VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

May 1, 2023

Ms. Rose Mary Mayhew, Administrator
Bel Aire Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Dear Ms. Mayhew:

Enclosed is a copy of your acceptable plans of correction for the Emergency Preparedness survey conducted on **April 5, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475049	A. BUILDING _____ B. WING _____	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL AIRE CENTER	35 BEL-AIRE DRIVE NEWPORT, VT 05855

(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
E 000	Initial Comments An unannounced onsite Emergency Preparedness survey was conducted on 04/03/23 through 04/05/23 by the Division of Licensing and Protection. There were no regulatory violations identified.	E 000	Please note that this filing of this plan of correction does not constitute an admission as to any alleged violations set forth in this statement of deficiencies. This plan of correction is being filed as evidence of the facilities continued compliance with all laws.	
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was conducted on 04/03/23 through 04/05/23 by the Division of Licensing and Protection. The following regulatory violations were identified:	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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.	F 657	F657 Resident #111 had no injuries from 4/2/2023 incident. All residents have the potential to be affected by the alleged deficient practice. Nursing staff reeducation done the week of 4-17-23 across all shifts. Audits of fall care plans following a fall will be conducted to ensure a new intervention was initiated timely. Audits will be done on a weekly basis x 4 then monthly x 2 Results of audits reported to QAPI Oversight by DNS or designee **Tag F 657 POC accepted on 5/1/23 by G. Mercure/P. Cota**	5/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Mary Mayhew | TITLE: Administrator | (X6) DATE: 4/28/2023

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 657	Continued From page 1 (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 upon interview and record review, the facility failed to revise the Care Plan to prevent future falls for 1 resident [Resident #111] of 21 sampled residents. Findings include: Per record review, Res. #111 was admitted to the facility on 3/28/23 with diagnoses that included weakness, mental disorders due to known physiological condition, delusional disorder, altered mental status, glaucoma, and a history of falls, including a fall the day before admission to the facility. Review of the resident's Care Plan reveals the resident was identified as 'at risk for falls related to advanced age, impaired cognition'. Review of the facility's 'Incident Description' dated 4/2/23 records "LNA [Licensed Nurse's Aide] went to [Res. #111's] room after hearing a crash. Resident was found by LNA laying on left side on floor near bed... Resident was weak, drowsy at the time and oriented x2. Resident had been drowsy prior to fall although less so... Resident not able to answer questions without falling asleep ..." Review of the facility's Falls Management Policy, revised 6/15/22, includes "A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient). An episode where a patient lost their balance and would have fallen if not for	F 657		

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F 657	Continued From page 2	F 657		

another person or if they had not caught themselves is considered a fall."
Incident Description notes dated 4/2/23 continue with "At [3:30 PM] resident was noted to be out of bed again and falling against wall. This writer caught resident and guided resident to the recliner nearby. Resident not able to ambulate due to dizziness and weakness ..."
Physician Notes dated 4/2/23 record "Due to low blood pressure, [Res. #111] has had 2 falls in the last 6 hours."
The Incident notes conclude with "At [7:00 PM] resident noted to be too weak to stand and was finally agreeable to Emergency Department transport."

Per review of Nursing Notes, Res. #111 returned from the hospital on 4/3/23 at 12:15 PM with diagnoses of dehydration and Urinary Tract Infection.
Per record review, Res. #111's Care Plan after the 2 falls, dated 4/3/23, revealed no new interventions added related to Res.#111's risk for falls after 2 falls within 6 hours on 4/2/23.

Review of the facility's Falls Management Policy, revised 6/15/22, includes "Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented." Under 'Practice Standards' in the policy is listed "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care."

On 4/4/23, Nursing documentation records Res. #111 fell again. The resident was assessed as showing signs and symptoms of delirium [e.g. inability to pay attention, disorganized thinking].

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F 657	Continued From page 3 An interview was conducted with the facility's Director of Nursing [DON] on 4/4/23 at 11:24 AM. The DON confirmed that Res. #111 had suffered 2 falls on 4/2/23 and was subsequently hospitalized overnight. Regarding the resident's Care Plan and h/her risk for falls, the DON stated that after the 2 falls on 4/2/23 the resident's Care Plan under Cardiovascular symptoms was updated, not under the resident's risk for falls. Review of Res. #111's Care Plan under Cardiovascular symptoms reveals the single word "hypotension" added to the focus area, with no new interventions added to address either cardiovascular symptoms or fall risk. Additionally, during the interview the DON reported that Res. #111 had fallen again that morning, on 4/4/23. Per record review later on 4/4/23, Res. #111's Care Plan regarding 'At Risk for Falls' was revised to include "history of hypotension" in the focus area, and interventions added listing 'Encourage resident to consume all fluids during meals' and 'Monitor for signs/symptoms of dehydration (increase temp, decrease output, mental status changes, dry mucous membranes, tachycardia) as resident allows'. The Care Plan revision was added after the interview with the DON on 4/4/23 in which the DON was informed of the lack of new fall prevention interventions after the 2 falls on 4/2/23, and after the DON reported that the resident had suffered another fall earlier that day on 4/4/23. Review of the resident's Care Plan revealed identical interventions ['Encourage resident to consume all fluids during meals' and 'Monitor for signs/symptoms of dehydration (increase temp,	F 657		

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F 657	Continued From page 4 decrease output, mental status changes, dry mucous membranes, tachycardia)] were added on 4/3/23 regarding the resident's risk for dehydration, not to prevent future falls, and the resident fell again on 4/4/23. Despite the interventions already being in place, the identical hydration interventions were added as 'new' fall interventions on the Care Plan on 4/4/23 after the DON interview. The 4/3/23 interventions failed to prevent the fall on 4/4/23, but were added as 'new' interventions on 4/4/23 to prevent future falls after proving inadequate.	F 657		
F 689 SS=D	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 upon interview and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible, including implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary for 1 resident [Resident #111] of 21 sampled residents. Findings include: Per record review, Res. #111 was admitted to the facility on 3/28/23 with diagnoses that included weakness, mental disorders due to known	F 689	F689 Resident #111 had no injuries from 4/2/2023 incident. All residents have the potential to be affected by the alleged deficient practice. Nursing staff reeducation done the week of 4-17-23 across all shifts. Audits of fall care plans following a fall will be conducted to ensure a new intervention was initiated timely. Audits will be done on a weekly basis x 4 then monthly x 2 Results of audits reported to QAPI Oversight by DNS or designee **Tag F 689 POC accepted on 5/1/23 by G. Mercure/P. Cota**	5/5/2023

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F 689	Continued From page 5 physiological condition, delusional disorder, altered mental status, glaucoma, and a history of falls, including a fall the day before admission to the facility. Review of the resident's Care Plan reveals the resident was identified as 'at risk for falls related to advanced age, impaired cognition'. Review of the facility's 'Incident Description' dated 4/2/23 records "LNA [Licensed Nurse's Aide] went to [Res. #111's] room after hearing a crash. Resident was found by LNA laying on left side on floor near bed... Resident was weak, drowsy at the time and oriented x2. Resident had been drowsy prior to fall although less so... Resident not able to answer questions without falling asleep ..." Review of the facility's Falls Management Policy, revised 6/15/22, includes "A fall is defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., patient pushes another patient). An episode where a patient lost their balance and would have fallen if not for another person or if they had not caught themselves is considered a fall." Incident Description notes dated 4/2/23 continue with "At [3:30 PM] resident was noted to be out of bed again and falling against wall. This writer caught resident and guided resident to the recliner nearby. Resident not able to ambulate due to dizziness and weakness ..." Physician Notes dated 4/2/23 record "Due to low blood pressure, [Res. #111] has had 2 falls in the last 6 hours." The Incident notes conclude with "At [7:00 PM] resident noted to be too weak to stand and was finally agreeable to Emergency Department transport."	F 689		

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F 689	Continued From page 6 Per review of Nursing Notes, Res. #111 returned from the hospital on 4/3/23 at 12:15 PM with diagnoses of dehydration and Urinary Tract Infection. Per record review, Res. #111's Care Plan after the 2 falls, dated 4/3/23, reveal a resident focus area added "At risk for dehydration as evidenced by infection." Interventions included "Encourage resident to consume all fluids during meals" and "Monitor for signs/symptoms of dehydration (increase temp, decrease output, mental status changes, dry mucous membranes, orthostatic hypotension, tachycardia." Further review revealed no new interventions added related to Res.#111's risk for falls after 2 falls within 6 hours on 4/2/23. Review of the facility's Falls Management Policy, revised 6/15/22, includes "Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented." Under 'Practice Standards' in the policy is listed "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care." Nursing Assessment for Res. #111 for the next morning, 4/4/23, records the resident as "Confused. Oriented only to person [not to place or time]" "Decision making capacity: Severely Impaired - rarely/ never makes decisions- staff needs to anticipate and meet patient needs." "Mental health behavior observation: agitation/restlessness, anxiety about surroundings, hallucinations, impulsive"	F 689		

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F 689	Continued From page 7 Additionally, the resident was noted to exhibit shortness of breath with both lying flat and with exertion and have weakness in both right and left legs with limited weight bearing. On 4/4/23, Nursing documentation records Res. #111 fell again. The resident was assessed as showing signs and symptoms of delirium [e.g. inability to pay attention, disorganized thinking]. Review of Res. #111's blood pressure reading after the 3rd fall in 3 days on 4/4/23 reveal the resident did not have low blood pressure which resulted in the fall. [Low blood pressure is generally considered a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic).] (https://www.mayoclinic.org/diseases-conditions/low...) An interview was conducted with the facility's Director of Nursing [DON] on 4/4/23 at 11:24 AM. The DON confirmed that Res. #111 had suffered 2 falls on 4/2/23 and was subsequently hospitalized overnight. Regarding the resident's Care Plan and h/her risk for falls, the DON stated that after the 2 falls on 4/2/23 the resident's Care Plan under Cardiovascular symptoms was updated, not under the resident's risk for falls. Review of Res. #111's Care Plan under Cardiovascular symptoms reveals the single word "hypotension" added to the focus area, with no new interventions added to address either cardiovascular symptoms or fall risk. Additionally, during the interview the DON reported that Res. #111 had fallen again that morning, on 4/4/23. Per record review later on 4/4/23, Res. #111's	F 689		

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F 689	Continued From page 8 Care Plan regarding 'At Risk for Falls' was revised to include "history of hypotension" in the focus area, and interventions added listing 'Encourage resident to consume all fluids during meals' and 'Monitor for signs/symptoms of dehydration (increase temp, decrease output, mental status changes, dry mucous membranes, tachycardia) as resident allows'. The Care Plan revision was added after the interview with the DON on 4/4/23 in which the DON was informed of the lack of new fall prevention interventions after the 2 falls on 4/2/23, and after the DON reported that the resident had suffered another fall earlier that day on 4/4/23. Review of the resident's Care Plan revealed identical interventions ['Encourage resident to consume all fluids during meals' and 'Monitor for signs/symptoms of dehydration (increase temp, decrease output, mental status changes, dry mucous membranes, tachycardia)] were added on 4/3/23 regarding the resident's risk for dehydration, not to prevent future falls, and the resident fell again on 4/4/23. Despite the interventions already being in place, the identical hydration interventions were added as 'new' fall interventions on the Care Plan on 4/4/23 after the DON interview. The 4/3/23 interventions failed to prevent the fall on 4/4/23, but were added as 'new' interventions on 4/4/23 to prevent future falls after proving inadequate.	F 689		
F 865 SS=C	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	F 865		

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F 865	Continued From page 9 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; §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:	F 865	F865 Commitment to correct. QAPI meetings will maintain a record of attendees and topics discussed. Next meeting scheduled for 4-21-23 with new Medical Director. Responsibility - Administrator **Tag F 865 POC accepted on 5/1/23 by G. Mercure/P. Cota**	4/21/23

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F 865	Continued From page 10 §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 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	F 865		

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F 865	Continued From page 11 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: Based on interview and review of limited Quality Assurance and Performance Improvement (QAPI) program documentation, the facility failed to address all systems of care in a comprehensive manner by identifying problems and opportunities for improvement. Findings include: On 04/05/23 at 10:30 am an interview with the administrator of Bel Air Center, reveals verbal confirmation that the facility tried to hold regular monthly "Virtual" QAPI meetings over the past year as it has been difficult to have in person meetings, "due to COVID, staffing issues and changes with medical directors." The nurse practitioner, physician and pharmacist do not	F 865		

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(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 865	Continued From page 12	F 865		

always attend, but does report monthly. Verbal report from the administrator indicates some of the topics for discussion have been, infection control, falls with injury, pharmacy reviews, anti-psychotic use and have recently started looking at behavior trends and Licensed Nurse Assistant (LNA) coding along with interventions for such behaviors as a Performance Improvement Project (PIP). The administrator could not supply documentation of meeting dates, attendees or agendas for verification during survey and little documentation was provided via E mail the day after survey on 04/06/23. This documentation consists of the following:

Quality Improvement Committee Meeting sign in Sheets (04/12/22), four attendees with the following titles: Medical Director, CNE also IP, CEO, NP. Discussion: Review of 03/30/22 recertification survey citations.
Quality Improvement Committee Meeting sign in Sheets (05/10/22), four attendees with the following titles: Medical Director, DNP, CNE also IP, CEO. Discussion: Review of Casper Report.
Quality Improvement Committee Meeting sign in Sheets (10/12/22), ten attendees with the following titles: Administrator, LPN, LPN/CRC, SSD, LPN, LPN, RD, GPS, RN, and Central Supply. There is no documentation to reflect what the agenda was for this meeting.

Other documentation supplied includes an Improvement Action Plan about falls dated (12/10/22) and quarter three & 4 Falls numbers and percentages. An in-service sign-in sheet was also provided about Abuse prohibition and falls paperwork (12/10 &12/13) which included twelve staff signatures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475049	A. BUILDING _____ B. WING _____	04/05/2023

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F 865	Continued From page 13 Per the facilities Quality Assessment and Performance Improvement Plan (updated - 01/12/23) on page 1. (2.3) states "Meets at least 10 times annually" and "all members mut sign the QAPIC Sing-in Sheet", and on page 2. "Documentation of Quality Assurance Performance Improvement activities is filed by month for a period of one year in the QAPI Binder." The facility does not have a QAPI Binder containing documentation of dates and meeting agendas. The administrator confirmed on 04/05/23 at 10:30 am that documentation of QAPI meeting agendas is not in an organized fashion to include reviews, analysis of data, implementation and outcomes of performance and improvement projects and that it is difficult to gain access to the virtual platform to verify other participants. Meeting dates do not reflect consistent quarterly meetings to meet the regulatory requirement and it is difficult to assess for a "comprehensive" QAPI program. See crossover tag F868.	F 865		
F 868 SS=C	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	F868 Commitment to correct. QAPI meetings will maintain a record of attendees and topics discussed. Next meeting scheduled for 4-21-23 with new Medical Director. Responsibility - Administrator **Tag F 868 POC accepted on 5/1/23 by G. Mercure/P. Cota**	4/21/23

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F 868	Continued From page 14 (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 interview and review of limited Quality Assurance and Performance Improvement (QAPI) program documentation, the facility did not hold consistent quarterly meetings and without all the proper attendees to address all systems of care in a comprehensive manner by identifying problems and opportunities for improvement. Findings include: On 04/05/23 at 10:30 am an interview with the administrator of Bel Air Center, reveals verbal	F 868		

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F 868	Continued From page 15 confirmation that the facility tried to hold regular monthly "Virtual" QAPI meetings over the past year as it has been difficult to have in person meetings, "due to COVID, staffing issues and changes with medical directors." The nurse practitioner, physician and pharmacist do not always attend, but does report monthly. The facility could not supply documentation of meeting dates, attendees or agendas for verification during survey and little documentation was provided via E mail the day after survey on 04/06/23. This documentation consists of the following: Quality Improvement Committee Meeting sign in Sheets (04/12/22), four attendees with the following titles: Medical Director, CNE also IP, CEO, NP. Quality Improvement Committee Meeting sign in Sheets (05/10/22), four attendees with the following titles: Medical Director, DNP, CNE also IP, CEO. Quality Improvement Committee Meeting sign in Sheets (10/12/22), ten attendees with the following titles: Administrator, LPN, LPN/CRC, SSD, LPN, LPN, RD, GPS, RN, and Central Supply. Per the facilities Quality Assessment and Performance Improvement Plan (updated - 01/12/23) on page 1. (2.3) states "Meets at least 10 times annually" and "all members mut sign the QAPIC Sing-in Sheet", and on page 2. "Documentation of Quality Assurance Performance Improvement activities is filed by month for a period of one year in the QAPI Binder." The facility does not have a QAPI Binder containing documentation of dates and meeting agendas.	F 868		

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F 868	Continued From page 16 The administrator confirmed on 04/05/23 at 10:30 am that documentation of QAPI meeting agendas is not in an organized fashion to include reviews, analysis of data, implementation and outcomes of performance and improvement projects and that it is difficult to gain access to the virtual platform to verify other participants. Meeting dates do not reflect consistent quarterly meetings to meet the regulatory requirement and it is difficult to assess for a "comprehensive" QAPI program. See crossover tag F865.	F 868		