, the facility failed to identify an unresolved quality deficiency which had been cited on a previous survey, and ensure actions were developed and implemented to attempt to correct the deficiency through the quality assessment and assurance (QAA) process, as evidenced by a repeated deficiency for elopements. This deficient practice had the potential to affect 10 of 10 residents residing in the facility who are at a risk for elopement.	F 0867	**F867 QAPI/QAA Improvement Activities** It is the intent of this facility to have a process to implement a corrective plan of action that includes monitoring, tracking, evaluating effectiveness for identified areas of concern. **What corrective action will be accomplished for those**	01/01/2024

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	Finding includes: The Quality Assurance and Performance Improvement (QAPI) plan was a general outline of how to set up a QAPI committee and what the committee should do. The QAPI plan was a data driven, proactive approach for improving the quality of life, care and services in long term care. The activities of QAPI involved members at all levels of the organization to identify opportunities for improvement, address gaps in systems or processes, develop and implement and improvement or corrective plan and continuous monitoring of interventions. The following deficiency was cited on this survey at Immediate Jeopardy with potential for more than minimal harm and had been cited previously: - F689 Free of Accident Hazards/supervision/devices was previously cited on Complaint survey dated 9/26/23. Cross reference F689 Review of the facility QAPI meetings for October 2023 and November 2023 lacked documentation of an ongoing review of elopements. During an interview on 12/12/23 at 3:25 p.m., the Administrator indicated elopements were not addressed on QAPI because it was followed daily in the morning meeting. 3.1-52(b)(2)		**residents found to have been affected by the deficient practice.**No residents identified for this deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**All residents have the potential to be impacted by this deficient practice. A 90 day look back QAPI meetings for potential areas requiring action plan and implemented as indicated was completed on 12/27/23. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.**The Administrator was in-serviced by the Regional Nurse Consultant on the QAPI policy and QAPI process of identifying areas of concern and implementing action plan for areas of concern on 12/28/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.The Director of Nursing or designee will educate all staff on the QAPI policy by 1/1/23. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.**The QAPI Audit Tool will be used to monitor action	

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			plans implemented during monthly QAPI meeting weekly x 6 months by the Administrator/Designee. RDO/RN C will attend QAPI once a month x 6 months to ensure the facility management is including all areas in the QAPI process. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator/Designee weekly until resolved. ="" b=""> Date of completion 1/1/24	