

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 3 and 4, 2016</p> <p>Facility number: 003282 Provider number: 003282 AIM number: N/A</p> <p>Census bed type: Residential: 77 Total: 77</p> <p>Sample: 7</p> <p>These state findings were cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by 21662 on March 7, 2016.</p>	R 0000	<p><b>DISCLAIMER: Preparation and implementation of this plan of correction does not constitute admission or agreement by Rittenhouse SeniorLiving of Indianapolis of the truth of the facts, findings, or other statements as alleged by the preparer of the survey /inspection dated June 5, 2014. RittenhouseSenior Living of Indianapolis specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider.</b></p>	
R 0095  Bldg. 00	<p>410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:</p> <p>(1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia.</p> <p>Based on interview and record review, the facility failed to ensure the Memory Care Director had 12 hours of Dementia specific training within 3 months of her employment as the Memory Care Director for 1 of 1 employees reviewed for dementia specific training. (Memory Care Director)</p> <p>Findings include:</p> <p>The Employee records were reviewed on 3/4/16 at 9:00 a.m.</p> <p>A document titled "Certificate of</p>	R 0095	<p>R095 Administrationand Management</p> <p>1.What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice: The programdirector will enroll and complete the 12 hours of dementia specific training. How the facility will identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken: All residents havethe potential to be affected.</p> <p>2.What measures will be put into place or what systemicchanges the facility will</p>	04/04/2016

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R 0120 Bldg. 00	<p>Achievement" dated 5/23/14, provided by the Memory Care Director on 3/4/16 at 3:00 p.m., indicated she was presented the certificate in recognition of the completion of 6 hours of Dementia Training on 5/23/14. The Memory Care Director did not have twelve hours of dementia training available to provide. At that time, the Memory Care Director indicated she had only been the Memory Care Director since July 2016. She indicated she had six hours dementia training on 5/23/14, and did not have the required 12 hours of dementia training prior to starting the position.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of</p>		<p>make to ensure that the deficient practice does not recur: Executive director will review the training of any program director hired in the future to ensure they have the required 12 hours of dementia training.</p> <p>3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Executive Director will monitor in-service training to ensure Program Director receives 6 hours of training yearly on an ongoing basis</p> <p>1. Date of completion: 4/4/16</p>	

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	<p>specialized populations served, medication administration, and nursing care, when appropriate, as follows:</p> <p>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure facility staff had 3 hours of dementia training annually for 5 of 5 employees reviewed for dementia training. (Activities #2, Cook #3, CNA #4, LPN #5, and CNA #6)</p> <p>Findings include:  The Employee records were reviewed on</p>	R 0120	R120 Personal  1.What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice: Staffwill be in-serviced in dementia training.  2. How the facility will identify other residents havingthe potential to be affected by the	04/04/2016			

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	<p>3/4/16 at 9:00 a.m.</p> <p>1. A document titled "Certificate of Achievement" dated 7/25/14, provided by the Resident Care Director (RCD) on 3/4/16 at 8:05 a.m., indicated an Activities staff member #2 was presented with a certificate in recognition of the completion of 6 hours of Dementia Training on 7/25/14. The Activity Staff member #2 lacked three hours of dementia training in her employee record.</p> <p>2. A document titled "Certificate of Achievement" dated 9/6/06, provided by the Resident Care Director (RCD) on 3/4/16 at 8:05 a.m., indicated Cook #3 was presented with a certificate in recognition of the completion of 6 hours of Dementia Training on 9/6/06. The Cook #3 lacked three hours of dementia training in her employee record.</p> <p>3. A document titled "Certificate of Achievement" dated 9/6/06, provided by the Resident Care Director (RCD) on 3/4/16 at 8:05 a.m., indicated CNA #4 was presented with a certificate in recognition of the completion of 6 hours of Dementia Training on 9/6/06. The CNA #4 lacked three hours of dementia training in his employee record.</p> <p>4. A document titled "Certificate of</p>		<p>same deficient practice and what corrective action will be taken. All resident have the potential to be affected</p> <p>3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: An in-service calendar will be prepared by the Executive Director and followed to ensure all staff will receive required training. Staff attendance will be recorded to track who has attended and opportunities provided to those who were unable to attend.</p> <p>1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Executive Director will monitor to make sure the in-services on the calendar are completed and staff are attending the required training.</p> <p>3. By what date the systemic changes will be completed:</p> <p>4. Date of Completion: 04/04/2016</p>	

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	<p>Achievement' dated 7/23/14, provided by the Resident Care Director (RCD) on 3/4/16 at 8:05 a.m., indicated LPN #5 was presented with a certificate in recognition of the completion of 6 hours of Dementia Training on 7/23/14. LPN #5 lacked three hours of dementia training in her employee record.</p> <p>5. A document titled "Certificate of Achievement' dated 9/6/06, provided by the Resident Care Director (RCD) on 3/4/16 at 8:05 a.m., indicated CNA #6 was presented with a certificate in recognition of the completion of 6 hours of Dementia Training on 9/6/06. The CNA #6 lacked three hours of dementia training in her employee record.</p> <p>During an interview on 3/4/16 at 12:15 p.m., the Memory Care Director indicated she did her dementia training from June to June every year or survey to survey, since their surveys were in June. She indicated she in-serviced the facility staff a "little" at a time on dementia, usually in 30 minute increments every month. She indicated she just started the Memory Care Director position in July 2015, so she had not gotten three hours of dementia training completed for each facility staff member for the year 2015. She indicated she thought she had until June 2016. She indicated she could not</p>			
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R 0122 Bldg. 00	"catch" all the facility staff members to in-service them on dementia, but she tried to get the staff members who primarily worked on the dementia unit trained at least monthly on a "little" bit of dementia.  410 IAC 16.2-5-1.4(g) Personnel - Deficiency (g) The facility must prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease. An employee with signs and symptoms of communicable disease, including, but not limited to, an infected or draining skin lesion, shall be handled			

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	<p>according to a facility's policy regarding direct contact with residents, their food, or resident care items until the condition is resolved. Persons with suspected or proven active tuberculosis will not be permitted to work until determined to be noninfectious and documentation is provided for the employee record.</p> <p>Based on observation, interview and record review, the facility failed to ensure a dietary staff member was free of cold symptoms in the food preparation area for 1 of 4 dietary staff members reviewed for employee health. (Dietary Manager)</p> <p>Findings include:</p> <p>On 03/03/2016 at 9:35 a.m., the Dietary Manager entered the kitchen. Her voice was audibly hoarse and she was sniffing. She indicated she had a cold.</p> <p>On 03/03/2016 at 11:45 a.m., the Dietary Manager was observed wearing a yellow mask beneath her chin. She performed a temperature check of prepared crab salad and placed uncovered, cooked green beans into the dietary cart to be delivered to the resident halls.</p> <p>On 03/03/2016 at 3:00 p.m., the Dietary Manager indicated she had a cold and it was getting worse. She indicated if she did not get better, she would need to go to the doctor to get an antibiotic. Her</p>	R 0122	<p>R122 Personnel What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Dietary manager was instructed to wear a mask whilein the community. Dietary manager wasafebrile. How the facilitywill identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken: All resident havethe potential to be affected. What measures will be put into place or what systemic changes the facility will make to ensurethat the deficient practice does not recur: Dietary manager was educated onproper use of the mask while in the food prep area and facility communicabledisease policy. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: Executive Director will monitor on an ongoing basis. By what date thesystemic changes will be completed: Date of Completion:04/04/2016</p>	04/04/2016			

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R 0217 Bldg. 00	<p>voice was audibly hoarse and she was sniffing.</p> <p>On 03/03/2016 at 3:20 p.m., the Executive Director (ED) indicated she would have the Dietary Manager wear a mask while at work.</p> <p>A current policy titled, "COMMUNICABLE DISEASES POLICY", undated, provided by the ED on 03/03/2016 at 3:20 p.m., indicated, "...Staff with communicable diseases will be excluded from...handling food..."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and</p>			
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	<p>(D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to update the service plan to reflect services provided for fall safety for 1 of 7 residents reviewed for service plans. (Resident # 79)</p> <p>Findings include:</p> <p>Resident #79's record was reviewed on 3/3/16 at 2:00 p.m. Diagnoses included, but were not limited to, depression, hypertension, osteoporosis and insomnia</p> <p>A document titled "Resident Evaluation/Service Plan For Residential Care" dated 1/12/16, provided by the Resident Care Director on 9/2/16 at 4:47 p.m., lacked documentation the resident</p>	R 0217	<p>R217 Evaluation What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: All service plans will be reviewed and updated toreflect resident's current condition. How the facilitywill identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken: All resident havethe potential to be affected so all service plans will be audited. What measures willbe put into place or what systemic changes the facility will make to ensurethat the deficient practice does not recur: Physician orders will be reviewedwhen written and used to update the service plans with any</p>	04/04/2016

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	<p>had frequent falls and urinary tract infections. The Mobility section under the Services provided indicated the boxes for "Monitor use of assistive device (specify) w/c [wheelchair], walker" and Other: "PT [Physical Therapy] /OT [Occupational Therapy] as indicated." were checked. The Transfer section under the Services provided indicated the boxes for "Supervise transfer to and from bed prn [as needed]" and "Supervise transfer to and from chair prn" were checked. The Toileting section under Services provided indicated the box for "Assist with toileting care, including use of adult briefs" was checked.</p> <p>Resident #79 had falls on the following date and times: 9/27/15 at 10:30 a.m.--she was found on the floor by the CNA. The resident indicated she was using her walker in her room and reached for her wipes on the counter, lost her balance and fell backwards and fell onto her buttocks.</p> <p>9/28/15 (time not determined)--the resident was found on the bathroom floor in her apartment lying on her right side. She fell attempting to transfer from the toilet to the wheelchair.</p> <p>11/14/15 at 10:06 p.m.--the resident was found on the floor in her room away from</p>		<p>changes. Unusual occurrences will be reviewed and interventions will be added to service plan as appropriate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Director of Nursing Services or designee will monitor service plans, 24 hour reports, unusual incidents and physician orders to determine if interventions need to be added to the service plan. Monitoring will occur on an ongoing basis. By what date the systemic changes will be completed: Date of Completion: 04/04/2016</p>	

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	<p>the foot of the bed close to the ice box. She indicated she was searching for a cold coke and lost her balance.</p> <p>11/21/15 at 12:00 p.m.--a CNA found the resident when she went to get her up for lunch. She was in the recliner and when she transferred from the recliner to the wheelchair she lost her balance and tipped over onto her left side.</p> <p>Resident #79 orders for antibiotics for Urinary Tract infections on the following dates and times: 9/11/15--Cipro (an antibiotic medication) 500 mg (milligrams) by mouth twice daily for 14 days.</p> <p>10/4/15--Nitrofurantoin (an antibiotic medication) 100 mg by mouth twice daily for 10 days.</p> <p>10/27/15--Macrobid (an antibiotic medication) 100 mg by mouth twice daily for 10 days.</p> <p>12/10/15--Septra DS (Double Strength) (an antibiotic medication) by mouth twice daily for 10 days.</p> <p>During an interview on 3/3/16 at 4:30 p.m., the Resident Care Director indicated the resident had a history of Urinary Tract infections prior to her</p>			

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R 0300 Bldg. 00	<p>admission. She indicated she had not addressed her frequent falls or Urinary Tract infections on her service plan.</p> <p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.</p> <p>Based on observation, interview and record review, the facility failed to ensure expired medications were discarded appropriately for 2 of 2 medication storage rooms. (Resident's #15, #80 and #46)</p> <p>Findings include:</p> <p>On 03/03/2016 at 11:00 a.m., a bottle of medication labeled Torsemide (a diuretic medication) 20 mg (milligrams) was observed for Resident #15, in an overflow medication storage cabinet. The expiration date on the bottle cap indicated 01/2016. At that time, LPN #1 indicated the medication was expired and Resident #15 was in "Rehab"</p>	R 0300	R300 PharmaceuticalServices What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: All expired meds were immediately removed anddisposed of in accordance with facility policy. How the facilitywill identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken: All resident havethe potential to be affected. Medication carts, overflow cabinets and medrefrigerators will be audited to ensure there are no expired medications. What measures willbe put into place or what systemic changes the facility will make to ensurethat the deficient practice does not recur:	04/04/2016

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NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260			
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	<p>(Rehabilitation).</p> <p>On 03/04/2016 at 2:00 p.m., Resident #15's record review was completed. Medications included, but were not limited to, Torsemide 20 mg one tablet twice daily by mouth. The resident's record lacked a disposition form indicating the medication had been destroyed.</p> <p>On 03/03/2016 at 2:10 p.m., a box of medication labeled Bisacodyl (a medication for constipation) 10 mg was observed for Resident #80 in the nurses station refrigerator on the Memory Care Unit. The label located on the exterior of the medication box indicated the expiration date was 12/20/2014. At that time, the Memory Care Director indicated Resident #80 had been discharged.</p> <p>On 03/04/2016 at 2:07 p.m., Resident #80's record review was completed. Medications included, but were not limited to, Bisacodyl 10 mg insert one suppository rectally every day as needed for constipation. The resident's record lacked a disposition form indicating the medication had been destroyed.</p> <p>On 03/03/2016 at 2:15 p.m., a bottle of Azasite 1% ophthalmic solution (an</p>		<p>All nurses and QMAs will be in-service on facility policy regarding expired meds on each shift. Pharmacy will audit the carts, overflow and refrigerators monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Director of Nursing will review the pharmacy report and follow up with any identified issues immediately. Executive Director will monitor the pharmacy report and corrections. Both the DON and ED will monitor on an ongoing basis. By what date the systemic changes will be completed: Date of Completion: 04/04/2016</p>				

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	<p>antibiotic eye drop) was observed for Resident #46 in the nurses station refrigerator on the Memory Care Unit. The label indicated the resident started the medication on 02/23/2016 and completed the medication on 02/29/2016. At that time, the Memory Care Director indicated the medication had been discontinued.</p> <p>On 03/04/2016 at 2:15 p.m., Resident #46's record review was completed. Medications included, but were not limited to, Azithromycin (Azasite) ophthalmic solution 1% one drop to both eyes twice daily for seven days. The resident's record lacked a disposition form indicating the medication had been destroyed.</p> <p>A current policy titled, "...MEDICATION DESTRUCTION" dated 01/01/05, provided by Memory Care Director on 3/3/16 at 3:00 p.m., indicated: "...Discontinued medications ... are destroyed in the facility...1. Unused portions of any medication/treatment which cannot be returned to pharmacy are to be destroyed in the facility when the medication is discontinued, expired, or the resident has been discharged...6. The nurses or pharmacist witnessing the destruction ensures... information is entered on the medication disposition</p>						

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NAME OF PROVIDER OR SUPPLIER  RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 W 96TH ST INDIANAPOLIS, IN 46260
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R 0408 Bldg. 00	<p>form within seven (7) days of the discontinuation...."</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure a resident had a Chest X-ray completed prior to admission for 1 of 4 new admission records reviewed. (Resident #78)</p> <p>Findings include:</p> <p>Resident #78's record was reviewed on 3/3/16 at 11:59 a.m. Diagnoses included, but were not limited to, hypertension, depression and Congestive Heart Failure.</p> <p>The resident was admitted to the facility on 10/1/15.</p> <p>A Nurse's note, dated 10/1/15 at 6:00 p.m., indicated a Chest X-ray for</p>	R 0408	R408 InfectionControl What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Chest x-ray was done as soon as possible afteradmission. Resident refused x ray on day of admission so in the futureresidents will not be admitted without the chest x-ray being completed. How the facilitywill identify other residents having the potential to be affected by the samedeficient practice and what corrective action will be taken: All resident havethe potential to be affected. The Director of Nursing Services or designee willaudit all resident charts ensure all residents have pre-admission x-ray and ifnot, will arrange for an x-ray for affected residents. What measures	04/04/2016

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	<p>admission was attempted, but the resident refused. The Chest X-ray was rescheduled for the next morning.</p> <p>A Nurse's note, dated 10/2/15 at 12:00 p.m., indicated a Chest X-ray for admission was completed.</p> <p>During an interview on 3/4/16 at 10:31 a.m., the Resident Care Director indicated Resident #78 did not have any other Chest X-ray prior to being admitted to the facility.</p>		<p>will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: Marketing Director was educated on proper pre-admission procedures which include making sure each resident, prior to admission has a physical and chest x-ray. The Director of Nursing Services will review each resident medical documentation prior to admission to ensure the chest x-ray is completed. Residents will not be signed in to the community nor admitted unless all pre-admission procedures, which includes chest x-ray, are complete. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Executive Director or designee will review the pre-admission documentation prior to sign in to ensure it is complete. New resident Notice form is completed prior to admission or at sign-in and has a check off for chest x-ray. Executive Director and Director of Nursing Services or designee will review the New Resident Notice Form for completion of all needed items. These items will be monitored by the parties above on an ongoing basis. By what date the systemic changes will be completed: Date of Completion: 04/04/2016</p>	