QAPI Plan

Fiddlers Green Manor

168 West Main Street

Springville, NY 14141

Effective Date: 1/31/2020

Reviewed 1/30/2024

The Governing Body and QA&A Committee of **Fiddlers Green Manor** develops a culture that involves leadership –seeking input from all staff, focus on nursing center staff, residents, their families and other stakeholders.

The Governing body is responsible for the development and implementation of the QAPI program. The Governing Body is responsible for:

1) Identifying and prioritizing problems based on performance indicator data
2) Incorporating resident and staff input that reflects organizational processes, functions and services provided to residents
3) Ensuring that corrective actions address gaps in the system and are evaluated for effectiveness
4) Setting clear expectations for safety , quality , rights, choices and respect
5) Ensuring adequate resources exist to conduct QAPI efforts

The QA&A Committee reports to executive leadership and Governing Body and is responsible for:

1) Meeting at a minimum, on a quarterly basis or more frequently if necessary.
2) Coordinating and evaluating QAPI program activities.
3) Developing and implementing appropriate plans of action to correct identified quality deficiencies
4) Regularly viewing and analyzing data collected under QAPI program and data resulting from departmental reports, tracking forms, PCC analytics, Medical data analytics, routine audits, observations, customer satisfaction tools, resident complaints and grievances, corporate compliance reporting and staff reporting tools.
5) Determining areas for PIP and Plan-Do-Study-Act (PDSA) rapid cycle improvement projects, Fish bone diagrams and root cause analysis.
6) Analyzing the QAPI program performance to identify and follow-up on areas of concern , develop QAPI subcommittees, and/or opportunities for improvement. Annual completion of CMS facility assessment and QAPI self assessment tool.

Utilizing Point Click Care (PCC) Insights program the Governing Body and QA &A Committee have access to visibly and virtually review all of an organization's QAPI activity through the insights program of PCC. This program allows development of all QAPI projects including but not limited to, viewing all PIP, analysis of data, including quality assessments, Quality Measures, benchmarks, facility QAPI Self Assessments, Care Area investigations, and other detailed reporting. Additionally; **Fiddlers Green Manor** uses various online programing to monitor systems for quality care through PCC, for PDPM/ MDS through **(PCC scrubber)** and Staffing through ONSHIFT. Data collection and Analysis is widespread team collaboration and has the ability through remote monitoring of quality improvement efforts.

Staff QAPI Adoption:

The QAPI program will be structured to incorporate input, participation and resistibility from all levels of facility staff. The Governing Body and QA&A Committee of **Fiddlers Green Manor** will develop a culture that involves leadership-seeking input from all staff, residents, their families and other stakeholders; encourages and requires staff participation in QAPI initiatives when necessary; and holds staff accountable for taking ownership and responsibility of assigned QAPI activities and duties.

QA&A Committee

QA&A Committee Members:

Medical Director / Designee: Dr Landis

Administrator: Courtney Fasolino

Director of Nursing Services: Wendy Egner, RN

Infection Control & Prevention Officer: Richard Cettell, ADON

*Additional Committee Members:

Director of Rehabilitation: Lynette Muscoreil, DPT

Social Services: Sierra Vitale

MDS Coordinator: Darlene Armenia, RN

Director of Medical Records: Kathy Sloand

Director of Activities: Alex Popple

RN Nurse Managers: Levon Hulton, RN, Samantha Valenti, LPN

Food Service Director: Amy Dowdall

Director of Maintenance: Alan Boyd

Director of Housekeeping/ Laundry: Paula Hansen

Director of Quality Assurance: Kate Wannemacher RN

Ancillary staff representative

Resident representative-president of resident council

Pharmacy services-Specialty

Design & Scope

Statements and Guiding Principles:

Mission and Vision: "Our mission is to offer our community the highest quality of personalized healthcare services to enhance the lives of those we care for and show pride for those who pursue and promote excellence in a homelike atmosphere".

Pillars of Success: Providing the foundation and support for leadership, wisdom, energy, compassion, empowerment, respect, integrity, strategic planning and a culture of trust. These are the values and principles defining Avante Care Management, LLC and Amerifalls, LLC

Types of Care and Services:

Skilled Nursing • Long Term Care • Post Acute Care • Rehabilitative Care • Hospice / Palliative Care • Pharmacy • Advanced wound care	Dietary • Dining Services • Dietician • Nutritional management	Health Information Services • EHR/EMR • MDS • Healthelink	Therapy • Physical • Occupational • Speech • Skilled Rehabilitation
Housekeeping • Laundry • Janitorial	Maintenance • Building Management • Landscape/grounds keeping • Preventative Maintenance	Social Services • Activities • Care coordination • Mental health • Discharge planning	Staff Education • On-boarding and orientation • Internal Continuing education (annually and periodically as needed) • External Continuing education (seminars, webinars, • Symposiums, etc) • IHO/WIO

			Core competancies for all staff, upon hire and annually - annual training topics must include but not limited to: - Communication - Resident Rights - Abuse, neglect, exploitation - QAPI - Infection Control - Compliance and Ethics - Behavioral Health and Trauma informed care - Any other topics guided thru the facility assessment
Human Resources • Staff retention and recruitment	Business Office • Funds management • Medicaid process assistance		
Core competencies for all staff			

Addressing Care and Services:

The QAPI program through corporate compliance standards Fiddlers Green Manor will adhere to QAPI (Quality Assurance and Performance Improvement) policy and procedures.

The QAPI program will aim for safety and high-quality standards with all clinical interventions and established benchmarks with service delivery while emphasizing autonomy, choices, and quality of daily life for residents and family. The facility will ensure our data collection tools and monitoring systems are in place and consistent for proactive analysis, (monthly) system failure analysis and corrective action. While being reflective of the complexities, unique care and services provided.

We will utilize the best available evidence of our performance initiatives. Including but not limited to: ongoing data review, national benchmarks, published best practices, clinical guidelines, PCC data analytics, PCC insights, medical data analytics, Interact data, care strategies, core analytics, CMS data, state data, all to assist in defining and measuring goals.

The scope of the QAPI program encompasses all types and segments of care and services that impact clinical care, quality of life, resident choice, and care transitions. These include, but are not limited to, customer service, care management, patient safety, credentialing, provider relations, human resources, finance, and information technology. Using monthly sub committees, the facility will review programs with PIP focus areas including state and federal data review. Aspects of

service and care are measured against established performance goals and key measures are monitored and trended on a quarterly or annual basis.

The QAPI program provides structured collection and analysis of quality data, record integrity, input from residents , family, staff , customer satisfaction reports, resident records, and the MDS. To accomplish this, PCC data analytics/Insights, Medical Data Analytics, have an in depth analysis , investigation, that compares the organization's performance against established indicators, and thresholds of quality as well as national benchmarks. Coupled with the QAPI, accreditation program standards, continuously executed and monitored, include the appropriate coverage of unique resident care areas, and proactively initiate appropriate investigative and important actions for areas identified as needing correction. Development of QAPI sub committees with PIP focus areas routinely established. Other sources used for data collection include Casper report, QRP, QM, VBP, NHQI, medical data analytics reports, resident council minutes, grievance reports, care pathways and 5 star reports.

Defining and Measuring Goals:

The organization will use national benchmarks provided by national associations, clinical organizations, and federal and state provided databases (e.g. CMS quality measures, Five-Star Quality Rating System, Survey Data) to establish baselines for organizational practices and goal benchmark setting. The organization will continue to monitor progress toward goals by comparing its results to these benchmarks and its historical performance.

The sampling, assessment and data collection tools in PCC are based on the CMS Quality indicator Survey (QIS) process and the Quality of Care and Life indicators (QCLIS) that identify potential areas of concern. Additionally, PCC contains critical element pathways, surveyor guidance and national benchmarks that provide a framework for defining and measuring QAPI program goals.

Governance & Leadership

Administrative Leadership:

NAME	ROLE
Mary Swartz	Director of Strategic Planning
Sam Sherman	Managing Member
Jeff Goldstein	Managing Member
Director of Admissions	Jody Bantle
Director of Quality Care	Kate Wannemacher
QA Consultant	Deb Widmer

Direction of QAPI Activities:

Administrative QAPI Team, Administrator with QA&A Committee Team, Administrative Leadership, will provide the direction of QAPI activities.

Feedback, Data Systems & Monitoring

Monitoring Process:

The system to monitor care and services will continuously draw data from multiple sources. These feedback systems will actively incorporate input from staff, residents, families, and others, as appropriate. Performance indicators will be used to monitor a wide range of processes and outcomes and will include a review of findings against benchmarks and/or targets that have been established to identify potential opportunities for improvement and corrective action. The system also maintains a system that will track and monitor adverse events that will be investigated every time they occur. Action plans will be implemented to prevent recurrence.

Point Click Care (EMR) provides a systematic approach to evaluating potential problems and opportunities for improvement through analysis of data gathering. This is accomplished through a variety of assessments such as resident, family and staff interviews, observations, medical record reviews, in-depth clinical reviews, facility level system process reviews and MDS data analysis, Interact data and documentation integrity.

Monitored Data Sources:

PCC	CMS/ NYS	Internal Systems
QIS Assessments	Care Pathway	Resident/family grievances or suggestions
QIS resident –level investigations and reports	Comparative survey data	Staff concern or suggestions, satisfaction
PCC insights	Survey data	MDS, EMR, PCC analytics, Interact
QIS Facility level investigations and reports	Five Star Quality Rating System	
PCC data analytics		
Interact data	CMS Quality Measures	Daily internal review of PCC documentation reports
Medical data analytics	Casper, NHQI, QRP, QM,VBP	Medical data analytics

Additional Systems:

Data Benchmarking

A Comprehensive Review of Department Health Surveys over the last 3 years will be conducted annually to evaluate trends and continuous quality deficiencies, paying particular attention to Immediate Jeopardy and Harm and repeat level deficiencies. Part Two of the benchmarking would be the development of quality assurance tool to baseline current data compliance and implement action plans to address areas of concern related to those high-risk areas identified. Those areas will then become standing agenda items of our Quality Assurance Performance Improvement Committee Meetings. Administrators are required to complete and collect reports for monthly operations conference call with Administrative Leadership. The reports are reviewed for trends for internal analysis and discussion. These reports are also forwarded to the administrative team for analysis for development of plans of action. Benchmarks are set in the data analytics programming.

Daily Morning Report

A daily morning report is conducted Monday through Friday to improve internal communication and care to residents. There is a standing agenda for the daily morning reports as follows:

- Establish census for the previous day.
- Discuss Admissions & Discharges for the day.
- Discuss Minimum Data Sets (MDS) that are due.
- Discuss any environmental concerns or needs.
- Comprehensive review of the 24-hour report by the interdisciplinary team.
- Daily review of documentation reports, missing documentation reports, change in condition reports via Point Click care.
- Open discussion.

New Admission Chart Reviews-Admission/Re-Admission Audits

Medical Chart reviews are completed on the day following the date of admission with the exception being Friday admissions. Those charts are reviewed on Monday. This process is to ensure orders are complete, assessments are complete and initial care plans are in place.

Annual Meeting Calendar

QAPI meetings will be held monthly.

There will be a standing Agenda related to residents who are at high risk involving care and treatment of residents and reporting of such. The standing agenda reporting will be as follows:

- DON report

- Accident Incident Review
- Skin and pressure ulcers
- Infection control (antibiotic stewardship and infection preventionist data)
- Weights and Hydration
- Point Click Care data analytics /Insights.
- Abuse/mistreatment/neglect/exploitation reports.
- Other high-risk incidents
- Medication error
- Pharmacy/ GDR/BMARC
- Education/ GO/competencies/certifications, Licensing, CHRC
- DOH reportable events.
- Risk management reported events
- QRP, VBP, Casper, 5 stars reports
- Navigator/customer service reports/complaints and grievances
- Corporate Compliance
- ISNP
- ADV Directives
- PASSAR
- Environmental services: projects, drills, inspections, pest control
- Staff recruitment and retention/vacancies
- Interact re-hospitalization report.
- MDS compliance
- Preventative maintenance reports
- Medical Data analytics reports
- Food safety, kitchen sanitation

Walking Rounds and MOD reports

Daily by Administrator, Director of Nursing & Director of Environmental Services

Education: upon hire, and annual mandatory topics, and ongoing staff education as identified through QAPI process and the facility assessment.

All staff is given the responsibility and authority to participate in (facility) Quality Assurance Performance Improvement Program. To fully accomplish this, all staff will be provided education regarding the program during their initial general orientation, and on an annual basis thereafter. This education will include a description of the program and how they fit into the plan, based on their particular job responsibilities. Competencies for staff are completed upon hire and annually.

In addition, staff is afforded the opportunity for education as need to ensure excellence in quality of care.

Key Internal Quality Assurance Performance Improvement (QAPI) Committee recommended audits and utilization review

Monthly review of clinical areas:

- Skin and pressure ulcer/ injury monitoring
- Fall prevention.
- Medication administration compliance and error rate
- Elopement prevention
- Infection control incidence tracking and trending report.
- Abuse reporting.
- Advanced directives
- Physician services
- Pharmacy services/ GDR recommendations
- MDS accuracy
- Hospital Transfers /discharge planning, and hospital re-admissions
- Nutrition services
- Daily and ongoing electronic medical record point of care documentation, and nursing documentation audit reports

- Daily and ongoing use of video surveillance for the purpose of facility safety and security

External Quality Improvement Programs

We will be partnering with external resources in order to stay current with standards of the industry regarding data collection and analysis and clinical standards of practice by utilizing the following programs:

- NYSFHA
- IPRO
- Medical Data Analytics
- Advancing Excellence
- Corporate compliance group
- CMS
- Interact
- OIG- Office of Inspector General
- Alzheimer's Association
- Hospice
- Local Colleges & Universities
- Hospitals
- Ombudsman / Center of Aging/ DSS

Adverse /Incident Event tracking System:

Significant Medical event and Adverse Events Chart Reviews

Reviews that are completed by the Director of Quality Assurance upon significant medical events occurring in the previous 24-hour period. Reviews are communicated to facility administration to address any concerns related to Quality, risk management, abuse, mistreatment, neglect, systems, process or policy.

Additionally, the facility will ensure policies and procedures demonstrate proficiency in the use of: PIP process, root cause analysis, fish bone, or 5 whys.

Education will be a product of these reviews for specific individuals, units or departments.

INTERACT root cause analysis tool for hospitalizations.

Method of Monitoring Multiple Data Sources:

Information will be collected on a routine basis from the previously identified sources and the data will be analyzed against the appropriate benchmarks and target goals for the organization.

PCC Insights, is a systemized and secure platform for data collection. PCC provides tools for establishing quality assessment and improvement. Includes collection of investigations and provides a structured electronic repository for QAPI program coordination and documentation.

Interact includes:

Data analysis and reporting tools that draw from multiple data sources and allows the organization to identify care area that exceeds regulatory thresholds. Tracking hospital re-admissions, ED transfers and monitors rates of hospital re-admissions, community discharge and resident and family satisfaction.

PCC analytics / Interact QAPI usage:

PCC and interact will be used by generating random samples of residents for analysis periodically throughout the year. At the end of the year of data collections the QAPI team will review reports to identify areas for improvement by utilizing the CMS QIS thresholds and in-depth investigations.

Performance Improvement Projects (PIPs)

Overall PIP plan:

Performance Improvement Projects will be a concentrated effort on a particular problem in one area of the facility or on a facility wide basis. They will involve gathering information systematically to clarify issues or problems and intervening for improvements. The facility will conduct PIPs to examine and improve care services in areas that the facility identifies as needing attention.

PIP Determination Process:

Areas for improvement are identified by routinely and systematically assessing quality of care and service and include high risk residents, high volume, and problem prone areas. Consideration will be given to the incidence, prevalence, and severity of problems, especially those that affect health outcomes, resident safety, autonomy, choice, quality of life and care coordination. All staff are responsible for assisting in the identification of opportunities for improvement and are subject to selection for participation in PIPs.

Assisting Team Members:

When a performance improvement opportunity is identified as a priority, the QA&A Committee will initiate the process to charter a PIP team. This charter describes the scope and objectives of the improvement project so the team working on it has a clear understanding of what they are being asked to accomplish. Team members will be identified from internal and external sources buy the

QA&A Committee or designated project manager, and with relationship to their skills, service provision, job function, and/ or area of expertise to address the performance improvement topic.

Managing PIP Teams:

The PIP project director or Team leader will manage the day-to-day operations of the PIP and will report directly to the QA&A committee.

Documenting PIPs:

PIPs will be documented in PIP format using PCC during execution. Utilizing PCC analytics platform and outline, the documentation in a structured format allows for PIP Team collaboration and visibly into PIP activity for team management and coordination of PIP efforts; provides a method of tracking PIP progress and documentation of findings of widespread and systemic improvement efforts; and allows for retaining and updating information related to ongoing projects for potential reference and future submission for survey compliance.

Systematic Analysis & Systemic Action

Recognizing Problems and improvement Opportunities:

We will use a thorough and highly organized / structured root cause analysis approach (e.x. failure mode and effects, analysis, fishbone diagrams, flow charting, five whys, etc.) to determine if and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. This systematic approach will help to determine when in-depth analysis is needed to fully understand the problem, it causes, and implications of a change. These systemic actions will look comprehensively across all involved systems to prevent future events and promote sustained improvement. The focus will be on continuous learning and improvement.

Identifying Change as an improvement:

Changes will be implemented using an organized and systemic process. The process will depend on the nature of the change to be implemented, but will always include clear communication of the structure, purpose, and goals of the change to all involved parties. Measures will be established that will monitor progress and change for PIPs and widespread improvement activities.

Communications & Evaluation

Internal and External QAPI Communication:

Regular reports and updates will be provided to the Administrative Leaders, management staff, resident council, external partners, and other stakeholders. This will be accomplished through multiple communications channels, Monthly operations call , staff meetings, new hire orientation, staff training sessions, e-mail updates and memos, story boards, resident council, administrative reports, local media and social media.

Identifying a working QAPI plan:

On at least an annual basis or as needed the QAPI Self-Assessment and facility assessment will be completed with input from the entire QAPI team and organizational leadership. The results of this assessment will direct us to areas we need to work on in order to establish and improve QAPI programs and processes in our organization.

We will also conduct an annual facility assessment to identify gaps in care and service delivery in order to provide necessary services. These items will be considered in the development and implementation of the QAPI plan. PCC provides an electronic platform for documenting QAPI and tracking changes in QAPI results over time.

Revision of QAPI plan:

The QA&A Committee will review and submit proposed revisions to the Governing Body for approval on an annual and /or as needed basis.

Supporting Documents:

Interact Hospital rate tracking tool

Monthly medication errors

PU tracking report/PCC

IPRO Infection tracking

Admission checklist

A/I tracking report/PCC

DON monthly report

Food safety and Kitchen Sanitation audit

Customer satisfaction reports

Complaint/Grievance logs

Environmental services audit

Manager on duty reports

Record of Plan Reviewed:

Courtney Fasolino Courtney Fasolino

Reviewed at QAPI meeting on 1/31/2024 with QAPI Team