STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225343	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Healthcare	460 Washington Street Norwood, MA 02062

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

15203

Based on interviews and records reviewed, for one of three sampled Residents (Resident #1), whose medical history included a traumatic subarachnoid hemorrhage without loss of consciousness and unspecified intracranial injury without loss of consciousness (traumatic brain injury/TBI), after being hit by a car as a pedestrian, he/she had limited attention and concentration, impaired judgement/insight, was assessed and care planned for the need for staff supervision while smoking and using smoking materials, the Facility failed to ensure that 1) staff consistently implemented and followed interventions from his/her Plan of Care related smoking safety with the need for staff supervision while he/she was in possession of smoking materials, and 2) that he/she was accurately assessed by nursing based on criteria identified on the facility elopement risk form related risk factors that needed to be considered, and that a plan of care should be developed and implemented.

Findings included:

1) The Facility Policy titled Smoking Policy-Residents, dated as last revised 3/2024, indicated that residents were evaluated on admission to determine the resident's ability to smoke safely. The Policy indicated residents who are supervised for smoking will be monitored by a staff member or designee during the smoking time.

Review of Resident #1's medical record indicated he/she was admitted to the Facility during August 2023 with diagnoses which included paranoid schizophrenia, delirium, alcohol use disorder, cocaine abuse uncomplicated (substance use disorder) and a history of a traumatic subarachnoid hemorrhage without loss of consciousness and unspecified intracranial injury without loss of consciousness (traumatic brain injury/TBI) after being hit by a car as a pedestrian.

The Record also indicated that Resident #1 had a court ordered legal guardian in place as of August 2023.

Review of Resident #1's Care Plan related to Smoking, dated as initiated 10/20/23, indicated that Resident #1 was to be supervised by staff in designated areas when smoking. The Care Plan goal indicated that Resident #1 would follow smoking policies and procedures, that Resident #1's safety while smoking would be monitored.

Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 3/01/24, indicated Resident #1's cognitive patterns were severely impaired.

(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: 225343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Norwood Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Washington Street Norwood, MA 02062	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Behavioral Health Group Medication Management Note, dated 4/03/24, indicated Resident #1 seen at the Facility for psychiatric evaluation and medication management. The Note indicated Resident #1's diagnoses included paranoid schizophrenia, alcohol abuse and cocaine use. The Note indicated that Resident exhibited anxiety, psychosis, circumstantial and disorganized thoughts and that his/her long term memory was impaired. The Note indicated that Resident #1 had limited attention/concentration and impaired judgement/insight. Review of facility video surveillance camera footage, dated 5/02/24, in combination with staff interviews, indicated that during the dinner time smoke break that day, after Resident #1 was given a cigarette by a staff member, he/she followed another resident, (for whom the door had been opened remotely by a supervisor) out to the smoking area and was able to light and start smoking his/her cigarette before the staff member assigned to supervise residents participating in the smoking break, was outside and in place to maintain Resident #1's and the other residents' safety while smoking. Resident #1, was outside smoking, for almost a full minute unattended by staff, before the assigned staff member exited the facility lobby and was physically present to supervise him/her and the other smokers. Review of the May 02, 2024 facility video surveillance camera footage showed the following: - at 16:21:30, (4:21:30 P.M.) Resident #1 (who required supervision with smoking for safety), Resident #2 and Resident #3 exit through the Facility front door, -at 16:21:44, (4:21:44 P.M.) Residents #1 and Resident #2 exchange a lighter while standing on the front stairs, light and begin smoking their cigarettes, -at 16:22:30 (4:22: 30) the Nurse Supervisor (assigned to supervise the smoking group) exits the front door with additional residents who are going outside to smoke. During an interview on 5/08/24 at 3:35 P.M., the Nurse Supervisor said that on 5/02/24, he was assigned to and supervised the residents 4:00 P.M., smoking break on 5/02/24. The Nurse Supervisor said that before taking the residents outside, he dispensed cigarettes to residents in the lobby while he sat at the reception desk. The Nurse Supervisor said that at one point, from the vantage point of reception desk, he saw that Resident #3, who was able to leave the Facility independently and smoke safely without staff supervision, was waiting at the front door, so he released the electronic door lock on the front door with the button located at the reception desk to allow Resident #3 to exit the Facility. The Nurse Supervisor said however, he had a limited view of the front door from where he was sitting, and said he did not realize that Resident #1, (who he had already given a cigarette to) had also gone outside with Resident #3, when he let him/her out of the facility. During an interview on 5/08/24 at 9:20 A.M. the Director of Nursing said when she interviewed the Nurse Supervisor about the incident, he told her that he paused for only a blink of second to reset alarms after opening the front door before joining the residents outside in the smoking area. However, review of the May 02, 2024 video surveillance camera footage indicated that Resident #1 had been outside of the Facility smoking without a staff person supervising him/her for safety for a full minute, before the Nurse Supervisor went outside to the smoking area to provide supervision to the residents. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the Facility Policy titled Elopements, dated as established 1/2017, indicated that staff should promptly report any resident who tries to leave the premise and attempt to prevent the departure in a courteous manner. Review of the Facility Policy titled Resident Participation-Assessment/Care Plan, dated as last revised 8/2019, indicated that the care planning process will included an assessment of the resident's strengths and his/her needs, be begun on the first day of admission and completed no later that the fourteenth day after admission, and the comprehensive care plan is developed within seven days of completing the resident assessment. Review of the Elopement Risk Evaluation Form used by the Facility, indicated that residents who have a history of Substance Abuse or Psychosis [both of which Resident #1 had] should be considered at risk for elopement and a care plan should be initiated. During an interview on 5/08/24 at 2:40 P.M, the MDS Nurse said that residents assessments were part of the electronic health record. The MDS Nurse said that different clinical staff in the Facility were assigned to complete certain assessments in the residents' electronic health record and the timeframe generally coincided with quarterly MDS assessments. Review of the Elopement Risk Evaluations completed by nursing for Resident #1, indicated that despite having both Substance Abuse and Psychosis, the evaluation determinations by nursing that indicated he/she was not at risk, were inconsistent with criteria identified on the facility assessment form. Elopement Risk Evaluations conducted by nursing during Resident #1's stay at the Facility indicated the following: - Resident #1's Elopement Risk Assessment, dated 8/03/23, indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, that the review of all triggers determination for this assessment by indicated he/she was not at risk for elopement and an elopement care plan was not developed. - However, Resident #1's Elopement Risk Assessment, dated 10/07/23, again indicated he/she had a Substance Abuse History and the review of all triggers determination for this assessment indicated he/she was at risk for elopement and that a care plan should be developed per Facility Policy, but was not. - Resident #1's Elopement Risk Assessment, dated on 11/30/23, again indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, the review of all triggers determination for this assessment indicated he/she was not at risk for elopement and an elopement care plan was not developed. - Resident #1's Elopement Risk Assessment, dated 2/26/24, again indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, the review of all triggers determination for the assessment indicated he/she was not at risk for elopement and an elopement care plan was not developed. Review of Resident #1's Care Plans indicated there was no documentation to support nursing having developed a care plan to address Resident #1's elopement risk. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/08/24 at 3:09 P.M., the MDS Nurse said that she reviewed Resident #1's care plans, including all care plans concerns which had been developed and resolved previously during his/her stay at the Facility, and said the Facility had not developed a care plan to address his/her risk of elopement at any time during his/her stay. During interviews on 5/09/24 at 10:43 A.M. and 2:30 P.M., the Regional Director of Clinical Operations, the Director of Nursing and the Administrator, they said that they were not aware that the Elopement Risk Evaluation Form used by the Facility indicated that residents who have a history of Substance Abuse or Psychosis should be considered at risk for elopement and a care plan should be initiated. The Regional Director of Clinical Operations, the Director of Nursing and the Administrator said they disagreed with the wording on the assessment form and thought it was inappropriate to determine elopement risk based on diagnosis alone.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 15203 Based on observations, interviews and records reviewed, for one of three sampled Residents (Resident #1), whose history included a traumatic subarachnoid hemorrhage without loss of consciousness and unspecified intracranial injury without loss of consciousness (traumatic brain injury/TBI), after being hit by a car as a pedestrian, who had limited attention/concentration and impaired judgement/insight, had a court appointed legal guardian, resided on a secured unit, and who was assessed and care planned for the need for staff supervision while smoking and using smoking materials, the Facility failed to ensure they provided an adequate level of staff to supervise the outside smoking area, as well as monitor and supervise the facility lobby during smoking break times to prevent an incident/accident, including an elopement. On 5/02/24, Resident #1, who was attending the 4:00 P.M., scheduled supervised smoke break group, was given a cigarette by the Nurse Supervisor, however he/she did not stay and wait with the other residents as they were getting their smoking materials, and when the Nurse Supervisor let Resident #3 (who was independent and could go out unsupervised to smoke) out the locked front door by releasing the electronic lock on the front door from the reception desk, unbeknownst to the Nurse Supervisor, Resident #1 and Resident #2 (who required supervision with smoking), also exited the Facility. After about one minute of being outside, unsupervised as there was no staff member outside in the smoking area, Resident #1 walked off Facility grounds and eloped from the facility. Resident #1 was not determined to be missing by staff until almost fifteen minutes later, when the smoke break ended. Resident #1's whereabouts were unknown for approximately nine days, and on 5/10/24, the Massachusetts Department of Mental Health informed the Facility that he/she checked him/herself into a Hospital Emergency Department about 13 miles away from the Facility. Findings include: Review of the Facility Policy titled Elopements, dated as established 1/2017, indicated that staff should promptly report any resident who tries to leave the premise and attempt to prevent the departure in a courteous manner. Review of the Facility Policy titled Smoking Policy-Residents, dated as last revised 3/2024, indicated that residents were evaluated on admission to determine the resident's ability to smoke safely with or without supervision. The Policy indicated residents who are supervised for smoking will be monitored by a staff member or designee during the smoking time. Review of the Report submitted by the Facility to the Department of Public Health (DPH) via the Health Care Facility Reporting System (HCFRS), dated 5/02/24, indicated that on 5/02/24 at 4:18 P.M., residents exited the Facility front door for the supervised smoking time and staff realized [after checking with staff on Resident #1's unit after the smoke break was over] that Resident #1 was not in the group. The Report indicated the inside of the Facility and the grounds were searched with the help of the police and Resident #1 was not found. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's medical record indicated he/she had been admitted to the Facility during August 2023 with diagnoses which included history of a traumatic subarachnoid hemorrhage without loss of consciousness and unspecified intracranial injury without loss of consciousness (traumatic brain injury/TBI), and bilateral tibia (large lower leg bone) open fractures after being hit by a car in June 2023, as a pedestrian. The Record also indicated Resident #1 medical history included paranoid schizophrenia, delirium, alcohol use disorder and Substance Use Disorder related history of cocaine abuse, uncomplicated and homelessness. The Record also indicated that Resident #1 had a court ordered legal guardian in place as of August 2023. Review of Resident #1's Quarterly Minimum Data Set (MDS) Assessment, dated 3/01/24, indicated Resident #1's cognitive patterns were severely impaired. Review of the Behavioral Health Group Medication Management Note, dated 4/03/24, indicated Resident #1 was seen at the Facility for psychiatric evaluation and medication management. The Note indicated Resident #1's diagnoses included paranoid schizophrenia, alcohol abuse and cocaine use. The Note indicated Resident #1's psychiatric history, including history of inpatient or outpatient behavioral health services, was unknown. The Note indicated that Resident #1 exhibited anxiety, psychosis, circumstantial and disorganized thoughts and impaired long-term memory. The Note indicated that Resident #1 had limited attention/concentration and impaired judgement/insight. Review of Resident #1's Smoking Assessments, dated 9/30/23 and 11/30/23. indicated he/she was safe to light smoking materials with staff supervision. Review of Resident #1's Care Plan related to Smoking, dated as initiated 10/20/23, indicated that Resident #1 was to be supervised by staff in designated areas when smoking. The Care Plan goal indicated that Resident #1 would follow smoking policies and procedures and interventions, and his/her safety during smoking would be monitored. Review of the May 02, 2024 facility video surveillance camera footage, showed the following: - at 16:21:30 (4:21:30 P.M.), Residents #1, Resident #2 (who required supervision with smoking) and Resident #3 exit through the Facility front door, - at 16:21:44 (4:21:44 P.M.) Residents #1 and Resident #2 exchange a lighter while standing on the front stairs and light their cigarettes, - at 16:22:00 (4:22:00 P.M.) Residents #1 and Resident #2 descend the stairs and Resident #1 walks away from the smoking area, turing left down the Facility driveway and out of the view of the video surveillance camera, and, - at 16:22:30 (4:22:30 P.M., one full minute after Resident #1 and Resident #2 exited the facility) the Nurse Supervisor exits the front door with additional residents and they proceed to the smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the May 02, 2024 video surveillance camera footage from a second facility video camera showed the following: - at 16:22:30 (4:22:30 P.M.) Resident #1 approaches the end of the Facility driveway and the main road, and, - at 16:22:40 (4:22:40 P.M.) Resident #1 turned left at the end of the driveway and out of view of the video surveillance camera. Review of the May 02, 2024, footage showed the Resident #1 walked the distance from the bottom of the Facility front stairs to the end of the driveway (and off of the Facility property) in 40 seconds. During an interview on 5/08/24 at 3:35 P.M., the Nurse Supervisor said that on 5/02/24 around 4:00 P.M., he was seated at the reception desk monitoring the lobby and the locked front door. The Nurse Supervisor said that as residents arrived for the 4:00 P.M. smoking break time, that he dispensed cigarettes to them from the reception desk. The Nurse Supervisor said that, at one point, he saw Resident #3 waiting at the front door. The Nurse Supervisor said Resident #3 was able to leave the Facility independently. The Nurse Supervisor said that he released the electronic lock on the front door, using the release button located at the reception desk, to allow Resident #3 to exit. The Nurse Supervisor said that his view of the front door was partially obstructed when he was seated at the reception desk, that he did not see Resident #1 or Resident #2 standing with Resident #3, when he let Resident #3 out. The Nurse Supervisor said a short time later, after he finished dispensing cigarettes, [per the May 02, 2024, video footage was at 16:22:30 (4:22:30 P.M.,)] he exited the lobby with the remaining residents to go out to the smoking area. The Nurse Supervisor said that once out in the smoking area, he then noticed that Resident #1 wasn't present. The Nurse Supervisor said that he asked the other residents where Resident #1 was and said they told him that Resident #1 had not come outside to smoke. The Nurse Supervisor said that although he remembered giving Resident #1 a cigarette for the 4:00 P.M. smoking break, had documented that he gave him/her a cigarette, said he second guessed himself and trusted that the residents were correct that Resident #1 had not come outside to smoke. Although the Nurse Supervisor had a cell phone on him, he did not call Resident #1's unit to check on him/her but instead, after the smoking break, he checked with the staff on the North 2 Unit (where Resident #1 resided) and they told him that Resident #1 had gone down to smoke. Further review of the May 02, 2024, facility video surveillance camera footage revealed that the Nurse Supervisor and all of the residents who had smoked, returned inside the Facility via the front door by 16:34:51 (4:34:51 P.M.) about 12 minutes after Resident #1 had left the premises, and by the time the Nurse Supervisor checked with staff on Resident #1's unit to see if he/she was there, more than 15 minutes had passed since he/she first exited the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Nurse Supervisor said that he notified the Director of Nurses and the Administrator that Resident #1 was missing and a search of the Facility and grounds was initiated. Review of the Facility Elopement Risk Evaluation Form used by the Facility indicated that residents who have a history of Substance Abuse or Psychosis should be considered at risk for elopement and a care plan should be initiated. Elopement Risk Evaluations conducted by nursing during Resident #1's stay at the Facility indicated the following: - Resident #1's Elopement Risk Assessment, dated 8/03/23, indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, that the review of all triggers determination for this assessment by indicated he/she was not at risk for elopement and an elopement care plan was not developed. - However, Resident #1's Elopement Risk Assessment, dated 10/07/23, again indicated he/she had a Substance Abuse History and the review of all triggers determination for this assessment indicated he/she was at risk for elopement and that a care plan should be developed per Facility Policy, but was not. - Resident #1's Elopement Risk Assessment, dated on 11/30/23, again indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, the review of all triggers determination for this assessment indicated he/she was not at risk for elopement and an elopement care plan was not developed. - Resident #1's Elopement Risk Assessment, dated 2/26/24, again indicated he/she had a Substance Abuse History and Diagnosis/History of Psychosis, the review of all triggers determination for the assessment indicated he/she was not at risk for elopement and an elopement care plan was not developed. Review of Resident #1's Care Plans indicated there was no documentation to support nursing having developed a care plan to address Resident #1's elopement risk, per their Elopement Risk criteria. During an interview on 5/08/24 at 3:09 P.M., the MDS Nurse said that she reviewed Resident #1's care plans, including all care plans concerns which had been developed and resolved previously during his/her stay at the Facility, and said the Facility had not developed a care plan to address his/her risk of elopement at any time during his/her stay. During an interview on 5/08/24 at 9:20 A.M. the Director of Nursing said that around 4:40 P.M. on 5/02/24, the Nurse Supervisor reported that Resident #1 was missing. The Director of Nurse said she supervised the search of the Facility and grounds while the Administrator and the Nurse Supervisor reviewed video surveillance camera footage of the 4:00 P.M. smoking break to identify whether Resident #1 left the Facility grounds during the smoking time. The Director of Nursing said that when the Administrator and Nurse Supervisor told her that they identified footage of Resident #1 leaving the Facility grounds at the beginning of the 4:00 P.M., smoking break, she notified the local police that the Facility had a missing resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Police Report, dated 5/02/24, indicated the Facility notified local police at 17:25 (5:25 P.M.) that Resident #1 was missing, (which was about an hour after he/she left Facility grounds while attending the supervised 4:00 P.M., smoking break, during which he/she required supervision to be provided by staff to monitor him/her for safety). The Director of Nursing said that, as of 5/09/24, Resident #1 remained missing, that local hospitals and shelters had been contacted, without locating him/her. On 5/10/24 the Facility was notified by the Department of Public Health via an email that Resident #1 went to a local Hospital Emergency Department and checked him/herself in because he/she was not feeling well, and he/she returned to the facility that same day. On 5/09/24, the Facility was found to be in Past Noncompliance and presented the Surveyor with a plan of correction (with an effective date of 5/06/24) that addressed the area(s) of concern as evidenced by: A) On 5/03/24, the Facility developed a new Smoking Supervision Plan which included two staff members would be assigned, ensuring the safety of smokers during every smoking break time, one staff member would be physically, continuously present outside in the smoking area supervising smokers/dispersing cigarettes and a second staff member would continuously be present in the Facility lobby supervising the reception area and residents, staff and visitors as they egress through the locked front door. B) On 5/03/24, the Facility developed and implemented a Supervised Smoking Form for the smoking supervisor to document which residents attended the smoking break time, the return of smoking materials to the staff member supervising smoking break and the return of all residents inside of the Facility after the smoking break time was over. C) On 5/03/24 through 5/06/24, Administrative and Clinicial Management reviewed the facility Elopement Policy and Risk Evalaution Form for purpose of revision. The Assistant Director of Nursing (ADON) provided education to licensed nursing staff regarding completion of the Elopement Risk Assessments, accuracy and evaluation of the assessment, identifying triggers for risk of elopement, and residents with SUD and/or Psychosis must be considered at risk for and care planned for elopement. D) On 5/03/24, the Director of Nursing initiated a change to the daily Staffing Schedule to assign particular nursing staff members for transport of residents who smoke from North 2 (the secure unit) to the smoking area at the start of each smoking break time. E) On 5/03/24, the Director of Nursing and Administrator initiated a plan for a leadership staff member (Administrator, Manager of the Day, nursing supervisor) to assign specific staff members to supervise the reception area and for staff, resident, visitor egress through the locked front door during each Facility smoking break time. F) On 5/03/24 and on-going, the Administrator, Director of Nursing and Assistant Director of Nurses trained all staff involved in the supervision of smokers (nursing, reception, activities) on the new Smoking Supervision Plan and the Supervised Smoking Form. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	G) On 5/03/24, the Administrator and/or Director of Nursing and/or their designee initiated interviews of staff members to be conducted five times weekly for two weeks to determine their understanding and compliance of the new Smoking Supervision Plan. H) On 5/03/24, the Administrator and/or Director of Nursing and/or their designee initiated that five observations to be conducted by administrative staff weekly for two weeks during the resident smoking break time, for compliance. I) On 5/03/24, the Director of Nursing and/or Administrator and/or their designee initiated administrative staff review of the Supervised Smoking Forms, at least five times a week for two weeks. J) The Administrator and/or Designee reviewed the corrective actions plans in an ad hoc QAPI meeting, and will continue to review for compliance, at QAPI to ensure compliance. K) The Administrator and/or Designee are responsible for overall compliance.