

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024
NAME OF PROVIDER OR SUPPLIER Intercommunity Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 Grand Avenue Long Beach, CA 90815	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 2 and Resident) were monitored during a smoking break while on the facility's patio by the appropriate number of staff in order to prevent a physical altercation between Resident 1 and Resident 2. This deficient practice resulted in a fracture to Resident 1's nose and Resident 1's transfer to a General Acute Care Hospital (GACH) where Resident 1 underwent a reduction (realignment of bones) of her nasal bones, and compression with rightward pressure to repair/straighten her nasal deviation. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dementia (loss of thinking, remembering, reasoning), bipolar disorder (mental disorder that causes a shift in mood and behavior) and schizophrenia (mental disorder that affects how someone thinks, feels, behaves). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/26/2024, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 had the ability to understand and be understood by others. The MDS indicated Resident 1 had hallucinations (seeing and hearing things that are not there) and delusions (false belief). During a review of Resident 1's undated Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team), the SBAR indicated on 8/18/2024 at approximately 8 a.m., Resident 1 was involved in a resident physical altercation with injury. The SBAR indicated Resident 1 was noted to have purple discoloration to the bridge of her nose, with epistaxis (nose bleed) and deviation (shifted to one side) with pain rated a 10 out of 10 (an 11 eleven point scale where pain in rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nurse Progress note, dated 8/18/2024 and timed at 8:45 a.m., the Nurse Progress note indicated at 8:05 a.m., on 8/18/2024, Resident 1 was observed sitting on a bench close to a Resident (Resident 2). The Nurse Progress note indicated Resident 1 told Resident 2 to stay away from her, don't move any closer and then elbowed Resident 2, Resident 2 then elbowed Resident 1 in her nose. During a review of Resident 1's Physician's Orders, dated 8/18/2024 and timed at 8:45 a.m., the Physician's Order indicated to transfer Resident 1 to GACH via ambulance for further evaluation related to Resident 1's nose injury. During a review of the GACH's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the GACH on 8/18/2024. During a review of the GACH's Computerized Tomography ([CT] a medical procedure that uses a computer to create detailed pictures of the inside of the body) report, dated 8/18/2024, of Resident 1's head, the CT report indicated Resident 1 sustained a fracture (break) and deformities her bilateral (affecting both sides) nasal bones and the frontal process of the maxilla (bone in the upper jaw that forms roof of mouth, eye socks and nose) was noted with overlying soft tissue swelling. During a review of the GACH's Emergency Documentation notes, dated 8/18/2024, the Emergency Documentation notes indicated Resident 1 underwent a reduction (realignment of bones) of her nasal fracture, and compression with rightward pressure to repair/straighten the nasal deviation. During a concurrent observation and interview on 8/22/2024 at 8:30 a.m., Resident 1 was observed in her room with yellowish-bluish discoloration on the bridge of her nose, and on both of he checks extending under both of her eyes. Resident 1 stated she was punched in the face the other day (8/18/2024) by Resident 2. Resident 1 stated, Resident 2 broke her nose and she had to go to the hospital to have it fixed. Resident 1 stated she had pain in face and her nose. During an interview on 8/22/2024 at 1:47 p.m., Certified Nurse Assistant (CNA) 1, stated she was assigned to monitor the patio on 8/18/2024. CNA 1 stated the monitor sits at the exit at the top of the stairs looking down on the patio area. CNA 1 stated on 8/18/2024 at approximately 8 a.m., she observed Resident 1 and Resident 2 sitting on a bench less than an arms' length apart. CNA 1 stated there were usually two staff members assigned to monitor the patio because the patio was large area and there were areas that were hidden from view . CNA 1 stated she observed and heard Resident 1 tell Resident 2 to move away, when Resident 2 did not comply, Resident 1 elbowed Resident 2 who then reacted by elbowing Resident 1 in the nose. CNA 1 stated she was unable to stop the altercation due to her position on the patio. During an interview on 8/23/2024 at 9:43 a.m., Registered Nurse (RN) 1, stated he was the supervising nurse on 8/18/2024, and at approximately 8 a.m., CNA 1 called him to the patio to assess Resident 1. RN 1 stated he observed Resident 1 with blood running from her nose, a purple discoloration on the bridge of her nose and her nose appeared to be deviated toward one side of her face. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/23/2024 at 3:10 p.m., the Director of Nursing (DON) stated all residents have the right to be free from verbal abuse including threats, harassment, intimidation, and mental abuse. The DON stated Resident 1 and Resident 2's altercation could have been prevented if the residents were redirected to sit further apart. The DON stated one staff person was assigned to the patio during non-smoking hours and two staff persons should be assigned during smoking hours. The DON stated at the time of Resident 1 and Resident 2's altercation, residents were beginning to arrive for their scheduled smoking time and the second staff person had not arrived at the patio yet. During a review of the facility's undated policy and procedure (P/P), titled, Abuse Prevention and Investigation, the P/P indicated the facility will not condone resident abuse by anyone including staff members, other residents, consultants, volunteers, staff, or other agencies serving the residents, family members, legal guardians, sponsors, friends, or other individuals. The P/P indicated the facility will identify, correct and intervene in situations in which abuse, neglect, and or misappropriation of resident property is more likely to occur, this includes an analysis of features of the physical environment that may make abuse or neglect, more likely to occur, such as secluded areas of the facility (such as outside walkways), deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned have knowledge of the individuals residents' care needs.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to report a physical altercation between two of three sampled residents (Resident 1 and Resident 2), to the California Department of Public Health (CDPH), within two hours of the incident. On 8/18/2024 at approximately 8 a.m., facility staff witnessed Resident 2 elbow Resident 1 in her nose, resulting in Resident 1 sustaining a bloody nose, ecchymosis (bruising) to her nose and a nasal deviation (shifted to one side). The facility reported the incident on 8/18/2024 at 11:55 p.m., (approximately 16 hours after the incident occurred). This deficient practice resulted in CDPH being unaware of the abuse incident and injury to Resident 1 and had the potential for a delay in CDPH's investigation and other abuse allegations to go unreported. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dementia (loss of thinking, remembering, reasoning), bipolar disorder (mental disorder that causes a shift in mood and behavior) and schizophrenia (mental disorder that affects how someone thinks, feels, behaves). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/26/2024, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 had the ability to understand and be understood by others. The MDS indicated Resident 1 had hallucinations (seeing and hearing things that are not there) and delusions (false belief). During a review of Resident 1's undated Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team), the SBAR indicated on 8/18/2024 at approximately 8 a.m., Resident 1 was involved in a resident to resident physical altercation with injury. The SBAR indicated Resident 1 was noted to have purple discoloration to the bridge of her nose, with epistaxis (nose bleed) and deviation (shifted to one side) with pain rated a 10 out of 10 (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). During a review of Resident 1's Nurse Progress note, dated 8/18/2024 and timed at 8:45 a.m., the Nurse Progress note indicated at 8:05 a.m., on 8/18/2024, Resident 1 was observed sitting on a bench close to a Resident (Resident 2). The Nurse Progress note indicated Resident 1 told Resident 2 to stay away from her, don't move any closer and then elbowed Resident 2, Resident 2 then elbowed Resident 1 in her nose. During a review of Resident 1's Physician's Orders, dated 8/18/2024 and timed at 8:45 a.m., the Physician's Order indicated to transfer Resident 1 to GACH via ambulance for further evaluation related to Resident 1's nose injury. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/2024 at 1:47 p.m., Certified Nurse Assistant (CNA) 1, stated she was assigned to monitor the patio on 8/18/2024. CNA 1 stated the monitor sits at the exit at the top of the stairs looking down on the patio area. CNA 1 stated on 8/18/2024 at approximately 8 a.m., she observed Resident 1 and Resident 2 sitting on a bench less than an arms' length apart. CNA 1 stated she observed and heard Resident 1 tell Resident 2 to move away, when Resident 2 did not comply, Resident 1 elbowed Resident 2 who then reacted by elbowing Resident 1 in the nose. During an interview on 8/23/2024 at 9:43 a.m., Registered Nurse (RN) 1, stated he was the supervising nurse on 8/18/2024, and at approximately 8 a.m., CNA 1 called him to the patio to assess Resident 1. RN 1 stated he observed Resident 1 with blood running from her nose, a purple discoloration on the bridge of her nose and her nose appeared to be deviated toward one side of her face. RN 1 stated he immediately notified the Director of Nursing (DON) and the Administrator of the incident via telephone. During an interview on 8/23/2024 at 3:10 p.m., the DON stated she did not report the incident of abuse immediately nor within 2 hours because she was busy attending to the needs of Resident 1 and Resident 2. The DON stated failure to report abuse can causes a delay in the investigation of the CDPH and is a violation of the federal regulations. During an interview on 8/23/2024 at 3:15 p.m., the Administrator stated he was not available to complete the reporting process on 8/18/2024 due to personal circumstances and he was not aware the incident of abuse was not reported to CDPH until 8/18/2024 at 11:55 p.m. The Administrator stated the facility was in violation of their policy and Federal regulations for not reporting the alleged incident of abuse between Resident 1 and Resident 2 within two hours. During a review of the facility's policy and procedure (P/P) titled, Abuse Reporting and Response, dated 8/1/2024, the P/P indicated it is the policy of the facility that abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility's Quality Assessment and Assurance committee ([QAA] a group of facility staff who identifies, evaluates, and implements measures to improve the quality of care and life for the residents in the facility) and Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, 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 ensure continued oversight of the facility's plan of correction (POC) of the deficient practices identified during the previous abbreviated survey (5/28/2024) pertaining to abuse prevention and reporting. This deficient practice resulted in the facility having another occurrence of resident-to-resident altercation resulting in physical injury to Resident 1 and the facility's failure to report the incident to the Department of Public Health within 2 hours of the occurrence. Cross referenced to F609 and F600 Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including dementia (loss of thinking, remembering, reasoning), bipolar disorder (mental disorder that causes a shift in mood and behavior) and schizophrenia (mental disorder that affects how someone thinks, feels, behaves). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/26/2024, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 had the ability to understand and be understood by others. The MDS indicated Resident 1 had hallucinations (seeing and hearing things that are not there) and delusions (false belief). During a review of Resident 1's undated Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team), the SBAR indicated on 8/18/2024 at approximately 8 a.m., Resident 1 was involved in a resident to resident physical altercation with injury. The SBAR indicated Resident 1 was noted to have purple discoloration to the bridge of her nose, with epistaxis (nose bleed) and deviation (shifted to one side) with pain rated a 10 out of 10 (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain). During a review of Resident 1's Nurse Progress note, dated 8/18/2024 and timed at 8:45 a.m., the Nurse Progress note indicated at 8:05 a.m., on 8/18/2024, Resident 1 was observed sitting on a bench close to a Resident (Resident 2). The Nurse Progress note indicated Resident 1 told Resident 2 to stay away from her, don't move any closer and then elbowed Resident 2, Resident 2 then elbowed Resident 1 in her nose. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/22/2024 at 8:30 a.m., Resident 1 was observed in her room with yellowish-bluish discoloration on the bridge of her nose, and on both of he checks extending under both of her eyes. Resident 1 stated she was punched in the face the other day (8/18/2024) by Resident 2. During an interview on 8/22/2024 at 1:47 p.m., Certified Nurse Assistant (CNA) 1, stated she was assigned to monitor the patio on 8/18/2024. CNA 1 stated the monitor sits at the exit at the top of the stairs looking down on the patio area. CNA 1 stated on 8/18/2024 at approximately 8 a.m., she observed Resident 1 and Resident 2 sitting on a bench less than an arms' length apart. CNA 1 stated there were usually two staff members assigned to monitor the patio because the patio was large area and there were areas that were hidden from view . CNA 1 stated she observed and heard Resident 1 tell Resident 2 to move away, when Resident 2 did not comply, Resident 1 elbowed Resident 2 who then reacted by elbowing Resident 1 in the nose. CNA 1 stated she does not remember receiving an in-service or training within the last few months pertaining to abuse or abuse reporting. During an interview on 8/23/2024 at 9:43 a.m., Registered Nurse (RN) 1, stated he was the supervising nurse on 8/18/2024, and at approximately 8 a.m., CNA 1 called him to the patio to assess Resident 1. RN 1 stated he observed Resident 1 with blood running from her nose, a purple discoloration on the bridge of her nose and her nose appeared to be deviated toward one side of her face. RN 1 stated he was not familiar with how to fax or call the CDPH and he had not received an in-service or training on the facility's abuse reporting process. During a review of the facility's Plan of Correction (POC) for the abbreviated survey completed on 5/28/2024, the POC indicated the facility would randomly check with the Director of Staff Development (DSD) to ensure the lesson plan of Abuse Mandatory Reporting was scheduled for all staff, and any non-compliance with the Abuse Investigation and Reporting policy would be reported to their UR/CQI committee on a quarterly basis for recommendation and or correction. During an interview on 8/23/2024 at 3:10 p.m., the DON stated she did not report the incident of abuse immediately nor within 2 hours because she was busy attending to the needs of Resident 1 and Resident 2. The DON stated failure to report abuse can causes a delay in the investigation of the CDPH and is a violation of the federal regulations. The DON stated she was not aware of a POC or QAPI discussions related to abuse prevention or reporting and had just began working as the DON in the facility 7/2024. During an interview on 8/23/2024 at 3:15 p.m., the Administrator (ADM) stated he was not available to complete the reporting process on 8/18/2024 due to personal circumstances and he was not aware the incident of abuse was not reported to CDPH until 8/18/2024 at 11:55 p.m. The Administrator stated the facility was in violation of their policy and Federal regulations for not reporting the alleged incident of abuse between Resident 1 and Resident 2 within two hours. (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/23/2024 at 3:30 p.m., with the Administrator, the facility's QAPI meeting minutes dated 7/9/2024 was reviewed. The QAPI minutes agenda indicated the topic of abuse to be discussed, however, abuse was not discussed during the QAPI meeting. The ADM stated the QAPI meeting should have included a discussion pertaining to the facility's status in Abuse training, reporting and tracking but they did not have the time to fit it into the QAPI meeting. The Administrator stated he did not ensure continued oversight of the facility's POC of the deficient practices identified during the previous abbreviated survey (5/28/2024) which ensured staff was educated and in serviced on the facility reporting policy. The Administrator stated he failed to present the new facility abuse policy titled Abuse reporting and Response dated 8/1/2024 to the DON. The Administrator stated failure to discuss and collaborate with the QAPI team, issues pertaining to abuse put the residents at risk for further occurrences and did not provide for an effective QAPI committee. During a review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance (QAPI) Committee, revised 4/2014, the P/P indicated the facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI program. The P/P indicates the Administrator shall delegate the necessary authority of the QAPI committee to establish, maintain, and oversee the QAPI program. The P/P indicates the primary goals of the QAPI committee are to establish , maintain, oversee facility systems and processes to support the delivery of quality of care and services, promote the consistent use of facility systems and processes during the provision of care and services, help identify actual and potential negative outcomes relative to resident care and resolve them appropriately, support the root cause analysis to help identify where patterns of negative outcomes point to underlying systemic problems, help departments, consultant and ancillary services implement systems to correct potential and actual issues in quality of care, coordinate the development , implementation, monitoring an evaluation of performance improvement projects to achieve specific goals, coordinate and facility communication regarding the delivery of quality resident care within and among departments and services, between facility staff , residents and family members.		