STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 48003 Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual review the facility failed to ensure 1 of 2 residents (Resident #20) Significant Change Minimum Data Set (MDS) assessments were completed within 14 days of identifying a significant change occurred. The facility reported a census of 24 residents. Findings include: Record review of Resident #20, communication note to the doctor documented the resident went on hospice on 12/29/23. Record review on 8/12/24 of Resident #20 revealed that a Significant Change MDS was not completed when Resident #20 went on hospice care. During an interview on 8/13/24 at 12:03 PM, the Assistant Director of Nursing (ADON) reported when a resident goes on or off hospice a significant change MDS is to be completed. She verbalized that she follows the RAI manual. During an interview on 8/13/24 at 12:05 PM, the Director of Nursing (DON) reported the facility follows the RAI manual. On 8/13/24 at 3:14 PM, the Administrator reported the facility does not have a policy for MDS completion. She reported they follow the RAI manual. Record review of the current RAI Manual dated 10/2023 on page 2-25 instructed the following: (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
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The Significant Change MDS date must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). A Significant Change MDS must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving their highest practicable well-being at whatever stage of the disease process the resident is experiencing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48003 Based on record review, staff interview, and Resident Assessment Instrument (RAI) Manual review, the facility failed to ensure 3 of 3 residents (Resident #21, #77, and #78) Discharge Minimum Data Set (MDS) assessments were completed when the resident was discharged from the facility. The facility reported a census of 24 residents. Findings include: 1. Record review of Resident #21, Progress Note dated 4/02/24 at 11:45 AM documented the resident discharged to home. Review of Resident #21's MDS assessments submitted lacked documentation of a discharge MDS completed. During an interview on 8/13/24 at 12:00 PM, the Assistant Director of Nursing (ADON) reported when a resident discharges the staff communicates to her the discharge and a discharge MDS is to be completed. She verbalized that she follows the RAI manual. During an interview on 8/13/24 at 12:05 PM, the Director of Nursing (DON) reported the facility follows the RAI manual. On 8/13/24 at 3:14 PM, the Administrator reported the facility does not have a policy for MDS completion. She reported they follow the RAI manual. Record review of the current RAI Manual dated 10/2023 on page 2-19 instructed the following: A Discharge MDS must be completed 14 calendar days after discharge. 2. Record review of Resident # 77, Progress Note dated 9/14/23 at 15:31 PM documented the resident discharged to another facility. Review of Resident #77's MDS assessments submitted lacked documentation of a discharge MDS completed. 3. Record review of Resident #78, Progress Note dated 2/20/24 at 15:44 PM documented the resident discharged to home. Review of Resident #78's MDS assessments submitted lacked documentation of a discharge MDS completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 49698 Based on facility record review, staff interview, and policy review, the facility failed to maintain a valid Pre-admission Screening and Resident Review (PASRR) for 1 of 1 residents screened (Resident #14). The facility reported a census of 24 residents. Findings Include: The Minimum Data Sample (MDS) for Resident #14, dated 06/28/24, indicated a brief interview for mental status (BIMS) score of 12, indicating moderate cognitive impairment. Diagnoses of Stroke, Seizure Disorder, Depression, and Mild Intellectual Disabilities. Review of a PASRR for Resident #14, dated 12/27/23, determined a Level II short term approval ending on 1/26/24. Indicating nursing facility care for now but should return to a setting in the community. Review of Resident #14's Care Plan, dated 12/29/24, failed to document determined PASRR Level II and services to be provided. Interview on 8/13/24 at 12:58 PM with Staff D, ADON, acknowledged PASRR had not been resubmitted, the ADON revealed this had not been done due to not knowing the process and was not sure how the short term PASRR worked. When Resident #14 was admitted to facility his goal was to return to the community, due to Resident #14's current health concerns he is not comfortable leaving the facility and has excepted he will continue to be in the facility for long term care. Because of this there had been no attempts for a lower level of care. Staff D also acknowledged failure to update Resident #14's Care Plan to include PASRR services to be provided. 8/13/24 at 3:14 PM, via email, Staff A, Administrator, stated the facility does not have a PASRR policy and follows regulatory guidelines. The Maximus PASRR manual dated 2/8/23 directs PASRR evaluations are referred to as Level II evaluations to distinguish them from their counterpart Level I screens; the Level I screen is a brief screen used to identify persons applying to or residing in Medicaid certified nursing homes that are subject to the Level II process. Once a person with a suspected or known diagnosis is identified through that screen, a Level II evaluation must be performed to determine whether the individual has special treatment needs associated with the MI and/ or ID/RC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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. 49698 Based on facility record review, staff interview, and policy review, the facility failed to develop a resident's comprehensive Care Plan and ensure Pre-Admission Screening and Resident Review Level II service recommendations were added to the resident's comprehensive Care Plan for 1 of 3 residents reviewed (Resident #14). The facility reported a census of 24 residents. Findings Include: The Minimum Data Sample (MDS) for Resident #14, dated 06/28/24, indicated a brief interview for mental status (BIMS) score of 12, indicating moderate cognitive impairment. Diagnoses of Stroke, Seizure Disorder, Depression, and Mild Intellectual Disabilities. Review of Resident #14's Care Plan, dated 12/29/24, failed to document determined PASRR Level II and services. 8/13/24 at 3:14 PM, via email, Staff A, Administrator, stated the facility does not have a Care Plan policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on observation, staff interview, and process review, the facility failed to ensure 4 of 4 residents received a well-balanced diet that met their nutritional needs. The facility reported a census of 24 residents. Findings include: During an observation on 8/14/24 at 11:35 AM -12:00 PM of the puree process for carrots, spaghetti, and bread revealed the following: Staff B, Cook, needed to make four servings of pureed carrots, she started by scooping four, four ounce scoops into the food processor. Then added two scoops of thickener and poured in milk and began to puree the carrots. Staff B added another scoop of thickener to make the proper consistency, then transferred the pureed carrots to a steam table pan and placed it in the oven to heat to proper temperature. Staff B, indicated a four ounce scoop would be used for the correct portion. At 11:49 AM, Staff B, Cook, placed two slices of bread and two and a half, six ounce scoops of spaghetti into the food processor, added milk and three scoops of thickener to make the proper consistency, then transferred the pureed spaghetti to a steam table pan and placed in the oven to heat to proper temperature. Staff B, indicated a six ounce scoop would be used for the correct portion size. Review of [NAME]. Puree Process, posted in kitchen at the puree and prep station revealed the following: Step 1. Measure out the desired number of servings into a container for pureeing. Step 2. Puree the food. Step 3. Add any necessary thickener or appropriate liquid of nutritive value and flavor to obtain desired consistency. Step 4. Measure the total volume of the food after it is pureed. Step 5. Divide the total volume of the pureed food by the original number of portions. (See puree scoop chart) Step 6. Heat or chill the pureed food to safe serving temperatures. Interview on 8/14/24 at 12:35 PM, Staff B, Cook, stated she was not aware of the process of measuring pureed food and using [NAME]. puree scoop chart to determine the portion size for each resident. Acknowledging the portions served at lunch were not accurate. Interview on 8/14/24 at 3:55 PM, with Staff A, Facility Administrator acknowledged the puree process was not completed correctly and portions were not accurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 5:29 PM via email, Staff A, Administrator, stated the facility does not have a policy for therapeutic diets or food preparation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49698 Based on observations, staff interviews, and policy review, the facility failed to serve food maintained at a safe and appetizing temperature. The facility reported a census of 24 residents. Findings include: On 8/12/24 at 12:16 PM, Dining observation revealed a pan of meatloaf sitting on top of the steam table, not inside the table where the heat is held. Review of food temperatures taken prior to serving indicated the meatloaf temperature of 177 degrees Fahrenheit (F). At 12:21 PM, after Staff C, Cook, served the last plate, meatloaf temperature was requested, revealing 64 degrees F. During Dinner observation on 8/14/24 at 6:25, after serving the last resident, Surveyor requested Staff C, Cook, temp pureed fish sticks in the steam table, revealing a temperature of 116 degrees F. Staff C acknowledged the food temperature needed to be above 135 degrees F. Interview with Staff A, Administrator on 8/15/24 at 8:59 AM, revealed hot foods should be held at 135 degrees F or above and cold foods at 41 degrees F or below. Review of facility provided document, Cooking and Hot Holding Food revision date 9/16, indicated: The internal temperature of Potentially Hazardous Foods (Time/Temperature for Safety Food) must be 41 F or below or 135 F or above at all times. Hot foods must be held at 135 F or above, to ensure foods do not remain at temperatures favorable to bacterial growth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on observation, record review, and staff interview, the facility failed to serve the appropriate diet for 1 of 5 residents with an order for mechanical soft/ground diet (Resident #23). The facility reported a census of 24 residents. Findings include: Review of Resident #23 Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 scored a 3 out of 15 on the Brief interview for Mental Status (BIMS) indicating severe cognitive impairment . The resident's diagnoses included seizure disorder, dysphagia, injury of head, limitation of activities due to disability, reduced mobility, and gastrostomy. Review of Resident #23 Care Plan dated 7/5/24 identified the resident required tube feedings (G-tube) related to swallowing problems and history of aspiration. Interventions included, resident prefers food intake by mouth and fluid intake by G-tube, Speech Therapy (ST) to evaluate and treat as ordered. Resident #23 is able to feed self with staff supervision. Review of a Facility Physician Signed ST order dated 7/10/24 revealed, Resident #23 was evaluated at lunch by ST today, ST recommends mechanical soft diet with ground meats and gravy for lubrication, thinned liquids, under direct supervision of staff. Review of an Order Summary dated 7/11/24 indicated Resident #23 had a regular diet, mechanical soft texture, regular consistency fluids, and ground meats with gravy. Review of a Facility Resident Special Diet document, indicated Resident #23 had a regular diet, mechanical soft, ground meats with gravy. During lunch on 8/12/24 at 12:16 PM, dietary staff were observed showing plated mechanical soft and puree plates to the nurse prior to serving residents. The nurse would indicate to the dietary staff if the plated food was appropriate for the resident. Interview on 8/14/24 at 3:55 PM, with Staff A, Facility Administrator, indicated after having another resident aspirate in the past, they implemented a second check of the plated food by the floor nurse prior to serving. The Administrator's expectations are for dietary to serve and follow the ordered diet. During dinner on 8/14/24 at 6:04 PM, Staff C, Cook, plated mechanical soft fish sticks and potato wedges, the dietary aid carried the plate and placed in front of Resident #23 seated at his table. Dietary staff failed to have nurse or staff do a second check of food. Staff A, Administrator, was sitting at the opposite side of the table assisting another resident eat. Surveyor had Staff A, Administrator, confirm if plated food was appropriate for Resident #23's needs. Staff A, Administrator confirmed the plated food did not meet mechanical soft diet orders. Staff A, Administrator reviewed special diet menu, indicating the potato wedges should have been served without the skin and the mechanical soft fish stick should have had a gravy on them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Staff A, Administrator on 8/15/24 at 8:59 AM, verified the mechanical soft diet served at dinner the previous evening to Resident #23, was not served as ordered. On 8/14/24 at 5:29 PM via email, Staff A, Administrator, stated the facility does not have a policy for therapeutic diets or food preparation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49698 Based on observation, staff interview, and policy review, the facility failed to store food in accordance with professional standards for food service safety. The facility reported a census of 24 residents. Findings include: On 08/12/24 at 10:15 AM, Initial observation of the kitchen's food storage and freezers revealed the following items were opened, unsealed (open to air), and/or lacked labeling to identify product and opened date; canister of butter, cottage cheese, condiments, milk, half of an apple pie, open package of hamburger buns, bag of stuffing, and a frozen bags of chicken. A slimy wet area was also observed on the floor of the walk-in cooler. During an interview 08/13/24 at 2:38 PM, Staff A, Administrator, acknowledged these items should have been sealed, labeled, dated when opened, and discarded when needed. Also acknowledged the slimy wet area in the walk-in cooler. On 8/14/24 at 11:35 AM, via email, Staff A, Administrator, stated the facility does not have a policy on food storage and labeling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165494	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tripoli Nursing & Rehab	604 Third Street SW Tripoli, IA 50676

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 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. 48003 Based on facility record review and staff interviews, the facility failed to provide satisfactory evidence that they identified their own high risk, high volume, and problem-prone quality deficiencies, and made a good faith attempt to correct them. The facility reported a census of 24 residents. Findings include: During an interview on 8/15/24 at 11:10 AM, the Administrator reported there is not a plan in place to do a follow up when concerns are identified to make sure they are continuing to keep a previous deficiency from happening again. Review of the facility's past survey violations document the facility failed to electronically transmit encoded, accurate, and complete MDS data to the CMS System. The facility continued to be in violation and lacked an implementation plan of action to correct the identified quality deficiency. The QAPI Plan dated 2014 directed that the facility will focus on systems and processes. The facility will encourage staff to identify potential errors and system breakdown and set goals to improve performance, measure progression toward the goal and revise it as necessary.