STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055387	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Skilled Nursing Center	2625 East Fourth Street Long Beach, CA 90814

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to conduct a timely Interdisciplinary Team ([IDT] health care professionals who work together with the resident to plan the residents plan of care) meeting for one of three sampled residents (Resident 1). The facility failed to ensure Resident 1's was given the opportunity to meet with the IDT to discuss any updates or concerns she has in her current plan of care. These deficient practices resulted in a delay in communication between Resident 1 and the IDT causing frustration and anxiety to the Resident 1 and had the potential to delay in the delivery of needed care and services. Findings: During a review of Resident 1's Admission Record (Face Sheet) the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including displaced fracture (broken bone) of the medial condyle of left femur (inside part of knee), left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and left hemiparesis (weakness and paralysis) following cerebral infarction ([stroke]lack of blood flow to brain). During a review of Resident 1's History and Physical (H&P) dated 5/3/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/7/2024, the MDS indicated Resident 1 always had the ability to be understood and understand others. The MDS indicated Resident 1 had functional limitation in range of motion (ROM - limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk for injury) in one upper (shoulder, elbow, wrist, and hand) extremity and one lower (hip, knee, ankle, foot) extremity. Resident 1 required partial to moderate assistance (helper does less than half the effort) from staff for showering, upper body dressing, personal hygiene, sitting to lying, lying to sitting on side of the bed, and sit to stand. The MDS indicated Resident 1 was occasionally (had less than seven episodes) incontinent of urine and had frequent (two or more episodes) of bowel incontinence during the assessment period. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's untitled Care Plan, initiated on 5/26/024, the Care Plan indicated Resident 1 had impaired and fluctuating Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) skills related to displaced (ends of a broken bone are no longer aligned, creating a gap) fracture of the left femur (thigh bone) left hemiplegia/hemiparesis, motor vehicle accident , left ankle joint injury, orthopedic after care, acute post hemorrhagic anemia (low blood count after injury), pneumothorax (collapsed lung), dissection (tear) of carotid artery (vessel carries blood to heart to head), and multiple rib fractures. During a review of Resident 1's Clinical Record (Interdisciplinary Team Person Care Conference Record), dated on 7/11/2024, the IDT record indicated Resident 1's Medical Doctor (MD) from the General Acute Care Hospital (GACH) referred Resident 1 to physical therapy. During a review of Resident 1's Social Services Note, dated 8/16/2024, the Social Service Note indicated Resident 1 approved for rehab services at outpatient physical therapy clinic beginning 9/4/2024 and Resident 1 had and appointment with her Primary Care Physician (PCP) on 9/3/2024. The Social Service Note indicated the Social Service Director (SSD) informed Resident 1 of the appointment, will continue to assist Resident 1 with all appropriate needs, and follow up as needed. During a review of Resident 1's Physician's Order Recap Report, dated 5/2/2024 to 12/4/2024, indicated Resident 1 had the following orders: 1. Follow-up appointment with neuroradiology in two weeks from 5/2/2024. 2. Appointment for CTA-neck on 7/1/2024 at 1 p.m. at the outside imaging center. 3. One month follow up appointment with PCP on 9/3/2024. 4. Outpatient physical therapy appointment on 9/30/2024 at 8:30 a.m. 5. Outpatient physical therapy appointment on 10/16/2024 at 2:30 p.m. 6. Outpatient physical therapy appointment on 10/22/2024 at 3:45 p.m. 7. Outpatient physical therapy appointment on 10/29/2024 at 3:45 p.m. 8. Return to the outpatient clinic on 12/5/2024 at 2 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024, at 10 a.m., Resident 1 stated she has been very frustrated with the communication between the members of the IDT team regarding her plan care. Resident 1 stated she do not have a clear understanding of her plan of care specifically regarding physician appointments and physical therapy goals. Resident 1 stated she has been coordinating her own physical therapy outside of the facility since her insurance wouldn't cover in house therapy at the facility. Resident 1 stated the facility is providing her with Restorative Nurse Assistant (RNA) therapy based on what her insurance will cover. Resident 1 stated she would the like facility to be aware of her appointments and would like clarification on what her recovery plan and discharge goals were. Resident 1 stated she thinks she may have missed certain physician appointments due to lack of coordination from the facility. Resident 1 stated she can plan her own appointments but wants everyone to be on the same page to ensure she do not miss appointments. Resident 1 stated she wants the nursing and rehabilitation department to be aware of her outside physical therapy appointments and how it affects her care in the facility. Resident 1 stated the lack of communication between her care and the IDT has caused her increased anxiety and worry. During an interview on 12/3/2024, at 3:10 p.m., the Director of Social Services (SSD) stated Resident 1 goes to an outside physical therapy clinic to receive physical therapy services. The SSD stated, once Resident 1 attends an appointment, the IDT team should be made aware of any recommendations to update Resident 1's plan of care. The SSD stated Resident 1's last IDT meeting was noted to be held on 7/11/2024 and another IDT should have been done since it was overdue. The SSD stated it is important for the IDT team and Resident 1 to meet regularly to ensure Resident 1 has a clear understanding on her plan of care and who is involved. During an interview on 12/4/2024, at 10 a.m., the Director of Rehabilitation (DOR) stated Resident 1 does not receive physical therapy in the facility due to lack insurance coverage. The DOR stated Resident 1 coordinates her own appointments with an outpatient physical therapy clinic. The DOR stated, the last IDT held for Resident 1 was on 7/11/2024. The DOR stated Resident 1 receives RNA therapy to perform passive range of motion exercises (caregiver moves a resident's body part or limb to gently stretch muscles and improve range of motion) on left upper and lower extremities in all joints and planes five times a week as tolerated to improve range of motion for contracture prevention (the practice of keeping the body moving to prevent the tightening of muscles, tendons, skin, and nearby tissue). The DOR stated she and the IDT are not sure what kind of services Resident 1 is receiving at the outpatient physical therapy clinic but it would be important for the IDT to know what the recommendations are from the outside physical therapy clinic to update Resident 1's plan of care. During an interview on 12/4/2024, at 3 p.m., the Director of Nursing (DON) stated she did not see any progress notes or summaries detailing a summary of Resident 1's physician visits. The DON stated she could not confirm whether nor not Resident 1 missed the physician appointments as listed in the physician order recap report. The DON stated, the IDT is not aware of the nature of Resident 1 's outside physical therapy appointments. The DON stated the IDT along with Resident 1 should have a clear understanding of when Resident 1 physician appointments and outside physical therapy appointments are scheduled and after they occur, what the outcomes and recommendations are if any. The DON stated the Resident 1 is overdue to have another IDT meeting as her most recently documented IDT was on 7/11/2024. The DON stated failure to conduct regular IDT meetings to discuss and update Resident 1 's plan of care can cause frustration to Resident 1 and cause a delay in care and necessary services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Care plan and care plan update revised 2/2023, the P&P indicated it is the policy of this facility to ensure each resident received quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the interdisciplinary comprehensive assessment and plan of care. The facility will assure the completion of the resident assessment process enabling the development of an individual comprehensive care plan for the resident. The interdisciplinary team will adhere to the schedule of the resident assessment. The P&P indicated, the IDT team involvement in adhering to these guidelines will ensure consistency in documentation and care plan update.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was provided the appropriate care and services to maintain her Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) by failing to provide Resident 1 with a commode (portable toilet) on 7/11/2024. This failure resulted in Resident 1 being forced to use a bedpan (container used to collect urine or feces used while lying or sitting in bed) which caused Resident 1 to feel embarrassed and degraded. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including displaced fracture (broken bone) of the medial condyle of left femur (inside part of knee), left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), left hemiparesis (weakness and paralysis) following cerebral infarction ([stroke] loss of blood flow to a part of the brain). During a review of Resident 1's Bowel and Bladder Evaluation dated 5/2/2024, the evaluation indicated Resident 1 was continent (ability to control the need to use to the toilet). During a review of Resident 1's History and Physical (H&P) dated 5/3/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/7/2024, the MDS indicated Resident 1 always had the ability to be understood and understand others. The MDS indicated Resident 1 had functional limitation in range of motion (ROM - limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk for injury) in one upper (shoulder, elbow, wrist, and hand) extremity and one lower (hip, knee, ankle, foot) extremity. Resident 1 required partial to moderate assistance (helper does less than half the effort) from staff for showering, upper body dressing, personal hygiene, sitting to lying, lying to sitting on side of the bed, and sit to stand. The MDS indicated Resident 1 was occasionally (had less than seven episodes) incontinent of urine and had frequent (two or more episodes) of bowel incontinence during the assessment period. During a review of Resident 1's untitled Care Plan, initiated on 5/3/2024, the Care Plan indicated Resident 1 had an ADL self-performance deficit related to limited mobility secondary to left lower extremity fracture. The Care Plan goal indicated Resident 1 will safely perform (bed mobility, transfers, eating, dressing, grooming, toilet use, and person hygiene with modified independence) through the target date of 2/8/2025. Under this Care Plan, the interventions indicated Resident 1 required one staff member to participate with transfer (chair to bed/chair transfer, toilet transfer). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Clinical Record (Interdisciplinary Team Person Care Conference Record), dated on 7/11/2024, the IDT record indicated Resident 1 requested a bedside commode. During an interview on 12/3/2024, at 10 a.m., Resident 1 stated she has been requesting a commode for several months but has yet to receive one. Resident 1 stated she feels angry that she has not been given the opportunity to get out of bed to use the commode as requested. Resident 1 stated staff have been giving her a bed pan to urinate and have a bowel movement which results in her feeling embarrassed and degraded that she must resort to using a bedpan. During an interview on 12/4/2024 at 10 a.m., the Director of Rehabilitation (DOR) stated Resident 1 was evaluated by the rehabilitation department and was appropriate to transfer with assistance from her bed to a chair. The DOR stated the Resident 1 should have been provided a commode to ensure Resident 1 maintained her independence. During an interview on 12/4/2024 at 3 p.m., the Director of Nursing (DON) stated Resident 1 could verbalize when she needs to use the toilet and should have been provided the opportunity to use a commode. The DON stated Resident 1's request for a commode should have been addressed by the IDT team during the time of the request on 7/11/2024. The DON stated the facility should ensure Resident 1 maintains or can improve ability to carry out her ADLs. The DON stated by failing to meet Resident 1's request for a commode put Resident 1 at risk for decline in mental health and did not enhance Resident 1's sense of dignity and independence. During a review of the facility's policies and Procedures (P&P), titled Activities of Daily Living (ADLs), Services to carry out, dated 11/2007, the P&P indicated it is the policy of the facility that residents are given the appropriate treatment and services to maintain or improve her abilities.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was seen by the psychiatrist as indicated per the physician orders. This failure resulted in Resident 1 not receiving the required behavioral health care services and placed Resident 1 at risk to suffer further mental anguish and decreased quality of life. Findings: During a review of Resident 1's Admission Record (Face Sheet) the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses including displaced fracture (broken bone) of the medial condyle of left femur (inside part of knee), left hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and left hemiparesis (weakness and paralysis) following cerebral infarction ([stroke]lack of blood flow to brain). During a review of Resident 1's History and Physical (H&P) dated 5/3/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/7/2024, the MDS indicated Resident 1 always had the ability to be understood and understand others. The MDS indicated Resident 1 had functional limitation in range of motion (ROM - limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk for injury) in one upper (shoulder, elbow, wrist, and hand) extremity and one lower (hip, knee, ankle, foot) extremity. Resident 1 required partial to moderate assistance (helper does less than half the effort) from staff for showering, upper body dressing, personal hygiene, sitting to lying, lying to sitting on side of the bed, and sit to stand. During a review of Resident 1's Order Summary Report (physician's orders), dated 5/2/2024, the report indicated Resident 1 had an order for psych to evaluate and treat as indicated. During a review of Resident 1's untitled Care Plan, initiated on 6/25/2024, the Care Plan indicated Resident 1 had a behavior of consistently fabricating stories, was very impulsive, constantly pressed the call light for the same concerns that were previously addressed, and exhibited attention seeking behavior such as yelling at the staff. The Care Plan goal indicated the following Resident 1 will have fewer episodes of fabricating stories through the review dated of 2/8/2025. Under this Care Plan, the interventions indicated to administer medication as ordered, monitor/document for side effects and effectiveness of medication, anticipate and meet needs, approach in a calm manner, assist to develop more appropriate methods of coping and interacting, encourage to express feelings appropriately, care givers to provide opportunity for positive interaction, attention stop and talk with Resident 1, document behaviors and resident response to interventions, educate family and caregivers on successful coping and interactions strategies, needs encouragement and active support by family/caregivers, explain all procedures to before starting and allow to adjust to changes, discuss behavior, and explain and/or enforce why behavior is inappropriate and or unacceptable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024, at 10 a.m., Resident 1 stated she has been very frustrated with the communication between the members of the IDT team regarding her plan of care. Resident 1 stated she does not have a clear understanding of her plan of care specifically regarding physician appointments and her physical therapy goals. Resident 1 stated the lack of communication between herself, and the IDT has caused her increased depression (mental health condition that involves a persistent low mood and loss of interest in activities for at least two weeks), anxiety and worry. Resident 1 stated it was affecting her daily life, was having a hard time focusing, and would like to see psychiatrist or psychologist. During an interview on 12/3/2024, at 3:10 p.m. the Social Services Director (SSD) stated upon his review of Resident 1 clinical records, Resident 1 's records do not indicate Resident 1 was seen by psychiatrist or psychologist since her admission on 5/2/2024. The SSD stated Resident 1's insurance does not cover the facility's contracted psychiatric visits and the facility has not made any efforts to facilitate Resident 1 in receiving a psychiatric visit. The SSD stated the facility placed Resident 1 at risk for mental health decline due to the lack of behavioral health services provided to Resident 1. The SSD stated the facility failed to ensure Resident 1's behavioral and psychosocial needs were met. During an interview on 12/4/2024, at 3 p.m., the Director of Nursing (DON) stated upon her review of Resident 1's clinical records, she did not see any progress notes or summaries indicating Resident 1 was seen by a psychiatrist. The DON stated Resident 1 did not receive a consult from a psychiatrist because Resident 1's insurance did not cover the services of the facility inhouse psychiatrist. The DON stated the facility should have followed up to ensure Resident 1's behavioral needs and well-being were being monitored and met. The DON stated by failing to follow up on Resident 1's behaviors, and by failing to facilitate Resident 1 in receiving a psychiatric consult, the facility placed Resident 1 at risk to suffer a decline in mental health and a decreased quality of life. The DON stated Resident 1 had a right to receive behavioral and mental health care and services which was not provided to her. During a review of the facility's document, titled Facility Assessment (assessment to determine what resources are necessary to care for it residents competently during both day to day operations and emergencies) 2024-2025, revised 10/1/2024 2019, the assessment indicated the facility will accept and care for residents with psychiatric conditions (medical condition that significantly impacts a person's thinking, feelings, behavior, or mood) such as adjustment disorder, depression, major depressive disorder, anxiety, failure to thrive, bipolar disorder, borderline personality disorder and mood disorders. The assessment indicated the facility will manage the medical conditions and medication related issues causing psychiatric symptoms and behavior, identity 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, SUD, traumatic brain injury. The facility assessment indicated the facility will support the residents' emotional and mental well-being and helpful coping mechanisms. During a review of the facility's policies and Procedures (P&P), titled Behavioral Health Services, revised 4/2019, the P&P indicated it is the policy of the facility to provide residents with necessary behavioral health care services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44958 Based on interview, and record review the facility's Quality Assessment and Assurance ([QAA] develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to develop and implement appropriate methods to measure the success of actions implemented addressing the continued concerns from the Resident Council pertaining to a delay in call light response during the hours of 11 p.m. to 7 a.m., and failed to address the delivery of Activities of Daily living (ADLs - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) care. This deficient practice has the potential to affect all 73 residents who reside in the facility to not receive the quality care necessary to meet their highest potential well-being. Findings: During a review of facility ' s Resident Council Minutes, dated 8/20/2024, the minute ' s indicated residents are not happy with the 11 p.m. to 7 a.m. shift as the staff could not be found. During a review of facility ' s Resident Council Minutes, dated 10/2/2024, the minute ' s indicated residents had concerns with Certified Nurse Assistant (CNA) during the 11 p.m. to 7 a.m. shift taking two hours to answer the call light and resident not being showered during the 3 p.m. to 11 p.m. shift. During a review of facility ' s Resident Council Minutes, dated 10/22/2024, the minutes indicated residents ' concerns included call lights not being answered in a timely manner, resident not being showered during the 3 p.m. to 11 p.m. shift, and not receiving activities of daily living care after dinner. During a review of facility ' s QAPI Projects 2024, dated 8/1/2024, the QAPI Project indicated the facility ' s goal was to improve call light response to achieve resident satisfaction in three to six months. The QAPI Project indicated the facility will collect data measuring and frequency by providing daily spot checks. The QAPI Project indicated the project plans included rounding and spot check every day, daily Guardian Angel rounds based on resident interview, Resident council will give feedback on call light response time, and monthly call light in-services to staff. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/4/2024 at 4 p.m., the Administrator (ADM) stated the facility is utilizing the Angel Rounds as an assessment of the care being delivered to the residents. The ADM stated the Angel Rounds do not include direct questions addressing the residents ' concerns mentioned in the resident council minutes such as how long residents must wait for the call light to be answered during the 11 p.m. to 7 p.m. shift, if residents received ADLs care during 11 p.m. to 7 a.m. shift, and if the resident a shower or bed bath during the 3 p.m. to the 11 p.m. shift. The ADM stated the facility ' s Angel Rounds does not measure the success of the actions implemented not track performance to ensure improvements are realized and sustained. The ADM stated failure to have an accurate system in place to measure the outcomes of interventions puts residents at risk for receiving substandard quality of care. During a review of the facility's policies and procedure (P&P), titled Quality Assurance and Performance Improvement, revised 1/2022, the P&P indicated the facility will establish and implement a Quality Assessment and Assurance Committee, develop a written Quality Assurance and Performance Improvement Plan which will be reviewed and updated annually and Implement Performance Improvement Projects (PIPs) through data driven and proactive approach. The purpose of the QAPI plan and process is to continually access the facility ' s performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individual ' s highest practicable physical, mental, and social well-being. The P&P indicated the QAPI components include design and scope, governance and leadership, feedback, data systems and monitoring, PIPs systemic analysis and systemic action.