Objective: The purpose of the Compliance Program Quality Plan is to guide our decisions related to safety, clinical quality, functional status, satisfaction and the cost of care and service delivery. We strive to take a proactive approach, keeping in mind the unique trends of this home and population. To do this all employees will participate in an ongoing compliance program and quality assurance and performance improvement efforts, which support our mission.

Responsibility: Board of Directors, employees, residents, medical staff, consultants, contractors, vendors, students, and volunteers

Policy: The Corporate Compliance Program and Quality Plan, combined with our community’s operational policies and procedures provide the Board of Directors, employees, residents, medical staff, consultants, contractors, vendors, students, and volunteers (collectively referred to as “Members” for purposes of this policy) with a clear understanding of the professional, legal and personal expectations and the goals we strive to achieve on an ongoing basis.

All employees have a responsibility to comply with and participate in the Corporate Compliance Program and Quality Plan, including the annual review and signing the Code of Conduct and conflict of Interest as a condition of employment.
Guiding Principles:

- Guiding Principle #1: Our organization uses quality assurance and performance improvement to make decisions and guide our day to day operations.
- Guiding Principle #2: The outcome of performance improvement activities in our organization is improved quality of care, quality of services and quality of life for residents.
- Guiding Principle #3: In our organization, Compliance and Quality includes all employees, all departments and all services provided.
- Guiding Principle #4: Performance improvement focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps and the elimination of waste, rather than on blaming individuals.
- Guiding Principle #5: Our organization makes data driven decisions. Data is gathered from the MDS and other areas of the medical record, claims, interviews, surveys, comparison data, data collected during quality work, from the input and experience of caregivers, residents, health care practitioners, families and other sources as appropriate.
- Guiding Principle #6: Our organization sets goals for performance and measures progress towards those goals.
- Guiding Principle #7: Our organization supports performance improvement by supporting a just culture, where employees support each other and are accountable for their own professional performance and practice.
- Guiding Principle #8: Our organization has a culture that encourages, rather than punishes, employees who identify errors, waste and other actual or potential system breakdowns.

Scope: The scope of the Quality Plan encompasses all segments of care and services provided including: safety, clinical care, functional status, satisfaction and cost, with participation from all departments.

<table>
<thead>
<tr>
<th>Segments of Care</th>
<th>Services Rendered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services</td>
<td>We provide comprehensive clinical care to residents with acute and chronic disease, respite care, rehabilitative services and end of life care. All care is resident-centered and focused around choice and individualized treatment plans. We strive to meet each resident’s goals of care, including developing and executing a transitional plan for discharge back to the community where possible.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Dietary Services</td>
<td>We provide nutritious meals under the supervision of a registered dietician. We consider resident choices and preferences by providing “Anytime Meals” menu options and snacks.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>We provide supervision and collaborate with medical and nursing team by reviewing, dispensing, and monitoring medication for effectiveness to ensure therapeutic goals are maintained for each resident.</td>
</tr>
<tr>
<td>Maintenance Services</td>
<td>We provide comprehensive building safety, repairs, and inspections to help ensure that all aspects of safety are enforced to help assure the safety and well-being of each resident, visitor and staff on the premises or in the building.</td>
</tr>
<tr>
<td>Housekeeping and Laundry Services</td>
<td>We provide and ensure that all health, sanitation and OSHA requirements are met through regular cleaning, disinfection, laundering, pest and rodent prevention and control and by following workplace safety practices in the building.</td>
</tr>
<tr>
<td>Activities/Life Enrichment</td>
<td>We provide one-on-one, small and large group activities to enrich the lives of residents and meet the unique individual interests of each resident in the Altenheim community.</td>
</tr>
<tr>
<td>Administrative Services</td>
<td>We align all business and clinical practices to ensure every resident has individualized care and services. We work to support the providers with the resources and equipment necessary to meet the care goals of those we serve.</td>
</tr>
</tbody>
</table>

**Quality Plan**

The Quality Plan at the St. Louis Altenheim aims for continuously identifying opportunities and improving safety, quality and cost effectiveness of care and services provided, while emphasizing autonomy and choice for residents.

The best available Administrative data (billing, CMS MDS/CASPER Report, CMS Interqual) Survey data, Clinical data (medical record, assessment, clinical process and outcome) and reference databases (local, state and national reference databases such as MO DHSS and CMS reports) benchmarks, published best practices, evidence-based clinical practice guidelines, etc. will be used to determine opportunities and define and measure goals.
Data collection tools for routine audits and monitoring systems with defined reporting cycles are in place and defined in the Quality Plan. The Quality Plan, including data collection tools and monitoring systems are reviewed and approved at least annually by the Compliance and Quality Committee and Board of Directors.

**Governance and Leadership**

St. Louis Altenheim’s governing body, the Board of Directors, is ultimately responsible for overseeing the Compliance and Quality Committee. The Administrator and CFO/Director of Finance have direct oversight responsibility for all functions of the committee and report directly to the governing body. The Compliance and Quality committee, which includes the medical director, is ultimately responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction.

An introduction to Compliance and Quality is provided with orientation. Facility-wide training is conducted to inform everyone in the facility about the Compliance Program and Quality Plan. Education is provided often and in multiple ways through regular all-staff meetings, department staff in-services, change-of-shift report, etc. Every employee understands that they are expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about quality, safety and satisfaction.

The Compliance Program and Quality Plan, including the Code of Conduct and Conflict of Interest are shared with consultants, contractors, and collaborating agencies, to assure understanding of the role and responsibilities each person has in the Compliance Program and Quality plan.

The St. Louis Altenheim ensures that all residents and families are aware of the facility’s Compliance Program and Quality Plan, and that their views are sought, valued and considered in facility decision making and process improvements through the resident Board member, the Resident and Family Councils, surveys and other resident and family events.

**Feedback, Data Systems, and Monitoring**

The St. Louis Altenheim Board of Directors has put in place systems to monitor care and services, drawing data from multiple sources. The community Administrator, any Department Director, the Compliance and
Quality Committee and/or a Performance Improvement (PIP) Team can add to the measures to monitor care and services as needed.

Feedback systems with routine reporting to the Compliance and Quality Committee and the Board of Directors actively incorporate input from staff, residents, families and others as appropriate. Data systems include using performance indicators to monitor a wide range of care processes and outcomes and reviewing findings against benchmarks and/or goals the facility has established for performance.

Feedback systems also include tracking, investigating and monitoring adverse events every time they occur and action plans implemented through Rapid Cycle plan, do, study, act (PDSA) cycles or other improvement methodology to prevent recurrences.

All publicly reported measures and other measures recommended by the Compliance and Quality Committee will be monitored and reported as defined in the annual Compliance Program and Quality plan approved by the Board of Directors. Any PIP team can add additional data to monitor as appropriate. Areas to consider may include, but are not limited to the following examples:

- Clinical care areas (e.g. pressure ulcers, falls, infections)
- Medications (those that require close monitoring, antipsychotics, narcotics)
- Concerns, complaints, grievances from residents, families or visitors
- Hospitalizations and other service use
- Resident and/or Caregiver satisfaction surveys
- Care plans, MDS, including ensuring implementation and evaluation of measurable interventions.
- State survey results and deficiencies
- Business and administrative processes (e.g. financial information, staff turnover, caregiver competencies and staffing patterns, such as permanent caregiver assignment). Data related to caregiver who call in sick or are unable to report to work on short notice, caregiver injuries, and worker’s compensation claims may also be useful.

Goals for performance in the areas that are being monitored will be recommended by the Compliance and Quality Committee and are reviewed and approved by the Board of Directors annually.
Benchmarks for performance such as the Nursing Home compare (www.medicare.gov/nhcompare), NNHQI, CASPER reports, the facility’s own performance, etc. will be used to monitor the facility’s progress.

Performance Improvement Projects

The Compliance and Quality Committee will review sources of information to determine if gaps or patterns exist in systems of care and/or services that could result in quality problems; or if there are opportunities to make improvements. Examples of potential areas to consider when reviewing data include:

- Resident MDS and care plan data for problem patterns/progress toward specified goals
- Nursing Home Compare (provides quality information about every certified nursing home in the country)
- State Survey results and plans of correction
- Trends in complaints
- Resident and family satisfaction surveys for trends
- Patterns of staff/caregiver turnover or absences
- Patterns of emergency room visits and/or hospital use

Multi-disciplinary Performance Improvement teams are approved by the Compliance and Quality Committee, after an assessment and prioritization of organizational needs and resources. Teams may be used to study processes, design new processes and make improvements in current processes consistent with/based on evidence-based guidelines, best practices or by identification and eliminating root causes of identified problems.

QI/PI teams use the Plan, Do, Check/Study, Act (PDCA) or other appropriate methodology to address the identified issue, such as Lean/PICOS or six sigma. Each team should have a leader and separate facilitator. Teams will be given a defined goal indicating their objective, a statement of the problem, an expected outcome(s), constraints, and a reporting schedule to the Compliance and Quality Committee. Upon completion of the team’s goal, teams will present a summation of their work to the relevant area and oversight committee(s). Team recognition occurs via leadership and the quality oversight structure.

Identification and prioritization of Initiatives

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining which
initiatives to prioritize. The Compliance and Quality Committee will use the following criteria to identify and prioritize the annual plan and any changes recommended for quality initiatives in the organization using the following criteria:

a) Incident Reports
b) Sentinel Events
c) High volume/problem prone/high cost.
d) Low volume/high risk-problem prone/high cost
e) Top ten Medical Conditions as defined by the Institute of Medicine (and applicable to residential, assisted and long-term nursing care provided)
f) Promotion of resident, visitor and employee safety issues
g) Initiatives consistent with mission, vision, values, strategic plan and direction
h) Availability of system resources to devote to project
i) Financial Risk

Data Collection, Analysis and Reporting

A Data Collection Plan will be defined in the Annual Quality Plan and each performance improvement initiative or project.

Evaluation of collected data is completed by the Compliance and Quality Committee, Department Director or PIP Team to monitor and identify levels of performance, trends or patterns that vary significantly from the norm or that exceed threshold levels of performance.

Communication

Data and findings will be reported to the appropriate quality and management groups and individuals on a monthly basis or as indicated in the Quality Plan.

A Quality Dashboard will be created for use by management, the Compliance and Quality Committee and the Board of Directors.

The State and national patient outcome database reports (including State and CMS reports) are used to compare performance with other facilities. This information will be utilized to determine areas for improvement and identify areas of success.

All quality committee meetings will have minutes recorded utilizing a format to document at least the attendees, topic(s), findings/conclusions,
recommendations/actions and timeframe for any deliverables. Minutes of meetings will be shared with/made available to the Compliance and Quality Committee, the Board of Directors, the management team and staff as part of ongoing safety improvement work product.

Evaluation

The Compliance and Quality Committee annually reviews the effectiveness of the Quality Plan to ensure the effort is improving clinical outcomes, satisfaction, and safety. An annual evaluation is completed by the Compliance and Quality Committee to identify components of the plan that require development, revision or deletion. Recommendations are made at least annually to the Board of Directors for development, revisions and/or deletions and are approved based on evidence that efforts are resulting in improvement or not and a discussion of which specific initiatives to continue in the upcoming year.

Review and discussion of the evaluation are noted in the minutes of the Board of Directors, in addition to the Board’s approval of the measures and quality goals for the following year.