

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 05/16/2016
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NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200124.</p> <p>Complaint IN00200124 - Substantiated. A State deficiency related to the allegations is cited at R90.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates May 12 & 16, 2016</p> <p>Facility number: 005722 Provider number: 005722 AIM number: N/A</p> <p>Census payor type: Other: 113 Total: 113</p> <p>Sample: 3</p> <p>These State findings are cited in accordance with IAC 16.2-5.</p> <p>Q.R. completed by 14466 on May 18, 2016.</p>	R 0000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. The facility respectfully requests an IDR for R 052.	

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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R 0033 Bldg. 00	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following:</p> <p>(1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility.</p> <p>(2) The most recently known addresses and telephone numbers of the following:</p> <p>(A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services.</p> <p>The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate.</p> <p>Based on observation and interview, the facility failed to ensure resident rights information and names of community advocates were posted in an area visible to all the residents of the facility.</p> <p>Findings included:</p> <p>During the survey, observation of the Resident Rights and names of community advocates information was located in the elevators. The information was not observed to be posted anywhere else nor a posting of where the information could be found.</p>	R 0033	<p>R033-- Resident's Rights (Noncompliance) 1. No residents were affected by the alleged deficient practice. At the time of survey, there were Resident Rights posters observed by the surveyor in both elevators, however, there was a poster located in the residents' mail room that was in place prior to the survey and not recognized. The facility will place three more posters with the appropriate contact information with one in the front lobby area and one outside of each nurses' station.</p> <p>2. All residents have the potential to be affected by the</p>	06/15/2016

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R 0052 Bldg. 00	<p>During an anonymous interview with a resident's family, they indicated they could not find who the Ombudsman was for the facility. The family was informed advocate information was posted in the elevator. Family indicated they at that time, "we never get on the elevator."</p> <p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from physical abuse for 1 of 1 resident reviewed for abuse in a sample</p>			R 0052	<p>alleged deficient practice. General Manager has conferred with the Resident Council President and will provide information to all residents about where to locate community advocates contact information at the next scheduled Resident Council meeting on June 1, 2016. 3. Regional Operations Manager will provide training to General Manager on placement and monitoring of resident rights information and names of community advocates on June 3, 2016. 4. General Manager and/or designee will conduct resident interviews to ensure awareness of resident right and community advocate information weekly x4 weeks, monthly x2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p> <p>R052-- Resident's Rights (Offense) 1. When the day shift aide on May 10 observed abrasions on Resident #B and reported them to the nurse, the</p>		06/15/2016

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	<p>of 3 (Resident #B).</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 5/12/16 at 12:30 p.m. Diagnoses for Resident #B included but were not limited to, dysphagia, dementia with behaviors, insomnia and difficulty walking. The resident was dependent on staff for mobility and transfers and was unable to move about safely without assistance.</p> <p>A nursing note dated 5/9/16 (no time), indicated Resident #B was found lying on the floor beside his bed with a pillow under his head. The resident did not have his pendant (call light resident wears around his neck). The call pendant was found hanging on the far side of the headboard in his room and not within Resident #B's reach. The resident could not tell how long he had been on the floor.</p> <p>Review of the call light report provided by the General Manager on 5/12/16 at 4:10 p.m., indicated Resident #B had pressed his call light on 5/9/16, 33 times ("event" and would be reset "clear" by unknown staff) between 12:17 a.m., and 4:37 a.m. CNA # 4 worked the night shift.</p>		<p>Abuse Prevention Policy, Reporting and Investigation were initiated. A full interval investigation was performed within the community. The incident was reported to ISDH on 5/10/16. The identified employees were immediately suspended pending investigation, and both employees were terminated following investigation. Greenwood Police were contacted with a report filed. Resident #B received a physical assessment and was also sent to Community Hospital South for further evaluation. Resident #B received hourly checks to monitor, a neuropsychological evaluation, and was provided an overnight 1:1 caregiver following the incident. The resident continued to be monitored for physical and psychosocial well being. His care plan and behavior interventions were reviewed and updated by the nursing team. The team met with the responsible party to review investigation findings and updated behavior interventions. The investigation did not confirm that Resident #B's abrasions were the result of abuse by the night shift C.N.A. but rather may have been caused when the resident fell and crawled on the carpet causing "rug burns." Several of the abrasions were from prior similar episodes when the resident attempted to get out of bed without assistance. The</p>				

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	<p>An undated statement written by LPN #5 indicated she had gone into Resident #B's room with CNA #4 (at the beginning of the shift) because, the resident had hidden his pendant. LPN #5 also indicated in that statement, Resident #B was very agitated toward the CNA, trying to hit him with his phone and yelling he was a robber.</p> <p>An undated document titled "Resident #B Abuse Allegation Investigation Document" provided by the General Manager on 5/12/16 at 12:30 p.m., indicated LPN #5 reported CNA #4 had told her he had previously taken away Resident #B's pendant, because he uses it a lot.</p> <p>A nursing note dated 5/10/16 at 8:30 a.m., indicated LPN #1 was called to Resident #B's room by the day shift CNA because the resident had multiple abrasions on his body. The nurses note also indicated the resident had told her, "the man, the thief" came into his room and attempted to take his pendant (call light) so he was being combative. The resident also stated "the man dragged him across the floor." Nurses notes also indicated she saw blood in multiple areas of the carpet from the side of the bed to the center of the room in the resident's</p>		<p>blood observed on the carpet was not all fresh from the night shift on May 9 but from prior similar episodes. 2. General Manager and Director of Nursing will audit resident charts, 24-hour reports, and call pendant information for any signs of abuse. If any signs of abuse are found, the facility will report the situation to all appropriate entities immediately and a complete investigation will be performed by the facility.</p> <p>3. General Manager will provide abuse, resident rights and abuse prevention in-service training for all staff members on 6/3/2016 with all training sessions completed by 6/15/2016. The training in-service will include types and definition of abuse, signs of abuse, indicators of abuse, protection of resident, reporting abuse, and abuse investigations. The Director of Nursing will also provide call pendant response, communication, and 24-hourreport training for all nursing staff members on 6/14/2016. Regional Operations Manager will in-service Director of Nursing, General Manager and Business office Manager on the screening protocol steps to take for abuse prevention, steps to take to protect a resident if abuse has occurred, steps to take to investigate reports of abuse, and required reporting actions to take for reports of abuse. The facility will continue to follow the Abuse</p>		

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	<p>apartment.</p> <p>The assessments for the abrasions on Resident #B from the DON and LPN #1 were indicated as follows: right side of the forehead-0.5 x 0.5 cm center back-8.4 cm, right side of wrist-2.2 x 2 cm, right center knee-1.5-x 2 cm and 4 x 2.5 cm, right outer knee-5 x 3 cm and 2 x 2 cm, right great toe-0.5 x 0.3 cm, left inner knee-2.2 x 1 cm and 3 x 3 cm left shin-0.4 x 0.1 cm, 0.4 x 0.1 cm, 1 x 0.1 cm, 1.2 x 0.6 cm and 3.5 x 0.5 cm</p> <p>Review of the call light report provided by the General Manager on 5/12/16 at 4:10 p.m., for 5/10/16, indicated Resident #B pressed his call light 19 times ("event" and would be reset "clear" by unknown staff) between 2:09 a.m., and 2:40 a.m. The call light was not utilized again until 10:13 a.m. CNA #4 worked the night shift.</p> <p>Resident #B was sent to the hospital for treatment and evaluation. Injuries reported by Center of Hope: facial abrasions, bruising in ribs, left cheek facial abrasions, skin tear right lateral wrist, hip, right great toe, right knee abrasions, back tenderness, back left hand abrasions , scabbing and left leg</p>		<p>Prevention Policy and Procedures. The facility provides Abuse Prevention and Resident Rights training to all new hires, annually and as necessary to all employees. 4. Director of Nursing will review 24 hour reports x3/weekly x4 weeks, weekly x2 weeks and monthly thereafter to ensure proper employee reporting of alleged or potential abuse situations. Charge nurses on every shift will thoroughly review 24-hour report and verbal reporting for any situations that would present concerns of abuse or potential for abuse daily. General Manager will interview residents to ensure they remain free from any forms of abuse twice weekly x2weeks, weekly x4 weeks, monthly x2 months and quarterly thereafter. GM will audit x3 new employee records per week x4 weeks and monthly thereafter to ensure appropriate screening protocol steps are followed. ROM will audit every report of abuse monthly x6 months and quarterly thereafter to ensure proper protection, investigation and reporting procedures have been followed. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. IDR – R052 The Hearth takes great pride in caring for the health and well-being of those we serve. We are an</p>	

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	<p>abrasions, skin tears scabbing down shin of right lower leg (no times noted) Resident #B's statement taken at the Center of Hope indicated, "Resident _____ [name, date of birth, and age], was in his room and states that someone came into his room and tried to take his call button around his wrist. [sic] They kicked him in the ribs and he has various injuries."</p> <p>During an interview on 5/11/16 at 8:20 p.m., the hospital Forensic Nurse indicated Resident #B's story was consistent that a man tried to rob him of his call light and threw him across the room (pictures were provided, of the wounds, on a disk).</p> <p>During an interview on 5/12/16 at 1:15 p.m., with Resident #B (son also present), he indicated a "robber" had tried to grab his pendant. The son indicated his father had reported to him previously about the "robber" on multiple occasions, but it was not reported to the staff because they thought Resident #B was confused. Resident B's son also indicated he has found the pendant in the room in various places that he didn't think his father could get to by himself, on the dresser across the room, on the other side of the headboard, and under the bed.</p>		<p>organization committed to the safety, respect and dignity of our residents and any type of abuse or mistreatment is strictly prohibited. The Hearth at Stones Crossing's response to any allegation of abuse or mistreatment is swift and thorough. As such and because we do not agree with all conclusions as cited in complaint IN00200124 at R052, we respectfully request an Informal Dispute Resolution hearing. We continue to believe that our investigation, although exhaustive, was unable to determine the definitive source of injuries and that our decision to terminate the employment of two employees caring for the resident was prudent for the protection of all residents. When Resident #B was found with fresh abrasions on the morning of May 10, our policy for Abuse Prevention, Reporting and Investigation was immediately initiated. A full interval investigation was performed within the community which included actions to immediately suspend both C.N.A.#4 and LPN #5. Investigative efforts included resident and family interviews of the source of injuries; physical assessment and first aid to address resident's injuries and pain along with recommendation for further evaluation at local hospital; provided comfort and reassurance to resident;</p>				

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	<p>During an interview with CNA #3 on 5/12/16 at 4:00 p.m., she indicated the Resident #B can be confused at times, but he has never been combative with me. I take care of him on day shift. During report from the night shift (5/10/16), CNA #4 had indicated, he had "gently" lowered Resident #B to the floor during the night and that the resident had been combative with him at some point that evening. When I went into the resident's room, I found him sitting up in the wheelchair in his brief and a tee shirt and had scrapes all over and was bleeding. I immediately went to the nurse to tell her of his injuries. (Review of CNA #3's statement indicated the resident had also told her he had to fight off the man who tried to take his phone).</p> <p>During an interview on 5/16/16 at 3:52 p.m., LPN #1 indicated, no staff from the night shift provided information to her (oncoming day shift) that Resident #B had been lowered to the floor.</p> <p>During an interview with the General Manager on 5/16/16 at 10:35 a.m., she indicated CNA #4 and LPN #5 will be terminated today.</p> <p>This State tag relates to Complaint IN00200124.</p>		<p>notification of family, physician and Administrator; suspension of employees; notification to required authorities including the Indiana State Department of Health as well a report filed with the Greenwood Police Department; interviews and written statements of involved staff; review of resident medical record and plan of care including resident's recent fall history as well as pendant use; review of employee personnel files; interviews of other residents/families C.N.A. #4 had cared for/interacted with; and conferment with Adult Protective Services and Ombudsman. On 05/10/16 at approximately 8:30am, Resident #B was found to have several fresh abrasions and stated that a man came into his room last night, tried to take/rob his phone/pendant and he had to fight the man off. This resident is not an accurate historian due to his diagnoses including dementia with behaviors, insomnia and altered mental status and has a history of falls prior to his admission to our community on 04/01/16 as well since his arrival to our community. Resident #B has poor safety awareness with a history of attempting to stand without assistance resulting in multiple falls, some with injuries (4/23/16: 9p found on floor next to recliner – states he slid off chair. 4/24/16: 7:30p resident</p>	

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			<p>trying to transfer self to toilet and lost balance. 4/25/16: 3:20am resident found on right side on floor by bed – said he couldn't sleep. 4/30/16: 7:20am resident found on floor at foot of bed stated slid off bed trying to get up unassisted. 5/2/16: 8:35am resident found on floor beside bed - resident said he was trying to go to bathroom- resulted in 2 abrasions on left knee area. 5/9/16: 8:00am Resident was found lying on floor beside his bed with pillow under his head - resident does not know how long he was on the floor). Documentation was provided to the surveyor for these falls, with the most recent on 5/2/16 resulting in injuries (see attachment A). Our nurse's assessment of the injuries of unknown origin reported on 5/10/16 shows 3 of 14 areas assessed as being older injuries with signs of healing (see attachment B). The fall on 5/2/16 resulted in blood stains on the carpet next to resident's bed and a work order was completed to clean these stains (see attachment C). There were new blood stains in the middle of the living area on the carpet as identified on 5/10/16 and pictures are attached (see attachment D). We believe these blood stains are from the big toe injury that was not dressed and dripped blood onto the floor while resident was sitting in his wheelchair. C.N.A.</p>		

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			<p>#4 reported to the oncoming C.N.A. on 5/10/16 as well as during the investigation interview that resident began sliding from the bed and he lowered resident to the ground. C.N.A. #4 reported that he summoned the assistance of the nurse and that they assisted resident back into the wheelchair; noted that resident did not appear to have injuries and left resident sitting up in wheelchair in the middle of the living area. In addition to the multiple falls during which resident attempted to stand without assistance, Resident#B's responsible party had a video camera in the room by 5/12/16, and reported to the General Manager that he had video of resident attempting to stand up on his own and falling back down on the bed. The recording at 6:15am on 5/12/16 showed resident sitting himself up on the side of the bed, reaching forward and grabbing the bathroom door handle and pulling himself up. Resident did not make it to a standing position but rather sat back down on the bedside. Video recording also shows resident removing the pendant from his wrist and tossing it onto the bed. Resident does have a diagnosis of insomnia as well as dementia with behaviors and there is much documentation of his being awake throughout the night with continual pendant use. Although</p>	

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			<p>these pendants are intended to be used for emergency purposes only in the assisted living setting, the resident appeared to enjoy the company and security of others often pushing his pendant for no specified reason and/or just to talk. The Alarm Response Report documentation provided to the surveyor reveals Resident #B used his pendant extensively during the night hours, which has fewer staff members in an assisted living environment. Review of Alarm Response Reports from 4/13/16 to 5/10/15 show Resident #B paged an average of 26 times during the hours of 8:00pm to 8:00am. This represents an excessive use of the pendant when compared to other assisted living residents and documented notes from the staff regarding reason for page commonly state "talk" or "food". Review of Alarm Response Reports from 5/12/16 through 5/16/16 reveal an average of 30 pages between the hours of 6:13pm and 8:32am which were dates when a 1:1 caregiver was with resident in the apartment between the hours of 10pm and 6am (see attachment E). Also, Alarm Response Reports from 5/18/16 to 5/25/15 show an average of 19 pages per night the hours of 11:45pm through 6:18am on the nights that the son of Resident #B was spending the night with him. In addition, there are several</p>	

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			instances noted in which resident removed his own pendant and threw it on the floor and/or placed it away from his body. For example, a nurse's note on 4/26/16 at 2:00pm documents an episode during which resident was yelling out –staff went in to help and resident stated someone stole his pendant and staff found it under the bed (see attachment F). Furthermore, during the investigation interview of LPN #5 she reported that on 5/10/16, she answered resident's pendant and resident stated that he did not need anything, but she did recall him having his pendant in his hand, and she placed it back on his wrist. Also LPN #5 reported that she had previously answered resident's pendant the prior week, and he did not have his pendant on at that time. She asked where it was, and he stated that he hid it so that we couldn't take it. She was able to convince him to get it out for her, and she put it back on him. On separate occasions, The Hearth provided an overnight 1:1 caregiver following the injuries of unknown origin per the request of the family and documentation completed by these caregivers from 5/12/16 to 5/15/16 shows Resident #B's excessive usage of the pendant, attempts to get up unattended, and the fact that he removes the pendant on his own and places it in various places (see attachment E). Additionally,	

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NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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			<p>resident's son shared a video recording of resident removing his pendant from his wrist and tossing it onto his bed. Interviews with current residents and family regarding care provided by C.N.A#4 cited no concerns about safety and some were very complimentary (see attachment G). After completion of a thorough and exhaustive internal investigation, we were unable to definitively conclude that C.N.A. #4 caused abrasions to the resident during the night shift ending May 10 by dragging the resident across the floor as claimed by the resident who suffers from dementia. Also, we were unable to definitively conclude that C.N.A. #4 may have taken the resident's pendant and placed it out of resident's reach. Despite this finding, both C.N.A. #4's and LPN #5's employment were terminated for failure to meet Hearth's performance standards and patient safety standards. Resident#B was provided with a 1:1 nighttime caregiver for several days to reassure resident's feelings of safety and security. In addition, staff continued to monitor resident's well being and safety with no new concerns noted and coordinated follow up psychological services. Resident #B's care plan was reviewed and updated to include additional individualized behavioral, insomnia and fall prevention</p>	

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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks;		interventions. The Administrator and General Manager also met with the responsible party to review investigation findings and updated care plan interventions. The Hearth is proud of our commitment to all residents' safety and security. Resident abuse or mistreatment has not, nor ever will be condoned within our communities. We have taken additional steps to emphasize this commitment including re-training of all staff on the prevention of resident abuse/mistreatment as well as new procedures for review of resident pendant use. We thank you for your consideration of the submitted information for our requested informal dispute resolution and will eagerly await the response of the ISDH.	

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	<p>(B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure the most current annual survey results were available for review.</p> <p>Findings include:</p>	R 0090	<p>R090- Deficiency 1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. The survey binder was immediately updated with all current survey information. 3. Regional Operations Manager</p>	06/15/2016

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	<p>Review of the survey book indicated the survey results were the annual survey from 2014, and no reports from 2015 through the current date were available.</p> <p>During an interview with the Executive Director on 5/12/16 at 2:30 p.m., she indicated the most current survey should be in the book and we will update the survey book.</p>		<p>will provide training to General Manager on the requirement to ensure the most current annual survey results are readily accessible for review on June 3, 2016. 4. General Manager will conduct audits to ensure that the survey binder is updated with required survey information monthly ongoing. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>		