

**Artesia Christian Home, Inc.**  
**Board of Directors' Meeting – Agenda**  
**Tuesday November 25, 2025**  
**4:00 PM**

**In Person & Zoom**  
**ZOOM ID CODE: 371-575-8625**  
**PASSWORD-ACH**

- I. Opening Prayer & Devotions- Randy VanEssen
- II. Roll Call –Steve Ornee
- III. Minutes of October 28th, 2025
- IV. Committee Reports
  - A. Finance Report- Pat Henry
  - B. Promotions Report
- V. Executive Director Report
  - A. SNF QAPI Plan & Performance Improvement Projects- attached for information
- VI. Old Business
- VII. New Business
  - A. Board Officer 2026 Nominations
    - 1. Vice All- Sandi Van Lant
    - 2. Secretary- Steve Ornee
    - 3. Treasurer- Tim Slegers
    - 4. Vice President- Terry Van Dyk
    - 5. President- Ken Solomon
  - B. Next MEETINGS
    - 1. **December 2<sup>nd</sup> , 2025 Hanging of Greens- Volunteers**
    - 2. **December 2<sup>nd</sup>, 2025, Christmas Board Dinner- Memory Care Activity Room- catered meal from Morrison Living, 5:30 pm**
    - 3. **December 6<sup>th</sup>, 2025, Christmas Market CARE Fund Fundraiser**
    - 4. **December 9<sup>th</sup>, 2025, Auxiliary Christmas Tea**
    - 5. **December 12<sup>th</sup>, 2025, Employee Appreciation Christmas Lunch**
    - 6. **NO BOARD MEETINGS IN DECEMBER**
    - 7. **January 14th, 2026, Promotions Committee- Noon via Zoom**
    - 8. **January 27th, 2026, Finance-3pm & Board-4 pm**
- VIII. Closing Prayer – Randy VanEssen

**Artesia Christian Home, Inc.**  
**Minutes from the Board of Directors' Meeting**  
**4:00 PM, October 28th, 2025 - ACH Conference Room, Artesia, California**



**I. Call to Order** - by T. Van Dyk at 4:00 PM. R. Verhoeven opened with a devotion and prayer.

**II. Roll Call** - 12 Board Members: 11 present (7 needed for quorum)

Staff

✓ Robin Brouwer ('26)	✓ Steven Ornee ('27-2) - Sect.	✓ Randy Van Essen ('25-2)	✓ M. Robison
✓ T. Slegers ('25)	Ⓢ Ken Solomon ('27-2) - Pres.	✓ S. Van Lant ('27-2) - Treas.	✓ P. Henry
✓ Bob Hultgrien ('26)	✓ Bob Struiksma ('27)	✓ Rob Verhoeven ('26)	✓ C. Levi
✓ Sondi Oldenburger ('26)*	✓ Terry Van Dyk ('25) - VP	✓ Barbara Zondervan ('26)	✓ A. Walsh
Ⓢ = Informed absence	* = Voting residential rep.	<i>Non-Voting Res. Rep.</i>	✓ Rosie Verhoef ('26)
✓ = Present	(##-2) = last year of term/2nd consecutive term		

**III. Minutes Approval** - Motion to approve the September 23, 2025 meeting minutes.

**Motion Passed**

**IV. Committee Reports**

- A. Finance committee Sept. 23, 2025 meeting minutes submitted.
- B. Promotion committee Oct. 8, 2025 meeting minutes submitted.

**V. Executive Reports** - oral summaries given, written reports submitted

- A. Financial Operations - P. Henry
- B. Executive Director - M. Robison
- C. Skilled Nursing - C. Levi
- D. Residential Services - A. Walsh
- E. Community Relations - M. Robison
- F. Facilities - M. Robison

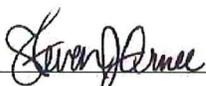
**VI. New Business** - Tom Turning will be the new Resident Representative on the Board.

**VII. Calendar**

Promotions	Wednesday, Nov. 12 <sup>th</sup>	Noon via Zoom
Finance / Board	Tuesday, Nov. 25 <sup>th</sup>	3PM/4PM
Board Christmas Dinner	Tuesday, Dec. 2 <sup>nd</sup>	5:30PM Memory Care Activity Rm
Christmas Market	Saturday, Dec 6 <sup>th</sup>	

**VIII.** At 5:02PM a motion to adjourn was made and R.Verhoven closed with prayer.

**Motion Passed.**

  
 \_\_\_\_\_  
 Steven Ornee, Secretary of the Board

\_\_\_\_\_  
 Date of Approval

**Artesia Christian Home, Inc.**  
**Finance Committee Meeting**  
**Tuesday, October 28, 2025**

- I. Sandy Van Lant opened the meeting in prayer at 3:00PM.
- II. Board Members present: Sandy Van Lant, Tim Slegers, Rob Verhoeven, Terry Van Dyk  
Board Members absent with notification: Ken Solomon  
Staff present: Executive Director – Michelle Robison, Controller -Patricia Henry
- III. The Minutes of the meeting for September 23 were reviewed and approved.
- IV. New Business
  - A. 2025 Christmas plans will include a dinner, t-shirts, and a dress up day for the staff. It was decided to withhold the usual employee Christmas Bonus due to financial constraints. As this was communicated to staff, it was noted that everyone did receive a 4% wage increase for the year.
  - B. Funds taken from our money market investments are scheduled to fund the lawsuit in the amount of \$587k on November 17.
- V. MONTHLY REPORTS for August were distributed for review
  - A. **Payroll Review:** Payroll reports for 8/15/2025 (5.74%OT & 5.74% Holiday OT), for 8/29/2025 (6.94% & 6.94% for Holiday OT)
  - B. **Extraordinary Revenue/Expenses Report** was reviewed for the month of August.
  - C. **Census by Month Report** though August 2025 was reviewed for the fiscal year
  - D. **Operations Reports for August, 2025 were reviewed.**  
Year to date totals are:
    1. **Skilled Nursing August 2025: loss:** \$100,924; **FY 2025 loss:** \$1,062,252
    2. **Assisted Living August 2025: income:** \$6,879; **FY 2025 loss:** \$28,912
    3. **Independent Living August 2025: income:** \$24,809; **FY 2025 income:** \$207,026
    4. **Memory Care August 2025: Income:** \$5,000; **FY 2025 loss:** \$73,018
    5. **ACH Operations total: August 2025: loss** \$20,113; **FY 2025 loss:** \$470,802
    6. **ACH Non-operating Summary:** For **August 2025** the total **Facility Non-Operating Income** (including interest, dividend income, donations, grant income and depreciation) was \$10,484; **FY 2025 Non-Operating Gain** of \$2,279.069
    7. **ACH total: July 2025 reported loss** of \$9,628; **FY2025 gain** of \$1,808,267
  - E. **Balance Sheet** for 8-31-2025 total assets (and liabilities and equity) of \$15,767,953
  - F. **Accounts Receivable** – Balance due as of 8-31-2025 is \$1,026,408
  - G. **Accounts Receivable Aging Report** – reviewed accounts over 30 days past due for the month of August.

**H. Summary of Cash & Investments** as of 8-31-25 was \$4,665,542.

**I. Investment Summary** still shows a return -12.74% YTD as we have not received our 3<sup>rd</sup> quarter report yet.

VI. Adjournment – The meeting was adjourned at 3:55 PM. Next meeting scheduled for November 25, 2025 at 3:00 PM.

Respectfully submitted, Terry Van Dyk

## ACH Promotions Committee Meeting, November 12, 2025

In attendance: Kristin Cramer, Eden Escobedo, Robin Brouwer, Bob Hultgrien, and Sandy Van Lant. Michelle Robison - absent with notice. Barb Zondervan - absent (emergency).

### Opening Prayer: Robin Brouwer

### Approval of Minutes from October 8, 2025 – approved

Google/Online Ads: Google searches: 3,000 views, 234 clicks (click-through rate of 7.89%)

Side ads: 134,000 views, 87 clicks. 18 conversions and 64 calls.

Census: **Memory care - 23** (3 female shared, 1 male shared, & 1 private available); **Skilled Nursing – 50** (open for admissions again); **Independent Living – Full; Asst. Living – 56** (3 North studios, 4 South 1-bedrooms available).

\*Some “waitlist” language changed on website to “call for availability”

### NEW BUSINESS:

- Annual Society Meeting wrap-up discussion. Received ~\$31,000 from donations + \$1,700 through GiveButter
- AL to host Scam Seminar presented by Right at Home - November 17
- Lunch & Learn scheduled for Nov. 13 (13 RSVPs)
- Key Club Flower Project - Nov. 29 Students from 9 area high schools will plant seasonal flowers and socialize with residents during coffee hour
- Messenger and Annual Letter went out last week

### OLD BUSINESS:

- Christmas Market: Currently have 20+ vendors signed up; \$1,296 raised to date. Entertainment is booked. Seeking more vendors, supporters, and volunteers - deadline Nov. 18. Please let Kristin or Eden know if you are available to help with setup or other needs at the event.

### Calendar:

- **Lunch & Learn:** November 13
- **Giving Tuesday campaign:** December 2
- **Hanging of the Greens:** December 2
- **Board Christmas Dinner:** December 2 in Memory Care Activity Room
- **Auxiliary Christmas Tea:** December 9
- **Victor’s Tacos for Employee Spirit Week: 10 a.m. - 1 p.m. Board members welcome to attend!**
- **75<sup>th</sup> Anniversary Celebration: May 2027**



## Artesia Christian Home, Inc.

Annual Society Meeting Agenda

Thursday - November 6, 2025

6:00PM - Dinner & Hymn sing

7:30PM – Meeting Call to Order

Held at First Christian Reformed Church, Artesia

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- I. Meeting Called to Order at 7:29pm by Ken Solomon, Board President
  - II. Declaration of Quorum – at least 50 members present from supporting churches.
  - III. Election of Board Members – to approve the following appointments:
    - a First Term – Elect Sharon Stephens, Trinity CRC, for a three-year term.  
Confirm Tim Slegers, First Artesia CRC, to complete a 3-year term that began in 2025.  
**Motion Passed**
    - b Second term – Elect Terry Van Dyk, Anaheim CRC, for a second 3-year term  
**Motion Passed**
  - IV. Recognition of service for retiring board members – Rich Haagsma, Randy VanEssen, Sondi Oldenburger by Michelle Robison
  - V. Reports Presented at meeting
    - a Women's Auxillary, Pat Verhoeven recap 2025 projects
    - b Executive Report, Michelle Robison
    - c Finance Committee, submitted by S. Van Lant, delivered by K. Solomon
  - VI. Concept Minutes read by Steve Ornee for approval. **Minutes Approved**
  - VII. Reports included in packet
    - a 2024 Society Minutes
    - b Independent Financial Auditor's Report
    - c Balance Sheet
    - d Donations Report
    - e Statement of Operations
    - f Finance Committee Annual Report
    - g Building and Grounds Annual Report
    - h Promotion Committee Annual Report
  - VIII. At 8pm, a **motion passed** to adjourn the meeting. K. Solomon closed with prayer.

**Artesia Christian Home, Inc.  
Actual vs Budget Statement of Operations - Summary  
September 30, 2025**

	Current Actual	Current Budget	Variance	YTD Actual	YTD Budget	Variance
<b>Operating Revenue</b>						
Medicare A	77,319.19	68,097.04	9,222.15	1,021,482.96	817,142.04	204,340.92
Medicare B	8,812.33	0.00	8,812.33	47,596.67	0.00	47,596.67
MediCal	376,629.50	332,149.50	44,480.00	5,125,214.40	3,985,799.50	1,139,414.90
Commercial Insurance	48,864.73	36,215.00	12,649.73	557,310.02	434,602.00	122,708.02
Private	789,916.21	857,916.00	(67,999.79)	9,067,989.29	10,295,047.00	(1,227,057.71)
Other Ancillary Revenue	11,001.12	0.00	11,001.12	142,744.02	0.00	142,744.02
<b>Total Operating Revenue</b>	<b>\$ 1,312,543.08</b>	<b>\$ 1,294,377.54</b>	<b>\$ 18,165.54</b>	<b>\$ 15,962,337.36</b>	<b>\$ 15,532,590.54</b>	<b>\$ 429,746.82</b>
<b>Operating Expense</b>						
Nursing & Residential Services	623,576.47	590,069.61	(33,506.86)	7,416,548.54	7,080,778.34	(335,770.20)
Facilities	114,561.94	100,390.85	(14,171.09)	1,250,403.64	1,204,723.20	(45,680.44)
Housekeeping Services	33,016.77	51,342.82	18,326.05	519,268.07	616,069.84	96,801.77
Laundry Services	18,625.70	22,402.38	3,776.68	259,292.96	268,828.56	9,535.60
Dining Services	207,445.54	188,981.75	(18,463.79)	2,305,211.78	2,267,760.98	(37,450.80)
Social Services & Life Enrichment	77,844.57	73,113.77	(4,730.80)	941,637.42	877,398.24	(64,239.18)
Staff Development	10,962.16	11,531.99	569.83	140,736.98	138,383.88	(2,353.10)
General & Administrative	190,811.78	213,057.58	22,245.80	2,888,904.99	2,556,844.96	(332,060.03)
Property Expenses	5,006.17	9,897.79	4,891.62	103,274.27	118,773.48	15,499.21
Other Expenses	0.00	0.00	0.00	1,799.47	0.00	(1,799.47)
Ancillary Expenses	55,079.19	42,425.37	(12,653.82)	630,448.98	509,093.44	(121,355.54)
<b>Total Operating Expense</b>	<b>\$ 1,336,930.29</b>	<b>\$ 1,303,213.91</b>	<b>\$ (33,716.38)</b>	<b>\$ 16,457,527.10</b>	<b>\$ 15,638,654.92</b>	<b>\$ (818,872.18)</b>
<b>Net Operating</b>	<b>\$ (24,387.21)</b>	<b>\$ (8,836.37)</b>	<b>\$ (15,550.84)</b>	<b>\$ (495,189.74)</b>	<b>\$ (106,064.38)</b>	<b>\$ (389,125.36)</b>
<b>Non-Operating</b>						
Extraordinary Items	(32,979.39)	0.00	(32,979.39)	2,116,356.20	0.00	2,116,356.20
Interest & Dividends	111,168.98	0.00	111,168.98	132,119.91	0.00	132,119.91
Donations	104,299.58	0.00	104,299.58	698,435.23	0.00	698,435.23
Depreciation Expense	(44,123.00)	0.00	(44,123.00)	(529,476.00)	0.00	(529,476.00)
<b>Total Non-Operating</b>	<b>\$ 138,366.17</b>	<b>\$ 0.00</b>	<b>\$ 138,366.17</b>	<b>\$ 2,417,435.34</b>	<b>\$ 0.00</b>	<b>\$ 2,417,435.34</b>
<b>Net Income (Loss)</b>	<b>\$ 113,978.96</b>	<b>\$ (8,836.37)</b>	<b>\$ 122,815.33</b>	<b>\$ 1,922,245.60</b>	<b>\$ (106,064.38)</b>	<b>\$ 2,028,309.98</b>

**Artesia Christian Home, Inc.**  
**Balance Sheet**  
**September 30, 2025**

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**Assets**

**Current Assets**

Cash	2,337,958.83
Accounts Receivable	826,423.02
Prepaid Expenses	213,245.50
	\$ 3,377,627.35

**Fixed Assets**

Land	1,216,888.94
Building & Improvements	14,769,977.02
Furniture Fixtures & Equipment	2,915,811.69
Work In Progress	44,013.59
Accumulated Depreciation	(9,130,628.00)
	\$ 9,816,063.24

**Other Assets**

Investments	2,835,141.18
	\$ 2,835,141.18

Total Assets	\$ 16,028,831.77
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**Liabilities and Equity**

**Current Liabilities**

Accounts Payable	775,507.59
Accrued Salaries & Benefits	523,136.23
Other Liabilities	1,748.05
	\$ 1,300,391.87

Total Liabilities	\$ 1,300,391.87
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**Equity**

Equity	12,806,194.30
Net Income (Loss)	\$ 1,922,245.60
	\$ 14,728,439.90

Total Liabilities and Equity	\$ 16,028,831.77
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**Artesia Christian Home, Inc.  
Investment Account Balance**

<u>Date</u>	<u>Market Value</u>	<u>Month to Month Change</u>	<u>Cumulative Change from 1/1</u>	<u>Cummulative Return*</u>
1/31/2025	2,274,543			
3/31/2025	1,856,842	(417,701)	(417,701)	-0.78%
6/30/2025	3,484,838	1,627,996	1,210,295	-12.74%
9/30/2025	2,835,141	(649,696)	560,598	24.65%

\*Data from Schwab/RAI Quarterly Statements

\*03/10/2025 Moved (\$400,000) from investment account to general account

\* 06 25/2025 Transferred \$1,500,000 from General Acct related to ERC Refund

**Artesia Christian Home, Inc.  
Cash & Investments Summary**

<b>Financial Institution</b>	<b>Account</b>	<b>As of 08/31/2025</b>	<b>As of 09/30/2025</b>
Schwab	CCRC Liquid Reserve Requirement by Dept of Social Services as of 1/30/2025	\$ 348,600	\$ 348,600
Schwab	Unemployment Fund Reserve	150,000	150,000
Schwab	Operating / Building Repairs / Emergencies Funds	2,986,238	2,336,541
	<b>Investments Total</b>	<b>3,484,838</b>	<b>2,835,141</b>
		<b>As of 08/31/2025</b>	<b>As of 09/30/2025</b>
Citizens Business Bank	General Account	98,247	288,875
Citizens Business Bank	Money Market Account- Reserves for Payroll & Operations	954,663	1,908,057
Citizens Business Bank	Business Savings - Reserve Required for Line of Credit	111,020	111,034
Bank of America	Pegboard Account	16,774	16,774
	<b>Cash Total</b>	<b>1,180,704</b>	<b>2,324,740</b>
<b>Total</b>		<b><u>\$ 4,665,542</u></b>	<b><u>\$ 5,159,881</u></b>
<b>Donation Information</b>		<b>YTD 08/31/20</b>	<b>YTD 09/30/2025</b>
	C.A.R.E. Fund	\$ 394,258	\$ 478,385
	General Fund	25,224	43,417
	Special Fund	174,653	176,633
	<b>Total Donations</b>	<b><u>\$ 594,135</u></b>	<b><u>\$ 698,435</u></b>

## Executive Director Report

November 25th, 2025

3:00 pm

Board Room/Zoom

### Upcoming Events

- December 2<sup>nd</sup>, 2025 Hanging of Greens- Volunteers
- December 2<sup>nd</sup>, 2025, Christmas Board Dinner- Memory Care Activity Room- catered meal from Morrison Living, 5:30 pm -see flyer
- December 6<sup>th</sup>, 2025, Christmas Market CARE Fund Fundraiser
- December 9<sup>th</sup>, 2025, Auxiliary Christmas Tea
- December 12<sup>th</sup>, 2025, Employee Appreciation Christmas Lunch
- **NO BOARD MEETINGS IN DECEMBER**
- January 14th, 2026, Promotions Committee- Noon via Zoom
- January 27th, 2026, Finance-3pm & Board-4 pm

### Executive Director

- Annual Society Meeting & Dinner 11-6-25
- Underwriting Committee Meeting with our Workman's Comp group- Guardian Comp
- LA County LTC Mutual Aid Planning Site Visit (LTC-MAP) – Emergency Preparedness planning activity with Scott Aronson.

### HR, COMPLIANCE & TECHNOLOGY OPERATIONS

- 2026 Open Enrollment for health insurance benefits held 3 meetings.

#### **Compliance & Ethics Highlights:**

- Class Action Hearing: Check was sent mailed to fund on November 19th. Funding is required no later than December 1<sup>st</sup>.
- Awaiting contract quote for an immigration compliance specialist to conduct an external I-9 Audit to ensure compliance and minimize risk.

### FINANCIAL OPERATIONS

- In process of responding to all FYE 2025 audit requests from Financial Auditors; Met with Carly and Samatha from Genske Mulder regarding audit who were onsite on 11-18-25
- Respond to audit requests related to Medi-Cal Audit 2024
- Uploaded FY2026 budget into Matrix
- Funded final legal Settlement 11/17/2025
- Review recalculations of 2025 403(b) payout
- Draft up Internal Controls Memo for Auditors
- Preparing calculation of Wage Standards for Opt-in 2026
- Review Close out for Calibrate Payroll Audit

<b>2025 YTD Total Occupancy</b>
<b>Occupancy Goal/September YTD- 94%/88%</b>
SNF: 91%/89%
ALF: 95%/83. %
MCC: 93%/92. %
Cottages: 95%/92.9 %

<b>2025 YTD Overtime: 7.63% (Holiday OT 9.0%)</b>
September Payroll: 5.3 % , 12.1% with Holiday, 6.5%, & Dining Payout 4.4%
August Payroll: 5.7%, 6.9%
July Payroll: 5.6%, 5.5 % /11.5% with Holiday & 6.4%
June Payroll: 4.7 % , 11.2% with Holiday & 5.5%
May Payroll: 6.7% & 6.9%
April Payroll: 7.8% and 7.6 %
March Payroll: 6.6% & 7.2%
February Payroll: 9.75 & 6.3%
January Payroll: 13.4% (with Holiday), 14.4% (with Holiday), 10.8%
December Payroll: 14.6% (with Holiday) 10.3%,
November Payroll: 10.7%, 12.3%
October Payroll: 9.8% 12.1 %

<b>2025 Charity Care Year End Total October '24- September '25</b>
\$691,688

<b>2025 C.A.R.E. Fund Year End Total October '24- September '25</b>
\$478,384.87

<b>2025 Year End Total Donations (including CARE FUND) October '24- September '25</b>
\$698,435.23

- |             |
|-------------|
| <b>SNF:</b> |
|-------------|
- Suspicious Rashes Outbreak opened by DPH on 10-17-25. We are following all the guidance provided to us by DPH. Despite remaining in an outbreak, DPH allowed us to open to new admissions starting on 11-7-25. We anticipate the outbreak closing on 12-2-25.

- Complaint Investigation from the DPH for the outbreak occurred on 10-28-25. Issued an intent to cite on 10-30-25; Have not yet received our 2567 with any deficiencies as of yet.
- Staffing Efforts:
  - Open Positions:
    - 1 CNAs (evening), 2 CNAs (day), 4 CNA (NOC)
    - 2 LVN (LVN) FT 3-11
  - Using registry on 11-7 for CNA and 3-11 LVN
  - 3 CNA on medical leave
  - 2 licensed nurses on medical leave

**Covid Updates:**

- No current cases.
- COVID and RSV vaccination clinic scheduled

**Quality Assurance Performance Improvement/ (QAPI) Activity:**

- Monthly QAPI Quarterly Consultant Meeting held on 11-19-25
- Reviewed the QAPI plan and Added 5 new PIP's. see attached for review.
- Continue to address suspicious rashes outbreak in line with our DPH & PIP.
- Distributed Facility Assessment to QAPI team & Board President for another review.
- QAPI Self-Assessment reviewed with the QAPI team. To begin implementing recommendations in 2026.

**RESIDENTIAL:**

- Hired and trained for new Care Partner V kitchen server positions in Memory Care. Rolled this out to start with MCC staff only as of 11/23/25
- Continuing to have more staff turnover on overnight shifts, was able to hire one more overnight person, and am currently interviewing for another one.
- Met with Jasmin and other department leaders regarding Attendance and Call Out policies rolling out in 2026.
- Closed out confirmed suspicious rash/scabies care in Assisted Living, only one case total.
- **Covid Updates:**  
No current cases.

**COMMUNITY RELATIONS:**

- Annual Society Meeting & Dinner (11/6/25)
- Presidents End of Year Letter went out November 10.
- Bethany Church Outing (11-11-25)
- ACH Lunch & Learn (11/13/25) – 12 RSVP & 10 attended
- Christmas Market Promotions in progress (12-06-25)
- ACH Christmas Week (12-08-25 to 12-2-25) – Taco's on Friday (12-12-25)
- Auxiliary Christmas Tea (12-09-25)
- Board of Directors Christmas Dinner (12-02-25)

<b>Rented or Occupied Rooms: As of 11/19/25</b>
SNF: 49 beds / 66 beds; Budgeted: 61 Admissions reopened 11-7
ALF: 5 rooms / 63 rooms; Budgeted: 52
MCC: 23 beds / 28 beds; Budgeted: 26
Cottages: 21 cottages / 21 cottages; Budgeted: 20

<b>Admissions/Discharges: YTD 10/01/24- 9/30/25</b>
SNF: 86 Admissions, 75 Discharges, 22 Passed
ALF: 25 Admissions, 22 Discharges, 0 Passed,
MCC: 16 Admissions, 11 Discharges, 3 Passed
Cottages: 9 Admissions, 7 Discharge, 0 Passed;
<b>Total: 136 Admissions, 115 Discharges, 25 Passed</b>

<b>Admissions/Discharges: October 2025</b>
SNF: 4 Admissions, 4 Discharges, 3 Passed 10/17/25 Admissions closed
ALF: 0 Admissions, 1 Discharges, 0 Passed,
MCC: 0 Admissions, 0 Discharges, 0 Passed
Cottages: 3 Admissions, 0 Discharge, 0 Passed;
<b>Total: 7 Admissions, 5 Discharges, 3 Passed</b>

**FACILITIES:**

- Disaster Coordinator facilitated a visit between Scott Aronson, a consultant for the LA County LTC Mutual Aid, Meredith Chillemi, Leading Age Vice President and ACH Safety Committee regarding Emergency Planning.
- Ice machine repair in SNF sub kitchen.
- Remodeled rooms #137 and #329
- ALF North & South Wood rot repair, replacing vertical and horizontal siding. Also includes stucco patching for rot areas
- Awaiting a quote for Covenant Center plumbing drain line repair
- Painting project is 3/4 quarters finished. Anticipate being finished with painting by end of November.
- Provided support SNF and AL to complete environmental disinfecting needs

**Satisfaction Surveys**

One SNF survey received 100 % satisfaction. “Care for with kindness” was what they liked best about ACH. “Very grateful for all, especially the Social Work team.”

### **Prayer requests**

- Prayers for a blessed and enjoyable holiday season
- Prayers teams as we prepare and anticipate our SNF survey
- Prayers for prospective residents as they consider ACH as a new home
- Health & Wellbeing of our residents, employees and families

Respectfully Submitted,

Michelle Robison, MSW, LCSW, RCFE, LNHA Executive Director



## **Current Quality Assurance & Performance Improvement (QAPI) Plan: Revised/Reviewed 11-10-25/7-29-25**

### **Vision**

Our vision is rooted in the Reformed Biblical perspective that believes by providing Christ-like compassionate care through tangible acts of love, we minister to the physical, emotional, and spiritual needs of those we serve.

### **Mission**

The mission of the Artesia Christian Home is to provide a continuum of high-quality services to faithful members of our supporting churches and community.

### **Purpose**

The purpose of this QAPI Plan is to guide **Artesia Christian Home** in continuously improving the quality of care and services we provide to our residents. This plan outlines a systematic, data-driven approach to quality improvement that is proactive, facility-wide, and resident-centered.

We take pride in continually enhancing how we care for and engage with our residents, their families, employees, and all who are connected with our facility. Our goal is to realize our vision of providing **Christ-like compassionate care through tangible acts of love.**

We support the belief that everyone should have a fair and just chance to achieve the best possible health regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography and preferred language.

To support this, all employees will be trained in QAPI principles and actively participate in ongoing quality improvement efforts that align with our mission—to provide a continuum of high-quality services to members of our supporting churches and the surrounding community.

**A copy of this QAPI Plan will be available at SNF North Station for reference and review**

## 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 QAPI in our organization is to improve the quality of care and the quality of life of our residents.

**Guiding Principle #3:** In our organization, QAPI includes all employees, all departments, and all services provided.

**Guiding Principle #4:** QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.

**Guiding Principle #5:** Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other parties affiliated with the facility.

**Guiding Principle #6:** Our organization sets goals for performance and measures progress toward those goals.

**Guiding Principle #7:** Our organization supports performance improvement by encouraging our employees to support each other as well as be 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 or system breakdowns.

## Scope

The scope of the QAPI program encompasses all areas of the Artesia Christian Home including resident/family feedback, staff satisfaction, individualized resident care plans, information technology, facility and maintenance plan, and QAPI.

Segments of Care	Services Rendered
<b>Clinical Care Services</b>	We provide comprehensive clinical care to residents with acute and chronic disease, rehabilitative needs, as well as end-of-life care. All care is person-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. We collaborate with psychiatric, psychological, and neuropsychological providers to facilitate care for mental health, emotional and psychological needs.
<b>Dietary</b>	We provide nutritional meals under the supervision of a registered dietician. We consider resident choices and preferences by providing several options for meals and embrace open dining hours.
<b>Pharmacy Services</b>	We provide supervision and collaborate with various pharmacies and a pharmacist consultant by reviewing, dispensing, and monitoring medication effectiveness to ensure therapeutic goals are maintained for each resident.
<b>Facility, Maintenance Services &amp; Emergency Preparedness</b>	We provide comprehensive building safety, repairs, and inspections to ensure all aspects of safety are enforced, assuring the safety and well-being for each resident, visitor, and staff who enters the building. We maintain an emergency preparedness plan to ensure safety and wellbeing of our residents, staff and visitors in the event of an emergency situation.
<b>Housekeeping</b>	We provide and ensure that all health, sanitation, and OSHA requirements are met through regular cleaning, disinfection, and sanitation of all aspects of the building.
<b>Administration</b>	We align all business practices to ensure every resident has individualized care, and we work to support the providers with the resources and equipment to meet the care goals of those we care for.
<b>Resident Rights</b>	Residents are informed of their rights on admission to the facility and at monthly resident council meetings. All staff shall ensure that all residents are treated with kindness, respect and dignity.
<b>Dementia Services</b>	We provide residents dealing with dementia focused and individualized care to reduce distressing behaviors and maximize the resident's strengths and abilities. We provide meaningful and comforting activities, adequate fluids to maintain hydration, and nutritious foods, and utilize only minimal medications for behavioral issues after non-pharmaceutical methods have failed.

The QAPI program at the Artesia Christian Home will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (residents' agents), by ensuring our data collection tools and monitoring systems are in place and are consistent for a proactive analysis. We will utilize the best available evidence (such as data from the CASPER Report, national benchmarks, published best practices, clinical guidelines etc.) to define and measure our goals.

## **Governance and Leadership**

The leadership of the Artesia Christian Home strives for a culture which encourages and empowers employees, residents and their families and/or representatives in participating in quality improvement. The Board of Directors assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; encouraging a culture of safety, transparency and accountability; providing annual employee training on QAPI principles, modeling active participation in QAPI initiatives.

The Executive Director/Administrator along with the Director of Nursing collaborate on execution and oversight of the QAPI program and plan. The QAPI Committee is responsible for ensuring the implementation and monitoring of the QAPI program and plan

The QAPI 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.

The QAPI Committee is made up of the following and they meet monthly:

- Administrator
- Director of Nursing
- Medical Director
- Infection Preventionist
- Medical Records Coordinator
- Assistant Director of Nursing
- Director of Staff Development
- Associate Director of Social Services
- Dining Services Representative
- Director of Facilities
- Associate Director of Human Resources

The following paid contractors also participate in our Quarterly QAPI Monitoring Meetings

- Pharmacy Consultant
- Laboratory Consultant
- Medical Records Consultant

Employees receive training annually and as needed to inform them about our QAPI plan at Artesia Christian Home. Artesia Christian Home encourages a culture of "If You See Something, Say Something". Employees are educated to help them understand that they are expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

At admission, Artesia Christian Home ensures that all residents and/or families are made aware of the facility's QAPI program, location of the plan, and that their views are sought, valued, and considered in facility decision-making and process improvements. During the residents' council meetings, residents are asked for feedback on areas for performance improvements. Any identified systemic issues identified are then brought to our QAPI meetings for discussion.

### **Feedback, Data Systems, and Monitoring**

Artesia Christian Home has systems in place that monitors care and services, drawing data from multiple sources, such as audits, charting and communications. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. It will include using established 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. It also includes tracking, investigating, and monitoring adverse events, and action plans implemented to prevent recurrences.

The QAPI Committee at the Artesia Christian Home will decide what data to monitor routinely. Areas to consider may include, but not limited to the following examples:

- Nursing
- Dietary and Nutrition
- State survey results and plans of correction
- Trends in complaints from family, staff and residents
- Resident and family satisfaction for trends
- Patterns of employee turnover or absences
- Environmental Services
- Compliance and ethics
- Staff Education and Training

Targets for performance in the areas that are being monitored will be set by the QAPI committee. The target will usually be stated as a percentage.

Benchmarks for performance such as the Nursing Home Compare ([www.medicare.gov/nhcompare](http://www.medicare.gov/nhcompare)), CASPER report, facility's own performance, etc. will be used to monitor the facility's progress.

### **Performance Improvement Projects (PIPs)**

The QAPI Committee at Artesia Christian Home will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems; or if there are opportunities to make improvements.

Examples of potential areas to consider when reviewing data include:

- Nursing
- Dietary and Nutrition
- State survey results and plans of correction
- Trends in complaints from family, staff and residents
- Resident and family satisfaction for trends
- Patterns of employee turnover or absences
- Environmental Services
- Compliance and ethics
- Staff Education and Training

Based on the result of the review of information, the QAPI Committee at Artesia Christian Home will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI Committee will determine which problems will become the focus for a performance improvement project (PIP).

Depending on the PIP to be started, the QAPI Committee will identify a team to look into a problem area and come up with plan(s) for correction and/or to be implemented.

### **Systematic Analysis and Systemic Action**

Artesia Christian Home applies a thorough and an organized approach to determine whether and how identified problems may be caused or impacted by the way care and services are organized or delivered. Artesia Christian Home's approach assesses systems to prevent future events and promote sustained improvements. Artesia Christian Home uses root cause analysis tools such as audit forms or following the Fishbone Diagram and "5 Whys" line of thinking process as a way to investigate and resolve issues and concerns for our QAPI program.

### **Communication**

The Executive Director, Director of Nursing or designee provides at minimum an annual update on the QAPI plan. This occurs during Board meetings, leadership team meetings and discussions, resident council meetings and annual QAPI training for employees.

The QAPI plan is available for review at the SNF Nursing Station for review.

Members of the QAPI committee provide reports quarterly or as needed on the status of the established QAPI PIPs during the facility's Quarterly QAPI monitoring meeting.

### **Evaluation**

At a minimum, the Executive Director & Director of Nursing along with support

from the QAPI Committee will review the QAPI plan annually.

The team will thoughtfully and thoroughly consider the progress made in the last year toward achieving the designated QAPI PIP's and current status of measurement in meeting and sustaining the performance indicators. Other factors to consider may be current trends in the long-term care industry as well as strategic goals for the facility.

The QAPI Committee will also annually self-assess the QAPI plan process.

## References

1. The Centers for Medicare & Medicaid Services. QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-05.pdf>. Accessed August 18, 2014.
2. The Centers for Medicare & Medicaid Services. QAPI Process Tool Framework. <http://www.cms.gov/Medicare/Provider-Enrollment-and-certification/QAPI/Downloads/ProcessToolFramework.pdf>. Accessed August 18, 2014.
3. Carolinas Center for Medical Excellence. Atlantic Quality Innovation Network: Action Collaborative for Excellence in Long-Term Care 2014 QAPI Plan.

## Current QAPI Performance Improvement Projects

The DON or designee will check California PNA vaccine guidance as well as CDC PNA vaccine guidance monthly for any changes and ensure the current recommendations are done for those residents who fit into the current guidance. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through February 2026.

Added\_ 11-10-25 \_\_\_\_\_ Achieved \_\_\_\_\_ Continue \_\_\_\_\_ Modify \_\_\_\_\_

The DON or designee will check all three nursing stations monthly to ensure that each station has a copy of the infection control policy binder to be easily accessible by staff. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through February 2026.

Added\_ 11-10-25 \_\_\_\_\_ Achieved \_\_\_\_\_ Continue \_\_\_\_\_ Modify \_\_\_\_\_

The DON or designee will check all three nursing stations monthly to ensure that each station has our local Public Health office information posted. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through February 2026.

Added\_ 11-10-25 \_\_\_\_\_ Achieved \_\_\_\_\_ Continue \_\_\_\_\_ Modify \_\_\_\_\_

The Licensed nurses will complete an audit form and write down any new medication orders received on their shift from a Physician. This will be endorsed to next shift (if not received on the ordering shift) for follow up and when medication is received, the Licensed Nurse receiving the medication will complete the rest of the form with date medication was received and their signature. If Medication does not come on the following shift the Licensed Nurse will call pharmacy to follow up. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 96% compliance through February 2026.

Added\_ 11-10-25 \_\_\_\_\_ Achieved \_\_\_\_\_ Continue \_\_\_\_\_ Modify \_\_\_\_\_

There will be an order in place for all current and future residents for the Licensed Nurse to check daily that an Identification band is in place, Additionally, the DON will do random observations to check that Id bands are in place for residents. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 96% compliance through February 2026.

Added\_ 11-10-25 \_\_\_\_\_ Achieved \_\_\_\_\_ Continue \_\_\_\_\_ Modify \_\_\_\_\_

**Associate Director of Social Services will develop and implement a Life Enrichment Partner (LEP) Mentorship program to support the professional development of new LEP's by December 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**Long term residents receiving flu vaccinations will be maintained at or above 90% through December 2025**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**Long term residents receiving pneumococcal vaccinations will be maintained at 74% (for whom it is appropriate) through December 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The current turnover rate in the Skilled Nursing Department (CNA, LVN, RN) is 40%. Artesia Christian Home will reduce this by 5%, achieving a new turnover rate of 35% by December 31, 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**Artesia Christian Home will decrease our number of falls to less than 3% per quarter by December 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**Artesia Christian Home will have no incidents or reports of abuse per quarter through December 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**Artesia Christian Home will have less than 3 grievances submitted each quarter and less than 10 complaints brought to staff's attention each quarter through December 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Dining Services Director or designee will do random checks to ensure all items are labeled, dated, and stored correctly and will report the findings to the facility's Quarterly**

**QAPI monitoring meeting with a threshold of 96% compliance through November 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Infection Preventionist (IP) or designee will monitor and track any residents with “suspicious rashes” and maintain an infection control program by ensuring they are added to line listings for surveillance purposes, placed on isolation, ensure precautionary measures are done and implemented and reach out to DPH if we suspect an outbreak has occurred for additional guidance on how to handle the situation. A root cause analysis will also be done for those residents with “suspicious rashes”. The IP or designee will report the findings to the Quarterly QAPI (Quality Assurance Performance Improvement) monitoring meeting with a threshold of 100% compliance through November 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Director Of Nursing or designee will monitor the current number of residents on psychotropic medications to ensure that every resident with psychotropic medications is receiving psychiatric services on a routine basis. The Associate Director of Social Services/SSD will report the number of residents and visits to the Quality Assurance Performance Improvement Quarterly monitoring meetings with a threshold of 100% through November 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Director of Nursing will monitor monthly that the licensed Pharmacist will conduct a drug regimen review for residents who are on psychotropic medications for irregularities, appropriateness and make recommendations on GDR’s. The Director of Nursing or designee will report that the number of residents who have orders for psychotropic medication are receiving a drug regime review looking at irregularities, appropriateness and potential recommendations on GDRs. The DON will report any recommendations made to the resident’s physician. The DON will use the audit form to track all GDR recommendations and keep copies of the GDR recommendations in the audit binder with the audit form. The DON will monitor that 100% of the residents on psychotropic medications were reviewed by the contracted licensed pharmacist and will report the findings to the Quality Assurance Performance Improvement Quarterly monitoring meetings with a threshold of 100% through November 2025.**

*Achieved* \_\_\_\_\_ *Continue* 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON will continue to monitor any reports for abuse or “injuries of unknown origin” and will monitor said events that they are reported to the Administrator (Abuse Coordinator) as well as the appropriate agencies within the required time frames. The**

**DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 100% compliance through December 2025.**

*Achieved* \_\_\_\_\_ *Continue* \_\_\_ 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DSD will monitor quarterly for the DON, ADON and herself that some hours of IP training have been done for the quarter to ensure they are on track to complete the 10 “recommended” hours by the end of the calendar year. The DSD will report the findings to the Quarterly QA monitoring meeting through December 2025 with goal of 100% compliance.**

*Achieved* \_\_\_\_\_ *Continue* \_\_\_ 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Administrator will open discussion with the QA Committee monthly or as needed if there are any newly identified needs, areas for improvement, system failures or other issues to be added to the QAPI plan. The Administrator will report the findings to the Quarterly QA monitoring meeting with a threshold of 100% compliance through December 2025.**

*Achieved* \_\_\_\_\_ *Continue* \_\_\_ 7-16-25 \_\_\_\_\_ *Modify* \_\_\_\_\_

**The facility’s DON will review chart records for residents with COC events needing 72hrs monitoring to check that resident assessment or treatment was not delayed. The DON will report the findings at the Quarterly QA monitoring meeting through October 2025 with a threshold of 96% compliance.**

*Achieved* \_\_\_\_\_ *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_ *New* \_\_\_ 7-29-25 \_\_\_\_\_

**2025 Achieved PIP's below:**

**The Infection Preventionist (IP) will now include the use of triple antibiotic ointment in the monitoring and reporting process and will ensure "individual infection reports" are completed and include this in the monthly and quarterly infection control reports. The IP will report the findings at the Quarterly QA monitoring meeting with a threshold of 100% through May 2025.**

*Achieved*\_\_7-16-25\_\_\_\_\_*Continue*\_\_\_\_\_*Modify*\_\_\_\_\_

**The Business Office Administrative Assistant will provide new staff upon hire (not up to date) a covid vaccine declination form and give a copy to the facility's Infection Preventionist for tracking purposes. The Infection Preventionist will report the findings at the Quarterly QA monitoring meeting with a threshold of 100% through May 2025.**

*Achieved*\_\_7-16-25\_\_\_\_\_*Continue*\_\_\_\_\_*Modify*\_\_\_\_\_

**The Director of Facilities will do random observations to monitor that fire pull stations are free of obstructions and will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through May 2025.**

*Achieved*\_\_7-16-25\_\_\_\_\_*Continue*\_\_\_\_\_*Modify*\_\_\_\_\_

**During the facility's weekly rehab meeting, Social Services will monitor and discuss any residents that have pending orders for part B rehab services waiting for authorization, the status of that order, if auth has been received, and when services were started. The Social Services department will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through May 2025.**

*Achieved*\_\_7-16-25\_\_\_\_\_*Continue*\_\_\_\_\_*Modify*\_\_\_\_\_

**The DON will monitor any events that require the use of the post incident (non-fall) investigation form and will monitor that the investigation and form is complete. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 100% compliance through May 2025.**

*Achieved*\_\_7-16-25\_\_\_\_\_*Continue*\_\_\_\_\_*Modify*\_\_\_\_\_

**The MDS Coordinator during care plan meetings or as needed will update care plans to reflect any new or known noncompliance issues. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through May 2025.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Medical Records Coordinator will audit and keep track of any new or discontinued orders not added or removed from the care plan within 72hrs (to allow for Nurses to correct it). The Medical Records Coordinator will notify the DON of any audits not completed in the time frame. The Medical Records Coordinator will report the findings to the Quarterly QA monitoring meeting with a threshold of 96% compliance through May 2025.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON or designee will monitor that all new or worsened pressure injuries have q2hrs signed turning schedules, RD was notified, care plan initiated or updated for changes, Braden scales assessments are done when a stage1 pressure injury or greater is identified, and the resident is placed on 72hrs charting. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 96% compliance through May 2025.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON or designee will monitor all rehab screens are done upon admission, quarterly and as needed and ensure any recommendations are carried out. The DON will also do random observations for those residents with orthotic or other splinting devices to ensure the order is being followed. The DON will report the findings to the Quarterly QA monitoring meeting with a threshold of 97% through May 2025.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DSD will monitor quarterly and as needs arise all residents using any type of mechanical lift to ensure the right type of device/method is being used and explore other options if needed to ensure resident safety. The DSD will report the findings to the facility's Quarterly QA monitoring meeting through May 2025 with a threshold of 98% compliance.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Medical Records Coordinator will monitor for all new admissions that there is an order in place to monitor dehydration. If there is no order, nursing will be notified to obtain an order from the residents MD. The Medical Records Coordinator will report the**

**findings to the Quarterly QA monitoring meeting with a threshold of 98% compliance through May 2025.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON will do random observations for those residents who received dialysis to monitor that they have dialysis emergency supply kits at the bedside in their room. The DON will report the findings to the Quarterly QA monitoring meeting through May 2025 with a threshold of 98% compliance.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON or designee will do random observations to ensure that each of the locks are still properly placed on the refrigerators. The DON will report the findings to the facility's Quarterly QA monitoring meeting through May 2025 with a threshold of 100% compliance.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The MDS Coordinator will complete quarterly pre-restraining assessments for those residents with orders for any alarming devices. Additionally, the DON or designee will monitor that informed consents are in place, in-services will be done upon hire and annually. The DON or designee will report both findings at the quarterly QA monitoring meeting through May 2025 with a threshold of 97% compliance.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The DON will monitor, and audit all fall incidents and audit that fall risk evaluations are completed post fall for all fall incidents. All residents who have a fall will have fall risk evaluations done post fall. The DON will report with findings at the Quarterly QA monitoring meeting through May 2025 with a threshold of 96% compliance.**

*Achieved* 7-16-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**Artesia Christian Home SNF will develop recruitment and retention policies to increase insights into our turnover challenges by December 2025.**

*Achieved* 5-12-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Associate Director of Social Services/SSD will work to secure an appropriate provider/s who can provide therapy services & psychological assessments to residents in need of psychological support. The Associate Director of Social Services/SSD will report on the progress or challenges associated with this project to the facility's Quality**

**Assurance Performance Improvement quarterly monitoring meetings with a goal of securing providers as soon as possible.**

*Achieved* 4-2-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**The Associate Director of Social Services/SSD will work to secure an appropriate provider/s who can provide in-house dermatology services who would prefer or would be better served in the facility. The Associate Director of Social Services/SSD will report on the progress or challenges associated with this project to the facility's Quality Assurance Performance Improvement quarterly monitoring meetings with a goal of determining the feasibility of this type of provider as soon as.**

*Achieved* 3-28-25 *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

**2024 Achieved PIP's below:**

- ❖ The facilities department or designee will do quarterly checks in the housekeeping closets to ensure there is an 18 in clearance from sprinkler deflectors and will report data to the facility's Quarterly QAPI (Quality Assurance Performance Improvement) monitoring meeting with a threshold of 100% compliance through December 2024.

*Achieved* \_\_\_\_\_ *X* \_\_\_\_\_ *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

- ❖ The facilities department or designee will do quarterly checks on all corridor doors to ensure a positive latch and will report data to the facility's Quarterly QAPI (Quality Assurance Performance Improvement) monitoring meeting with a threshold of 100% compliance through December 2024.

*Achieved* \_\_\_\_\_ *X* \_\_\_\_\_ *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

- ❖ The DSD (Director of Staff Development) or designee will perform random audits during care to ensure residents' rights are being honored. The DSD or designee will report their findings to the facilities quarterly QAPI (Quality Assurance Performance Improvement) monitoring meeting with a threshold of 100% compliance through December 2024.

*Achieved* \_\_\_\_\_ *X* \_\_\_\_\_ *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

- ❖ The DON or designee will follow up with all rehab screens and ensure any recommendations are written on the form and orders carried out. The DON or designee will report the findings to the facilities quarterly QAPI (Quality Assurance Improvement) monitoring meeting with a threshold of 100% compliance through December 2024.

*Achieved* \_\_\_\_\_ *X* \_\_\_\_\_ *Continue* \_\_\_\_\_ *Modify* \_\_\_\_\_

- ❖ The IP (Infection Preventionist) Nurse or designee will continue to do random handwashing/hand hygiene observations with an increased focus related to medication pass. The IP nurse or designee will report their findings to the facilities quarterly QAPI

(Quality Assurance Improvement) monitoring meeting with a threshold of 100% compliance through December 2024.

Achieved  Continue  Modify

- ❖ The IP (Infection Preventionist) Nurse or designee will review each ATB order a resident receives and ensure there is completed documentation if the resident meets clinical criteria and if not that we have brought this to the prescribing doctor's attention and their response. The IP nurse or designee will report their findings to the facilities quarterly QAPI (Quality Assurance Performance Improvement) monitoring meeting with a threshold of 98% compliance through December 2024.

Achieved  Continue  Modify



ACH Board of Directors

# *Christmas Dinner*

Tuesday, December 2nd

5:30 PM

ACH Memory Care  
18105 Mundare, Artesia CA 90701

RSVP by Friday, November 28th  
562.865.5218 option 2  
email: [info@achome.org](mailto:info@achome.org)





## FY26 Artesia Christian Home Board Schedule

**Board Meetings - Fourth Tuesday of the Month unless otherwise noted**

January 27, 2026	4:00 pm-5:00 pm
February 24, 2026	4:00 pm-5:00 pm
March 24, 2026	4:00 pm-5:00 pm
April 28, 2026	4:00 pm-5:00 pm
May 26, 2026	4:00 pm-5:00 pm
June 23, 2026	4:00 pm-5:00 pm
July 21, 2026	4:00 pm-5:00 pm
AUGUST NO MEETING	
September 22, 2026	4:00 pm-5:00 pm
October 27, 2026	4:00 pm-5:00 pm
Thursday- November 5, 2026-Annual Meeting	5:30 pm -8:30 pm
November 24, 2026	4:00 pm-5:00 pm
DECEMBER NO MEETING	



## FY26 Artesia Christian Home Finance Committee Schedule

**Committee Meetings - Fourth Tuesday of the Month unless otherwise noted**

January 27, 2026	3:00 pm-4:00 pm
February 24, 2026	3:00 pm-4:00 pm
March 24, 2026	3:00 pm-4:00 pm
April 28, 2026	3:00 pm-4:00 pm
May 26, 2026	3:00 pm-4:00 pm
June 23, 2026	3:00 pm-4:00 pm
July 21, 2026	3:00 pm-4:00 pm
AUGUST NO MEETING	
September 22, 2026	3:00 pm-4:00 pm
October 27, 2026	3:00 pm-4:00 pm
November 24, 2026	3:00 pm-4:00 pm
DECEMBER NO MEETING	



## **FY26 Artesia Christian Home Promotions Committee Schedule**

**Committee Meetings – Second Wednesday of the Month @ Noon unless otherwise noted**

February 11, 2026	Noon
March 11th, 2026	Noon
April 8, 2026	Noon
May 13, 2026	Noon
June 10, 2026	Noon
July 8 2026	Noon
AUGUST NO MEETING	
September 9, 2026	Noon
October 7, 2026	Noon
November 11, 2026	Noon
DECEMBER NO MEETING	