STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555070	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland	11701 Studebaker Road Norwalk, CA 90650

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview, and record review, the facility failed to ensure the resident, who had diagnosis of type 2 diabetes [a disorder characterized by difficulty in blood sugar control and poor wound healing]) and was receiving blood sugar lowering medication, had blood sugar monitoring to ensure the effectiveness of Empagliflozin (medication to lower blood sugar) and to prevent the resident from having hyperglycemia (level of glucose (blood sugar) in the blood is abnormally high) leading to diabetic ketoacidosis (life-threatening complication of diabetes that occurs when the blood sugar levels are too high and untreated for a prolonged length of time) for one of 3 sampled residents (Resident 1). The facility failed to: 1. Ensure Resident 1 ' s Medical Doctor (MD) ordered Resident 1 ' s blood glucose monitoring to ensure the Empagliflozin (blood sugar level regulating medication) was effective and to prevent Resident 1 from developing hyperglycemia or hypoglycemia (occurs when the blood glucose [simple sugar-body ' s primary source of energy/food] level drops below the level the body can function with normally). 2. Ensure the Nurse Practitioner (NP) had knowledge of Resident 1 ' s diagnosis of type 2 diabetes (diabetes mellitus) and ordered Resident 1 ' s blood glucose (sugar) monitoring. 3. Ensure Licensed Vocational Nurse (LVN) 3 was aware of Resident 1 ' s diagnosis of type 2 diabetes to deliver care, accordingly, including monitoring the resident for signs and symptoms of hyperglycemia or hypoglycemia. 4. Ensure LVN 1 and LVN 3 contacted Resident 1 ' s MD to alert the MD of the lack of an order for Resident1 ' s blood glucose monitoring. 5. Ensure the Director of Nursing (DON) clarified Resident 1 ' s orders with Resident 1 ' s MD and NP to ensure Resident 1 was properly monitored for blood glucose level to prevent the resident from developing hyperglycemia or hypoglycemia. 6. Ensure the licensed nurses developed a plan of care for Resident 1 ' s diagnosis of diabetes and intake of Empagliflozin, blood glucose lowering medication, to have interventions in place for resident ' s glucose monitoring and signs and symptoms of hyperglycemia or hypoglycemia. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	7. Ensure staff followed the facility ' s policy and procedure (P&P) titled, Diabetes Mellitus, Resident, Nursing Care of revised November 2017, which indicated the policy of the facility was to recognize and assist in the treatment of complications commonly associated with diabetes. The policy indicated the facility will document pertinent laboratory studies including blood sugar. On 12/17/2024, Resident 1 was transferred via 911 (emergency medical transportation) due to altered level of consciousness (not fully responsive to environment) to the General Acute Care Hospital (GACH) where he was found to have a blood sugar level of 595 milligrams per deciliter ([mg/dl -unit of measurement]; reference range 70 mg/dl to 99 mg/dl) upon admission with the diagnosis of diabetic ketoacidosis (life-threatening complication of diabetes that occurs when the blood sugar levels are too high and untreated for a prolonged length of time). This deficient practice resulted in Resident 1 having an altered level of consciousness due to very high blood sugar levels leading to diabetic ketoacidosis which had the potential to lead to a diabetic coma (a condition when the body is overwhelmed with the amount of blood sugar levels, and the resident cannot wake up or respond purposefully to the environment) and death. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, occlusion and stenosis (blockage) of left carotid artery (vessel that supplies head and neck with blood) and atherosclerotic heart disease (blockages in vessels that supply the heart with blood). During a review of Resident 1's Minimum Data Set ([MDS] -resident assessment tool), dated 12/17/2024, the MDS indicated Resident 1 ' s cognitive (the mental process of thinking, learning, remembering, and using judgement) skills for daily decision-making were moderately impaired. During a review of Resident 1's Order Summary Report (physician ' s orders), dated 12/12/2024, the Order Summary Report indicated an order for Empagliflozin Oral Tablet 10 milligrams ([mg]-unit of measurement) one tablet daily for diabetes mellitus. During a review of Resident 1 ' s Medication Administration Record (MAR) dated from 12/1/2024 through 12/31/2024, the MAR indicated Empagliflozin 10 mg was administered on 12/12/2024, 12/13/2024, 12/15/2024, 12/16/2024 and 12/17/2024 as ordered. During a review of Resident 1 ' s Change of Condition (COC), dated 12/17/2024 and timed at 1:54 p.m., the COC indicated Resident 1 had signs and symptoms of altered mental status (a significant change in mental function), hypotension (low blood pressure [force exerted by your blood pushing against the walls of your arteries as your heart pumps blood throughout your body]) and hyperglycemia . The COC indicated Resident 1 ' s systolic blood pressure [pressure of blood in your arteries when the heart beats] was 90 millimeters of mercury ([mmHg - unit of measure] reference range 90 -120mm Hg). The COC indicated the facility staff notified Resident 1 ' s NP and the NP ordered for Resident 1 to be transferred to the GACH via 911. During a review of Resident 1 ' s MAR dated 12/17/2024, the MAR indicated a physician ' s order dated 12/17/2024 and timed at 2:04 p.m. to give Lispro Insulin (quick acting medicine used to lower blood sugar) 15 Units (unit of measurement) STAT (immediately) for hyperglycemia one time only. (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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Follow up Skilled NP Progress Notes, dated 12/17/2024 and timed at 1 p.m. , the Skilled NP ' s Progress Notes indicated Resident 1 was hyperglycemic, when the residents ' blood sugar level was checked and 15 units of Lispro insulin was administered but Resident 1 ' s blood sugar remained high (unspecified) after administration and Resident 1 was lethargic (a state of being drowsy and dull, listless, unenergetic, indifferent, sluggish and inactive) with blood pressure at 71/56 mmHg. The Skilled NP Progress Notes indicated nursing staff was advised to transfer Resident 1 via 911 to the GACH. During a review of Resident 1 ' s GACH emergency room Note, dated 12/17/2024 and timed at 2:08 p.m., the GACH emergency room Note indicated Resident 1 was sent to the GACH from the facility due to high blood sugar (unspecified), causing diabetic ketoacidosis and low blood pressure of 81/45. The GACH emergency room Note indicated Resident 1 ' s blood glucose level on 12/17/2024 at 2:30 p.m., was 595 mg/dl (reference range 70 mg/dl to 99 mg/dl). The note indicated Resident 1 was admitted with the diagnosis of diabetic ketoacidosis. During an interview on 1/28/2025 at 11:50 a.m., Licensed Vocational Nurse (LVN) 3 stated, on 12/17/2025 she was assigned to care for Resident 1. LVN 3 stated on 12/17/2024 Resident 1 ' s caregiver called her to Resident 1 ' s bedside. LVN 3 stated upon arrival to Resident 1 ' s room, Resident 1 appeared to have a decreased level of consciousness. LVN 3 stated, the care giver asked her (LVN 3) what Resident 1 ' s blood sugar readings were. LVN 3 stated, she informed the care giver she did not know Resident 1 was diabetic needing blood sugar checks. LVN 3 stated, she told Resident 1 ' s caregiver that the resident ' s blood sugar had not been monitored (since admission on 12/11/2024 [eight days]) because there was no physician ' s order to monitor Resident 1 ' s blood sugar. LVN 3 stated Resident 1 was transferred to the GACH via 911 on 12/17/2024. During an interview on 1/28/2025 at 11:30 p.m., the facility consultant pharmacist (Pharm) stated Empagliflozin is medication used to lower the sugar level in the blood. The Pharm stated residents should have their blood sugar levels monitored regularly (not specified)to determine the residents ' response to Empagliflozin. The Pharm stated failure to monitor resident ' s blood sugar level places residents at risk of having undetected hyperglycemia and hypoglycemia. The Pharm stated without blood glucose monitoring, we cannot adequately assess the effectiveness of blood sugar lowering medication. During an interview on 1/28/2025 at 2 p.m., Resident 1 ' s NP stated she did not order Resident 1 ' s blood glucose monitoring because she did not know he had type 2 diabetes. The NP stated she had limited clinical documentation to review upon Resident 1 ' s arrival and may have missed important information pertaining to Resident 1 ' s medical history. The NP stated the facility nursing staff did not call her to clarify the need for blood sugar checks since Resident 1 was a diabetic. The NP stated she would have ordered blood glucose checks if they had. The NP stated she only found out of Resident 1 ' s diagnosis of diabetes from Resident 1 ' s home care giver, who was at Resident 1 ' s bedside at the time Resident 1 was already hyperglycemic. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/29/2025 at 8:45 a.m., Resident 1 ' s Medical Doctor (MD) stated he did not assess Resident 1 during Resident 1 ' s stay at the facility. The MD stated he delegated Resident 1 ' s care to his NP. The MD stated, on 12/17/2024 upon learning Resident 1 was receiving Empagliflozin he would have ordered blood glucose monitoring to ensure the medication was effective for Resident 1. The MD stated Resident 1 was at risk for hyperglycemia and hypoglycemia which the nursing staff should be assessing for in addition to regular blood glucose level testing. The MD stated failure to monitor for signs and symptoms of hyperglycemia and hypoglycemia placed Resident 1 at risk for a decline of health, diabetic ketoacidosis, diabetic coma, and possible death. During an interview on 1/29/2025 at 11:55 a.m., LVN 1 stated on 12/12/2024 and 12/13/2024, she administered Empagliflozin to Resident 1. LVN 1 stated Empagliflozin is a medication to lower blood sugar. LVN 1 stated it is important to know the resident ' s blood sugar level prior to administering Empagliflozin to ensure the resident is not hypoglycemic or hyperglycemic. LVN 1 stated although it is important to assess Resident 1 ' s blood sugar prior to administrating Empagliflozin, she did not see a physician ' s order to check Resident 1 ' s blood sugar level and did not think to question the lack of physician ' s order for blood sugar testing. During an interview on 1/29/2025 at 4 p.m., the DON stated it was her responsibility to ensure all newly admitted residents ' clinical documents were reviewed to ensure residents receive the appropriate care and treatments. The DON stated she was aware Resident 1 had diabetes and did not have a physician ' s order for blood glucose monitoring. The DON stated, she assumed the physician care team (MD and NP) knew Resident 1 had type 2 diabetes. The DON stated she should have clarified the orders with Resident 1 ' s care team to ensure Resident 1 was properly monitored for complications of hypoglycemia and hyperglycemia. The DON stated upon review of Resident 1 ' s clinical documentation, there was no care plan developed to address Resident 1 ' s diabetic care. The DON stated a diabetic care plan would address monitoring resident ' s blood sugar as directed by the physician, appropriate diabetic diet, monitoring signs and symptoms of hyperglycemia and or hypoglycemia. The DON stated Resident 1 should have had a care plan in place to ensure Resident 1 was being monitored for complications of diabetes. During a review of the Medication Guide for Empagliflozin, undated, the Medication Guide indicated Empagliflozin can cause serious side effects including diabetic ketoacidosis. During a review of the online article from American Diabetic Association (a nonprofit organization the funds research to prevent, cure and manage diabetes) website titled Diabetes and Diabetic Ketoacidosis (DKA), the article indicated DKA is a life-threatening condition that can lead to diabetic coma and even death. The article indicated treatment for DKA takes place in the hospital, but it can be prevented by learning the warning signs and by checking blood glucose regularly. The early symptoms include thirst, frequent urination and high blood sugar level. https://diabetes.org/ During a review of the online article from American Diabetic Association website titled Treatment and Care, check your Blood Glucose (sugar), Diabetic Testing and Monitoring the article indicated blood sugar monitoring is the primary tool used to find out if blood glucose levels are within range. https://diabetes.org/ (continued on next page)

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	555070	A. Building B. Wing	01/30/2025

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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 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Diabetes Mellitus, Resident, Nursing Care of revised November 2017, the P&P indicated the policy of the facility is to recognize and assist in the treatment of complications commonly associated with diabetes. The policy indicated the facility will document pertinent laboratory studies including blood sugar. During a review of the facility ' s Job Description Director of Nursing Revised October 2021, the job description indicated the DON would assist in the management and direction of the Nursing Department in accordance with federal, state and local standards, guidelines and regulations that govern the facility and as may be directed by the Administrator and Medical Director, to ensure the highest degree of quality of care is always maintained. The job description indicated the DON would communicate information to nursing personnel regarding new resident admissions and resident discharges and provide oversight. The job description indicated the DON would develop a written plan of care (preliminary and comprehensive) for each resident with identified problems/needs, which indicates the care to be given, goals to be accomplished and which professional service is responsible for each element of care.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure the residents ' ordered medications were available for administration and were administered to residents as prescribed by the physician for one of three sampled residents (Resident 1). The facility failed to: A. Ensure Resident 1, who had a history of Coronary Artery Disease (CAD-disease in which there is a narrowing or blockage of the blood vessels that carry blood and oxygen [gas needed for survival] to the heart) , received Ticagrelor (medication used for the prevention of stroke [blood flow to the brain is interrupted] , heart attack [blood flow to heart interrupted]) as directed by the physician. B.Ensure Resident 1 ' s physician care team was notified when Ticagrelor was not available for administration. These deficient practices resulted in; 1.Resident 1 missing 7 doses of Ticagrelor on 12/12/2024, 12/13/2024, 12/14/2024 and 12/15/2024, which put Resident 1 at risk for heart attack and stroke, leading to a decline in health and death. 2. Resident 1 ' s physician care team not having the opportunity to order potential alternative treatments or services because the Ticagrelor was not available. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] and with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) , occlusion and stenosis (blockage) of left carotid artery (vessel that supplies head and neck with blood) and atherosclerotic heart disease (blockages in vessels that supply the heart with blood). During a review of Resident 1's Minimum Data Set (MDS -resident assessment tool), dated 12/17/2024, the MDS indicated Resident 1 ' s cognitive skills for daily decision-making were impaired. During a review of Resident 1's Order Summary Report (physician ' s orders), dated 12/12/2024, the orders indicated Ticagrelor oral tablet 90 milligrams (mg-unit of measurement) give one tablet by mouth twice a day to prevent heart attack and stroke to start on 12/12/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Medication Administration Record (MAR) dated 12/1/2024 through 12/31/2024, the MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice a day to prevent heart attack and stroke. The MAR indicated the following : on 12/12/2024 in the box to document the 9am Ticagrelor 90 mg administration, there was a 2 documented and initialed by Licensed Vocational Nurse (LVN) 1, on 12/13/2024 in the box to document the at9am and 5pm Ticagrelor 90 mg administration there was a 7 in the box initialed by LVN 1, on 12/14/2024 in the box to document the Ticagrelor 90 mg 9am and 5pm administration there was a ,7 in the box initialed by LVN 2, and on 12/15/2024 in the box to document 9am and 5pm the Ticagrelor 90 mg there was a 7 in box initialed by LVN 3. During a review of Resident 1 ' s electronic Medication Administration (electronic -MAR) note dated 12/12/2024 at 10:48 am, the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice a day to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/13/2024 at 11:37 am, the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/13/2024 at 4:43 p.m., the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/14/2024 at 10:40 a.m., the electronic-MAR indicated give Ticagrelor oral tablet 90 milligrams (mg-unit of measurement) give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/14/2024 at 10:40 a.m., the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/15/2024 at 10:33 a.m., the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During a review of Resident 1 ' s e-MAR note dated 12/15/2024 at 6:03 p.m., the electronic-MAR indicated give Ticagrelor oral tablet 90 mg give one tablet by mouth twice to prevent heart attack and stroke waiting for medication to be supplied. During an interview on 1/28/2025 at 11:50 a.m., LVN 3 stated on 12/15/2024 she cared for Resident 1 and remembered his medication, Ticagrelor was not available during the 9am administration and the 5pm administration. LVN 3 stated she did not inform the physician that Resident 1 missed the 9am and 5pm doses. LVN 3 stated, she indicated in the eMAR note that the medication was missing. LVN 3 stated she was not trained to write a Change of Condition or notify the physician of missing medications. LVN 3 stated, Resident 1 was at risk of having a heart attack or stroke due to not receiving Ticagrelor as ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2025 at 11:30 p.m., the facility consultant pharmacist (Pharm) stated Ticagrelor was a medication used to prevent heart attack or stroke. The Pharm stated it was important for the medication to be given as directed by the physician and missed doses should be reported to the physician so the resident can be monitored or treated appropriately. The Pharm stated if the medication was not available the physician may order another treatment or order additional areas of monitoring for the resident. The Pharm stated Resident 1 is at risk for heart attack, stroke or death if Ticagrelor is not administered as prescribed. During an interview on 1/29/2025 at 11:55 a.m., LVN 1 stated on 12/12/2024 and 12/13/2024, she cared for Resident 1 and remembers his medication, Ticagrelor was not available during the 9am administration and the 5pm administration. LVN 3 stated she did not remember calling the physician to inform the physician of the missing medication. LVN 1 stated when a prescribed medication is not available to administer the facility process is to notify the supervisor and the supervisor will contact the physician. LVN 1 stated the facility kept a binder to track medications that were unavailable and needed to be refilled. LVN 3 stated, Resident 1 required Ticagrelor to prevent heart attack and stroke. During an interview on 1/28/2025 at 2:15p.m., the Nurse Practitioner (NP) stated she was not informed by the nursing staff that Resident 1 ' s Ticagrelor was not being administered as ordered due to the medication not being available. The NP stated, had she been notified she may have changed Resident 1 ' s medication regimen to another antiplatelet (prevent blood clots from forming) medication. The NP stated Resident 1 was put at higher risk for heart attack and stroke, due to the medication not being administered as ordered. During a concurrent interview and record review on 1/28/2025 at 3:30 pm, with the Director of Nursing (DON), Resident 1 ' s clinical documents were reviewed. The DON stated upon her review, there were no COC notes to indicate Resident 1 was missing Ticagrelor. The DON stated the clinical documents did not indicate facility staff informed Resident 1 ' s physician or NP that Ticagrelor was not being administrated as ordered. The DON stated, I do not know what happened, the nurses knew to call the physician whenever a medication is not available. The DON stated facility staff should have notified Resident ' s 1 physician so additional interventions can be implemented or new orders could be placed. The DON stated failure to administer Ticagrelor as ordered by the physician and failure to notify Resident 1 ' s physician team placed Resident 1 at higher risk of heart attack, stroke and death. During a review of the facility ' s policy and procedure (P&P) titled, Medication Orders, Prescriber medication orders revised September 2010, the P&P indicated the prescriber shall be contacted for direction when the delivery of a medication will be delayed, or the medication is not available. During a review of the facility ' s Job Description Direction of Nursing Revised October 2021, the job description indicated the DON will assist in the management and direction of the Nursing Department in accordance with federal, state and local standards, guidelines and regulations that govern the facility and as may be directed by the Administrator and Medical Director, to ensure the highest degree of quality of care is maintained at all times. The job description indicates the DON will manage and direct all aspects of the nursing services department. The job description indicated the DON will observe medication passes and treatments to ensure quality

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 44958 Based on interview and record review the facility's Quality Assessment and Assurance (QAA- committees established for the purpose of improving the safety and quality of health services) and Quality Assurance Performance Improvement (QAPI- approach to maintaining and improving safety and quality in nursing homes) committee failed to establish monitoring systems such as fedback to ensure the corrective actions implemented to address the deficiencies of the recent abbreviated survey conducted on 9/30/2024 were maintained. These deficient practices placed the facility residents at risk for not receiving appropriate care needs and services to adequately afford their highest practicable well-being. Findings: During a concurrent interview and record review on 1/29/2025 at 3 p.m., with the Director of Nursing (DON), the CMS 2567 (document that lists deficiencies found in a health care facility during a survey) issued to the facility dated 9/30/2024 was reviewed. The DON stated, during the recent abbreviated survey conducted on 9/30/2024, the facility was found deficient in the following areas: ensuring medications were available for the residents and ensuring all residents had appropriate care plans. The DON stated the facility ' s date of completion, or date the facility was expected to fully correct the deficiencies and comply with regulations was 10/2/2024. During an interview with the DON and the Administrator (ADM) on 1/30/2024 at 3:30 p.m., the Administrator stated once the QAA has identified a systemic issue and corrected the issue, the QAA must ensure the corrective actions continue to be implemented and are sustained. The Administrator acknowledged the facility had opportunities for continue to monitor and to ensure improvement of all mentioned deficient practices but failed to do so effectively. During a record review of the facility's policy Quality Assurance and Performance Improvement (QAPI) revised 12/ 2023, the policy indicated: the facility will establish and implement a Quality Assessment and Assurance committee, develop a written Quality Assurance and Performance Plan, which will be used to continually assess the facility ' s performance using systemic interdisciplinary , comprehensive and data driven approach to maintaining and improving safety and quality. The policy indicated the Quality Assessment and Assurance Committee (QAA) functions include QAPI plan, identifying and prioritizing Process Improvement Plans, implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained. The policy indicated the QAPI plan components will include establishing goals and thresholds for performance improvement, feedback, data systems and monitoring demonstrating evidence of identification, reporting, investigating, analysis and prevention of adverse events.