STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205091	A. BUILDING _____ B. WING _____	R-C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CENTER	27 COOL ST WATERVILLE, ME 04901

(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 (Census 76 Capacity 90 beds) On 8/14/24, 8/15/24, 8/20/24, and 8/21/24, the Division of Licensing and Certification conducted on-site visits at Oak Grove Center for the purpose of following up on deficiencies cited on a complaint survey dated 5/29/24(complaints #ME00046614, #ME00046446, #ME00047414, #ME00046522, and #ME00047526). It was determined that Oak Grove Center is not in substantial compliance with 42 CFR Part 483, Subpart B - Requirements for Long Term Care Facilities. At 42 Code of Federal Regulations (CFR) Part 483, Subpart §483.25(d)(1) - F689 - Free from Accident Hazards/Supervision, the facility failed to ensure that the residents environment was free from the potential risk of serious accidents/tripping hazards relating to loose, unsecured laminate plank type flooring that moves out of place when walked upon and carts wheeled over them for 3 of 3 units (Wyeth, Jewett and Millay), Noncompliance with this requirement constituted a determination of immediate jeopardy (IJ), beginning on 5/3/24 when a work order was completed for the sliding floor and priority for work order was a medium. Immediate jeopardy is defined as a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. See §483.25(d)(1) also known as F689 for details. On 8/14/24 at 4:00 p.m., the Administrator was provided written notification (IJ template for F689)	{F 000}		

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

Khrpca MHA 9-12-24

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 related to the IJ situation, and a removal plan was requested. On 8/15/24, the facility summitted an acceptable removal plan. The removal plan was reviewed and approved by the State Agency on 8/15/24 at 1:36 p.m. This removal plan indicated the following: 1) On 8/14/24 the Maintenance Director repaired and secured the identified loose floorboards found at time on onsite visit. 2) On 8/14/24 and 8/15/24, the Market Clinical Advisor and Senior Maintenance Director completed a full facility round/observation to determine any identified accident hazards, inclusive of loose floorboards and fixed any potential hazards. 3) Education was drafted for all staff members which discussed the specifics of the policy, which are the following: a) If an employee discovers a loose floor tile, the employee will initiate the following actions: - Secure the area by covering the loose floor tiles with a "wet floor" triangle sign to prevent an incident or further incidents from occurring. Notify the supervisor immediately. - The supervisor will immediately notify the administrator/designee and the maintenance director of the loose tile(s), upon which the tile will be remedied within 2 hours. 4) The long-term repair plan will be to replace the affected flooring. Until then, daily audits of flooring will be conducted by NHA/Designee to identify any potential hazards for immediate correction. 5.A Quality Assurance / Performance Improvement (QAPI) Meeting was conducted on 8/15/24, to review the policy OPS100 Accidents/Incidents. 6. There are 104 employees. Education has been	{F 000}		

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{F 000}	Continued From page 2 provided to 70 employees. The remaining staff will not be allowed to work until receiving this education. Full staff education will be completed by 8/15/24 at 3:00 p.m. On 8/21/24 at noon, two surveyor's verified that the facility's removal plan was implemented and effective by observations of all hallway floors on all units and confirmed that all areas had been repaired. Surveyors also observed that staff identified an area that is in need of repair, staff marked the floor with a piece of blue tape and put a triangle shaped wet floor sign down. Surveyors also observed a maintenance worker repairing the floor timely by pulling up and re-gluing loose flooring. Surveyors verified staff training on the new process for reporting loose flooring and what steps are to be taken by: reviewing the training, reviewing attendance sheets, and by staff interviews, which confirmed staff all received the training and knew what to do. The surveyor determined the removal of the IJ was on 8/15/24.	{F 000}		
{F 689} SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document reviews, the facility failed to ensure that the residents environment was free from the potential	{F 689}		

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{F 689}	Continued From page 3 risk of serious accidents/tripping hazards relating to loose, unsecured laminate plank type flooring that moves out of place when walked upon and carts wheeled over them for 3 of 3 units (Wyeth, Jewett and Millay), this has the potential for falls for 25 ambulatory residents out of 76 residents (15 residents are fall risk), staff and visitors. In addition to the immediate jeopardy, the facility failed to ensure that the residents environment was free from the potential risk of accidents relating to chipped/gouged and splintered door surface and a broken floor type door stop 2 of 2 days of survey. (8/14/24 and 8/15/24) Findings: 1, On 8/14/24 at 10:00 a.m., two surveyors were walking in Wyeth hallway, when the four-foot piece of laminate plank type flooring slid forward under a surveyor's foot and moved forward out of place , sliding about 12 inches. Two surveyors then observed the floor buckling/pushing up approximately twenty feet ahead due to floor sliding out of place when a surveyor stepped on it. It was noted at this time the floor was not secured(unglued) to the floor and moving out of place. On 8/14/24 at 10:20 a.m., two surveyors observed all 3 units and took approximate measurements of flooring that was loose and coming up. Wyeth Unit Hallway: a 4 foot long x 2 foot wide Section, a 40 foot long x 4 foot wide Section, a 55 foot long x 4 foot wide Section and a 15 foot long x 4 foot wide Section. Jewett Unit Hallway: a 15 foot long x 2 foot wide Section, a 32.5 foot long x 4 foot wide Section, a 50 foot long x 4 foot wide Section and a 25 foot	{F 689}		

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{F 689}	Continued From page 4 long x 2 foot wide Section Millay Unit Hallway: a 4 foot long x 2 foot wide section by room 30 and a 4 foot long x 2 foot wide section by nurses station On 8/14/24 at 10:28 a.m., in an interview, the surveyors discussed the approximate measurements with the Senior Maintenance Director, who confirmed the findings that all the unit hallway floors had loose and unsecured sections of laminate plank type flooring which made them an accident hazard. On 8/14/24 at 10:30 a.m., two surveyors observed the facility Maintenance Director, gluing down loose and unsecured laminate plank type flooring in the middle of the Wyeth Unit hallway. In an interview at this time, the Maintenance Director stated that the flooring was coming up and comes up all the time. He went on to state that he glues floor planking down throughout the building every week and spends hours doing it. At this time the Maintenance Director confirmed that the flooring is loose and unsecured, and it does not stay adhered to the floor. On 8/14/24 at 10:00 a.m., in an interview, Registered Nurse (RN #1) stated to a surveyor that multiple large sections of flooring were coming up in the facility on all 3 units and that the flooring had been loose and not secure for months. On 8/14/24 at 10:10 a.m., in an interview, Licensed Practical Nurse (LPN #1) and Certified Nursing Assistant (CNA #1) confirmed that they know of three residents that walked in the halls often on Wyeth Unit. On 8/14/24 at 10:15 a.m., in an interview, LPN #2 confirmed that she knows of two residents that	{F 689}	F689: Accident Hazards All loose floor planking was glued down and complete replacement of the affected flooring will be scheduled pending outcome of warranty claim. Resident room door #7, #10 and #41 were repaired. NHA or designee will review flooring and doors throughout the Center and additional loose floor planking found will be glued down and doors found in disrepair will be fixed. The NHA or designee will provide education to all staff on OPS100 Accidents/Incidents. The NHA or designee will audit the flooring daily until complete repair takes place to ensure there is no loose floor planking and report findings at the monthly QAPI meeting. The NHA or designee will audit resident room doors weekly for four weeks then monthly for three months or until resolved to ensure they remain in good repair and are free of accident hazards as is possible and report findings at the monthly QAPI meeting.	9-20-24

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{F 689}	Continued From page 5 walked in the hall in the Jewett Unit. On 8/14/24 at 11:20 a.m., in an interview with the Senior Maintenance Director, he informed two surveyors that the floors have been a problem for a while. He stated the facility has talked with the company that previously did the current flooring and they informed the facility that they can do the same thing. The Senior Maintenance Director also discussed speaking with another flooring company and the company would not commit to fix the flooring due to the underlayment and that resurfacing the floor would result in the same problem they are experiencing now. On 8/14/24 at 2:20 p.m., in an interview with a family member, stated they have noticed parts of the floor missing. The family member states tthey noticed this within the past week. On 8/14/24 at 2:30 p.m., in an interview, Resident #3 stated that he/she sees pieces of the flooring coming up and then the maintenance man keeps repairing it. He/she stated that every time they push kitchen carts over the floor, pieces of the flooring curl up and move and then they're put back in by Maintenance. He/she went on to state that a little while later they will come up again. He/she stated that they don't seem to be able to make them stay on the floor and that he/she knows this is dangerous and a tripping hazard and that someone is going to get hurt. On 8/14/24 at 2:35 p.m., in an interview, RN.#2 stated that she has seen heavy carts pushed over the floors in the hallways and the it makes the flooring curl up and move. She went on to state that she has seen loose on unsecured flooring many times in the past few months and that maintenance just reglues them down and then a	{F 689}		

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{F 689}	Continued From page 6 short time later they all come up again. On 8/14/24 at 2:40 p.m., in an interview, CNA #2 stated that she has walked residents with walkers in the hallways and pieces of the flooring have stuck to the bottom of the walkers and come up and moved. She stated that the flooring is loose and not secured to the floor. She went on to state that maintenance will put them back down but then a short time later they will come up again. She went on to state that they will tell maintenance and maintenance will fix the flooring but it will only last a very short time before it starts to come up again. She stated this has been happening for months. On 8/14/24 at 2:45 p.m., in an interview, CNA #3 stated that she has seen the loose flooring come up when people walk on the floor and when heavy carts are pushed up and down the hallway. She stated that the flooring is very loose and not secure to the floor in large sections of the hallways. She went on to state that they will tell maintenance and maintenance will fix the flooring, but it will only last a very short time before it starts to come up again. On 8/14/24 at 2:50 p.m., in an interview, Resident #4 stated that he/she has seen the floor peeling up and moving and that it has been like that for a very long time. He/she stated that carts that are pushed up the hallway make the floor come up and move. He/she stated he/she has been at the facility for a long time and it has been like this for about a year. He/she states the hallway flooring always comes up a short time later even after maintenance fixes it. On 8/14/24 at 2:55 p.m., in an interview, Resident #1 stated that the floors are bad and coming up in the hallway outside his/her room. He/she went on to state the wheelchair that he/she uses makes	{F 689}		

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{F 689}	Continued From page 7 the floor move and come up. He/she stated he/she notices when the kitchen carts go by that the wheels make the floor move. He/she said it's sometimes hard to move his/her wheelchair around on the loose, moving floor. He/she also stated that he/she has seen people walk by his/her room with their walker and it was hard for them to slide the walker over the moving pieces that were coming up. He/she went on to state that he/she walks with therapy up and down the hallways and sometimes his/her walker gets caught on a piece of flooring that has moved and come up. On 8/14/24 at 3:00 p.m., in an Interview with another family member, stated he/she has never slipped or tripped on the flooring. Family member #2 then stated he/she has noticed that the flooring throughout the facility is separating and has big gaps. He/she then stated that they believe that the ongoing flooring issue could be hazardous for residents, family, visitors, and staff. On 8/14/24 at 3:15 p.m., in an interview, Dietary Aide(#1) stated that when he pushes the kitchen carts down the hallways that the flooring comes up all the time. He stated the wheels make the flooring curl up and then it moves. He stated the flooring has been loose and unsecured for a very long time. He stated maintenance attempts to get the flooring back down but it come up again short time later. On 8/15/24 at 9:20 a.m., in an interview, the Market Clinical Advisor stated the facility did a complete building audit of all the flooring on 8/14/24. The Market Clinical Advisor then stated they applied blue tape on problem areas of the flooring.	{F 689}		

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{F 689}	Continued From page 8 On 8/15/24 at 9:28 a.m., two surveyors observed blue tape secured to the floor on all three units. On 8/15/24 at 11:55 a.m., in an interview, the Senior Maintenance Director stated that one of the workers called into the facility was using the wrong glue to put the floor down today and that he has sent the worker out to get the exterior construction diffusive glue which works on vinyl. He stated that one of the people he had asked to come in and help brought in their own adhesive, and it was not the right adhesive and it was caught by the surveyor. He stated that the glue was not the problem but the problem was the paper underlayment under the vinyl floor which is causing you not to stay. He said that will be removed by a company when they do the floor. He went on to state that a company will be replacing the floor and they will be using the correct floor glue which is made to adhere to existing floor without damage the floor at all and it is made for vinyl flooring. On 8/15/24 at 11:55 a.m. during a review of work orders -Work Order #4784, created on 3/15/24- Room/Area Hallways All Units - Notes: I have contacted Senior Maintenance Director to discuss the use of a different adhesive on the unit hallway floors. The silicone product doesn't seem to be working in some areas and the flooring slats are loose. Location Hallways All Units Priority-Medium. Comments- directed to use an Luxury Vinyl Tile (LVT) plank adhesive -Work Order #4909 created on 5/3/24 - Room/Area hallway - floor board slid out of place- Priority Medium -Work order Summary Date: 6/25/24 - A piece of the floor tile fell out in the Jewett hallway by the	{F 689}		

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{F 689}	Continued From page 9 nurse's station. This is a tripping hazard, please fix right away. -Work Order #5216 created on 8/12/24-Room/Area between Room 40 & 41,-Flooring Adhesive used to repair facility hallway flooring isn't holding 2. On 8/15/24 at 1:20 p.m., two surveyors observed in resident Room #7, the laminate door protector ripped and pulling away from the room entrance door creating sharp edges. In resident Room #10 the laminate door protector ripped and pulling away from the bath room door creating sharp edges. On 8/15/24 at 1:30 p.m., the Market Clinical Advisor confirmed the findings. 3. On 8/15/24 at 1:40 p.m., two surveyors observed in resident room 41 a broken door stop at entrance to the room which had a screw sticking up approximately ¾ inch out of the floor. Confirmed with Kyle Smith Senior Maintenance Director on 8/15/2024 at 1:38 p.m. On 8/15/24 at 1:38 p.m., the Senior Maintenance Director confirmed the finding.	{F 689}		
F 843 SS=D	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically	F 843		

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F 843	Continued From page 10 appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to demonstrate a good faith effort to secure a written transfer agreement with a local hospital to ensure the safe and orderly transfer of residents for care and treatment. Finding: On 8/20/24 at 1:50 p.m., in an interview with a surveyor, the Administrator stated she was unable to locate a written transfer agreement with the local hospital which was approved for participation in the Medicare and Medicaid programs. The Administrator stated she had contacted the office of the hospital's President and was told	F 843	F843: Transfer Agreement The Center attempted in good faith to enter into a transfer agreement with the local hospital. The NHA or designee will review all hospitals approved for participation under Medicare and Medicaid that are sufficiently close to the Center and attempt in good faith to enter into a transfer agreement if one is not already in place. The Market Advisor or designee will provide education to the Administrator and Director of Nursing on policy OPS142 Transfer Agreements. The NHA of designee will audit transfer agreements monthly or until resolved to ensure the Center has attempted in good faith to enter into agreements with hospitals approved for participation under Medicare and Medicaid that are sufficiently close to the Center and report findings at the monthly QAPI meeting.	9-20-24

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F 843	Continued From page 11 there was no written transfer agreement and that it was not needed by the hospital. The Administrator confirmed that she was told there had only been a verbal agreement between the facility and the hospital for the transfer of residents. The local hospital was noted to be 1.2 miles from the facility. The Administrator provided a copy of the transfer agreement with the next closest hospital, 17 miles away from the facility.	F 843		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		

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F 865	Continued From page 12 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation	F 865	F865: QAPI Program/Plan The NHA or designee will review all current performance improvement plans and additional identified plans not being followed will be implemented. The NHA or designee will provide education to the QAA committee on policy OPS103 Center Quality Assurance and Performance Improvement Process. The NHA or designee will audit performance improvement plans weekly for four weeks then monthly for three months or until resolved to ensure they are being implemented and evaluated and report findings at the monthly QAPI meeting.	9-20-24

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F 865	Continued From page 13 of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		

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F 865	Continued From page 14 Based on observations, review of the plan of correction, and interviews, the facility's Quality Assurance Committee failed to ensure that the plan of correction for identified deficiencies from the Annual Long Term Care Survey Process for Federal Recertification on 2/1/24 was effective. The deficiencies, F689 (Free of Accident Hazards/ Supervision/Devices) was again identified during the 8/14/24 and 8/15/24 Revisit Survey. Findings: During the Annual Long Term Care Survey Process for Federal Recertification survey, dated 2/1/24, a deficiency was cited at F689 (Free of Accident Hazards/ Supervision/Devices) for failure to ensure that the residents environment was free from the potential risk of accidents relating to unsecured faux wood flooring for 1 of 3 units(Wyeth) for 1 of 1 observations. The facility's Plan of Correction for F689, with a completion date of 3/13/24, indicated that an audit will be conducted for the remaining units to ensure all flooring is secured down, The floor flooring will be inspected monthly for the next three months and The findings will be reported to the QAPI meeting for further review and recommendations. During the Revisit Survey on 8/14/24 and 8/15/24, F689 was again cited for failure to follow their Plan of Correction to ensure that the residents environment was free from the potential risk of accidents relating to laminate plank type flooring and to ensure all flooring is secured down for 3 of 3 units(Wyeth, Jewett and Millay) for 2 of 2 days of survey. (8/14/24 and 8/15/24).	F 865		

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F 865	Continued From page 15 On 8/14/24 at 10:20 a.m., two surveyors observed all 3 units and took approximate measurements of the three unit's flooring that was loose and coming up. Wyeth Unit Hallway: a 4 foot long x 2 foot wide Section, a 40 foot long x 4 foot wide Section, a 55 foot long x 4 foot wide Section and a 15 foot long x 4 foot wide Section. Jewett Unit Hallway: a 15 foot long x 2 foot wide Section, a 32.5 foot long x 4 foot wide Section, a 50 foot long x 4 foot wide Section and a 25 foot long x 2 foot wide Section Millay Unit Hallway: a 4 foot long x 2 foot wide section by room 30 and a 4 foot long x 2 foot wide section by nurses station On 8/14/24 at 10:28 a.m., in an interview, the surveyors discussed the approximate measurements with the Senior Maintenance Director who confirmed the findings that all the units hallway floors had loose and unsecured sections of laminate plank type flooring which made them an accident hazard.	F 865		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 868		

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F 868	Continued From page 16 (iv) The infection preventionist. §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: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on review of the quarterly Quality Assurance Performance Improvement/Quality Assurance Assessment (QAPI/QAA) Committee meeting attendance sheets and interview, the facility failed to ensure that the Medical Director attended 3 of 4 quarterly meetings. Finding: A review of the quarterly QAPI/QAA meeting attendance sheets indicate that the Medical Director did not attend the 9/25/23, 12/20/23, and 3/14/24 quarterly meetings.	F 868	F868: QAA Committee The Medical Director will attend a quarterly QAPI meeting in September. The NHA or designee will ensure Medical Director attendance at all future quarterly QAPI meetings. The NHA or designee will provide education to the QAA committee on policy OPS103 Center Quality Assurance and Performance Improvement Process. The NHA or designee will audit attendance at the monthly QAPI meeting monthly for three months or until resolved to ensure all required participants are present and report findings at the monthly QAPI meeting.	9-20-24

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F 868	Continued From page 17 A review of the facility's policy, Center Quality Assurance Performance Improvement process, with a revision date of 10/24/22, stated, "Process. 2. The QAA Committee: 2.1. Functions under the authority of the Administrator and the governing Body and is composed of 2.1.1 Administrator, 2.1.2 Director of Nursing, 2.1.3 Medical Director, 2.1.4 Infection Preventionist, or designee, 2.1.5 Consultant Pharmacist (recommended), 2.1.6 Patient and/or family representatives (if appropriate), 2.1.7 Three (3) additional staff representatives, including, but not limited to department heads, certified nursing assistants, rehabilitation services, hospice, home health, etc. 2.2 Meets at least quarterly." On 8/20/24 at 3:50 p.m., in an interview with the surveyor, the Administrator and Director of Nursing confirmed that the Medical Director did not attend 3/14/24 quarterly committee meeting.	F 868	F941: Communication Training Employees #2 and #5 have received training in communication. A audit of all direct care staff educational files was conducted to ensure mandatory communication training was completed. The facility ensures that all direct care staff receive education in effective communication skills reflecting the needs of the resident population served. All direct care staff will be re-educated to this process. DON/Designee will conduct audits reviewing communication education weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. (Edu: Healthstream SID LTC: Communication, Effective for all CNA, nurses, dept heads)	9-20-24
F 941 SS=E	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure that all direct care staff received training in effective communication skills reflecting the needs of the resident population served, for 2 of 5 employee education records reviewed (#2, #5) Finding:	F 941		

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F 941	Continued From page 18 A review of the Facility Assessment for 2024-2025, revealed the facility frequently provides care to residents with cognitive impairments, neurological and psychiatric conditions, as well as sensory impairments. The assessment stated the facility "strives to provide person-centered care and psychosocial, spiritual support so that the needs of emotional and mental well-being, (and) support for helpful coping mechanisms are met." A review of staff education records for the past year lacked evidence that employees #2 and #5 had received training regarding effective communication. On 8/20/24 at 3:50 p.m., in an interview with two surveyors, the Administrator and Director of Nursing confirmed the finding.	F 941	F944: QAPI Training Employees #2 and #5 have received QAPI education. An audit of staff educational files was conducted to ensure mandatory Quality Assessment and Performance Improvement (QAPI) education was conducted. The facility ensures education for all staff to facilitate understanding of QAPI program and processes, and systems to engage staff in participation in identifying improvement opportunities and participating in PI (Performance Improvement) teams. Staff will be re-educated to this process. DON/Designee will conduct audits reviewing QAPI education weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. (Edu: Healthstream 3Q LTC: Quality Assessment and Performance Improvement (QAPI) : for all staff)	
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff received mandatory training on it's Quality Assurance and Performance Improvement Program (QAPI), which included the staff's role and communication with the program, for 2 of 5 employee files reviewed (#2, #5).	F 944		

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F 944	Continued From page 19 Finding: Review of the facility's "Center Quality Assurance Performance Improvement Process" policy, with a revision date of 10/24/22, stated "Process. 2.11 The QAA (Quality Assurance and Assessment) Committee promotes full employee participation in identifying and improving key processes. 2.11.1 Ensures education for all staff to facilitate understanding of QAPI program and processes, and systems to engage staff in participation in identifying improvement opportunities and participating in PI (Performance Improvement) teams. 2.11.2 Assures QAPI program and processes are presented at staff orientation and at annual mandatory inservice programs." A review of employee education files lacked evidence that employees #2 and #5 received annual mandatory training regarding the facility's QAPI program. On 8/21/24 at 3:50 p.m., in an interview with two surveyors, the Administrator and Director of Nursing confirmed the finding.	F 944		
F 946 SS=E	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.	F 946		

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F 946	Continued From page 20 §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure it's standards, policies and procedures for it's Compliance and Ethics program were communicated to all staff, for 2 of 5 employee files reviewed (#2, #4). Finding: A review of employee education files lacked evidence that employees #2 and #4 received annual mandatory training regarding the facility's Compliance and Ethics program. On 8/21/24 at 3:50 p.m., in an interview with two surveyors, the Administrator and Director of Nursing confirmed the finding.	F 946	F946: Compliance and Ethics Training Employees #2 and #4 have received compliance and ethics education. An audit of staff educational files was conducted to ensure compliance and ethics training has been completed. The facility ensures that its standards, policies and procedures related to compliance and ethics, are communicated to staff. Direct care staff will be re-educated to this process. DON/Designee will conduct audits on compliance and ethics education weekly x 4 weeks, bi-weekly x 4 weeks, monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	9-20-24
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 5 employee files reviewed (#2) contained evidence of training to meet the residents' behavioral health care needs. Finding:	F 949		

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F 949	Continued From page 21 A review of the Facility Assessment for 2024-2025, noted its population profile includes a high frequency of residents admitted with neurological, cognitive, and psychiatric/mood conditions. Functional care requirements for mental health states "manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities." A review of the facility's policy, "Behaviors: Management of Symptoms," with a revision date of 7/1/24, stated "Center staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting behavioral health needs of patients. Education shall be based on the role of the staff member and patient needs identified through the facility assessment." A review of employee #2's education file lacked evidence that training in behavioral health care needs had been provided. On 8/20/24 at 3:50 p.m., in an interview with two surveyors, the Administrator and Director of Nursing confirmed the finding.	F 949	F949: Behavioral Health Training Employee #2 received behavioral health education. An audit of staff educational files was conducted to ensure behavioral health education has been completed. The facility ensures that center staff receive education to ensure appropriate skill sets for meeting behavioral health needs of patients. Direct care staff will be re-educated to this process. DON/Designee will conduct audits on compliance and ethics education weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	9-20-24