DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155336	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHALET REHABILITATION AND HEALTHCARE CENTER	4851 TINCHER RD INDIANAPOLIS, IN 46221

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 26, 27, 28, 29, and 30, 2023 Facility number: 000229 Provider number: 155336 AIM number: 100266850 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 7 Medicaid: 44 Other: 26 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 7, 2023.	F 0000	7-25-2023 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Facility# 000229 Provider# 155336 AIM# 100266850 Re: Recertification and Licensure Survey Chalet Rehabilitation and Healthcare Center 4851 Tincher RD Indianapolis, IN 46221 Dear Ms. Buroker: On June 26,27,28, and 29 a Recertification and State Licensure Survey was conducted. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edward	Hughes	07/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			as of the date set forth in the Plan of Correction of June 25,2023 Please feel free to call me with any further questions at 317-856-4851. Respectfully submitted, Edward Hughes Executive Director, Chalet Healthcare and Rehabilitation	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation and interview, the facility failed to provide a reasonable accommodation of needs for 1 of 24 residents reviewed. A call light was out of reach. (Resident 25) Findings include: On 6/26/23 from 9:30 a.m. until 9:45 a.m., Resident 25 was observed in her room sitting in a broda chair with both eyes closed. The chair was facing the door to the resident's room. The chair was next to the resident's bed. The residents call light was observed to be out of the reach of the resident. On 6/26/23 from 10:30 a.m. until 10:45 a.m., observed Resident 25 in her room. The resident's call light was out of the reach of the resident.	F 0558	F- 558 Reasonable Accommodations Needs/Preferences The facility respectfully requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Call light provided for resident	07/25/2023

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	On 6/27/23 from 11:22 a.m. until 11:45 a.m., observed the same. On 6/28/23 from 9:30 a.m. until 9:45 a.m., observed the same. On 6/29/23 from 8:20 a.m. until 8:40 a.m., observed the same. During an interview on 6/26/23 at 9:45 a.m., LPN 1 indicated due to impaired cognition Resident 25 never used her call light. During an interview on 6/27/23 at 11:25 a.m., Resident 25's room mate indicated Resident 25 did not always have her call light in reach. During an interview on 6/28/23 at 8:20 a.m., the Director of Nursing (DON) indicated all residents should have a call light in reach. There was no reason for a resident to have a call light out of reach. On 6/28/23 at 8:28 a.m., the DON provided a policy titled Call light Policy, dated November 2020, and indicated it was the current policy being used by the facility. A review of the policy indicated "Purpose: To respond to the resident's requests and needs in timely manner...4. Call lights will be kept within the residents reach when in room...6. Check to ensure the call light is in the resident's reach prior to leaving room..." 3.1-3(v)(1)		#25 and clipped to linens within easy reach of resident. Care plan updated to reflect. 2. How the facility identified other residents: • Any resident that resides within the facility has the potential to be affected. • An audit was conducted to determine that call lights were accessible to facility residents, any areas of concern were immediately addressed. 3. Measures put into place/ System changes: • Staff educated on components of F558 Reasonable Accommodations Needs/Preferences, including accessibility of call lights. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing /designee who will audit call light accessibility for 15 residents 5 days weekly to include all shifts. • Concerns will be corrected when identified and reviewed during daily morning meetings as well as reviewed monthly during Quality Assurance Meeting. • Audits will continue daily to include all shifts for 6 months and or until 100% compliance is achieved for 3 consecutive months. • The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. 5. Date of Compliance 7-25-2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on interview and record review, the facility failed to develop and implement a comprehensive care plan for monitoring the side effects of psychotropic and antipsychotic medications for 1 of 5 residents reviewed for medication monitoring. (Resident 71) Finding includes: On 6/28/23 at 4:15 p.m., Resident 71's clinical record was reviewed. The diagnoses included, but were not limited to, post-traumatic stress disorder (PTSD), dementia in other diseases classified elsewhere, mild, with anxiety; unspecified mood (affective) disorder, and generalized anxiety disorder. Physician orders included, but were not limited to: - donepezil HCL (for treatment of behavioral and cognitive effects of cognitive effects of dementia)	F 0656	F656 Develop/Implement Comprehensive Care Plans The facility request paper compliance for this citation This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Identified resident #71 was assessed and the care plan	07/25/2023

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	tablet - give 5 mg (milligrams) by mouth one time a day for mood disorder, start date 2/20/23 and no stop date noted; - fluoxetine HCL (antidepressant) 20 mg capsule - give 1 dose by mouth one time a day for mood disorder, start date 2/20/23 and no stop date noted; and - zyprexa (antipsychotic) oral tablet 2.5 mg - give 1 tablet by mouth one time a day for mood disorder, start date 2/20/23 and no stop date noted. The Quarterly MDS (Minimum Data Set) assessment, dated 6/9/23, indicated Resident 71 was severely cognitively impaired, had anxiety disorder, PTSD, unspecified mood (affective) disorder, and dementia in other diseases classified elsewhere, mild, with anxiety. Resident received antipsychotic and antidepressant medications. Resident 71's care plan indicated: -"Resident is at risk of adverse reactions r/t [related to] antipsychotic medications, start date 3/29/23 and target date 8/13/23...will have no adverse reactions noted r/t psychotropic/antipsychoactive medications through next review...target date 8/13/23..."; -"Antidepressant medication use...start date 3/29/23..."; and -"Antipsychotic medication use...start date 3/29/23..." The clinical record indicated Resident 71's Physician prescribed zyprexa, donepezil HCL, and fluoxetine HCL on 2/20/23. The comprehensive care plan for monitoring the side effects of those		reviewed and revised to include monitoring of side effects for psychotropic and antipsychotic medications. 2) How the facility identified other residents: • An audit was conducted on those residents that currently receive psychotropic and antipsychotic meds to identify that side effect monitoring was present. • Care plans are initiated/reviewed upon admission-readmission, annually, quarterly, for significant change and as needed. • Care plans are additionally reviewed and updated as needed during scheduled care plan meetings. 3) Measures put into place/ System changes: • In-service conducted by MDS Coordinator for the interdisciplinary team to review procedures for development of comprehensive care plan and implementation of side effect monitoring for psychotropic and antipsychotic medications. • Resident care plans will be reviewed/updated on admission, readmission, change of condition, quarterly and annually, with significant change and as needed. 4) How the corrective actions will be monitored: • The Director of Nursing and MDS Coordinator will randomly review	

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	medications were not initiated until 3/29/23. During an interview on 6/29/23 at 1:11 p.m., the Director of Nursing Services (DNS) indicated the medication monitoring should have been included as part of the comprehensive care plan when those medications were prescribed. On 6/29/23 at 12:50 p.m., the DNS provided an undated copy of the Care Plans Protocol and indicated it was the current policy in use by the facility. A review of the policy indicated, "...care plan be completed or modified within 7 days of Completion date of comprehensive assessments. Facilities should also evaluate the appropriateness of the care plan...care plans should be revised on an on-going basis to reflect changes in the resident the care the resident is receiving...must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..." 3.1-35(a)		three residents ‘care plan records weekly ensuring that care plans have been developed that accurately reflect resident status and include side effect monitoring as required. • MDS coordinator will review during scheduled care plan meetings to ensure care plans are reflective of resident’s status. • Any issues identified will be immediately addressed. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance:	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State			

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	law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure the daily posted nurse staffing reflected the actual hours worked by staff for 5 of 5 days during the survey. Finding includes: During an observation on 6/26/23 at 11:00 a.m., the posted daily staffing lacked actual hours worked by staff. On 6/27/23 at 8:30 a.m., the same was observed. On 6/28/23 at 9:00 a.m., the same was observed.	F 0732	F-732 C Posted Nurse Staffing Information The facility respectfully requests a desk review for this citation. Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and	07/25/2023

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	On 6/29/23 at 8:45 a.m., the same was observed. On 6/30/23 at 8:10 a.m., the same was observed. During an interview on 6/30/23 at 9:15 a.m., the DON (Director of Nursing) indicated the facility should have included the actual hours worked on the daily staffing postings. On 6/30/23 at 1:15 p.m., the DON provided a policy, dated as revised on 11/2022 and titled, "Nursing Services - Nurse Staffing Information", and indicated it was the policy currently in use. The policy indicated, "The facility will post the following information daily: ...c. The total number and the actual hours worked..."		federal regulatory requirements. 1. Immediate actions taken for those residents identified: • Daily Nurse Staffing Information Posted. 2. How the facility identified other residents: • Residents residing in the facility have the potential to be affected but no resident was identified to have been. 3. Measures put into place/ System changes: • Nursing staff/ Department heads educated on requirements of F-698 Posted Nurse Staffing Information. 4. How the corrective actions will be monitored: • The responsible party for this plan of correction is the Administrator/Designee who will review posted nurse staffing hours information 2 times weekly and or until 100% compliance has been met for 3 consecutive months, at which time the QA committee can make recommendations to revise the plan of correction. • Results of posting reviews will be taken to QA meeting monthly to identify trends and analysis. 5. Date of Compliance	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs			

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	of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.			
	Based on interview and record review, the facility failed to obtain orders for a laboratory services for 3 of 3 residents reviewed. (Resident 28, Resident 29, Resident 71). Findings include: 1. On 6/26/23 at 11:45 a.m., Resident 28's clinical record was reviewed. Resident 28's diagnosis included, but was not limited to, Type II diabetes melllitus (a chronic condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). Resident 28's physician orders were reviewed. Resident 28 had an order with an active status for an Hgb A1C test for every 3 months; the order date was for 2/8/23 and the order lacked a start date or an end date. On 6/29/23 at 9:55 a.m., Resident 28's pharmacy recommendations were reviewed. A pharmacy record review, dated for 4/20/23, indicated missing lab results for Resident 28. The recommendation stated, "Resident [28] has a lab order for an AC [the A1C test-also known as the hemoglobin A1C or HgbA1c test-is a simple blood test that measures your average blood sugar levels over the past 3 months] to be drawn q [every] 3 months. Results were unavailable in the record at the time of review." The pharmacy recommendation also included the following handwritten statements of, "initial lab order on	F 0770	F 770 D Laboratory Services The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: • Residents # 28, 29, and 71 had lab orders reviewed with physician and obtained as ordered. 2) How the facility identified other residents: • Lab audit was conducted of facility residents. Any discrepancies were reviewed with physician and labs were obtained as ordered.	07/25/2023

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	2/8/23" and "April draw performed on 4/28/23". On 6/29/23 at 1:05 p.m., the DON (Director of Nursing) indicated that Resident 28's Hgb A1C blood draw laboratory test should have been entered with a start date and should have been drawn when the order was placed in February. 2. On 6/28/23 at 2:31 p.m. the clinical record of Resident 29 was reviewed. The diagnosis included, but was not limited to, Diabetes Mellitus with diabetic autonomic (poly) neuropathy (a type of nerve damage caused by diabetes). Physician orders included, but were not limited to to the following: -"Lab - A1C [a simple blood test that measures your average blood sugar levels over the past three months to help the health care team manage diabetes] every three months due 11/21/22 every 90 days ...start date 11/18/2022 and no stop date noted ..."; The monthly Consultant Pharmacist Recommendation documents indicated the following: - The monthly pharmacy review, dated 1/19/23, indicated "Resident has a lab order for A1C q [every] 3 months ordered on 11/18/22 for draw on 11/21/22. Results were unavailable in the record at time of review. Please follow up with lab to have results forwarded or lab scheduled to be drawn." - The monthly pharmacy review, dated 6/19/23, indicated "Resident has a lab order for A1C q [every] 3 months that was due in May. Results were unavailable in the record at time of review. Please follow up with lab to have results forwarded or lab scheduled to be drawn."		• Pharmacy recommendations were reviewed for the past 30 days to determine that lab recommendations were noted. Any discrepancies were immediately addressed. 3) Measures put into place/ System changes: • New admissions and re-admissions orders will be reconciled by 2 nurses to include labs to verify accuracy. Labs will be drawn as ordered. • Nurses were educated on ensuring lab orders were entered as ordered with start and stop dates. • New lab orders will be reviewed during regularly scheduled morning/clinical meetings. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing/designee who will audit new orders 5 days weekly for accuracy of lab orders and results. • The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	During an interview on 6/29/23 at 2:47 p.m., the Director of Nursing Services (DNS) indicated Resident 29's physician orders for the A1C labs should have been drawn and monitored. 3. On 6/28/23 at 4:15 p.m. the clinical record of Resident 71 was reviewed. The diagnosis included, but were not limited to, Type 2 Diabetes Mellitus (DM) with diabetic neuropathy (a type of nerve damage caused by diabetes), Type 2 DM with unspecified complications, and acute kidney failure. The monthly Consultant Pharmacist Recommendation document, dated 6/19/23, indicated "This resident has diabetes with no A1C level [a simple blood test that measures your average blood sugar levels over the past three months to help the health care team manage diabetes] available from the past 6 months. Please consider A1C level at this time and every 6 months thereafter..." During an interview on 6/29/23 at 2:47 p.m., the Director of Nursing Services (DNS), indicated Resident 71 should have had scheduled routine AIC lab draws. During an interview, on 6/30/23 at 8:47 a.m., the DNS indicated nursing staff should have clarified with Resident 71's physician and obtained the routine A1C lab draws. On 6/29/23 at 12:00 p.m., the DNS provided a copy of the Physician Orders Policy/Guidelines document, dated November 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...physician orders are reviewed and noted accordingly per licensed		5) Date of compliance: 7-25-2023	

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	155336	A. BUILDING 00 B. WING	06/30/2023

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	nursing staff...nursing responsibilities: current medications orders plus allergies and pertinent laboratory test results...new orders will be reconciled by 2 nurses to verify accuracy..." On 6/30/23 at 9:05 a.m., the Administrator provided a copy of the Diagnostic - Laboratory - Radiology policy, dated November 2022, and indicated it was the current policy in use by the facility. A review of the policy indicated. "...The facility will provide or obtain laboratory services to meet the needs of its residents and will be responsible for the quality and timeliness of the services...the facility will file in the resident's clinical record...diagnostic reports..." 3.1-49(a)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a clean homelike environment for 4 of 24 rooms observed. Liquid was on the floor and commodes were dirty. (Resident 24, Resident 182, Room 9, Room 10, Room 21) Findings include: 1. On 6/28/23 from 10:30 a.m. until 10:40 a.m., a thick clear, slick liquid was observed on the floor in front of Resident 24's bathroom. No staff were present. At 10:45 a.m., Housekeeper 2 was observed to clean the area. Housekeeper 2 indicated that Resident 24 spits on the floor.	F 0921	F 921 D Safe/Functional/Sanitary/Comfortable Environ The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	07/25/2023

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	On 6/29/23 from 11:06 a.m. until 11:10 a.m., a thick clear, slick liquid was observed on the floor in the hall next to the beauty shop. 2. During an interview 6/29/23 at 10:30 a.m., Resident 182 indicated his commode had "been nasty since he had been admitted to the facility." On 6/30/23 at 9:45 a.m., observed the commode in Room 9 to have a dark brown area approximately 1/4 inch in width, on the floor surrounding the commode. On 6/30/23 at 10:00 a.m., observed the commode in Room 10 to have a dark brown area approximately 1/4 inch in width, on the floor surrounding the commode. On 6/30/23 at 10:10 a.m., observed the commode in Room 21 to have a dark brown area approximately 1/4 inch in width, on the floor surrounding the commode. During an interview on 6/30/23 at 10:11 a.m., Housekeeper 2 indicated she was not sure what the substance on the floor surrounding the commode was or how to remove it. During an interview on 6/30/23 at 10:12 a.m., Housekeeper 3 indicated several commodes had the same dark brown area surrounding the commode. Staff were supposed to put a work order in when they see it. During in interview on 6/30/23 at 10:15 a.m., the Housekeeping Supervisor indicted she tried to use a tool (putty knife) to remove the stained area. She indicated, "It's the caulking" it needed to be replaced. Maintenance would be who needed to replace the caulking. "We would have normally		deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • No resident was identified to have been affected. • Identified areas were placed on cleaning schedules. (Room 9, 10, 21, Resident 24, Resident 182) • A facility wide audit was completed to identify commodes that needed caulking removed and repaired. 2)How the facility identified other residents: • No resident was identified to have been affected related to cleaning concerns identified. • Facility wide walk through was completed by Administrator, Housekeeping and Maintenance Supervisor to identify needed cleaning concerns, to include resident rooms, and visitor facilities. 3)Measures put into place/ System changes: • Angel Rounds will be completed 5 times weekly to identify any areas of needed cleaning and reviewed in scheduled stand-up meeting. • An audit was conducted of resident and visitor bathrooms to	

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	put in a work order." During an interview at 10:30 a.m., the Maintenance Director indicated he did not have any current work orders and was unaware of the areas around the commodes. On 6/30/23 at 11:40 a.m., the current work orders were reviewed. The current work orders lacked any orders to fix the commodes. On 6/30/23 at 11:14 a.m., the Director of Nursing provided a policy titled Safe/Clean Environment, dated 11/2020, and indicated it was the current policy being used by the facility. A review of the policy indicated "...5. The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public." 3.1-19(f)		determine needed areas of cleaning. • Maintenance Supervisor scheduled replacement of caulking to commodes noted to need removal. • Housekeeping will schedule cleaning of Resident #24 room 2 times daily. 4)How the corrective actions will be monitored: • The responsible party for this plan of correction is the joint effort of the Executive Director/Maintenance Director/Housekeeping Supervisor who will round weekly to identify needed repairs and or cleaning needs. • Identified areas requiring repair are placed on a Preventative Maintenance log for follow up. • Identified areas requiring additional cleaning will be placed on a cleaning schedule for follow up. • The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months. • The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 7-25-2023	

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