STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154020	A. BUILDING 00 B. WING	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REGIONAL MENTAL HEALTH CENTER	8555 TAFT ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 0000 Bldg. 00	This visit was for a hospital recertification survey. Facility Number: 005184 Survey Date: 02/14-16/2022 QA: 2/21/2022	A 0000	N/A	
A 0085 Bldg. 00	482.12(e)(2) CONTRACTED SERVICES The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the facility failed to provide a comprehensive delineated list of current contracts for review. Findings include: 1. On 2/14/2022 at 1025 hours, S1, Director of Accreditation/Quality Improvement, was asked to provide a list of all contracts the facility currently maintained as being active. A partial listing of "memorandum's of understanding" was provided, but did not include all currently active contracts. 2. In interview on 2/16/2022 at 1600 hours, S1, Director of Accreditation/Quality Improvement, confirmed that no comprehensive and delineated listing of all of F1's active contracts was available for review.	A 0085	How the deficiency will be or has been corrected: **The hospital currently maintains a list of Memos of Understanding (MOUs), and this list will be expanded to include a list of all contracted services. This list will include the physical and/or digital location of the contract, the person responsible for maintaining the contract, and the date of expiration for each contract. Results of contracted service evaluations will be attached to the list as well.** How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur:	03/18/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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			The comprehensive contract list will itself be reviewed annually to ensure that all required updates have taken place. Staff will be trained to notify the Quality Improvement Team if new contracts have been established throughout the year, so the list can be updated in real time. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained: Director of Accreditation and Quality Improvement	
A 0398 Bldg. 00	482.23(b)(6) SUPERVISION OF CONTRACT STAFF All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). Based on document review, observation and interview; nursing failed to follow policy regarding suicide precautions in 1 of 4 (patient 4) medical records reviewed. Findings include: 1. Review of policy titled: Suicide Assessment and	A 0398	How the deficiency will be or has been corrected? Staff are no longer issuing scrub pants with draw strings, and have ordered pants with elastic waist lines instead. Staff have been educated as to the reasons for the change, and will sign that they	03/18/2022

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	Intervention, Inpatient Unit - Procedure Version # 8, last approved 04/27/2021, indicated - Remove belts, suspenders, shoelaces and any strings in shirts and pants. 2. Review of patient 4's medical record on 02/15/22 at 1015 indicated suicide precaution ordered at suicide precaution (SP) 2 - moderate risk of immediate suicide. 3. During observation of group activity on 02/15/22 at 0930, this writer observed patient 4 with red strings hanging from waist of pants. 4. Interview with S4 (Inpatient Psychiatric Supervisor, Registered Nurse [RN]) on 02/15/22 at 1530 confirmed patient 4 was wearing scrub pants with draw string and nursing did not follow policy leaving patient 4 access to string in pants.		have reviewed the policy and procedure on Unit precautions and the protocols associated with those precautions. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur.Scrub pants with string tie waists will no longer be used on our Inpatient Unit, preventing the reoccurrence of this risk. The Unit will continue to practice annual environmental risk assessments and quarterly safety rounds to identify other risks to individuals who are prone to suicide, self-harm, or violence. Newly hired staff will sign that they have reviewed the policy and procedure on Unit precautions and the protocols associated with those precautions. 3. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained.Inpatient Nursing Supervisor and Nursing staff	
A 0700 Bldg. 00	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. Based on record review and interview, the facility	A 0700	What was done to correct the deficiency:	03/18/2022

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	failed to maintain automatic sprinkler systems (see tag K353), failed to conduct fire drills or documented orientation training on each shift for 4 of 4 quarters (see tag K712), failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 1 of the past 12 months (see tag K918) and failed to ensure a written record of weekly inspections for the generator was maintained for 14 of 52 weeks (see tag K918). The cumulative effect of these systemic problems resulted in the hospital's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.		Fire sprinkler - We sent a copy of the finding to the company who inspects our hydrants. The hydrant works, but the automatic drain needs repair. It turns out that the company is unable to acquire the necessary parts to replace the drain, so they will instead need to replace the whole hydrant. A purchasing order has been submitted and we are waiting on a projected date of completion from the company. Fire Drills - The fire drill schedule for 2022 has been re-developed and documented to make sure that once-per-shift-per-quarter drills are laid out with proper intervals. Staff who oversee fire drills are being trained on the calendar. We will conduct the remainder of fire drills for 2022 as “stay in place” drills for the safety of staff and clients until restrictions due to COVID-19 are no longer necessary. Staff who participate will be oriented to the contents of our fire safety plan and will be expected to know their means of egress and how to access those means of egress. Finally, we have switched to a new fire drill documentation form recommended by The Joint Commission. This new critique sheet will allow us to better evaluate our drills and provide timely follow-up education.	

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			Generator Monthly - Upon further investigation, tests were in fact being done, but were not being documented properly. Documentation forms for weekly and monthly testing will be reviewed, and more importantly, will be assigned to staff whom themselves will be re-trained in appropriate procedures. Documentation will be placed immediately in the Books of Evidence, and an interim filing location (the source of the records issue in this citation) has been eliminated—a staff member was using his own book to document, and will no longer do so. Generator Weekly - Upon further investigation, tests were in fact being done, but were not being documented properly. Documentation forms for weekly and monthly testing will be reviewed, and more importantly, will be assigned to staff whom themselves will be re-trained in appropriate procedures. Documentation will be placed immediately in the Books of Evidence, and an interim filing location (the source of the records issue in this citation) has been eliminated—a staff member was using his own book to document, and will no longer do so.	

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			HOW WILL WE ENSURE THAT THE ISSUES DO NOT RECUR: Fire Sprinklers - We will register on our local Inspector's site so we can download reports after each inspection. We did not have timely access to the reports in the past, and this change will allow us to monitor deficiencies without delay and be more proactive. Fire Drills - Drill results will be reported to the Safety Committee on a quarterly basis. The Safety Committee will also approve the annual fire drill calendars to ensure they follow all applicable standards and regulations. Generator Monthly - General Services Supervisor will audit the documentation books every month and report results to the Safety Committee on at least a quarterly basis. **Generator Weekly -** General Services Supervisor will audit the documentation books every month and report results to the Safety Committee on at least a quarterly basis. PERSON RESPONSIBLE FOR CHANGES/SUSTAINABILITY OF CHANGES:	

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A 0701 Bldg. 00	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: 1. Based on review of "System Inspection Certificate" documentation dated 10/19/21 during record review with the General Services Supervisor from 10:30 a.m. to 1:35 p.m. on 02/15/22, the Fire Hydrant located at Ground Southeast parking was in need of repair. The	A 0701	General Services Supervisor How the deficiency will be or has been corrected. We sent a copy of the finding to the company who inspects our hydrants. The hydrant works, but the automatic drain needs repair. It turns out that the company is unable to acquire the necessary parts to replace the drain, so they will instead need to replace the whole hydrant. A purchasing order has been submitted and the company hopes to complete the replacement by 3/11/22. However, since we are unable to guarantee the completion by this time, we will use the 90-day date of 5/17/22, with the understanding that this citation is expected to be resolved much sooner than that. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. We will register on our local Inspector's site so we can download reports after each inspection. We did not have	05/17/2022

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	inpection report stated the fire hydrant failed the annual test with problem listed 'will not self drain'. Based on interview at the time of record review, the General Services Supervisor stated stated he was not aware there was a problem with the fire hydrant and documentation of the repair or replacement of the aforementioned fire hydrant on or after 10/19/21 was not available for review. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 1 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.		timely access to the reports in the past, and this change will allow us to monitor deficiencies without delay and be more proactive. These changes will be completed by 3/18/22. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	

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	Findings include: 2. Based on record review on 02/15/2022 between 10:30 a.m. and 1:35 p.m. with the Director of Facilities and General Services Supervisor present, there was no monthly generator load test documentation available for January of 2022. Based on interview at the time of record review, the General Services Supervisor confirmed there was no emergency generator load test documentation for January 2022. 3. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 14 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: 3. Based on record review with the General Services Supervisor on 02/15/22 from 10:30 a.m. to 1:35 p.m., documentation for the weeks of: January 3rd, 10th, 31st, December 20th & 27th, November 1st, October 11th, August 2nd & 23rd, July 19th, June 14th & 21st, May 24th and April 26th weekly generator testing was not available for review. Based on an interview at the time of record review, the General Services Supervisor confirmed weekly			

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	generator testing documentation for the aforementioned weeks was not available for review at the time of the survey. These findings were reviewed with the Accreditation & Quality Improvement Director, Director of Facilities, and General Services Supervisor during the exit conference.			
A 0709 Bldg. 00	482.41(b) LIFE SAFETY FROM FIRE Life Safety from Fire Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 4 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and residents. Findings include: Based on record review on 02/15/22 with the General Services Supervisor at 1:10 p.m., the only completed fire drill within the last twelve months was conducted 04/20/2021 at 9:52 a.m. There were no other fire drills or documented orientation training related to the current fire plan to review	A 0709	How the deficiency will be or has been corrected. The fire drill schedule for 2022 has been re-developed and documented to make sure that once-per-shift-per-quarter drills are laid out with proper intervals. Staff who oversee fire drills are being trained on the calendar. We will conduct the remainder of fire drills for 2022 as “stay in place” drills for the safety of staff and clients until restrictions due to COVID-19 are no longer necessary. Staff who participate will be oriented to the contents of our fire safety plan and will be expected to know their means of egress and how to access those means of egress. Finally, we have switched to a new fire drill documentation form recommended by The Joint Commission. This new critique sheet will allow us to better evaluate our drills and provide timely follow-up education.	03/18/2022

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	for the past twelve month period. Based on interview at the time of record review, the General Services Supervisor stated the facility decided not to conduct fire drills due to the COVID19 Public Health Emergency, and the facility has discussed resuming fire drills in the near future. The General Services Supervisor confirmed there were no fire drill documentation or orientation training to review at the time of the survey. This finding was reviewed with the Accreditation & Quality Improvement Director, Director of Facilities and General Services Supervisor at the exit conference.		How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Drill results will be reported to the Safety Committee on a quarterly basis. The Safety Committee will also approve the annual fire drill calendars to ensure they follow all applicable standards and regulations. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. General Services Supervisor	
A 0748 Bldg. 00	482.42(a)(1) INFECTION CONTROL PROFESSIONAL Infection prevention and control program organization and policies. The hospital must demonstrate that: (1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership; Based on document review and interview, the facility failed to ensure the Infection Preventionist was qualified through education, training, experience or certification and appointed by the	A 0748	How the deficiency will be or has been corrected. CDC Infection Control trainings were identified for the Infection	03/18/2022

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	governing body (S5). Findings Include: 1. Interview on 02/16/22 at 10:30 am with S1 (Director of Accreditation/Quality Improvement [QI]) confirmed that S5 (Chief Nursing Officer) was the Infection Preventionist for the inpatient unit. 2. Review of S5's personnel file lacked documentation of infection control education. 3. Interview with S1 on 02/16/22 at 1:40 pm confirmed that S5's personnel file lacked documentation of infection control education, training, experience or certification. 4. It could not be determined if S5 was appointed by the Governing Board as the Infection Preventionist. Requested Board minutes from S1 where S5 was appointed to be the Infection Preventionist at 10:30 am and 1:40 pm on 02/15/22.		Control Chair. These trainings will be completed and documented in the Chair's employee file by 3/18/22. Trainings will continue to occur annually, and the Chair will prioritize trainings that not just teach about infections and pathogens, but also offer practical advice to help leaders manage the concrete risks facing a hospital team. The CEO approved the agency and hospital Infection Control Chairs, and these approvals will be presented to the Board of Directors on 3/17/22. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the4 deficiency will not recur. The Infection Control Chair will have annual infection control training added to their annual performance evaluation and will have a documented training every year. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Chief Nursing Officer, Chief Human Resource Officer	
A 0750 Bldg. 00	482.42(a)(3) INFECTION CONTROL SURVEILLANCE, PREVENTION The infection prevention and control program			

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	includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and Based on observation, document review and interview, the facility failed to keep a sanitary environment in 6 of 6 (E-206, E-207, E-208, E-209, E-210 and E-211) restrooms observed. Findings Include: 1. Tour of facility on 02/14/22 at 2:20 pm with S3 (Service Director-Acute Intensive Services) and S4 (Inpatient Psychiatric Supervisor), this surveyor observed wipeable, copious amounts of dust on top of lights, dark colored build-up on shower seams and around the cover over the hot and cold knobs in each shower in 6 bathrooms (E-206, E-207, E-208, E-209, E-210 and E-211). 2. Review of the Housekeeping Procedures indicated cleaning of the inpatient restrooms daily. 3. Interview with S3 and S4 on 02/14/22 at approximately 2:30, confirmed copious amounts of dust on top of lights, dark colored build-up on shower seams and around the cover over the hot and cold knobs in each shower in 6 bathrooms (E-206, E-207, E-208, E-209, E-210 and E-211).	A 0750	How the deficiency will be or has been corrected. The Inpatient Unit has been thoroughly cleaned since the survey. To keep it clean, a new cleaning protocol has been put in place. At least once a month, internal housekeeping staff supplemented by a contracted housekeeping agency will clean the Inpatient Unit from top to bottom. This will be in addition to the normal cleaning duties performed daily by housekeeping staff. Once we are able to hire more internal housekeeping staff, this deep cleaning in tandem with the contracted agency will decrease to a quarterly basis. In the meantime, we are aggressively recruiting for housekeeping positions. All housekeeping staff will be trained to notify the Supervisor of General Services if they ever notice that something beyond a normal daily cleaning is required, and this will trigger another deep cleaning regardless of the interval from the previous cleaning. Meanwhile, new fan vents for bathrooms were ordered and have arrived, and were installed as of 3/7/22.	03/18/2022

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	154020	A. BUILDING 00 B. WING	02/16/2022

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			How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. Staff will be trained to check conditions, and report if anything beyond normal daily cleaning is required. Cleaning schedules will be reviewed quarterly by the Supervisor of General Services, who will determine if work needs to be re-assigned between in-house and contracted cleaning services. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Supervisor of General Services	
A 0772 Bldg. 00	482.42(c)(2)(i) IC PROFESSIONAL RESPONSIBILITIES POLICIES Standard: Leadership responsibilities (2) The infection preventionist(s)/infection control professional(s) is responsible for: (i) The development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines. Based on document review and interview, the facility failed to provide tuberculin testing per policy in 3 of 3 new hires, since 01/01/21 (P3, P5	A 0772	How the deficiency will be or has been corrected. Procedures have changed so that	03/18/2022

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	and P11). Findings Include: 1. Review of policy titled: Infection Control-Program Policy (Version #4) last approved 07/16/2021 indicated staff should follow all Infection Control policies and procedures (adhering to State Board of Health, CDC and OSHA guidelines). 2. Review of the CDC guidelines, TB Screening and Testing of Health Care Personnel (updated March 8, 2021) indicated if the Mantoux tuberculin skin test is used to test health care personnel upon hire, two-step testing should be used. 3. Review of P3 and P5 (each a Registered Nurse) and P11's (Mental Health Technician) personnel files had documentation of 1 tuberculin test, but lacked documentation of a second tuberculin test; each hired in 2021/2022. 4. Interview on 02/16/22 at 12:25 pm with S8 (Director of Human Resources) confirmed P3, P5 and P11 lacked documentation of a 2nd tuberculin test needed to complete the 2-step tuberculin testing.		all new hires will now receive a 2-step test. Human Resources staff are being educated on this change. Moving forward, we will conduct annual education on Tuberculosis exposure risks for all healthcare personnel. We will also conduct individual healthcare personnel risk assessments on an annual basis for patient-facing areas, and our procedure will be changed to require testing based on the aforementioned risk assessments rather than a blanket annual testing requirement. We will continue to have yearly education on tuberculosis risk prevention. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. TB testing protocol for newly hired staff is codified in policy and procedure, which comes up for annual review within our electronic document management software, Policy Tech. We were compliant with our previous policy for TB testing, and we do not anticipate difficulty complying with our augmented procedure. To make sure, Human Resources conducts audits of staff files on an ongoing basis to see if any documentation is expired or missing, which will allow for the identification of any missing annual TB risk	

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			assessments or indicated tests. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Chief Nursing Officer, Chief Human Resources Officer	
A 1644 Bldg. 00	482.61(c)(1)(iv) Treatment Plan - Team Responsibilities [The written plan must include] The responsibilities of each member of the treatment team; and Based on document review and interview, the facility failed to include all disciplines in reviewing the treatment plan for 1 of 4 (Patient 2) treatment plans reviewed. Findings Include: 1. Review of policy titled: Treatment Plan Policy (Version #4) last approved 04/28/2021, indicated that the plan is to be reviewed by all persons involved. 2. Review of Patient 3's Treatment Plan, created on 02/13/22 (date of admission) at 6:54 pm completed and signed only by Registered Nurse and Patient. 3. Review of Treatment Plan Meeting on 02/14/22 indicated a list of multi-disciplinary names with hand written check marks by the names (virtual meeting). Lack of documentation of which Patient/s were discussed or notes stating such in the medical record. 4. Interview on 02/15/22 at 10:00 am with S4 (Inpatient Psychiatric Supervisor) confirmed that	A 1644	How the deficiency will be or has been corrected. A daily meeting has already been added to the calendar for staffing of hospital clients, led by the unit therapist with nursing input. Our upcoming electronic medical record update includes a “Staffing Note” document that allows for documentation of any changes in treatment planning, names of those who attend meetings, etc. This feature will go live on April 1. This is the soonest our EMR provider can implement this change. In the meantime, staff will include this information in a scanned document. It will note that the interdisciplinary team met, discussed the plan of care, and identified changes (if any) to the client’s plan. All staff will be trained on this temporary documentation practice by 3/11/22. How the deficiency will be	04/01/2022

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	since Patient 3 was admitted over the weekend, they would have been discussed at the Treatment Plan Meeting on 02/14/22.		prevented from recurring i.e., measures put into place or systematic changes made to insure the deficiency will not recur. The “Staffing Note” will be a required feature once it is implemented, and this system change will prevent this issue from recurring. Who is responsible to insure the deficiency will be/has been corrected and compliance maintained. Inpatient Nursing Supervisor	