Laguna Honda Hospital Action Plan

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Emergency Preparedness Program (EPP)				
Root Cause 1: Lack of alternative communication methods during emergencies				
Milestone 1: LHH Executive Team has selected Everbridge as a secondary mode of communication. Everbridge is an electronic alert system used to communicate critical, real-time information to staff during emergencies through text message, phone calls, and emails. It is used by a wide variety of facility and county EMS agencies in California.	Chief Executive Officer (CEO)	Minutes from LHH Executive Leadership meeting	1/6/23	1/13/23
Milestone 2: Update emergency preparedness communication plan.	Interim Administrative Director of Operations	EPP committee meeting minutes	1/6/23	1/19/23
Milestone 3: Develop a spreadsheet that lists each speaker location in the hospital and Administration building.	Interim Administrative Director of Operations	Spreadsheet with each speaker locations	1/6/23	1/19/23
Milestone 4: Conduct auditory audit to validate that the clarity and volume for the PA system is adequate. Testing will occur at each speaker location in order to determine adequate functionality. Record results on spreadsheet.	Interim Administrative Director of Operations	Spreadsheet with notation next to each speaker indicating "Working" or "Needs Repair" or "Needs Replacement"	1/6/23	1/31/23
Milestone 5: Complete feasibility assessment to repair paging system and alternative communications that can be implemented (to include design, construction, configuration, and cost).	Interim Administrative Director of Operations	Feasibility assessment	1/6/23	2/15/23
Milestone 6: Actively assign, monitor, and ensure staff enrollment into Everbridge as mandated by the DPH Disaster Service Worker and Everbridge enrollment policy.	CEO	Everbridge enrollment tracking form	1/6/23	4/30/23
Milestone 7: Develop and distribute communication for newsletter and/or Townhall meeting to inform all staff of the new process.	CEO	Evidence of communication	1/25/23	4/30/23
Milestone 8: During active, routine drills, validate emergency communications (e.g., Everbridge). Include AAR for the training/test.	Interim Administrative Director of Operations	AAR form	2/1/23	4/30/23

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Milestone 9: Based on the paging system feasibility assessment (Milestone #5), schedule and prioritize work orders for any repairs or identified alternative communication methods. On the spreadsheet, log that the order has been made and the date it was made.	Interim Administrative Director of Operations	Spreadsheet with audit results has date that work order was made, including anticipated date of completion.	2/16/23	2/23/23
Milestone 10: Initiate tracking system for paging system repairs with clear end date and completion status.	CEO	Paging repair spreadsheet tracking system	2/16/23	3/18/23
Root Cause 2: Lack of leadership involvement in the EPP				
Milestone 1: Establish partnership and collaborate with Public Health Emergency Preparedness and Response (PHEPR) for active participation in emergency preparedness.	CEO	Email communication	1/6/23	1/20/23
Milestone 2: Ensure EPP activations/drills are added as standing agenda item to QAPI/QAA and provide after-action report (AAR) for the month of review.	CEO	QAPI/QAA minutes	1/6/23	4/30/23
Milestone 3: Find a subject matter expert (SME) to support, in collaboration with PHEPR, development of training for appropriate response to EPP drills/emergencies.	Health Network COO	Email communication confirming retention of SME	1/20/23	1/31/23
Milestone 4: Create a calendar of executive leadership rounds to actively interact with staff members to communicate and reinforce expectations for emergency preparedness. Obtain the EPP (Milestone #3) drilling schedule from Facilities and set schedule for leadership participation.	CEO	Calendar of leadership rounds	1/20/23	1/31/23
Milestone 5: Create a standardized rounding form to document findings from interactions that occur during rounding and just-in-time feedback education for urgent, time-sensitive issues.	CEO	Rounding form	2/1/23	2/28/23
Milestone 6: The SME will train and coach executive leadership on the appropriate response to set the LHH standard for emergency response in various locations when a drill or emergency occurs and ensure staff are appropriately responding.	CEO	Training Materials	3/1/23	3/15/23
Milestone 7: PDSA the executive leadership rounding tool based on the results of trialing the rounding form.	CEO	Rounding form	3/15/23	3/31/23
Milestone 8: The data obtained from the standardized rounding will be compiled by LHH CEO Chief of Staff and analyzed for trends/patterns and gaps in the process during the LHH Executive Staff Meeting.	CEO	Rounding schedule	3/15/23	4/30/23
Milestone 9: Data compiled from leadership rounding will be reported to QAPI/QAA program for potential corrective items.	CEO	QAPI/QAA meeting minutes	4/1/23	4/30/23
Root Cause 3: Hazard vulnerability exercises not routinely conducted				

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Milestone 1: Establish a form that will be used for AARs. Ensure the form has a space that notes which residents and staff participated in the drill (e.g., sign-in sheet) and which residents, staff, and executive team members participated in the drill and AAR.	CEO	AAR form	1/6/23	1/19/23
Milestone 2: Create a crosswalk document that notes the gaps and poorly assessed areas in the current HVA that needs to be addressed based on recent survey findings.	Interim Administrative Director of Operations	Crosswalk document	1/6/23	1/31/23
Milestone 3: Identify the unique drills that need to be performed in 2023. Create a 2023 "Drills" calendar that lists (1) Date/shift for each drill (must be each shift/each quarter); (2) Type of drill that will occur, and (3) Estimated date of completed AAR.	Interim Administrative Director of Operations	Annual calendar of drills	1/6/23	1/31/23
Milestone 4: Ensure EPP activations/drills are added as standing agenda item to QAPI/QAA and provide AAR for the month of review.	CEO	QAPI/QAA agenda and minutes	1/6/23	4/30/23
Milestone 5: Emergency Prep Committee to provide a monthly summary of the AAR findings to Communications for the development of a staff publication. The summary will be used as a feedback loop to staff to communicate AAR findings, such as tasks performed well and tasks that need improvement and relevant education for that improvement.	Interim Administrative Director of Operations	Monthly summary article that was sent to Communications	1/6/23	4/30/23
Milestone 6: Distribute a communication summary from the previous months activation/drills that notifies staff regarding tasks performed well and tasks that need improvement and relevant education (e.g., SBAR and teach-back documents for team huddles) for identified areas of improvement.	Interim Administrative Director of Operations	Evidence of communication	1/6/23	4/30/23
Milestone 7: Working with DET, Security, Nursing, Facilities staff and the community coalition (hospital council emergency preparedness workgroup), PHEPR, identify two exercise topics that will occur for 2023.	Interim Administrative Director of Operations	Evidence of communication	2/1/23	2/15/23
Milestone 8: Confirm LHH's participation in community-based activations and/or exercises (e.g., PHEPR).	Interim Administrative Director of Operations	Work plan	2/1/23	2/15/23
Milestone 9: Submit calendar to QAPI/QAA committee for recording and awareness.	CEO	QAPI/QAA minutes	2/1/23	2/15/23
Milestone 10: Update the HVA based on the findings from the HVA review.	Interim Administrative Director of Operations	Revised HVA	2/1/23	2/28/23

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Milestone 11: Active participation in the PHEPR community-based activations and/or exercises.	Interim Administrative Director of Operations	Meeting minutes	2/1/23	4/30/23
Root Cause 4: EPP resources not readily accessible to staff				
Milestone 1: Conduct a baseline visual audit assuring that the November 2022 revised departmental EGM is present at the standardized location in each care area and to identify gaps in EGM availability.	Interim Administrative Director of Operations	Excel Spreadsheet	1/6/23	1/13/23
Milestone 2: Based on findings from audit, make corrections.	Interim Administrative Director of Operations	Email communication	1/6/23	1/13/23
Milestone 3: Connect with community subject matter experts (SMEs such as CAHF, ZSFG Emergency Preparedness, or PHEPR) to learn there if there is a quick reference guide for all emergencies.	Interim Administrative Director of Operations	Meeting minutes	1/6/23	1/19/23
Milestone 4: Based on finding from community SMEs, select format for a quick reference guide.	Interim Administrative Director of Operations	Quick reference guide document	1/20/23	2/7/23
Milestone 5: Create prototype quick reference guide and test the contents with multiple audiences for clarity and usefulness.	Interim Administrative Director of Operations	Quick reference guide document	2/8/23	2/21/23
Milestone 6: Determine the specific location of the quick reference guide and quantity needed.	Interim Administrative Director of Operations	Spreadsheet with the unit &/or dept name, location, and quantity of quick reference guide.	2/8/23	2/28/23
Milestone 7: Determine the specific city threshold languages, in addition to English, for the quick reference guide.	CEO	Email communication	2/21/23	3/14/23
Milestone 8: Send quick reference guide for production.	Interim Administrative Director of Operations	Email communication	3/15/23	4/14/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 9: Coordinate announcement with communications to put notice in staff communication emails that quick reference guides are distributed and their locations.	Interim Administrative Director of Operations	Email communication	4/15/23	4/15/23
Milestone 10: Distribute and train staff on the contents of the quick reference guides and the locations where they can find the guide.	Interim Administrative Director of Operations	Review distribution list and unit sign-in sheets to verify training.	4/15/23	4/30/23
Root Cause 5: Staff not adequately trained for emergencies				
Milestone 1: EPP committee will identify specific roles for immediate emergency response (e.g., on the nursing unit who secures the fire extinguishers, life saving equipment are placed on generator power (red outlets), who ensures resident safety when not on a care unit?).	Interim Administrative Director of Operations	Meeting minutes	1/6/23	1/31/23
Milestone 2: Modify Standard Work to reflect changes made based on workgroup findings.	Interim Administrative Director of Operations	Revised Standard Work	1/6/23	1/31/23
Milestone 3: Develop materials and scenarios for interactive in-person education for fire drills where role definition is executed and badge buddy information is reinforced.	CEO	Training material/notes	1/24/23	3/10/23
Milestone 4: Identify interpreters for in-person sessions and translators for written materials.	Health Network Chief Operating Officer (COO)	List of interpreters/translators	2/1/23	2/28/23
Milestone 5: Host unit-based fire drills to ensure comprehension of training and roles. Training to impact three shifts and weekends.	CEO	Compliance reports	3/13/23	4/30/23
Milestone 6: Host training for other departments and complete scenario-based training.	CEO	Compliance reports	3/13/23	4/30/23
Root Cause 6: Resident and Visitors Unaware of Emergency Plan				
Milestone 1: Create crosswalk between current resident handbook and identify gaps where information about their response during an emergency is missing.	Interim Administrative Director, Care Experience	Crosswalk document	1/6/23	1/19/23
Milestone 2: Edit resident handbook for gaps identified during the crosswalk. Include pictures in handbook wherever possible to improve comprehension.	Interim Administrative Director, Care Experience	Draft handbook	1/20/23	2/10/23

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Milestone 3: Modify AAR form so it can include resident information that participated in drills.	Interim Administrative Director of Operations	AAR form	1/6/23	1/19/23
Milestone 4: Identify team members and review their role to provide teaching opportunities for residents and identify their involvement during drills.	Interim Administrative Director, Care Experience/CNO	Team roster	1/6/23	1/31/23
Milestone 5: While revising the handbook for literacy level and readability, solicit feedback by having it reviewed at Resident Council.	Interim Administrative Director, Care Experience	Resident council minutes & draft handbook	1/20/23	2/10/23
Milestone 6: Send resident handbook for translation and production.	Interim Administrative Director, Care Experience	Draft handbook	2/10/23	3/24/23
Milestone 7: In a one-week time, complete distribution to residents. Ongoing orientation/education will occur at community meetings, resident council meetings, and additional individual distribution.	Interim Administrative Director, Care Experience	Compliance reports	3/24/23	3/31/23
Milestone 8: In a one week time, complete distribution to resident representative on record.	Interim Administrative Director, Care Experience	Mailing distribution list (email, USPS)	3/24/23	3/31/23
Milestone 9: Create a checklist that has LHH resident names and the 7 key teaching opportunities to assure resident inclusion and knowledge of drills: 1) if there is a Trauma Informed need specific to drills and emergencies 2) care plan update and note documenting this information and resident preferences 3) purpose of drills (assure resident safety) 4) what to expect during a drill/emergency 5) how often drills are conducted 6) their role in a drill 7) if they want to participate in a drill	Interim Administrative Director, Care Experience/CNO	Review checklist and resident names	2/14/23	3/24/23
Milestone 10: Submit final resident handbook product to the QAPI/QAA committee.	Interim Administrative Director, Care Experience	QAPI/QAA meeting minutes	4/1/23	4/30/23

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Milestone 11: Add annual review of Resident Handbook to Care Experience work plan.	Interim Administrative Director, Care Experience	Work plan	4/1/23	4/30/23
Root Cause 7: Fire drill feedback not provided to staff to drive improvement (New Monitoring Survey RCA Root Cause)				
Milestone 1: Emergency Prep Committee to provide a monthly summary of the fire-response AAR/drills (via fire drill participation forms) findings to Communications for the development of a staff publication. The summary will be used as a feedback loop to staff to communicate fire-response AAR/drills findings, such as tasks performed well and tasks that need improvement and relevant education for that improvement. (See RC #3, Milestone #5)	Interim Administrative Director of Operations	Monthly Summary Document	1/24/23	2/3/23
Milestone 2: Distribute a communication summary from the previous months fire response activation/drills that notifies staff regarding tasks performed well and tasks that need improvement and relevant education (e.g., SBAR and teach-back documents for team huddles) for identified areas of improvement. (See RC #3, Milestone #6)	Interim Administrative Director of Operations	Monthly Staff Communication	2/4/23	2/14/23
Competent Staff, Training, and Quality of Care				
Root Cause 1: Lack of leadership with SNF experience, regulatory knowledge				
Milestone 1: Perform environmental scan of SNF-related certifications and/or credentialing that are available in the SNF industry, including, but not limited to, nursing home administrator license, certified medical director, certified director of nursing, infection prevention certification, education/training, and RAC-CT certification.	Chief Executive Officer (CEO)	Environmental scan report with results regarding SNF licensures, credentials, and certifications	1/2/23	1/11/23
Milestone 2: Identify leadership, medical staff, and management staff roles that may require SNF credentials based on environmental scan results.	CEO	Document with table of staff and associated licensure, credentialing, and/or certification needs	1/12/23	1/14/23
Milestone 3: Enroll LHH leadership from multiple disciplines into the CAHF leadership academy, which starts in March 2023, based on the above Milestones #1 & #2.	CEO	Acceptance letters from CAHF to confirm enrollment	2/1/23	3/31/23
Milestone 4: Create job description to hire a licensed nursing home administrator.	CEO	Document with job description	2/1/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Advertise a job description to hire a licensed nursing home administrator (NHA).	Human Resources/DPH Chief Operating Officer (COO)	Job posting verification	3/15/23	4/30/23
Milestone 6: In the interim of the NHA search process, retain NHA consultant to support LHH.	CEO	Document confirming retention of consultant	1/6/23	1/30/23
Milestone 7: In the interim of the CMO/medical director search process, join California Association of Long-Term Care Medicine (CALTCM) to provide mentorship/coaching to current physician leadership in support of LHH.	CEO	Document confirming membership	1/6/23	2/28/23
Milestone 8: Retain an IP consultant, with a CIC, to support infection prevention staff to ensure compliance with SNF regulations.	CEO	Document confirming retention of consultant	1/6/23	1/30/23
Milestone 9: Identify leadership and middle management job descriptions for future hires proposed to be updated to include SNF-specific experience and/or requirement of licensure, certification, or credentialing obtained within a year of hire.	CEO	List of job descriptions	3/1/23	3/31/23
Milestone 10: Execute changes in job descriptions for future hires based on SNF credentialing/certification requirements.	CEO	Documented standard HR language describing recommended SNF expertise	4/1/23	4/30/23
Root Cause 2: Lack of care rounds to reinforce training and knowledge				
Milestone 1: Identify executive leaders and middle managers required to participate in leadership rounding program to observe the environment, interact with residents and staff members to build rapport, identify concerns, and gather feedback.	CEO	Document with list of required leadership rounders	1/6/23	1/20/23
Milestone 2: Create a weekly rounding schedule that includes: rounder name, units to round, and questions based on topics/issues that should be addressed.	CEO	Rounding schedule document	1/20/23	1/31/23

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Milestone 3: Create standardized rounding tool and feedback document for findings, which will be completed and submitted after every scheduled round.	CNO	Rounding report template document	2/1/23	2/28/23
Milestone 4: Create QAPI/QAA report that identifies number of completed rounds, identify findings and trends requiring immediate mitigation, important themes, and successes observed during leadership rounding.	Chief Quality Officer (CQO)	Rounding executive report template	2/1/23	2/28/23
Milestone 5: Implement executive rounding program	COO	Rounding schedule document	3/15/23	4/30/23
Milestone 6: Executive leaders will meet with SNF industry-expert coaches to review rounding findings and identify high-vulnerability areas, follow-up items, and staff education that need to be addressed through rounding.	CEO	Meeting minutes	4/1/23	4/30/23
Milestone 7: Report rounding results through QAPI/QAA.	CQO	QAPI/QAA Report	4/3/23	4/30/23
Root Cause 3: Lack of accountability for mandatory educational requirements				
Milestone 1: Create standard work regarding staff training expectations, accountability, and process for non-compliance if indicated as applicable.	CEO/CNO/CQO/HR	Document outlining education and process	1/6/23	1/13/23
Milestone 2: Identify how to gather and quantify individual training completion reports through ELM and other training mechanisms.	CNO	Document describing steps to extract and monitor individual training data	1/2/23	2/15/23

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Milestone 3: Create training for the standard work to support middle managers in escalating staff non-compliance to leadership.	CEO/CNO	Document outlining steps to escalate training non-compliance	1/9/23	1/15/23
Milestone 4: Train leadership and middle managers on updated standard work and escalation process to ensure staff are properly trained.	CEO/CNO	Compliance reports	1/16/23	1/31/23
Milestone 5: Create nursing-unit based training reports to support middle managers in tracking and following up on staff education completion and accountability after providing adequate time to complete the training.	CNO	Template of report	2/15/23	3/15/23
Root Cause 4: Lack of focused scope of work in Department of Education and Training (DET)				
Milestone 1: Complete assessment of DET department to identify current scope of work, roles, responsibilities, and tasks that fall outside of traditional training and education work, such as HR functions.	CNO	Assessment report of current DET scope of work	1/6/23	1/10/23
Milestone 2: Using assessment results, develop DET scope of service with tasks and responsibilities.	CNO	Document outlining updated DET scope of work	1/9/23	1/27/23
Milestone 3: Complete scope of service reconfiguration proposal of DET department to include analysts and clerical staff to support the newly defined functions of the department.	CEO/CNO	Department scope statement	3/1/23	4/30/23
Root Cause 5: Adult learning approaches absent in training				
Milestone 1: Develop training curriculum for DET department competencies for applying adult-learning principles.	CNO	Training materials	1/16/23	1/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 2: Train DET staff on competencies needed to effectively apply selected adult-learning techniques with staff training and education.	CNO	Compliance reports	2/1/23	2/28/23
Milestone 3: Identify educational topic and pilot test in-person education on nursing units using a selected adult-education approach (e.g., teach back with return demonstration) .	CNO	Standardized report to track education outreach with assesses of effectiveness	3/1/23	4/30/23
Milestone 4: Create monthly educational/training calendar with identified topics based on regulations, problem-prone areas, or other areas of need identified by leadership.	CNO	Training and education calendar document	4/1/23	4/23/23
Root Cause 6: LHH leadership not members of SNF associations				
Milestone 1: Perform environmental scan of national, state, and regional SNF associations and identify areas of expertise, benefit to LHH, and membership costs.	CEO	Environmental scan report or SNF associations	1/6/23	1/21/23
Milestone 2: Identify leadership and staff member roles to join respective associations (e.g., CAHF).	CEO	Document with table listing staff and associations to join	1/11/23	1/31/23
Milestone 3: Identify funding for association memberships for identified staff members.	CFO	Email approval for association membership budget	2/1/23	2/28/23
Milestone 4: Define expectations of association membership, including, but not limited to, meeting attendance and sharing information with colleagues at LHH.	CEO	Document describing association membership expectations	2/1/23	3/31/23
Milestone 5: Create report template for staff to submit meetings attended and description of key ideas and resources to share with other staff members.	CEO	Template of individual report to monitor association engagement	3/1/23	3/31/23
Milestone 6: Create quarterly CEO report to monitor association participation (e.g., active memberships with expiration dates/membership deadlines, number of meetings attended, etc.)	CEO	Template of report to monitor overall association engagement	4/1/23	4/30/23
Comprehensive Care Plans and Quality of Care				
Root Cause 1: Ineffective care planning by interdisciplinary team				
Milestone 1: Complete a crosswalk to the phase 3 requirements and best practices to update policies and procedures related to MDS and care plans.	Chief Nursing Officer (CNO)	Policy and procedures with track changes	1/6/23	1/14/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 2: Develop or identify existing MDS/care plan education with topics to include, but not limited to, nurse leader role, individualization of the care plan process including updates ensuring individualization based on any changes, how to complete required sections of the MDS, trauma informed care, quality of care, restorative nursing needs, and regulations associated with MDS and care plans.	CNO	Training materials	1/6/23	1/31/23
Milestone 3: Create a charter defining a new resident care conference (RCC) model that will be used to ensure resident-centered care and participation.	CNO/Chief Medical Officer (CMO)	Charter document	1/9/23	1/25/23
Milestone 4: The role of each member of the interdisciplinary team (IDT) will be evaluated and defined.	CNO/CMO	IDT team member role/responsibility descriptions	1/9/23	1/25/23
Milestone 5: The MDS policy will be reviewed, evaluated, and updated to accurately reflect the sections of the MDS required to be completed by each team member to coordinate with the care plan.	CNO/CMO	Policy and procedures with track changes	1/9/23	1/25/23
Milestone 6: Expedited approval of updated MDS policy and RCC charter	Chief Quality Officer (CQO)	Documented approval	1/26/23	3/14/23
Milestone 7: An in-person meeting will be held with the MDS team to review expectations of roles and responsibilities of each member of the team involved in the MDS and care planning process and review the RCC charter.	CNO/CMO	Meeting minutes	2/1/23	2/15/23
Milestone 8: Implement MDS/care plan education with members of the IDT.	CNO/CMO	Compliance reports	2/1/23	2/28/23
Milestone 9: Create a standardized form that will be maintained in a binder/folder to document supervisory leadership observations of the RCC and offer coaching and guidance.	CNO	Standardized form	2/1/23	2/15/23
Milestone 10: Supervisory leadership from members of the IDT will attend at least one RCC monthly on each unit to ensure accountability of active team participation.	CEO	Completed RCC observation forms	2/15/23	4/30/23
Milestone 11: To create an accountability structure, data from the observations will be analyzed for trends and patterns to identify gaps and areas of improvement to be acted upon by QAPI/QAA.	CNO	RCC observation form	2/15/23	4/30/23
Milestone 12: Implement a standardized process to document and communicate resident preferences and needs for individualized care plans.	CNO	Process documentation and/or standard work	1/26/23	2/28/23

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Root Cause 2: Lack of MDS Department oversight and accountability				
Milestone 1: Assign existing MDS coordinators to specific units. They will be responsible to oversee individual care plan for each unit. This information will be shared via an organizational chart with departments for reference.	CNO	Nursing department organizational chart + MDS Coordinator Roles & Responsibilities Document	1/6/23	1/10/23
Milestone 2: LHH will develop a standardized tool for evaluation of the care plan to ensure individualization.	CNO	Care plan evaluation tool	1/6/23	1/25/23
Milestone 3: Using a standardized tool, conduct baseline audit for each MDS nurse specifically looking at MDS coding and care plan individualization to evaluate performance.	CNO	Audit results	1/6/23	1/25/23
Milestone 4: Review results with department manager and leadership and appropriate stakeholders.	CNO	Meeting minutes	1/25/23	1/31/23
Milestone 5: The RCC charter will indicate that the MDS Coordinator will lead the IDT in RCC meetings to ensure active participation by themselves and members to build the unit-based care team.	CNO	RCC Charter	1/25/23	1/31/23
Milestone 6: Validate competency of every MDS coordinator.	CNO	Checklist validating competency	2/1/23	2/28/23
Milestone 7: Create a dashboard to track data collected by the standardized audit tool to monitor the integrity and individualization of each care plan.	CQO	Completed dashboard template	2/1/23	2/28/23
Milestone 8: Results of MDS coding and care plan individualization will be monitored through the unit-based QAPI/QAA Program.	CQO	Meeting minutes	3/1/23	3/30/23
Milestone 9: Results of MDS coordination validation will be monitored by MDS leadership, including, but not limited to, coaching and support.	CNO	Meeting minutes	3/1/23	4/30/23
Root Cause 3: LHH not using consistent nursing assignment				
Milestone 1: Conduct literature search on best practices for consistent assignments in SNFs.	CNO	Literature Review	1/6/23	1/21/23

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Milestone 2: Examine staffing needs in order to implement consistent staffing on nursing units.	CNO	Staffing Needs Document	1/6/23	1/21/23
Milestone 3: Develop an operational work plan for consistent assignments.	CNO	Work Plan	1/23/23	2/10/23
Milestone 4: Present operational work plan to CEO for approval.	CNO	Email document	2/10/23	2/13/23
Milestone 5: Educate staff on benefits of consistent assignments, such as quickly identifying resident changes in condition, and the proposed program for pilot units.	CNO	Compliance reports	3/1/23	3/15/23
Milestone 6: Identify unit based PCA champions for consistent assignments on pilot units.	CNO	Email document	3/1/23	3/15/23
Milestone 7: Pilot consistent staffing program to identify implementation barriers to inform PDSA process on one unit in North tower and one unit on South tower.	CNO	Staffing documents	3/15/23	4/7/23
Milestone 8: Develop a report that evaluates the effectiveness of pilot program to PDSA implementation across LHH and plan for spread in units as indicated.	CNO	Report	4/15/23	4/30/23
Root Cause 4: Limited care planning participation by nurse leaders				
Milestone 1: LHH will obtain a SNF care plan subject matter expert (SME) (e.g., SNF DON consultant) to provide education and coaching to nurse leaders (e.g., nurse managers, nursing directors) on their roles and responsibilities to the care plan process.	CNO	Scope of work document	1/6/23	2/15/23
Milestone 2: With the assistance of the SME or industry best-practice resource, the LHH DONs will define in writing the roles and responsibilities of nurse leaders, including their active participation, in developing and implementing individualized care plans.	CNO	Document with roles and responsibilities NMs and nursing directors related to care plans	2/1/23	2/21/23
Milestone 3: Mandatory education will take place in person with compliance monitored through DET. Results will be shared with CNO for coaching and support.	CNO	Compliance reports	2/22/23	2/28/23
Milestone 4: The SME will provide weekly coaching to the nurse leaders including the MDS department to ensure active participation in developing and implementing individualized care plans.	CNO	SME weekly summary	3/1/23	4/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Root Cause 5: EHR not optimized for SNF setting				
Milestone 1: Identify team members who will develop a charter to identify the steps for the business plan for EHR optimization.	Chief Executive Officer (CEO)/Chief Information Officer (CIO)	Meeting minutes	1/6/23	1/10/23
Milestone 2 : Develop future state process for accessing a daily report sheet for staff.	CNO/CIO	Meeting minutes	1/6/23	1/31/23
Milestone 3: Complete charter.	CEO/CIO	Charter	1/11/23	1/31/23
Milestone 4: Create Kardex system within the EHR to include daily care needs and essential care plan elements that are to be defined.	CNO/CIO	Completed Kardex system	2/1/23	2/28/23
Milestone 5: LHH will develop a business plan per the charter with timelines and milestones to customize the current EHR to the SNF setting and LHH's unique population needs.	CEO/CIO	Meeting minutes	2/1/23	4/30/23
Milestone 6: Develop Kardex training for nursing staff that includes methods to implement and update the Kardex.	CNO/CIO	Training materials	3/1/23	3/31/23
Milestone 7: Implement in-person training for direct-care staff on the Kardex and daily report sheet through a hands-on in-person based training.	CNO/CIO	Compliance reports	4/1/23	4/30/23
Milestone 8: Implement the daily use of the Kardex on each unit with oversight by the nursing leadership.	CNO/CIO	Verification of Kardex implementation on units	4/16/23	4/30/23
Milestone 9: The MDS team will review each Kardex with the RCC to ensure accuracy and individualization. The results will be presented to QAPI/QAA for evaluation of trends and patterns and opportunities for improvement.	CQO	Documented verification of Kardex accuracy	4/16/23	4/30/23
Root Cause 6: Limited access by direct-care staff to care plan information				
Milestone 1: See Root Cause #5 for implementation of a Kardex system to guide daily resident care and interactions.	CNO/CIO	Verification of Kardex implementation on units	1/6/23	4/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 2: An education plan and curriculum will be developed for direct care staff who have various levels of knowledge on 1) using care plans 2) how to include care plan interventions in their practice and 3) access care plans through the EHR 4) how to update care plans. This will be completed on an on-going basis at time of hire and annually. This will include in-person scenario based learning. Departments include nursing, activities, social services, medical staff, therapy, food and nutrition and others as indicated.	CNO	Education plan	2/15/23	3/14/23
Milestone 3: LHH will utilize a train the trainer education plan with DET providing the training program to the nurse managers.	CNO	Compliance reports	3/15/23	3/31/23
Milestone 4: The nurse managers will use a scenario-based training with return demonstration to the direct care staff to ensure staff comprehension at the unit level.	CNO	Compliance reports	4/1/23	4/30/23
Milestone 5: Mandatory education will be monitored by DET and nurse directors for compliance. Staff non-compliance to mandatory training will result in executive follow-up.	CNO	Monitoring report	4/1/23	4/30/23
Milestone 6: LHH will report education compliance metrics to QAPI for evaluation of trends and patterns to ensure implementation of process improvement interventions as necessary by the QAA Committee.	CNO	QAPI/QAA meeting minutes	4/1/23	4/30/23
Root Cause 7: Lack of specialized skills to individualize care plans				
Milestone 1: Utilizing the current LHH Behavioral Health Emergency Response Team (BERT) staff (onboarded Dec. 2022), complete review and re-assessment of current BERT program and operations to identify opportunities for improvement, in collaboration with the existing DPH BERT team at Zuckerberg San Francisco General (ZSFG) Hospital as a SME, regarding scope of work, roles, responsibilities, and tasks to ensure the BERT primary function is training and supporting direct care staff with therapeutic responses to residents with escalating behavioral health issues.	Chief Nursing Officer (CNO)/CMO	Assessment report of current BERT scope of work and gaps	1/6/23	2/10/23
Milestone 2: Finalize updated BERT scope of service, job duties, and work/responsibilities including participation in resident care councils (RCCs) and care plans.	CNO/CMO	Finalized program scope	2/10/23	2/28/23
Milestone 3: Develop weekly metrics modeled after the ZSFG BERT Program's dashboard (consultations, interventions, RCCs attended) to demonstrate impact of the current LHH BERT program, understand ongoing resource needs, and continuously communicate the availability of the team at the weekly nursing leadership meeting as a feedback loop.	CNO/CMO	Weekly BERT metrics	2/17/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 4: To provide ongoing education to staff regarding behavioral health interventions utilized and/or available for residents, the BERT team will provide a just-in-time follow-up educational bullet points for the unit huddle board.	CNO/CMO	Huddle board bullet/education points	2/17/23	2/28/23
Milestone 5: Recruit and hire additional qualified BERT candidates as identified in Milestone #1's assessment to join the existing LHH BERT program.	CNO/CMO	Job posting	1/27/23	3/30/23
Milestone 6: Train and mentor new BERT members using existing BERT staff on response protocol and roles/responsibilities (assuming successful recruitment and hiring).	CNO/CMO	Complete orientation/ competency checklists for BERT members	4/1/2023 or upon hire if earlier	4/30/23
Milestone 7: Develop prioritization criteria for RCC sessions requiring BERT member's participation.	CNO/CMO	Document of criteria	1/26/23	1/30/23
Milestone 8: Incorporate BERT team into monthly RCC meetings per prioritization criteria to provide care plan input, monitor effectiveness of interventions, appropriateness of out on pass, and other pertinent updates.	CNO/CMO	Care Plan Meeting Schedule	2/1/23	2/28/23
Milestone 9: BERT team will assess care plans for monitoring effectiveness of interventions, appropriateness of out on pass, and other pertinent updates. Findings will be reported monthly at NEC Quality and Safety meetings.	CNO	NEC Report	3/1/23	3/31/23
Milestone 10: DONs will analyze the data from BERT team for trends and patterns and report relevant data to QAPI/QAA committee.	CQO	QAPI/QAA meeting minutes	4/1/23	4/21/23
Resident Rights and Freedom from Harm				
Root Cause 1: Lack of consistent leadership rounding				
Milestone 1: LHH will identify the team members responsible for completing rounds	Chief Executive Officer (CEO)	List of team members	1/6/2023	1/20/2023
Milestone 2: LHH will review and revise the expected weekly schedule for rounding.	CEO	Schedule	1/20/23	1/31/23
Milestone 3: LHH will create the standardized leadership rounding form to include elements that reviews resident care standards related to abuse and neglect, resident rights and other care concerns.	CEO	Rounding form	2/1/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 4: PDSA the leadership rounding tool based on the results of trialing the rounding form.	CEO/Chief Nursing Officer (CNO)	Rounding Form	3/15/23	3/31/23
Milestone 5: Develop training on resident care standards related to abuse and neglect, resident rights, and care concerns. The education will include techniques on addressing these concerns and the escalation process.	CEO/CNO	Training materials	1/14/23	1/31/23
Milestone 6: LHH will provide routine education at least quarterly and as needed to Executive leadership on resident care standards related to abuse and neglect, resident rights, and care concerns.	CEO/CNO	Compliance reports	3/1/23	4/30/23
Milestone 7: Using the standardized leadership rounding tool, begin rounds.	CEO	Rounding schedule	3/15/23	4/30/23
Milestone 8: The data obtained from the standardized rounding will be compiled by LHH CEO Chief of Staff and analyzed for trends/patterns and gaps in the process during the LHH Executive Staff Meeting.	CEO	Data monitoring	3/15/23	4/30/23
Milestone 9: Data compiled from leadership rounding will be reported to QAPI/QAA program for potential corrective items.	CEO	QAPI/QAA meeting minutes	4/1/23	4/30/23
Root Cause 2: Lack of proactive intervention to prevent abuse				
Milestone 1: Crosswalk abuse and neglect policies to align with all CMS SNF regulations.	Chief Quality Officer (CQO)	Crosswalk document	1/6/23	1/20/23
Milestone 2: Perform analysis on abuse and neglect investigation process.	CQO	Analysis report	1/6/23	1/31/23
Milestone 3: Post for dedicated investigation staff in order to increase reliability on reporting and ensure unbiased investigation.	CQO	Job postings	1/6/23	3/30/23
Milestone 4: Make policy changes and obtain approval as indicated per the crosswalk.	CQO	JCC Meeting agenda	1/14/23	3/14/23
Milestone 5: Develop a report with recommendations to present to the QAPI/QAA committee based on the results of the analysis.	CQO	Recommendations report	1/28/23	2/21/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 6: Create training module for staff using adult learning principles that includes Phase 3 requirements for abuse and neglect.	CQO/CNO	Training materials	2/1/23	2/28/23
Milestone 7: Continue to monitor and report of abuse using meaningful criteria that identifies trends and patterns. This will be reported to QAPI/QAA on a monthly basis.	CQO	QAPI meeting minutes	2/1/23	4/30/23
Milestone 8: Implement recommendations from report as indicated in order to have standardized investigative plan.	CQO	Investigation plan	2/21/23	4/15/23
Milestone 9: Host training sessions for staff on abuse policies and procedures.	CQO/CNO	Compliance reports	3/1/23	4/30/23
Root Cause 3: Unnecessary physical restraint use				
Milestone 1: Conduct LHH wide visual audit of devices and create a device list that have the restraint definition per the PIP charter currently in place. Identify location and volume of restraints by type and reason for restraint.	Chief Medical Officer (CMO)/CNO	Audit results	1/6/23	1/31/23
Milestone 2: Work with Purchasing, Facilities and Rehab to determine the type of alternatives to bedrails for mobility and other ADLs that can be acquired. Identify vendor through SFDPH system.	CMO/CNO	Vendor List	1/6/23	2/15/23
Milestone 3: LHH will implement a Restraint Performance Improvement Project with a defined scope and project manager.	CMO/CNO	PIP Charter	1/6/23	1/24/23
Milestone 4: As part of the PIP, perform gap analysis looking at (1) regulatory needs, (2) the current LHH program, and (3) the LHH policies.	CMO/CNO	Gap analysis report	1/6/23	2/15/23
Milestone 5: Identify local, restraint-free SNFs using public data on Nursing Home Compare. Visit identified SNFs and learn best practices and lessons-learned regarding how they reduced restraints.	CMO/CNO	Meeting notes	1/6/23	2/15/23
Milestone 6: Create a clinical pathway for physical restraints as a resource tool for staff.	CMO/CNO	Clinical pathway document	1/6/23	2/15/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 7: Develop the education materials for staff including medical staff, on the federal regulations related to physical restraints.	CMO/CNO	Training materials	2/1/23	2/28/23
Milestone 8: Provide resident and/or their representative individualized education regarding restraints, pros and cons , and alternatives to restraints, based on the resident's needs and assessment.	CMO/CNO	Education materials	2/1/23	3/15/23
Milestone 9: Order support equipment, as indicated.	CMO/CNO	Purchase Order /Rental List	2/15/23	2/28/23
Milestone 10: Using a small test of change, and incorporating the unit based Restraints Committee, identify the first 2 nursing units and provide unit based education, conduct a visual audit of restraint devices, create a device list, consult with RCT to determine appropriateness/ less restrictive alternative as indicated, evaluate regulatory compliance, appropriate elements of documentation (e.g., assessment, physician order, consent, care plan, etc.), and eliminate restraints as indicated.	CMO/CNO	Pre-initiative restraint device list from visual audit, and post initiative restraint device list with assessment, care plan, consent, physician order, and outcome	1/30/23	2/6/23
Milestone 11: Incorporating the unit based Restraints Committee, identify 2 additional nursing units and provide unit based education, conduct a visual audit of restraint devices, create a device list, consult with RCT to determine appropriateness/ less restrictive alternative as indicated, evaluate regulatory compliance, appropriate elements of documentation (e.g., assessment, physician order, consent, care plan, etc.), and eliminate restraints as indicated.	CMO/CNO	Pre-initiative restraint device list from visual audit, and post initiative restraint device list with assessment, care plan, consent, physician order, and outcome	2/7/23	2/12/23
Milestone 12: Incorporating the unit based Restraints Committee, identify 3 more nursing units and provide unit based education, conduct a visual audit of restraint devices, create a device list, consult with RCT to determine appropriateness/ less restrictive alternative as indicated, evaluate regulatory compliance, appropriate elements of documentation (e.g., assessment, physician order, consent, care plan, etc.), and eliminate restraints as indicated.	CMO/CNO	Pre-initiative restraint device list from visual audit, and post initiative restraint device list with assessment, care plan, consent, physician order, and outcome	2/14/23	2/23/23
Milestone 13: Incorporating the unit based Restraints Committee, identify 3 nursing units and provide unit based education, conduct a visual audit of restraint devices, create a device list, consult with RCT to determine appropriateness/ less restrictive alternative as indicated, evaluate regulatory compliance, appropriate elements of documentation (e.g., assessment, physician order, consent, care plan, etc.), and eliminate restraints as indicated.	CMO/CNO	Pre-initiative restraint device list from visual audit, and post initiative restraint device list with assessment, care plan, consent, physician order, and outcome	2/24/23	3/2/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 14: Incorporating the unit based Restraints Committee, identify 3 nursing units and provide unit based education, conduct a visual audit of restraint devices, create a device list, consult with RCT to determine appropriateness/ less restrictive alternative as indicated, evaluate regulatory compliance, appropriate elements of documentation (e.g., assessment, physician order, consent, care plan, etc.), and eliminate restraints as indicated.	CMO/CNO	Pre-initiative restraint device list from visual audit, and post initiative restraint device list with assessment, care plan, consent, physician order, and outcome	3/3/23	3/10/23
Milestone 15: The falls and restraints subcommittee for each of the 13 nursing units will report ongoing status of restraints and efforts to reduce restraints to the nursing quality committee. The subcommittee will evaluate the individual needs of each resident specific to restraints and identify interventions for reduction and barriers requiring mitigation plans. Updates will be updated to care plans and immediately communicated to the resident care team and the resident/resident representative.	CMO/CNO/CQO	Meeting Minutes	3/1/23	4/30/23
Milestone 16: Following the nursing quality committee, the DONs will report nursing restraints to QAPI/QAA. Feedback received by the QAPI/QAA will be incorporated as part of the restraint subcommittee's PDSA process.	CMO/CNO/CQO	QAPI/QAA meeting minutes	3/1/23	4/30/23
Root Cause 4: Low staff and resident awareness of grievance process				
Milestone 1: LHH will determine a standardized and appropriate placement on each nursing unit and several in community spaces for grievance forms and drop boxes to be located.	Interim Administrative Director, Care Experience	Spreadsheet for locations or map	1/6/23	1/20/23
Milestone 2: Summary report of grievances for the week will be shared at the Executive Leadership meeting so that leaders are equipped to address grievances during rounding.	Interim Administrative Director, Care Experience	Meeting Minutes	1/6/23	1/20/23
Milestone 3: Leadership will order the drop boxes and form holders.	Interim Administrative Director, Care Experience	Order form	1/14/23	1/27/23
Milestone 4: Facilities will install dropboxes and form holders.	Interim Administrative Director of Operations	Work order	2/1/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Grievance data will be analyzed for trends and patterns and reported to resident council monthly.	Interim Administrative Director, Care Experience	Resident Council Minutes	2/1/23	4/30/23
Milestone 6: The monthly analysis of grievance data will be reported to QAPI/QAA for critical analysis and follow up action.	Interim Administrative Director, Care Experience	QAPI/QAA minutes	2/1/23	4/30/23
Milestone 7: Review grievance policy and procedure and Standard Work to assure alignment with the above mentioned milestones.	Interim Administrative Director, Care Experience	Policy document	2/15/23	2/23/23
Milestone 8: The Patient Safety Advocate or designee will check each new drop box daily during rounds and collect the forms.	Interim Administrative Director, Care Experience	Grievance Log	2/23/23	4/30/23
Milestone 9: When a form is collected, the grievance will be triaged by the Patient Safety Advocate or designee for response. The grievance will be logged into the grievance log and assigned to the appropriate departments for timely follow up.	Interim Administrative Director, Care Experience	Grievance Log	2/23/23	4/30/23
Milestone 10: The Grievance Officer (or designee) will review the grievance log for appropriate response and timeliness.	Interim Administrative Director, Care Experience	Grievance Log	2/23/23	4/30/23
Root Cause 5: Lack of SNF resident-centered, best practice interventions				
Milestone 1: Conduct literature search on best practices for frequency of rounding in the SNF environment (e.g., "purposeful rounding").	CNO	Literature Review	1/6/23	1/21/23
Milestone 2: Examine feasibility to implement rounding based on the identified best practice interventions.	CNO	Feasibility assessment	1/6/23	1/28/23
Milestone 3: Conduct literature search on best practices for No Pass Zone.	CNO	Literature Review	1/6/23	1/21/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 4: Develop educational materials for No Pass Zone initiative.	CNO	Educational Materials	1/18/23	2/15/23
Milestone 5: Develop an operational work plan for rounding.	CNO	Work Plan	1/18/23	2/28/23
Milestone 6: Provide education on No Pass Zone initiative.	CNO	Email document	2/15/23	2/28/23
Milestone 7: Develop training on rounding and the proposed program.	CNO	Training materials	2/15/23	3/15/23
Milestone 8: Educate staff on rounding and the proposed program for pilot units.	CNO	Compliance reports	3/16/23	3/31/23
Milestone 9: Pilot rounding program on one unit in North tower and one unit on South tower	CNO	Staffing documents	4/1/23	4/22/23
Milestone 10: Begin implementing rounding program on remaining units.	CNO	Report	4/23/23	4/30/23
Milestone 11: Develop a report that evaluates the effectiveness of pilot program and plan for spread in units as indicated	CNO	Report	4/23/23	4/30/23
Root Cause 6: Lack of strong accountability standards				
Milestone 1: The CEO will review at a mandatory Leadership Forum the expectations for Directors, Managers, and Supervisors to follow the standard work process for staff progressive accountability that demonstrate documented non-compliance with regulatory standards.	CEO	Meeting minutes	1/6/23	1/19/23
Milestone 2: Directors, Managers and Supervisors will be provided educational/ coaching opportunities on how to document staff non- compliance and implement the approved staff progressive accountability standard work. This will occur at the Leadership Forum.	CEO	Educational Materials	1/6/23	1/19/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 3: The CEO will release a memo to staff that conveys that leadership and HR will reinforce the established expectations for staff behavior with regards to address resident needs, the staff progressive accountability standard work, and the LHH code of conduct.	CEO	Copy of memo	1/23/23	1/25/23
Milestone 4: During the Executive Rounds, standard work will include an assessment of the staff's understanding of residents rights and freedom from harm standards.	CEO	Rounding Assessment Spreadsheet & Associated Documentation	3/15/23	4/30/23
Milestone 5: Upon completion of the Rounds, Executive Leadership will document findings in the designated spreadsheet (see Milestone #1).	CEO	Rounding Assessment Spreadsheet & Associated Documentation	3/15/23	4/30/23
Milestone 6: Executive Leadership with review staff feedback regarding new expectations for staff accountability and the aggregate findings for trends and patterns. The review and appropriate follow-up action plans will be reported monthly through QAPI/QAA.	CEO	QAPI/QAA minutes	4/1/23	4/30/23
Root Cause 7: Ineffective resident council meetings				
Milestone 1: LHH will develop a calendar for the resident council meeting schedule that includes facility-wide and community meetings (unit-level).	Interim Administrative Director, Care Experience	Calendar	1/6/23	1/13/23
Milestone 2: LHH will develop the meeting agenda for the facility- wide and community meetings (unit-level) to include a review of grievances and concerns trends, resident rights and other resident concerns.	Interim Administrative Director, Care Experience	Meeting agenda	1/9/23	1/20/23
Milestone 3: Standardized meeting minutes will be developed for resident council meetings and utilized.	Interim Administrative Director, Care Experience	Meeting minutes	1/16/23	1/27/23
Milestone 4: Leadership will educate the facilitator of meetings to ensure knowledge of the standardized agenda and meeting minutes.	Interim Administrative Director, Care Experience	Compliance reports	1/23/23	2/6/23
Milestone 5: Implement new agenda and meeting minutes at facility-wide and community based resident council meetings.	Interim Administrative Director, Care Experience	Meeting minutes	2/2/23	4/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 6: Data from the meetings will be collected and analyzed to be reported to QAPI/QAA for evaluation of trends, patterns, gaps and need for further interventions.	Interim Administrative Director, Care Experience	QAPI/QAA minutes	2/28/23	4/30/23
Milestone 7: Develop outreach strategy to increase resident council meeting attendance.	Interim Administrative Director, Care Experience	Process documentation and/or standard work	2/2/23	3/6/23
Root Cause 8: Lack of formalized restorative nursing program				
Milestone 1: Perform gap analysis looking at (1) regulatory needs, (2) the current LHH program, and (3) the policies.	CNO	Gap analysis report	1/9/23	1/25/23
Milestone 2: Update current restorative program plan to define parameters and update policies, using federal regulatory standards.	CNO	Scope of service program document	1/26/23	2/8/23
Milestone 3: Review current program job positions and corresponding job descriptions to clarify specific roles and responsibilities.	CNO	Job description document	1/26/23	2/8/23
Milestone 4: In partnership with rehab, screen residents to identify restorative nursing needs.	CNO	Facility census report	1/26/23	2/28/23
Milestone 5: Update pertinent resident care plans to reflect restorative nursing program participation, as indicated.	CNO	Random selection of 30 care plans	3/1/23	3/30/23
Milestone 6: Initiate training for restorative nursing staff for program elements, job functions, and documentation requirements.	CNO	Training materials	2/1/23	2/28/23
Milestone 7: To maintain program integrity and resident functionality, continue ongoing evaluation quarterly following OBRA MDS schedule to ensure residents' restorative needs are met.	CNO	Random selection of 30 care plans	3/1/23	4/30/23
Milestone 8: Updated program elements and policies and procedures will be submitted to the QAPI/QAA committee.	CQO	QAPI/QAA meeting minutes	3/1/23	4/30/23
Root Cause 9: Lack of regulatory knowledge of bed hold and transfer/discharge (New Monitoring Survey RCA Root Cause)				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 1: Collaborate with regulatory subject matter expert (SME) to revise standard work to confirm written notice of bed hold and transfer/discharge is provided to residents, residents' representatives, and ombudsmen when discharged from LHH.	CNO	Revised standard work dated for Feb. 2023	1/26/23	2/8/23
Milestone 2: Update related policies and procedures to align with standard work developed in Milestone #1.	CNO/CQO	Updated policy document	2/9/23	2/15/23
Milestone 3: Train day shift staff on new standard work, including required documentation, timeliness, and electronic health record (EHR) compliance.	CNO	Sign-in sheets for training	2/9/23	3/3/23
Milestone 4: Train AM and PM shift staff on new standard work, including required documentation, timeliness, and electronic health record (EHR) compliance.	CNO	Sign-in sheets for training	3/1/23	3/31/23
Milestone 5: Bed hold and transfer metrics will be reported to NQIC and QAPI committee for tracking/trending and act upon identified gaps.	CNO	NQIC report and QAPI report	3/6/23	4/18/23
Root Cause 10: Resident activities not fully resumed after COVID-19 (New Monitoring Survey RCA Root Cause)				
Milestone 1: Assess appropriate activities that can be implemented following COVID-19 protocols. Solicit feedback from residents at unit-based community meetings.	Interim Administrative Director, Care Experience	Assessment report	1/26/23	2/24/23
Milestone 2: Share above assessment and recommendations to resident council.	Interim Administrative Director, Care Experience	Resident council minutes	3/2/23	3/6/23
Milestone 3: Develop and disseminate an updated calendar of increased activities and events to all residents.	Interim Administrative Director, Care Experience	Updated calendar	2/24/23	3/6/23
Milestone 4: Assess staffing levels and volunteer options needed to support resident activities.	Interim Administrative Director, Care Experience	Staffing and volunteer assessment report	3/7/23	3/31/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Determine and implement resident feedback process regarding satisfaction with current activities and events.	Interim Administrative Director, Care Experience	Feedback process documentation/ results	2/24/23	4/30/23
Milestone 6: Implement above (Milestones #1 - 4) activities that can be safely resumed or added based on resident feedback.	Interim Administrative Director, Care Experience	Attendance in activities/events	4/1/23	4/30/23
Milestone 7: Review and update activities policy and procedures for residents with dementia to ensure alignment with regulations.	Interim Administrative Director, Care Experience	Updated activities policy and procedures for residents with dementia	1/27/23	3/21/23
Milestone 8: Update the facility assessment to reflect changes made to the activities program.	CQO	Facility Assessment	4/15/23	4/30/23
Medication Management and Administration				
Root Cause 1: Medication self-administration policies not routinely followed				
Milestone 1: The policy related to medication self-administration will be updated to reflect phase 3 regulations and modified practices to reflect nursing recording in the MAR for PRNs and routine administered medications. This will be completed in collaboration between nursing, physicians and pharmacy.	Chief Medical Officer (CMO)/Chief Nursing Officer (CNO)/Chief Pharmacy Officer (CPO)	Updated policy document	1/6/23	1/14/23
Milestone 2: Review and revise medication self-administration assessment tool to align with regulations.	CPO	Updated assessment	1/6/23	1/31/23
Milestone 3: Pharmacy, in collaboration with DET, will develop training curriculum for policy change on medication self-administration and will host a meeting with nursing leadership (e.g., nurse directors, nurse managers, MDS, and clinical nurse specialists).	CPO	Training materials and meeting minutes	2/16/23	2/28/23
Milestone 4: Identify mechanism to include medication self-administration assessment into the resident medical record.	CPO	Work order/SBAR for updated EHR Build	2/1/23	2/15/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Nurse managers will provide standardized in-person education (see Milestone #3) to their licensed staff regarding the updated policies.	CNO	Compliance reports	3/1/23	3/15/23
Milestone 6: Per LHH's policy and procedure and assessment tool the IDT will review residents for appropriateness of medication self-administration.	CNO	Report verifying documentation	3/16/23	4/30/23
Milestone 7: For residents who self administer routine scheduled medications, the nurse will observe the resident taking the medication and record in the MAR and PRN, according to policy.	CNO	Pharmacy's monthly drug regimen review for nursing	1/26/23	4/30/23
Milestone 8: The nurse leaders will begin conducting random monthly checks to ensure medications at the bedside are securely stored. Audit findings will be shared with nurse managers and any problems will be immediately addressed. Data will evaluated for trends and shared at QAPI/QAA for feedback and evaluation.	CQO	Nursing monthly audit	4/15/23	4/30/23
Root Cause 2: Non-compliance with safe medication management practices				
Milestone 1: Medication cart times will be set to auto-lock at one minute.	CNO/CPO	Memo notification from Pharmacy	1/6/23	1/22/23
Milestone 2: Pharmacy Leadership and Nursing Leadership will develop a program that focuses on safe storage, accurate labeling, appropriate medication disposal and checking expiration dates.	CNO/CPO	Program charter	1/6/23	2/15/23
Milestone 3: The safe medication storage, labeling, and disposal program will be submitted through an expedited review and approval through QAPI/QAA.	CNO/CPO	Document outlining program	2/16/23	2/28/23
Milestone 4: Create education for Licensed Nurses to include at least medication safe storage, labeling, disposal of medication and biologicals and the management of medication carts.	CNO/CPO	Education module	2/16/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Pharmacy and nursing will collaborate to implement the medication pass critical element pathway as a shared responsibility. Licensed nurses passing medications will be observed across three shifts. This will include focused observations on high-risk medications.	CNO/CPO	Evaluation of monthly med passes	2/1/23	4/30/23
Milestone 6: DET will provide education to the Licensed Nurses to include at least medication safe storage, labeling, disposal of medication and biologicals and the management of medication carts. This education will occur at least quarterly, in-person with each licensed nurse on staff.	CNO/CPO	Compliance reports	3/1/23	3/31/23
Milestone 7: Implement the elements of the safe medication storage, labeling, and disposal program.	CNO/CPO	NQIC and QAPI/QAA minutes	4/1/23	4/30/23
Milestone 8: Pharmacy and nursing will gather data from the safe medication storage, labeling, and disposal program data and the medication pass observations and report to NQIC and QAPI/QAA. Audit findings will be shared with nurse managers and any problems will be immediately addressed. Data will be evaluated for trends and shared at QAPI/QAA for feedback and evaluation.	CNO/CPO	NQIC and QAPI/QAA minutes	4/1/23	4/30/23
Root Cause 3: Lack of interdisciplinary team collaboration				
Milestone 1: The unit-based team will review and understand the regulatory requirements for psychotropic medications.	CMO, CNO, CPO	Education module and compliance report	2/21/23	3/18/23
Milestone 2: The monthly meeting agenda will be developed to include review of gradual dose reductions, drug regimen review, and unnecessary medications.	CPO/CMO	Meeting minutes	2/21/23	3/18/23
Milestone 3: Each unit will establish the IDT to include at a minimum, physicians, nurse managers, social services, and a pharmacist and meeting times for the monthly psychotropic/behavior meeting.	CMO, CNO, CPO	Meeting minutes	2/21/23	4/30/23
Milestone 4: Minutes will be maintained in a folder/binder at the unit level.	CQO	Audit of binders at each unit	2/21/23	4/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Data from the drug regimen review response will be collected and analyzed for review at QAPI/QAA to identify any trends, patterns or gaps in processes.	CPO/CMO	QAPI/QAA Report	3/1/23	4/30/23
Root Cause 4: Lack of herbal supplement safety verification processes				
Milestone 1: Nurse leaders will perform a visual audit to determine if any herbal supplements are observed at the bedside in resident rooms. A list will be made for each resident with notation of results, which will be shared with pharmacy, physician, and nursing leadership.	CMO/CPO	Audit results	1/6/23	1/13/23
Milestone 2: LHH will review and revise the policy and procedure for herbal supplements, including supplements that are non-USP verified to determine allowable supplements within the regulations.	CPO	Updated policy document	1/6/23	1/19/23
Milestone 3: For any new supplements identified, pharmacy will ensure compliance with facility policy.	CPO	Audit results	1/20/23	4/30/23
Milestone 4: Once determined, the list of residents taking supplements will be reviewed by the Resident Care Team (RCT), to include physicians, pharmacists, nursing leadership and social services.	CMO/CNO	Pharmacy list	1/14/23	1/31/23
Milestone 5: The care plan of these residents will be reviewed and updated at each RCT.	CNO	Pharmacy list	1/14/23	4/30/23
Behavioral Health and Substance Abuse				
Root Cause 1: Lack of behavioral health and SUD experience				
Milestone 1: Secure external consultant's report that investigates alternative models to meet resident behavioral health needs utilizing industry standards and meets regulatory compliance.	CEO/CMO	Consultant Report	1/6/23	1/31/23
Milestone 2: Utilizing current LHH Psych Department Subject Matter Expert (SME), external consultants report (Milestone #1), and feedback from BERT assessments and staff, convene a team of behavioral health SMEs to conduct a frontline staff assessment that identifies staffing, training, and programmatic structure needs for behavioral healthcare in a SNF setting.	Chief Executive Officer (CEO)/Chief Medical Officer (CMO)	Meeting minutes	2/1/23	2/28/23
Milestone 3: Workgroup from Milestone #2 & LHH leadership will create behavioral healthcare staffing, training, and programmatic workplan.	CEO/CMO	Assessment report & recommendations	3/1/23	3/15/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 4: Based on current knowledge of gaps and findings from the assessment report that includes feedback from BERT, provide training on necessary BHS-related topics (example: de-escalation training, overdose prevention, motivational interviewing). This training will be ongoing and utilize adult learning principles, such as case studies, verification of knowledge, and in-person and electronic modalities. Units will be prioritized based on resident need and volume.	CEO/CMO	Education & Training program + compliance reports	3/16/23	4/30/23
Milestone 5: Implement recommendations from Milestone #3 in addition to the training from Milestone #4.	CEO/CMO	Status update of workplan implementation	3/16/23	4/30/23
Root Cause 2: Care plans not consistently updated with SUD needs				
Milestone 1: Revise release of information (ROI) consents as indicated.	CMO	ROI consent form	1/6/23	1/31/23
Milestone 2: Establish a workflow with provider accountability for consistently obtaining consents and communicating individualized needs to IDT for care planning.	CMO	Workflow document	1/6/23	1/31/23
Milestone 3: Crosswalk ROI consent workflow with LHH policy and procedures to ensure regulatory alignment.	CMO	Crosswalk document	1/6/23	1/31/23
Milestone 4: Review policy to determine the mechanisms available if LHH cannot adequately provide care to residents with BH or SUD needs.	CMO	Policy document	1/6/23	1/31/23
Milestone 5: Use expedited process to obtain form and policy approval	CQO	Committee approval	2/1/23	3/15/23
Milestone 6: Develop BH/SUD education regarding proper ROI consent, workflow, resident assessment, the care planning process, individualized therapeutic interventions specific to BH/SUD needs.	CMO/CNO	Education materials	1/15/23	2/15/23
Milestone 7: Implement interdisciplinary BH/SUD education.	CMO/CNO	Compliance reports	2/15/23	3/15/23
Milestone 8: Develop a monitoring process with metrics for ROI consents.	CQO	Metric definitions	3/15/23	4/1/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 9: Begin implementing and report ROI consent data as indicated to QAPI/QAA.	CQO	QAPI/QAA Meeting minutes	4/1/23	4/30/23
Root Cause 3: Understaffed Behavioral Emergency Response Team				
Milestone 1: Utilizing the current LHH Behavioral Health Emergency Response Team (BERT) staff (onboarded Dec. 2022), complete review and re-assessment of current BERT program and operations to identify opportunities for improvement, in collaboration with the existing DPH BERT team at Zuckerberg San Francisco General (ZSFG) Hospital as a SME, regarding scope of work, roles, responsibilities, and tasks to ensure the BERT primary function is training and supporting direct care staff with therapeutic responses to residents with escalating behavioral health issues.	Chief Nursing Officer (CNO)/CMO	Assessment report of current BERT scope of work and gaps	1/6/23	2/10/23
Milestone 2: Finalize updated BERT scope of service, job duties, and work/responsibilities including participation in resident care councils (RCCs) and care plans.	CNO/CMO	Finalized program scope	2/10/23	2/28/23
Milestone 3: Develop weekly metrics modeled after the ZSFG BERT Program's dashboard (consultations, interventions, RCCs attended) to demonstrate impact of the current LHH BERT program, understand ongoing resource needs, and continuously communicate the availability of the team at the weekly nursing leadership meeting as a feedback loop.	CNO/CMO	Weekly BERT metrics	2/17/23	2/28/23
Milestone 4: To provide ongoing education to staff regarding behavioral health interventions utilized and/or available for residents, the BERT team will provide a just-in-time follow-up educational bullet points for the unit huddle board.	CNO/CMO	Huddle board bullet/education points	2/17/23	2/28/23
Milestone 5: Recruit and hire additional qualified BERT candidates as identified in Milestone #1's assessment to join the existing LHH BERT program.	CNO/CMO	Job posting	1/27/23	3/30/23
Milestone 6: Train and mentor new BERT members using existing BERT staff on response protocol and roles/responsibilities (assuming successful recruitment and hiring).	CNO/CMO	Complete orientation/ competency checklists for BERT members	4/1/2023 or upon hire if earlier	4/30/23
Milestone 7: Develop prioritization criteria for RCC sessions requiring BERT member's participation.	CNO/CMO	Document of criteria	1/26/23	1/30/23
Milestone 8: Incorporate BERT team into monthly RCC meetings per prioritization criteria to provide care plan input, monitor effectiveness of interventions, appropriateness of out on pass, and other pertinent updates.	CNO/CMO	Care Plan Meeting Schedule	2/1/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
See Milestones #3 and 4. **Milestone 9**: Develop education regarding BERT Response protocol. Given additional modifications to this section of the action plan, this Milestone is now being addressed through Milestones #3 and 4.	CNO/CMO	Training material with BERT team reviewing BERT protocol.	4/15/23	4/30/23
See Milestones #3 and 4. **Milestone 10**: Implement education regarding BERT response protocol. Given additional modifications to this section of the action plan, this Milestone is now being addressed through Milestones #3 and 4.	CNO/CMO	Compliance reports	5/1/23	5/13/23
Root Cause 4: Security staff not trained on LHH policies and procedures				
Milestone 1: In collaboration with security partners, assess the training security staff currently receives and identify gaps and needs in relation to LHH policies regarding illicit substances, visitor searches, safety, and SNF regulations.	CEO	Assessment report of current security training, gaps, and needs	1/9/23	1/31/23
Milestone 2: Add agenda items to monthly security meetings to discuss security staff training and LHH policy updates.	CQO	Meeting agenda	1/18/23	4/30/23
Milestone 3: Develop training topics, delivery methods, and materials for security staff.	CEO	Document with security staff training topics	1/31/23	2/28/23
Milestone 4: Create security staff training schedule	CEO	Calendar of security staff training	1/31/23	2/28/23
Milestone 5: Create process to communicate relevant policy changes to security leadership with guidance on how to execute changes.	CEO	Document describing process	1/31/23	2/28/23
Milestone 6: Implement and complete security training.	CEO	Compliance reports	3/1/23	3/31/23
Infection Prevention and Control				
Root Cause 1: Lack of nursing involvement				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 1: Finalize a transition plan playbook for IP to move from Quality Management to Nursing oversight.	Chief Nursing Officer (CNO)	Transition plan document	1/6/23	1/15/23
Milestone 2: Adapt the scope of services document to ensure that the alignment between IP, Nursing, and Quality is clearly delineated.	CNO	Scope of service document	1/6/23	1/15/23
Milestone 3: In addition to the current two IP-certified staff, identify infection control champions for each nursing unit.	CNO	List of IPC champions	1/6/23	1/31/23
Milestone 4: Communicate IPC department changes to LHH staff members (e.g., newsletter, memo).	CNO	Evidence of communication	1/16/23	1/31/23
Milestone 5: Inventory current IC report functions to ensure that the group is meeting the requirements outlined in the IP annual plan, the facility bylaws, and the QAPI/QAA program.	CNO	Meeting minutes	1/16/23	1/31/23
Milestone 6: Following the playbook, integrate the IP team into the nursing quality and safety meeting and reporting structure at LHH.	CNO	Meeting minutes	1/23/23	4/30/23
Milestone 7: Train infection control champions on roles, responsibilities, and expectations.	CNO	Compliance reports	2/1/23	2/21/23
Milestone 8: IPC will implement monthly meetings with unit-based IPC champions.	CNO	Meeting minutes	2/1/23	4/30/23
Root Cause 2: Misaligned IPC facility risk assessment				
Milestone 1: Finalize IPC facility risk assessment tool to meet the unique internal and external needs of LHH and long-term care requirements & best practices.	CNO	Risk assessment tool	1/6/23	1/15/23
Milestone 2: Retain an IP-certified expert consultant with nursing home/long-term care expertise to support IPCP regulatory compliance.	CNO	Verification of IP consultant	1/6/23	1/15/23
Milestone 3: Rank risk by measure to create an annual plan for the facility with distinct and timely interventions to drive improvement efforts toward specified goals	CNO	Annual Plan	1/6/23	1/15/23
Milestone 4: Develop surveillance metrics for each goal to ensure that the facility is on target to meet goal. Communicate any successes and/or challenges/barriers.	CNO	Finalized goals and surveillance metrics & communications	1/6/23	2/28/23
Milestone 5: Periodically (monthly) assess the plan action steps to determine success and adjust as needed to meet the goals of the organization.	CNO	Meeting minutes	2/1/23	4/30/23
Root Cause 3: Non-compliant policies and procedures				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 1: A crosswalk will be completed between IPCP regulations (all CMS regulations to include phase 3) and current policy and procedures, the surveillance program, the water management program, and the antibiotic stewardship program, to identify gaps.	CNO	Document with table comparing current policies with Phase 3	1/6/23	1/20/23
Milestone 2: Identified IPC policy gaps will be updated to the phase 3 regulations and approved through expedited process.	CNO	Meeting minutes documenting approval of Phase 3 policy updates	1/6/23	1/23/23
Milestone 3: Create a monthly review calendar to regularly review regulations and LHH policies to ensure they are current and accurate, and update accordingly.	CQO	Calendar document with monthly review goals	1/10/23	1/16/23
Milestone 4: Review facility assessment against phase 3 changes to policies and procedures to ensure updates are incorporated into the facility assessment.	CQO	Facility assessment	1/16/23	1/31/23
Milestone 5: Communicate to staff any changes that have occurred to IP policy and procedures identified during the monthly review and update. Validate knowledge retention via a teach back mechanism or return demonstration during IPC rounds.	CNO/CQO	Monthly staff communications (Daily Situation Status) + IPC Rounds staff roster for teach back.	2/7/23	4/30/23
Milestone 6: Facility assessment will be approved through the QAPI/QAA process to include PIPS, MEC, and JCC.	CQO	Meeting minutes documenting approval of updated facility assessment	2/21/23	4/12/23
Milestone 7: Update the pneumococcal vaccination policy to align with CDC guidance.	CQO/CPO	Updated policy document	1/15/23	1/31/23
Root Cause 4: Inadequate EHR				
Milestone 1: Perform a crosswalk between required infection control reporting to available reports within EHR (patient days/device days/isolation information/lab data/pharmacy data.)	CNO	Table outlining crosswalk	1/6/23	2/28/23
Milestone 2: Once crosswalk is complete, work with the EHR team to build reports, for any required information that isn't currently available, within EHR via reports	CNO/ Chief Information Officer (CIO)	Surveillance Workbook	3/1/23	3/30/23
Milestone 3: LHH will establish regular communications with EHR team to optimize system to meet SNF reporting requirements	CIO	Evidence of communication	2/1/23	4/30/23
Milestone 4: Leverage the reports function of the system to provide information on opportunities for high risk of improvement. At a minimum this will include daily isolation reports to clinical units and ancillary partners to ensure that isolation needs are clearly communicated.	CNO	Isolation list	2/1/23	2/28/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Root Cause 5: Lack of adequate staff and level of competency				
Milestone 1: Perform an analysis of the current infection control staff to include unique skills, experience, certification and competency.	CNO	Orientation Form	1/6/23	1/15/23
Milestone 2: Identify the IP department operational needs	CNO	IPC Org. Chart	1/6/23	1/31/23
Milestone 3: Define role expectations via an infection control position.	CNO	Roles & Responsibilities	2/1/23	2/28/23
Milestone 4: Implement an individualized education plan for each of the current IC team members. This plan will include best practice expectations from the Association of Professionals in Infection Control and Prevention (APIC), CMS, the CDC, and CDPH.	CNO	Completed orientation form	3/1/23	4/30/23
Root Cause 6: Insufficient hand hygiene and personal protective equipment (PPE) audits				
Milestone 1: Create a standardized assessment tool to evaluate the environment of care, life safety, hand hygiene, isolation, and cleaning expectations.	CNO	Assessment Tool	1/6/23	1/15/23
Milestone 2: Identify IP staff rounding teams to evaluate the environment of care, life safety, hand hygiene, isolation, and cleaning.	CNO	Roster of rounders	1/6/23	1/15/23
Milestone 3: Create weekly rounding calendar to ensure IP staff rounds occur on nursing units, as well as specific observations with wound care, trach care, tube feeding care, and medication administration.	CNO	Calendar document	1/6/23	1/20/23
Milestone 4: Develop unit-based IPC Champion program and begin IC audit and unit-based IP staff rounding into facility wide surveillance activities with a focus on high-risk opportunities for improvement.	CNO	Audit results	1/16/23	4/30/23
Root Cause 7: Lack of effective IPC education to all staff				
Milestone 1: Identify IPC educational topic and carry out in-person education on nursing units using a selected adult-education approach (e.g., teach-back with return demonstration).	CNO	Compliance reports	3/1/23	3/31/23
Milestone 2: Create monthly educational/training calendar with identified topics based on regulations, problem-prone areas, or other areas of need identified by leadership/changing guidelines/priority areas identified via surveillance/audits as they relate to IPC. **Known t**opics will include PPE use, proper hand hygiene, and biohazard bin organization and clutter in rooms.	CNO	Training and education calendar document	4/1/23	4/15/23
Quality Assurance & Performance Improvement				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Root Cause 1: QAPI Program not aligned to skilled nursing facility (SNF) setting				
Milestone 1: Outline the required members, their purpose and role, in the QAPI/QAA subcommittees for nursing units to include the topics of (1) psychotropic medication and behavior monitoring, (2) restraints and falls, (3) nutrition and wounds, and (4) infection control and antibiotic stewardship.	Chief Quality Officer (CQO)/Chief Nursing Officer (CNO)/Chief Medical Officer (CMO)	Committee charter	1/6/23	1/25/23
Milestone 2: Develop meeting agenda, time frames, ground rules, and meeting roles. A standardized form will be created for each subcommittee meeting minutes.	CQO/CNO	Template for meeting agenda	1/14/23	1/21/23
Milestone 3: The minutes/form will be maintained in a folder/binder to be reviewed by the Nurse Director after each meeting to analyze and collaborate for trends/patterns and to determine next steps, such as a formal Performance Improvement Project.	CQO/CNO	Binder/Folder	1/14/23	1/21/23
Milestone 4: Implement wound/nutrition regular subcommittee meetings at unit level to be facilitated by the Unit Dietician with IDT involvement.	CQO/CNO/CMO	Meeting minutes	1/25/23	2/28/23
Milestone 5: Implement restraint/falls regular subcommittee meetings at unit level to be facilitated by the Nurse Manager with IDT involvement.	CQO/CNO/CMO	Meeting minutes	2/6/23	4/30/23
Milestone 6: Implement psychotropic/behavior monthly subcommittee meetings at unit level to be facilitated by the Nurse Manager with IDT involvement.	CQO/CNO/CMO/Chief Pharmacy Officer (CPO)	Meeting minutes	2/22/23	3/6/23
Milestone 7: The Nursing Quality Improvement Committee (NQIC) will report to the QAPI/QAA committee and provide oversight and guidance for performance improvement projects to ensure outcomes focused problem solving that is resident centered	CNO/CQO	QAPI/QAA minutes	2/21/23	4/30/23
Milestone 8: Implement infection control/antibiotic stewardship monthly subcommittee meetings at unit level to be facilitated by the Nurse Manager with IDT involvement.	CQO/CNO/CMO	Meeting minutes	3/7/23	3/21/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 9: Data from subcommittee minutes will be reported to the NQIC by the Nurse Director and/or Director of Nursing for analysis of trends and patterns.	CQO/CNO	QAPI/QAA report	1/22/23	4/30/23
Root Cause 2: Lack of strong QAA Committee oversight				
Milestone 1: The QAPI/QAA committee members will be identified with their roles and responsibilities defined for the program.	CQO/ QI Physician Champion	Document with QAPI/QAA Committee roster	1/6/23	1/20/23
Milestone 2: Create training on how to analyze data, facilitate meetings, implement charters and techniques of supporting staff through process improvement projects.	CQO/ QI Physician Champion	Training materials	1/6/23	2/10/23
Milestone 3: Create an effective and relevant dashboard based on data collection to convey an accurate status of regulatory compliance and resident outcomes, including pressure injury, and to inform the governing body.	CQO/ QI Physician Champion	Dashboard	1/6/23	2/28/23
Milestone 4: Train and coach committee members on how to analyze data, facilitate meetings, implement charters and techniques of supporting staff through process improvement projects.	CQO/ QI Physician Champion	Compliance reports	3/1/23	4/30/23
Root Cause 3: Direct-care staff and medical staff not active in QAPI activities				
Milestone 1: Develop and implement unit based huddle boards, which includes data relevant to the unit, such as pressure injury, including benchmarks established for performance and will include tracking, monitoring of resident events to be reviewed daily.	CNO/CQO	Huddle board report template document	1/6/23	1/20/23
Milestone 2: Create standard work for facilitation and purpose of the daily huddle board to guide a standardized process for nursing units including mechanisms to raise concerns for staff and residents/representatives.	CNO/CQO	Standard work document	1/6/23	1/20/23
Milestone 3: Develop training on development of RCAs and PDSA techniques. Education will include in-person demonstrations with scenario based learning to measure understanding.	CQO	Training materials	1/6/23	2/10/23
Milestone 4: The rounding team will incorporate questions in their teach back rounding sessions to include RCA, PDSA, mechanisms to raise concerns, Performance Improvement Projects, and the 5 elements of QAPI.	CQO	Rounding forms	1/17/23	4/30/23
Milestone 5: Nurse Managers, charge nurses, licensed nurses, medical staff, and CNAs/PCAs will be educated and coached on facilitation of the huddle board such as data presentation, data analysis, trends/patterns, current PDSAs, RCAs, and mechanisms for staff/residents/representatives to raise concerns utilizing current best practices.	CNO/CQO/CMO	Training materials	1/14/23	4/30/23

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 6: Nurse Managers and Charge Nurses will receive training from an industry expert on the development of RCAs and PDSA techniques. Teach back will be used to verify knowledge.	CNO/CQO	Compliance reports	2/1/23	2/28/23
Milestone 7: Supervisors (Nurse Directors) and middle managers (Nurse Managers) will meet regularly to review their data and unit based PDSA's.	CNO	Discussion notes	2/1/23	4/30/23
Root Cause 4: QAPI policies and procedures not current to Phase 3				
Milestone 1: A crosswalk will be completed between regulations (phase 3) and current policy and procedures to identify gaps.	CQO	Document with table comparing current policies with Phase 3	1/6/23	1/9/23
Milestone 2: QAPI identified policy gaps will be updated to the phase 3 regulations and approved through expedited process.	CQO	Meeting minutes documenting approval of Phase 3 policy updates	1/6/23	3/14/23
Milestone 3: Create a monthly review calendar to regularly review regulations and LHH policies to ensure they are current and accurate, and update accordingly.	CQO	Calendar document with monthly review goals	1/10/23	1/16/23
Milestone 4: Review facility assessment against phase 3 changes to policies and procedures to ensure updates are incorporated into the facility assessment.	CQO	Facility assessment	1/16/23	1/31/23
Milestone 5: Create a real-time process to effectively communicate to staff the status of policy and procedure changes identified during the monthly QAPI review and update.	CQO	Evidence of communication	2/7/23	4/30/23
Milestone 6: Facility assessment will be approved through the QAPI process to include PIPS, MEC, and JCC.	CQO	Meeting minutes documenting approval of updated facility assessment	2/21/23	4/12/23
Root Cause 5: Lack of QAPI competencies by middle management and staff				
Milestone 1: Develop in-person, scenario-based training for middle managers and staff that includes QAPI roles and responsibilities, data collection, QI strategies, and how to incorporate feedback from staff and residents.	CNO, CQO, and Administrative Director 1 and 2	Training materials	1/6/23	2/28/23
Milestone 2: Create a monthly education calendar to ensure continued knowledge retention of middle managers and staff of the QAPI/QAA process.	CNO, CQO, and Administrative Director 1 and 2	Education Calendar	1/6/23	1/31/23
Milestone 3: Implement in-person, scenario-based training for middle managers and staff on QAPI/QAA roles and responsibilities, data collection, QI strategies, and how to incorporate feedback from staff and residents.	CNO, CQO, and Administrative Director 1 and 2	Compliance reports	3/1/23	3/31/23
Root Cause 6: Facility assessment not properly operationalized (New Monitoring Survey RCA Root Cause)				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 1: Identify existing facility assessment training from national, state, or regional organization.	CQO	Identified training program	1/27/23	2/14/23
Milestone 2: LHH leadership (LHH Leadership Forum attendees, includes managers) and quality management (QM) will participate in an education program related to facility-assessment development.	CQO	Training compliance reports and/or sign-in sheets and/or certificates of completion	2/15/23	3/17/23
Milestone 3: Based on the above training (Milestone #2), LHH will evaluate facility programs across the facility to determine the resources necessary to care for residents during daily operations and emergencies (e.g., wound care program) and update the facility assessment to ensure it is accurate.	CQO	Revised facility assessment	3/20/23	4/7/23
Milestone 4: QAA Committee will provide oversight of the facility assessment revisions to ensure regulatory compliance.	CQO	Committee meeting minutes	4/18/23	4/30/23
Fire and Life Safety (New Monitoring Survey RCA Category)				
Root Cause 1: Lack of fire and life safety awareness				
Milestone 1: Utilizing current FLS consultant expertise, create a Fire and Life Safety education program for LHH Leadership Forum (includes all department managers) to cover the basics of Fire Life Safety, initial response during emergency situations such as a fire, and the ongoing reinforcement education plan.	CEO	Education Program/ Presentation	1/24/23	2/10/2023
Milestone 2: Provide above Fire and Life Safety education program to all department managers at LHH Leadership Forum to serve as a "train-the-trainer" program.	CEO	Education session sign-in sheets/ attendance	2/13/23	2/17/2023
Milestone 3: The LHH Fire Life Safety team and expert consultants and the trained department managers will conduct frontline training sequenced throughout the facility (15% in February, 35% in March, 50% in April).	CEO	Education session sign-in sheets/ attendance	2/13/23	4/30/2023
Milestone 4: Department managers in partnership with the LHH Fire Life Safety team and expert consultants will conduct ongoing reinforcement education on a weekly basis throughout the facility via "EPP huddle question/talking points of the week" provided from the Facilities department.	CEO	Calendar of Weekly Huddle Talking Points + Email confirming distribution to managers	2/2/23	2/28/2023
Root Cause 2: Ineffective work order management process				
Milestone 1: Audit all outstanding work orders to determine high priority, possible close outs and regulatory needs.	Interim Administrative Director of Operations	Audit results	1/24/23	2/10/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 2: After audit is complete, prioritize work orders as needed and complete work.	Interim Administrative Director of Operations	Prioritized work orders	2/11/23	2/17/2023
Milestone 3: SME (FLS Consultant) to work with the Facilities team to create a work order schedule based on regulatory needs. Schedule to be built annually.	Interim Administrative Director of Operations	Regulatory work order schedule	1/24/23	2/17/2023
Milestone 4: Facilities team to partner with DET and Communications to provide training on work order submittal education at future town halls and through the DSS.	Interim Administrative Director of Operations	Training information	1/24/23	3/8/2023
Milestone 5: Interim Director of Operations to work with SME to develop an executive dashboard for work orders, showing the current status of all orders.	Interim Administrative Director of Operations	Sample executive dashboard	2/10/23	2/24/2023
Milestone 6: Interim Director of Operations will create an additional dashboard to share with department managers as a monitoring tool for their specific work orders.	Interim Administrative Director of Operations	Sample manager dashboard	2/27/23	3/8/2023
Milestone 7: Interim Director of Operations to train and set expectations to the senior facilities staff to manage work order list on a daily basis and triage as necessary based on the dashboard.	Interim Administrative Director of Operations	Roles & Responsibilities or Standard Work Document	2/27/23	3/3/2023
Milestone 8: Interim Director of Operations to report patterns and trends in work orders at QAPI.	Interim Administrative Director of Operations/ CQO	QAPI agenda and minutes	4/3/23	4/11/2023
Root Cause 3: Lack of code compliance knowledge				
Milestone 1: Determine Facilities team members who will participate in the 1-hour online training (American Health Care Association Survey Prep for the New Facilities Manager Training).	Interim Administrative Director of Operations	List of staff required to take training	1/24/23	2/7/2023
Milestone 2: Schedule mandatory training via self sign-up and complete by the required deadline (Milestone #3).	Interim Administrative Director of Operations	List of staff required to take training with scheduled times	2/8/23	2/22/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 3: Assigned staff to provide certificate of completion to department supervisor and DET.	Interim Administrative Director of Operations	Spreadsheet showing completion based on receiving certificates	2/23/23	3/22/2023
Milestone 4: After training occurs, hold in-person team debrief session with consultant SME and utilize knowledge verification questions.	Interim Administrative Director of Operations	Sign-in sheet with minutes from debrief session	3/23/23	3/31/2023
Root Cause 4: Ineffective preventative maintenance program				
Milestone 1: SME to conduct baseline assessment to determine high-priority, high-risk non-compliant equipment.	Health Network COO	Assessment Report	1/24/23	2/10/2023
Milestone 2: Identify and inventory all equipment with preventative maintenance requirements and ensure it is included in TMS.	Health Network COO/ Interim Administrative Director of Operations	Before and After TMS reports	2/13/23	3/3/2023
Milestone 3: SME to work with biomed and facilities to create a preventative maintenance program that supports month-to-month preventative maintenance.	Health Network COO/ Interim Administrative Director of Operations	Program policies and procedures	2/13/23	3/31/2023
Milestone 4: Chief Engineer & SME to train facilities staff and vendors on compliance procedures to maintain equipment integrity through Preventative Maintenance Program.	Health Network COO/ Interim Administrative Director of Operations	Training program documents and sign-in sheets and/or compliance reports	2/13/23	4/30/2023
Milestone 5: Tag all equipment appropriately as per program protocol.	Health Network COO/ Interim Administrative Director of Operations	Before and After TMS reports	2/13/23	3/31/2023
Milestone 6: Establish reoccurring work orders to create a PM schedule with appropriate assignments in alignment with Milestone #3's findings.	Health Network COO/ Interim Administrative Director of Operations	TMS report and/or spreadsheet	4/3/23	4/10/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 7: Monitor progress via executive dashboard and report to QAPI with patterns and trends.	Health Network COO/ Interim Administrative Director of Operations/ CQO	QAPI report and minutes	4/10/23	4/11/2023
Resident Quality of Care (New Monitoring Survey RCA Category)				
Root Cause 1: Lack of a functioning wound care program				
Milestone 1: Just-in-time in-person education will be developed and provided for licensed staff responsible for immediate wound and skin assessments to include clinical components related to skin assessment, Braden scores, and documentation related to wound care and interventions.	CNO	Training materials and sign-in sheets	12/13/22	12/14/2022
Milestone 2: Following the education in Milestone #1, LHH will assess 100% of all residents and complete a Braden score to re-establish a baseline of skin integrity issues for each resident. Any skin integrity issues noted in the assessment will result in notification to physicians for updated orders and interventions.	CNO	Unit spreadsheets with assessments completed	12/13/22	12/20/2022
Milestone 3: WOCNs (led by WOCN knowledgeable of SNF regulations) will be deployed from the SF Health Network to LHH for development of the wound care program and management of the identified wounds from Milestone #2.	CNO	Electronic announcement of WOCNs	1/3/23	1/5/2023
Milestone 4: The WOCNs will review all current skin integrity issues identified in Milestone #2 and provide recommendations to physicians, dietician, and direct care staff for interventions to promote wound healing.	CNO	Resident wound care tracking sheet/list	1/5/23	2/3/2023
Milestone 5: Any skin integrity issues noted in the assessment above (Milestone #4) by the WOCNs will be addressed with physician orders and interventions. This will be validated via a crosswalk with EMR wound orders.	CNO	Assessment crosswalk with EMR wound order reports	1/5/23	2/3/2023
Milestone 6: Utilize Electronic Learning Module (ELM) for all licensed nurses to complete training module related to pressure injuries and documentation.	CNO	Compliance reports for all active licensed nurses	12/14/22	1/31/2023
Milestone 7: Identify unit-based wound care champions who will support the WOCNs ongoing wound care work.	CNO	List of unit-based wound care champions	1/16/23	2/1/2023
Milestone 8: Provide 1:1 bedside training between the WOCNs and the identified (Milestone #6) unit-based wound care champions who will support the WOCNs ongoing wound care work. Competencies will be utilized.	CNO	Competency assessment form	2/2/23	3/31/2023
Milestone 9: Ongoing evaluation of the wound care interventions will be evaluated weekly and more frequently as needed and adjustments made based on findings by identified unit wound care champions. Care plans will be updated as changes are identified by the IDT or RCT to ensure individualized person-centered care.	CNO	Random selection of 13 wound care plans monthly (target one per neighborhood)	4/1/23	4/30/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 10: Charter will be developed for the implementation of unit-based QAPIs including a subcommittee specifically for wound and nutrition.	CNO/CQO	QAPI Wound Care Charter	1/6/23	1/25/2023
Milestone 11: Unit level QAPI wound/nutrition meetings will be implemented on all nursing units to ensure sustainability of the program. Results of the meetings will be reported to QAPI committee for tracking/trending and act upon identified gaps.	CQO/CNO/CMO	Meeting minutes	1/25/23	2/28/2023
Milestone 12: Re-establish a wound care program sustainability workplan that will include a scope of service, SNF regulatory requirements, and the cadence of regular wound/skin assessments that aligns with the unit-based QAPI program and subcommittees.	CNO/CQO	Workplan	2/1/23	2/22/2023
Milestone 13: In-person training of staff to the above wound care program (Milestone #12).	CNO/CQO	Sign-in sheets and/or compliance reports	3/1/23	3/31/2023
Milestone 14: Implement the above wound care program (Milestone #12).	CNO/CQO	Communication from CNO indicating implementation	4/1/23	4/30/2023
Root Cause 2: Lack of effective IDT wound care communication				
Milestone 1: Distribute memo announcing deployment of WOCNs from SF Health Network and expectations for physician involvement in wound care plan.	CMO	Electronic announcement of WOCNs	1/3/23	1/5/2023
Milestone 2: Provide information session to medical staff regarding onboarding of WOCNs and the specialized training they have for wound care.	CMO	Minutes from med staff report	1/23/23	2/3/2023
Milestone 3: Create new communication channel through secure chat in the EMR to expedite nurse and physician communication regarding wound care, needed interventions, referrals, and physician orders.	CMO	Summary email from CMO to Med. Staff	1/23/23	1/27/2023
Milestone 4: Conduct an assessment to identify the communication gaps between the wound care clinic physicians and the resident PCPs.	CMO	Gap assessment	2/4/23	2/15/2023
Milestone 5: Address the above (Milestone #4) gaps by developing an improved process with associated standard work between the wound care clinic and resident PCPs.	CMO	Standard work document	2/16/23	2/20/2023
Milestone 6: Provide training on the above (Milestone #4 & #5) process and standard work at med staff meeting.	CMO	Sign-in sheets and/or attendance report	2/21/23	2/27/2023
Milestone 7: Wound care and nutrition charter (Milestone #10, Root Cause #1) will be provided to medical staff for the purpose of educating them of the new program and their role and responsibilities.	CMO	Med staff meeting minutes or summary email	1/25/23	2/3/2023
Root Cause 3: Inconsistent tube-feeding management				

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 1: Review existing Tube-Feeding PIP charter to ensure deficiencies noted in the monitoring survey are addressed within the current workplan and modify as needed.	CNO	Modified charter	1/15/23	2/3/2023
Milestone 2: Review protocols and policies to align with evidence-based practices and regulatory compliance.	CNO	Protocols/policies with tracked changes and comments	1/15/23	2/3/2023
Milestone 3: Conduct baseline tube-feeding audit with head of bed orders at 90 degrees.	CMO	Audit report	1/25/23	1/30/2023
Milestone 4: Using multiple modalities (live instruction, job aids, and ELM) educate licensed nurses to the tube feeding standards of care, including how to program the pump correctly, validate tube placement, free water, medication administration, and head of bed (HOB) orders.	CNO	Training compliance reports and sign-in sheets	1/17/23	2/22/2023
Milestone 5: Provide PCA/CNA education regarding tube feeding care, specifically head of bed management via an SBAR and teach back to be reviewed at huddles.	CNO	SBAR and Teach Back	1/25/23	1/31/2023
Milestone 6: Place work order to modify EMR to align with evidence-based practices related to head of bed positioning and tube feeding orders.	CNO	EMR build ticket #	12/5/22	12/7/2022
Milestone 7: Modify EMR in accordance to work order Milestone #3 to align with evidence-based practices related to head of bed positioning and tube feeding orders.	CIO	EMR screenshot of changes	12/7/22	2/20/2023
Milestone 8: Educate medical staff to the EMR modifications related to head of bed positioning and tube feeding orders.	CMO	Meeting minutes and record of attendance	2/21/23	2/23/2023
Milestone 9: Conduct a second tube-feeding audit with head of bed orders at 90 degrees and compare to original (Milestone #3)	CMO	Audit report	3/1/23	3/15/2023
Milestone 10: Share audit tube feeding order report (Milestone #9) at QAPI committee for tracking/trending and act upon identified gaps. Original order audit report (Milestone #3) to be shared at February QAPI, second report at April QAPI.	CMO/CNO	QAPI Report and minutes	2/21/23	4/18/2023
Root Cause 4: Inconsistent resident pain assessment documentation				
Milestone 1: Review existing Assessment and Documentation of Pain Management Elements PIP charter to ensure deficiencies noted in the monitoring survey are addressed within the current workplan and modify as needed.	CNO	Modified charter	1/15/23	2/3/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 2: Utilizing ELM and, as needed, 1:1 education in person, provide education to all nursing staff on pain assessment improvement, including elements and methods of pain assessment, LHH pain policy revisions, proper documentation of pain assessments in EMR, related Phase 3 regulations, and care plan documentation for pain including identifying individualized non-pharmacological interventions.	CNO	ELM compliance reports	12/1/22	1/31/2023
Milestone 3: Conduct teach back education to verify knowledge retention from ELM (Milestone #2).	CNO	Teach back roster (# of teach back recipients)	2/1/23	2/23/2023
Milestone 4: Create audit tool to assess resident charts for required documented elements of pain assessment and reassessment.	CNO	Audit tool	12/15/22	1/3/2023
Milestone 5: Conduct baseline audit of resident charts to ensure compliance to pain assessment and reassessment per policy.	CNO	Audit results	1/3/23	1/31/2023
Milestone 6: Conduct ongoing audit assessments of resident charts to ensure compliance to pain assessment and reassessment per policy and conduct just-in-time education on the findings.	CNO	Audit results	2/1/23	2/24/2023
Milestone 7: Share feedback at unit-based QAPI meetings, which will be implemented on all nursing units to ensure sustainability of the program. Results of the meetings will be reported to QAPI committee for tracking/trending and act upon identified gaps.	CNO/CQO	NQIC and QAPI/QAA minutes	2/24/23	2/27/2023
Food and Nutrition Services (New Monitoring Survey RCA Category)				
Root Cause 1: Menu management system not routinely verified				
Milestone 1: Review all mechanical soft thicken liquid diet menu to identify those meals without sauce and add a substitute gravy. Make changes in CBORD and verify through test tray tickets and a full menu cycle audit.	Interim Administrative Director of Operations	Test tray ticket compliance spreadsheet & Full Menu Cycle Audit	1/11/23	2/13/2023
Milestone 2: Develop work scope statement for CBORD vendor to make changes related to diabetes management diet changes (1500 calories, 1800 calories, and no concentrated sweets) in CBORD.	Interim Administrative Director of Operations/ CIO	Work scope statement	1/24/23	1/26/2023
Milestone 3: Until changes made in the CBORD program, develop new process with associated standard work so dietary can conduct daily and meal-by-meal manual changes as clinically indicated in order to assure proper carbohydrate consistency for diabetic-related diets.	Interim Administrative Director of Operations	Process document and standard work	1/24/23	2/3/2023
Milestone 4: Train staff to above standard work.	Interim Administrative Director of Operations	Training sign-in forms	2/4/23	2/10/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Implement above (Milestone 7) standard work and audit process for compliance.	Interim Administrative Director of Operations	Audit of randomly selected resident tray tickets on a daily basis	2/10/23	2/28/2023
Milestone 6: Modify CBORD contract as needed, dependent on the availability of vendor (CBORD) resources.	CEO/CIO	Contract	1/27/23	3/1/2023
Milestone 7: CBORD vendor makes above diabetic-related diet modifications (Milestone 2) in CBORD, dependent on the availability of vendor (CBORD) resources.	CIO	Before and After CBORD Menu	3/1/23	4/30/2023
Milestone 8: Share meal ticket compliance (Milestone 7) feedback at QAPI for tracking/trending and act upon identified gaps.	Interim Administrative Director of Operations	QAPI Report and minutes	3/1/23	3/21/2023
Milestone 9: For CBORD sustainability, identify two FNS clinical staff and two FNS operational staff to receive in-depth CBORD (menu-management system) training to serve as CBORD superusers.	Interim Administrative Director of Operations	Email to Exec Sponsor identifying staff for training	1/24/23	1/27/2023
Milestone 10: Train above staff (Milestone 9) to serve as CBORD superusers.	Interim Administrative Director of Operations	Training completion documentation	3/1/23	3/31/2023
Milestone 11: Establish a process with standard work that includes a designated CBORD user to review menu item entry accuracy in the system for quality assurance and routinely run nutritional analysis for registered dietician (RD) to review.	Interim Administrative Director of Operations	Process document and/or standard work	3/1/23	3/15/2023
Milestone 12: Train and implement above (Milestone 11) standard work.	Interim Administrative Director of Operations	Training sign-in forms	3/16/23	3/31/2023
Root Cause 2: Lack of IDT collaboration around nutritional status				
Milestone 1: Draft required SBAR for EMR modification and request implementation of necessary reports to track resident weight variance monthly across the facility.	Interim Administrative Director of Operations	EMR SBAR	1/24/23	1/31/2023
Milestone 2: Implement above reporting request (Milestone 1) into EMR	CIO	Report sample	1/31/23	3/1/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 3: Create a process with associated standard work for the clinical nutrition team to set up internal system to review weight variance and those residents with pressure injury at least monthly.	Interim Administrative Director of Operations	Process documentation and/or standard work	2/1/23	2/6/2023
Milestone 4: Train to above (Milestone 3) process and standard work.	Interim Administrative Director of Operations	Training sign-in forms	2/7/23	2/15/2023
Milestone 5: Implement wound/nutrition regular subcommittee meetings at unit level to be facilitated by the Unit Dietician with IDT involvement (See QAPI, RC #1, Milestone #4).	CQO/CNO/CMO	Meeting minutes	1/25/23	2/28/2023
Milestone 6: Share feedback at unit-based QAPI meetings (wound and nutrition subcommittee). Results of the meetings will be reported to QAPI committee for tracking/trending and act upon identified gaps.	Interim Administrative Director of Operations	QAPI sub-committee meetings and QAPI report	2/21/23	3/21/2023
Root Cause 3: EHR documentation incomplete and inaccurate due to a lack of staff knowledge and inconsistent practices on data entry. Optimization opportunities need to be evaluated.				
Milestone 1: Assess the EMR to establish opportunities for optimization, user knowledge deficits, and mitigation strategies within the software specific to nutrition.	CIO/ Interim Administrative Director of Operations/ CNO	Assessment document/report	1/25/23	2/24/2023
Milestone 2: Make recommendations for EMR optimization, inservice learning, additional superuser training at the unit-level, and documentation process improvement.	CIO/ Interim Administrative Director of Operations/ CNO	Assessment document/report with recommendations	1/25/23	2/24/2023
Milestone 3: Create workplan for EMR optimization based on the recommendations from Milestone #2.	CIO/ Interim Administrative Director of Operations/ CNO	Implementation workplan	2/25/23	3/15/2023
Milestone 4: Create training program based on the recommendations from Milestone #2.	CIO/ Interim Administrative Director of Operations/ CNO	Training program	2/25/23	3/15/2023

TASK	EXECUTIVE SPONSOR	DELIVERABLE AND/OR MONITORING METRIC	START	END
Milestone 5: Prioritize workplan for EMR optimization based on assessment and implement training program based on the recommendations from Milestone #3, to include inservice training on the importance of oral nutritional intake documentation and how to correctly document in the EMR and identification of additional superusers.	CIO/ Interim Administrative Director of Operations/ CNO	Sign-in sheet for training, superuser list, and EMR optimization screenshots	3/16/23	4/30/2023
Root Cause 4: Use of outdated clinical nutrition standards of practice				
Milestone 1: Conduct assessment of current standards of practice via literature review and acute care practice standards being used by SF General.	Interim Administrative Director of Operations	Literature Review	1/6/23	1/31/2023
Milestone 2: Identify gaps and corrective actions to those gaps for the clinical nutrition guidelines.	Interim Administrative Director of Operations	Gap analysis documentation	2/1/23	2/8/2023
Milestone 3: Update facility clinical nutrition practice guidelines based on current standards and identified gaps.	Interim Administrative Director of Operations	Updated practice guidelines	2/1/23	2/8/2023
Milestone 4: Review and approve updated facility clinical nutrition practice guidelines based on identified gaps with medical director.	Interim Administrative Director of Operations	Meeting minutes & Medical director documented approval	2/9/23	2/23/2023
Milestone 5: Review updated and approved facility clinical nutrition practice guidelines with MEC.	Interim Administrative Director of Operations	MEC minutes	2/24/23	2/27/2023
Milestone 6: Review updated and approved facility clinical nutrition practice guidelines with all members of the clinical nutrition team.	Interim Administrative Director of Operations	Sign-in sheets	3/1/23	3/15/2023