STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155381	A. BUILDING 00 B. WING	05/21/2021

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HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaints IN00352216, and IN00353021. Complaint IN00352216 - Unsubstantiated due to lack of evidence. Complaint IN00353021 - Unsubstantiated due to lack of evidence. Survey dates: May 16, 17, 18, 19. 20, and 21, 2021 Facility number: 000551 Provider number: 155381 AIM number: 100267400 Census Bed Type: SNF/NF: 105 SNF:10 Total: 115 Census Payor Type: Medicare:9 Medicaid:84 Other:12 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 28, 2021.	F 0000	Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on May 16th-21st, 2021. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and The Lodge's credible allegation of compliance. We allege compliance on June 11, 2021. Submission of this plan of correction does not constitute an admission by The Lodge or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

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

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to evaluate residents for self-administration of medications for 1 or 1 residents observed to have medications at bedside. (Residents 23) During an interview with Resident 23 on 5/18/21 at 9:18 a.m., a medication cup containing 8 pills was observed on the resident's chest of drawers next to a cup of water. The resident indicated the nurse left them their for him to take when he wanted to take them. The resident's clinical record was reviewed on 5/19/21 at 1:44 p.m. Diagnoses included, but were not limited to, adjustment disorder with depressed mood, difficulty walking, and unsteadiness on feet. The clinical record lacked a self-medication administration assessment. A quarterly minimum data set (MDS) assessment dated 3/12/21, indicated the resident had moderate cognitive impairment. A current care plan dated 3/26/21, with the problem statement of risk for aspiration, choking, and swallowing problem related to dysphagia (trouble swallowing). Interventions included, but were not limited to, cue resident for safe swallowing techniques and monitor for aspiration, choking and swallowing problems and notify doctor as needed. A current care plan dated 11/25/19, with the problem statement of resident unable to independently perform late loss activities of daily	F 0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A self-administration assessment was completed for resident 23. Resident 23 was not indicated to self-administer medications. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who self-administer medications have the potential to be affected and have been audited to ensure a self- administration assessment has been completed. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were educated regarding completing self-administration assessments for residents who self-administer their medications. Licensed nurses and QMAs will be educated upon hire and annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit 5 random residents who self-administer their medications to ensure a self-administration assessment has been completed	06/11/2021

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	living, requiring assistance and encouragement with eating. Interventions included, but were not limited to, monitor for any swallowing issues and provided assistance as needed. During an interview on 5/17/21 at 10:28 a.m., RN 5 indicated she left his medication at bedside because that's the way the resident indicated he took them. She was unaware if he had a self-administration evaluation. During an interview on 5/20/21 at 9:56 a.m., the Director of Nursing (DON) indicated medications should not be left at beside unless the resident had an order for self-administration of medication. A current facility policy, undated, titled, "Medication Administration: General Policies & Procedures," provided by the assistant director of nursing (ADON) on 5/20/21 at 10:05 a.m., included, but was not limited to, "Administration:... 5. The nurse or approved designee should always remain with the resident to observe the medication is swallowed.... 11. Residents are not allowed to self-administer any medication unless specifically authorized to do so by the interdisciplinary team (IDT) and the attending physician." 3.1-11(a)		weekly x 12 weeks, then monthly for 6 months.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.			

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	§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this			

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	chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected a J-tube (surgically placed feeding tube) for 1 of 2 residents reviewed for tube feeding. (Resident 108) Findings include: The clinical record for Resident 108 was reviewed on 5/20/21 at 9:58 a.m. Diagnoses included, but were not limited to, acute pancreatitis with infected necrosis and gastro-esophageal reflux disease. A current physician's order, dated 5/5/21, indicated to clean J-tube site with soap and water and apply drain sponge, daily. The resident had a 5-day Minimum Data Set (MDS) assessment dated 5/3/21, which lacked indication of a J-tube. During an interview on 5/20/21 at 11:18 a.m., the MDS Coordinator indicated the J-tube should	F 0636	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 108 has discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents with J-tubes have the potential to be affected. Residents have been audited by MDS to ensure accuracy of the MDS assessments. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?	06/11/2021

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	have been coded on the 5-day MDS for Resident 108. She indicated she used the RAI (Resident Assessment Instrument) as the policy and procedure for completing MDS assessments. 3.1-31(a)		MDS coordinator and assistant were educated using the RAI manual to ensure accuracy of the MDS assessments. Associates will be educated annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? MDS Coordinator or designee will audit all new admission assessments for accuracy 5 days a week for 4 weeks, weekly x 12 weeks and monthly x 8 months.	
F 0656 SS=D Bldg. 00	483.21(b)(1) 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).			

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	(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 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.			
	Based on observation, interview, and record review, the facility failed to develop and/or implement care plans regarding communication and nutrition for 2 of 26 residents review for care plan development and implementation (Residents 100 and 67). Findings Include: 1. During an observation of 5/16/21 at 11:33 a.m., Resident 100 was in bed with his eyes open. He did not speak when spoken to or appear to understand what was said to him. On his wall was a sign with characters indicative to an Asian language. Resident 100's clinical record was reviewed on 5/19/21, at 9:48 a.m. The residents current diagnoses included, but were not limited to, toxic encephalopathy and dysphagia.	F 0656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care plan for resident 100 has been updated to include having a primary language other than English. Resident 67 has been assessed by therapy to determine level of nursing support needed with eating and care plan has been updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents who have a primary language other than English have	06/11/2021

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	The resident had a 2/4/21, Admission, Minimum Data Set (MDS) assessment which indicated the resident stuttered and had difficulty forming sentences. The Care Area Assessment (CAA) completed with the MDS had a communication worksheet which indicated "Resident speaks Mandarin. Wife is at side at most times and speaks little English. Resident is also noted to have some confusion." The CAA indicated the resident needed a communication care plan developed. A 5/03/2021, 8:59 a.m., progress note indicated "Res is alert oriented to self/surroundings, has some confusion. Difficult to assess full level of orientation due to language barrier. Does speak some English. Uses communication boards and gestures...." A 5/05/2021, 12:31 p.m., progress note indicated, "Resident is alert and oriented to self only with confusion noted. Complications with communication r/t resident's primary language is not English and does not speak English. Communication boards available at bedside..." His clinical record lacked a care plan regarding communication and/or having a primary language other than English. At no time during the survey process was Resident 100 heard to speak English and no staff were observed to communicate with the resident using a communication board/book. During an interview on 5/19/21 at 9:45 a.m., RN 8 indicated the resident did not have a communication board, could speak a little English, and if he spoke Chinese you needed to say speak		the potential to be affected. Residents have been audited to ensure their care plans reflect communication when their primary language is not English Residents residing in the facility have the potential to be affected and are assessed by therapy at least quarterly and annually to determine nursing support needed with eating and care plans are updated. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? The MDS coordinator received education regarding updating the care plans per the RAI manual related to Care Area Assessments Process and Care Planning. Education will be provided annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The MDS Coordinator or designee will audit residents who have a primary language other than English to ensure the care plans are implemented. Audit will occur weekly x 12 weeks, then monthly x 6 months and quarterly thereafter.	

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	English to remind him. During an interview on 5/20/21 at 1:24 p.m., CNA 7 indicated she communicated with Resident 100 by hand gestures, touching items and pointed. She indicated he gestured and pointed as well. During an observation and interview on 5/20/21 at 1:36 p.m., LPN 6 indicated she believed Resident 100 had a communication board in a drawer. She then looked around the resident's bedside table. She moved many items and removed a three ring binder from the bottom of the pile. She indicated the three ring binder was for communication. The binder had pictures and words in Chinese. She indicated she had tried Google translator on occasion without success. Lastly she indicated she would call his son to translate if needed. During a 5/20/21, 2:08 p.m., interview, the DON indicated Resident 100 did not have a care plan for communication and/or speaking a primary language other than English. 2. During an observation on 5/16/21 at 9:32 a.m., Resident 67 was lying in bed with his legs hanging over the side. During an observation on 5/16/21 at 11:00 a.m., the resident was lying in bed with his legs hanging over the side. An over the bed table was in front of his legs with his breakfast tray still in place. During an observation on 5/16/21 at 12:30 p.m., the resident was lying in bed with his legs hanging over the side. An over the bed table was in front of his legs with his breakfast tray still in place. On 5/16/21 at 12:40 p.m., the Assistant Dietary			

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	Manager delivered a lunch tray to Resident 67's roommate. She did not address the food tray for Resident 67. On 5/16/21 at 12:47 p.m., the Assistant Dietary Manager delivered resident lunch tray, and asked the Dietary Manager to assist her with removing Resident 67's breakfast tray. The Assistant Dietary Manager assisted the resident with opening his drinks and getting him ready to eat. The resident was sitting on the side of his bed eating his ice-cream with his fingers. The clinical record for Resident 67 was reviewed on 5/20/21 at 11:18 a.m. Diagnoses for the resident included, but were not limited to, Marasmic kwashiorkor disease (chronic protein deficiency), Dysphagia oropharyngeal phase, and Vascular dementia. Current signed physician's orders for the resident included, but were not limited to, the following orders: a. Regular diet: Special instructions: Gravy/sauces on meats, turn head and tuck to the left with each bite. The order originated on 11/23/20. The quarterly Minimum Data Set (MDS) assessment, completed on 4/15/21, indicated the resident had severe cognitive impairment, needed extensive assist with eating, and one staff to physically assist with eating. The resident had a current, updated on 4/29/2021, health care plan that included but was not limited to the problem of "Resident is at nutritional risk for weight loss related to: hypokalemia, congestive heart failure, marasmic kwashiokor,			

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	anemia, abnormal weight loss, dementia, and dysphagia. 5/11/20 Has shown a weight loss which may be related to an intake of less than established needs. 6/8/20 has shown a weight loss of 8.5% x 87 days and loss of 11.6% x 175 days. 7/7/20 has shown weight loss which may be related to varied intake. 9/9/20 has shown a weight loss x 95 and 182 days. 11/20/20 Has shown a weight loss x 182 days". Interventions for this problem included but was not limited to, monitor meal services and provide assistance and encouragement as indicated for eating. Requires gravy/sauces with meats and monitored head turn/tuck with meals related to dysphagia. Resident 67's point of care history form, dated 5/16/21 through 5/20/21, provided by the Corporate Nurse Consultant on 5/20/21 at 3:18 p.m., included, but was not limited to the following information, five out of nine meals documented the resident received supervision only, and four out of the nine meals documented the resident ate independently. For seven out of nine meals documented the resident received set up help only and two of the nine meals documented no set up or physical help from staff. Review of the current facility policy, revised December 2016, titled "Care Plans" provided by the Corporate Nurse Consultant on 5/20/21 at 4:05 p.m., included, but was not limited to, "Policy: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. ...8. The comprehensive, person-center care plan			

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	will: ...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. ...m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels... ...12. The comprehensive, person-centered care plan is developed within seven(7) days of the completion of the required comprehensive assessment (MDS)."			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed offer sufficient activities to meet residents' desires and preferences for 7 of 10 residents interviewed in a group setting (Resident 61, 90, 89, 23, 33, 7, and 36). The facility also failed to assess residents with cognitive impairments for activity needs and preferences or implement an activity program designed to meet individual resident needs for 3 of 3 dependent residents reviewed for activity programing(Residents 48, 24 and 22). Findings include:	F 0679	Residents 61, 90, 89, 23, 33, 7, and 36 have been interviewed regarding activity preferences. The families of residents 48, 24, and 22 have been interviewed to determine resident preferences for activities. *Residents residing in the facility have the potential to be affected and have been interviewed to determine their preferences for activities. The families of cognitively impaired residents*	06/11/2021

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	A. During a resident group interview on 5/19/21 at 1:30 p.m., with residents consisting of facility identified interviewable residents, the following activity concerns were identified: a. Residents 61, 90, 89, 23, 50, 33, 7 and 36 indicated they would like more activities. b. Residents 61, 90, 89, 23, 33, 7 and 36 indicated they did not enjoy the activities which were offered in the mornings. c. Residents 61, 90, 89, 23, 33, 7 and 36 indicated no facility employee had spoken to them about the type of activities they desired or the frequency of activities they desired. d. Residents 61, 90, 89, 23, 33, 7, and 36 indicated there were no structured Sunday group activities. They additionally indicated they would enjoy weekend activities. They indicated there was sometimes a Saturday sing-a-long, which they enjoyed. e. The Activity Department handled family visits and could not do as many other activities due to the time the visits required. f. The Activity Room was often in use for family visits. g. There was only one activity offered per day. Review of the facility activity attendance records for May 7 to May 19, which were provided by the Activity Director on 5/20/21 at 10:47 a.m., indicated 7 of the 9 residents who requested an increased in activities were regular activity attendees (Residents 33, 89, 7, 36, 61, 23 and 90).		*have been interviewed to determine resident preferences. The activity department will implement an activity program designed to meet the individual needs of the residents.* The activity director was educated regarding the importance of assessing resident preferences and developing an activity program designed to meet the individual needs of the residents. Administrator will interview and observe 5 random residents who participate in activities to determine whether they feel the activity programming is meeting their needs weekly x12 weeks, then monthly for 6 months.	

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	1. Resident 61's clinical record was reviewed on 5/20/21 at 9:26 a.m. A 4/9/12, quarterly,v Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact and had minimal depression symptoms. A full 10/6/20, Annual, MDS indicated participating in in their favorite activities was very important to the resident. The facility attendance records for May 7 to May 19 had records of attendance for nine activities and the resident attended all nine available activities. 2. Resident 89's clinical record was reviewed on 5/20/21 at 9:04 a.m. A 2/19/20, quarterly MDS Assessment indicated the resident was cognitively intact and had minimal depression symptoms. A full 11/16/20, full, admission MDS assessment indicated participating in in their favorite activities was very important to the resident. The facility attendance records for May 7 to May 19 had records of attendance for nine activities and the resident attended all 9 available activities. 3. Resident 23's clinical record was reviewed on 5/20/21 at 11:35 a.m. A 3/12/2, quarterly, Minimum Data Set (MDS) Assessment indicated the resident was moderately cognitively impaired and had no depression symptoms. A full 10/11/19 Admission MDS assessment indicated participating in in their favorite activities was some what important to the resident. The facility attendance records for May 7 to May 19 had records of attendance for nine activities the resident attended seven.			

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	4. Resident 33's clinical record was reviewed on 5/20/21 at 8:52 a.m. A 5/14/2, quarterly, Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact and had mild depression symptoms. A full, 11/9/20, admission MDS assessment indicated participating in their favorite activities was very important to the resident. The facility attendance records for May 7 to May 19 had records of attendance for nine activities and the resident attended seven. 5. Resident 7's clinical record was reviewed on 5/20/21 at 9:03 a.m. A 5/12/21, quarterly Minimum Data Set (MDS) Assessment indicated the resident was cognitively intact and had depression symptoms. A full 11/23/20, admission MDS assessment indicated participating in in their favorite activities was somewhat important to the resident. The facility attendance records for May 7 to May 19 had records of attendance for nine activities and the resident attended four. 6. Resident 36's clinical record was reviewed on 5/20/21 at 9:18 a.m. A 3/19/21, quarterly, Minimum Data Set (MDS) Assessment indicated the resident was cognitively impaired and had moderate depression symptoms. A full, 10/3/20, admission MDS assessment indicated participating in their favorite activities was somewhat important to the resident. The resident had a, current, 3/19/21 care plan need about the importance for her to participate in social group activities. An approach to this need was to attend out of room social groups. The facility attendance records for May 7 to May			

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	19 had records of attendance for nine activities and the resident attended nine. 7. Resident 90's clinical record was reviewed on 5/20/21 at 9:50 a.m. A 1/21/21, quarterly, Minimum Data Set (MDS) Assessment indicated the resident was cognitively impaired and had no depression symptoms. A full, 1/27/20, annual, MDS assessment indicated participating in their favorite activities was very important to the resident. The resident had a , current, 4/30/2021 care plan need regarding her desire to participate in out of room group activities. The facility attendance records for May 7 to May 19 had records of attendance for nine activities and the resident attended nine. Review of the facility May 2021 activity calendar, which was provided by the Activity Director on 5/20/21 at 10:47 a.m. indicated the following: a. The maximum activities offered each day was three. b. Sundays had no listed activities. c. Saturdays had one listed activity d. May 17 had Morning Chair Exercise scheduled at 10:30 a.m. e. May 18 had Morning Chair Exercise scheduled at 10:30 a.m. and Coffee and News at 11:00 a.m. f. May 19 had Morning Chair Exercise scheduled at 10:30 a.m. During observations on 5/17/21, 5/18/21, 5/19/21 and 5/20/21 the scheduled morning activities did			

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	not occur. 2a. Resident 24's clinical record was reviewed on 5/19/21 at 3:12 p.m. The resident's current diagnoses included but were not limited to, chronic obstructive pulmonary disease and congestive heart failure. A 3/12/21, quarterly MDS indicated the resident was severely cognitively impaired, sometimes understood others, was sometimes understood by others and was dependent on staff for transportation in a wheelchair. The resident had a, current, 3/10/21 care plan need regarding her preference for small group activities. An approach to this problem was "to encourage/invite the resident to engage in preferred activities such as, cooking, exercising, and word games." The resident's clinical record lacked any activity progress note, activity assessment/evaluations or activity attendance for March, April, and May 2021. At no time during the survey process which included, but was not limited to, 5/16/21 from 11:00 a.m. to 3:30 p.m., 5/17/21 from 9:00 a.m. to 2:30 p.m., 5/18/21 from 9:00 a.m. to 3:30 p.m., 5/19/21 from 9:00 a.m., to 4:30 p.m. and 5/20/21 from 9:00 a.m. to 4:30 p.m., was Resident 24 observed to attend a structured group activity or be invited to an activity. b. Resident 48's clinical record was reviewed on 5/19/21 at 3:00 p.m. The resident's current diagnoses included but were not limited to, dementia and depression.			

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	A 4/1/21, annual MDS indicated the resident was severely cognitively impaired, sometimes understood others, was sometimes understood by others and was dependent on staff for transportation in a wheelchair. The resident had a, current, 3/10/21 care plan need regarding her need for social interaction in a group setting. An approach to this problem was "to encourage/invite the resident to be brought to activities by the activity staff. The resident's clinical record lacked any activity progress note, activity assessment/evaluations or activity attendance for March, April, and May 2021. At no time during the survey process which included, but was not limited to, 5/16/21 from 11:00 a.m. to 3:30 p.m., 5/17/21 from 9:00 a.m. to 2:30 p.m., 5/18/21 from 9:00 a.m. to 3:30 p.m., 5/19/21 from 9:00 a.m., to 4:30 p.m. and 5/20/21 from 9:00 a.m. to 4:30 p.m., was Resident 48 observed to attend a structured group activity or be invited to an activity. During a 5/19/21, 1:00 p.m. interview, Resident 48's family indicated the resident truly enjoyed music and singing and would benefit from music based activities. She also indicated she did not believe the resident enjoyed watching TV because she could no longer follow the program.c. Observations for Resident 22 included, but were not limited to, the following; On 5/16/21 at 10:48 a.m., she was in her room sitting in a wheel-chair. On 5/17/21 at 9:45 a.m., she was lying in bed. On 5/19/21 at 2:27 p.m., she was lying in bed. Resident 22's clinical record was reviewed on			

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	5/18/21 at 10:04 a.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, and Parkinson's disease. Physician orders included, but were not limited to: 1. May participate in activities of choice, the order date was 5/19/20 2. Citalopram (an antidepressant) 40 mg (milligram), one tablet once a day, the order date was 12/8/20. 3. Wellbutrin XL (an antidepressant) extended release, one tablet once a day, the order date was 5/17/21. A 3/10/21 quarterly MDS (Minimum Data Set) assessment indicated she had severe cognitive impairment. She was totally dependent for bed mobility, transfers, with locomotion on and off the unit, dressing, eating, and personal hygiene. An Activity Assessment, with a completion date of 5/11/21 at 2:25 p.m., indicated the resident had indicated it was somewhat important for her, while a resident at the facility, to have books, newspapers, and magazines to read, to listen to music she liked, to go outside to get fresh air when the weather was good, and to participate in religious services or practices. A current care plan, edited on 5/11/21, indicated she had dementia with behavioral disturbance that required the use of anticonvulsant medication. Interventions included, but were not limited to, encourage to attend activities of her choice, dated 7/2/20. A current care plan, edited on 5/11/21, indicated she had major depressive disorder and required the use of antidepressant medications.			

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	Interventions included, but were not limited to, activities staff to assess and encourage her to attend activities that she enjoyed, dated 7/2/20. A current care plan, edited on 5/19/21, indicated she enjoyed socialization with peers, liked music and wanted to keep her mind occupied. The goal, with a target date of 8/11/21, indicated she would attend three music programs with peers weekly, and would attend four trivia programs with peers. Interventions included, but were not limited to, activity staff would provide her with a calendar of monthly activity, activity staff would inform her of and invite her to all activities of choice, and would transport to and from activity if necessary, all dated 7/2/20. A current care plan, edited on 5/14/21, indicated the resident was not able to participate in activities but enjoys watching television and listening to music. The goal, with a target date of 8/11/21, included, but was not limited to, the resident would participate in preferred activities, such as exercise and musical pursuits, twice a week or as tolerated. Interventions included, but were not limited to, provide her with an activity calendar, dated 3/2/21. During an interview, on 5/20/21 at 8:53 a.m., the Activity Director indicated the resident required assistance to participate in activities, enjoyed music, had attended bingo the day before (5/19/21), and music was played in the dining room during meals. Review of the resident's attendance in activity programs, provided by the Activity Director on 5/20/21 at 10:47 a.m., indicated the following: a. In February 2021, she had one in person visit.			

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	b. In March 2021, she had 14 in person visits and one Skype call. c. In April 2021, she had 15 in person visits and two Skype calls. d. In May as of 5/19/21, she had 10 in person visits and two Skype calls. These monthly attendance calendars did not indicate she had attended any other activities. During a 5/20/21, 1:09 p.m. interview the Activity Director indicated she began her position in February 2021. She had not yet attended the state approved activity director's training program and had not meet with an activity consultant prior to the survey. She had received training regarding the computer system, but had yet to have training about activity program development. The residents did not attend the morning activities and she had not asked residents why they did not attend morning activities. She had not considered changing the activities that where offered in the morning. The Activity Director indicated she was responsible for family visitation oversite and the family visitation occurred in the activity room. She had not developed or offered any activities designed to meet the needs of residents who have cognitive impairment. She did not document any evaluations or progress note in the clinical record as part of the assessment process. Until today's date, she did not understand what one to one activities where and the need to document what occurred and the resident's participation. During an interview with the DON on 5/20/21 at 2:08 p.m. he indicated, the facility did not have activity progress note, activity evaluations/assessments or activity attendance			

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	records for March, April and May 2021 for Residents 22, 48, and 24. Review of a current facility policy, titled "Quality of Life - Resident Self Determination and Participation," with a revised date of December 2016 and provided by the Administrator on 5/20/21 at 8:30 a.m., indicated " ...1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: ...e. Activities hobbies and interests; and f. Religious affiliation and worship preferences. 2 ... b. Gather information about the residents' personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record;...3. Residents are encouraged to make choices about aspects of their lives in the facility, including: ...d. Participating in community activities inside and outside the facility. 4. Residents are provided assistance as needed to engage in their preferred activities on a routine basis ...." 3.1-33(a)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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 when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and			

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	Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review, and interview, the facility failed to ensure a multi-dose vial of medication was labeled with open dates for 1 of 2 medication rooms observed (West Hall Medication Room) and failed to ensure medications were securely stored for 2 of 2 random observations. (Rehabilitation Hall and 200 Hall Medication Carts). Findings include: During an observation of the West Medication Room, accompanied by the Staff Development Coordinator on 5/17/21 at 9:54 a.m., three opened and undated vials of Tubersol Tuberculin Purified Protein Derivative, used for intradermal tuberculin testing, were in the refrigerator. The Staff Development Coordinator indicated each vial should have been dated when it had been opened. Information from the website https://www.fda.gov/media/74866/download, indicated a vial of Tubersol which has been entered and in use for 30 days should be	F 0761	Tubersol Tuberculin Purified Protein Derivatives in the West Hall Medication Room were discarded and replaced. The capsule on top of medication cart in hall 200 was immediately discarded and medication cart was locked. The Novolog flex pen and inhaler on top of medication cart in Rehabilitation Hall were placed inside the mediation cart and the cart locked immediately. Medication rooms and medication carts were audited immediately to ensure multi-dose vials were dated and the mediations were securely stored Licensed nurses and QMAs received education regarding drug storage policy. Education will be provided upon hire and annually DON or designee with audit the medication rooms to ensure multi-dose vials are dated and	06/11/2021

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	discarded. 2. During a random observation on 5/16/21 at 9:32 a.m., the medication cart on the 200 hall was unlocked and unattended. Upon viewing the cart, a blue and red capsule was lying on top of the cart unattended. QMA 17 indicated the cart should always be locked and there should not be any medication left unattended. 3. During a initial facility observation on 5/16/21 at 9:25 a.m., the medication cart on the front Rehabilitation hall was observed with a Novolog flexpen (insulin) and an inhaler on top of the medication cart. There was no staff in the hallway. LPN 13 was observed walking down hallway towards cart on 5/16/21 at 9:27 a.m. She indicated she should have placed the insulin pen and inhaler in the medication cart drawer and closed computer with resident information viewable. Review of a current facility policy, titled "DRUG STORAGE," undated and provided by the ADON (Assistant Director of Nursing) on 5/20/21 at 10:05 a.m., indicated "...3. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...11...Insulin and other multi-dose vials or pens must be discarded after 28 days or according to manufacturer's recommendations...."		medications are securely stored 5 days a week for 4 weeks, weekly x 12 weeks and monthly x 8 months	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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	comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be			

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corresponding actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure trash and linens were properlly disposed of for 4 of 4 random observations and failed to ensure the laundry room floor and floor mat were kept clean and free of debris, for 1 of 1 laundry rooms observed. Findings include: 1. During a tour of the laundry room on 5/20/21 at 3:40 p.m., accompanied by the DON, a floor mat near the clean laundry folding table had visible debris on top of it, the floor in the clean area had	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Trash and linen were properly disposed immediately. The laundry room floor and floor mat were immediately cleaned. (Attachment A) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?	06/11/2021

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	visible debris. He indicated they had an outside service that cleaned the floor mat. On 5/20/21 at 3:42 p.m., the Environmental Supervisor indicated the floor and the floor mat both needed swept and cleaned, staff sweep and mop the floor at the end of the day, and he did not know when the floor mat would be cleaned again. On 5/21/21 at 9:33 a.m., the Administrator indicated they did not have logs related to sweeping and mopping the floors or floor mat in the laundry room and they did not have an outside service that cleaned the floor mat. Review of a current facility policy, titled "Laundry Routine (AM)," undated and provided by the Administrator on 5/21/21 at 9:33 a.m., indicated " ...2:00 pm - ...Clean, Sweep, Dust in Clean Laundry ...." 2. a. On 5/16/21 at 9:30 a.m., during a random observation of room 203, a trash bag was lying on the floor with no staff in the room. CNA 18 indicated she forgot to pick it up, and it should not be on the floor. b. On 5/18/21 at 3:22 a.m., during an random observation of the 200 hall, a large plastic bag of used Styrofoam cups was on the floor in front of employee lounge. CNA 19 indicated the bag should not be on floor. c. During a random observation on 5/19/21 at 10:01 a.m., Room 200 B had a trash bag lying in the middle of the floor. CNA 18 entered room to remove past residents' belongings and indicated the bag was left there and should not have been on the floor. d. During a random observation on 5/19/21 at 9:25		*Residents residing in the facility have the potential to be affected and continue to be screened daily for temperatures, signs of respiratory distress and atypical signs and symptoms. (Attachment B)* *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*	

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	a.m., Room 214, a large bag of trash and a large bag of soiled linen was on the floor outside the room in hall. CNA 20 indicated the bags should not be on the floor. 3.1-18(a)		·CMS-CDC Fundamentals of Covid-19 Prevention Training Self-Assessment Questionnaire completed indicating need for "Cleaning Environmental Surfaces and Shared Equipment" which was implemented for facility staff. (Attachment C) ·The facility LTC Infection Control Self-assessment was reviewed with the consulting Infection Preventionist resulting in an updated LTC Infection Control assessment being completed with input from the Consultant IP/Medical Director and DON (Attachment D) ·Root Cause Analysis (RCA) with facility consultant Infection Preventionist, including input from the facility Medical Director/DON/IP was completed (Attachment E) ·Consultant Infection Preventionist educated IDT/Leadership team on cleaning environmental surfaces and shared equipment utilizing CDC power point. (Attachment F) ·Involved staff were educated regarding cleaning environmental	

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			surfaces and shared equipment to include ensuring trash and linens are properly disposed and laundry room floor and floor mat are kept clean and free of debris utilizing CDC guidance and power point information. (Attachment G) ·Staff were educated regarding cleaning environmental surfaces and shared equipment to include ensuring trash and linens are properly disposed and laundry room floor and floor mat are kept clean and free of debris utilizing CDC guidance and power point information. (See Attachment H) 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? DON/Designee will audit through direct observation during facility rounds to ensure trash and linen are properly disposed and the laundry room floor and floor mat are kept clean and free of debris. Audits will occur daily x 4 weeks, weekly x 12 weeks and monthly x 8 months for total of 12 months. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below	

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			100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00352216, and IN00353021. Complaint IN00352216 - Unsubstantiated due to lack of evidence. Complaint IN00353021 - Unsubstantiated due to lack of evidence. Survey dates: May 16, 17, 18, 19, 20, and 21, 2021 Facility number: 000551 Residential Census: 38 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quaity review completed on May 28, 2021.	R 0000	Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on May 16th-21st, 2021. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and The Lodge's credible allegation of compliance. We allege compliance on June 11, 2021. Submission of this plan of correction does not constitute an admission by The Lodge or its management company that the allegations contained in the survey report is a true and accurate portrayal of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. We respectfully request a desk review.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff			

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	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 (D) preference; of the resident. (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. (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. (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. (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.			
	Based on interview and record review, the facility failed to complete service plans for 3 of 3 residents review for service plan development following admission (Residents 28, 27 and 31). Findings Include: A. Resident 28's clinical record was reviewed on 5/21/21 at 9:10 a.m. Current diagnoses included, but were not limited to, anxiety, depression, and hypertension. He was admitted to the facility on 4/23/21. The resident's record lacked a service	R 0217	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Service plans were updated for Resident 28, 27, and 31 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to	06/11/2021

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	plan. During an interview on 5/21/21 at 1:45 p.m., the RN consultant indicated this resident did not have a service plan. B. During an interview on 5/21/21 at 9:57 a.m., Resident 27 indicated he did not recall discussing a service plan with anyone at the facility. His clinical record was reviewed on 5/21/21 at 10:32 a.m. Diagnoses included, but were not limited to, Parkinson's disease and depressive episodes. The resident had admitted to the facility on 2/2/21. The clinical record did not include a service plan. During an interview on 5/21/21 at 11:41 a.m., the Marketing Director indicated the service plan needed to be done to allow the plan of care to be determined. She was unable to find his service plan. During an interview on 5/21/21 at 2:16 p.m., the DON indicated this resident did not have a service plan. C. Resident 31's clinical record was reviewed on 5/21/21 at 11:56 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, chronic obstructive pulmonary disease, and chronic kidney disease. The resident had admitted to the facility on 11/15/20. The clinical record did not include a service plan. During an interview on 5/21/21 at 2:16 p.m., the DON indicated this resident did not have a service		be affect. All service plans were audited to make sure every resident had a current service plan. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Interim Unit Manager and Marketing Director were educated on the importance of having service plans How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee will audit 5 random residents to ensure updated service plans are on file weekly x 12 weeks, then monthly for 6 months.	

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	plan. During an interview on 5/21/21 at 2:45 p.m., the Administrator indicated the facility did not have a policy related to service plans, and they follow State regulations.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to appropriately label over-the-counter medications brought in to the facility by the resident that were stored in the medication cart in 2 of 2 medication carts. (Middle hall medication cart and Long hall medication cart) Findings include: 1. On 5/21/21 at 1:50 p.m., during observation of the middle hall medication cart, accompanied by LPN 16, the following was observed: a. A vial of Humulin N (insulin) lacked a date opened. LPN 16 indicated the vial had 20% of insulin remaining. b. A vial of Humulin R (insulin) lacked a date opened. LPN 16 indicated the vial had 90% of insulin remaining. c. A Humalog Kwikpen lacked an opened date. LPN 16 indicated 200 of 300 units remained.	R 0302	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Insulin pens lacking open dated were discarded and replaced. The bottle of acetaminophen and bottle of senna were also discarded and replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Medication rooms and medication carts were audited immediately to ensure medications were dated and labeled appropriately. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?	06/11/2021

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	d. A Humalog Kwikpen lacked an opened date. LPN 16 indicated 18 of 300 units remained. e. A Lantus Solostar pen (insulin) lacked an opened date. LPN 16 indicated 218 of 300 units remained. f. A bottle of acetaminophen (pain reliever) 500 milligram (mg) lacked a physician name. LPN 16 indicated 30% of the bottle remained. g. A bottle of senna (laxitive) 8.6 mg lacked a physician name. LPN 16 indicated bottle was 1/2 full. 2. On 5/21/21 at 1:59 p.m., during observation of the long hall medication cart, accompanied by LPN 16, the following was observed: a. A Novolog Flexpen lacked an opened date. LPN 16 indicated 240 of 300 units remained. b. A Humalog Kwikpen lacked an opened date. LPN 16 indicated 250 of 300 units remained. c. A Humalog Kwikpen lacked an opened date. LPN 16 indicated 7 of 300 units remained. d. A Lantus Solostar pen lacked an opened date. LPN 16 indicated 25 of 300 units remained. During an interview on 5/21/21 at 2:05 p.m., LPN 16 indicated all insulin pens should be labeled with date opened. During an interview on 5/21/21 at 2:47 p.m., the Administrator indicated the facility has no written policies for the assisted living facility, but follow the state regulations.		Licensed nurses and QMAs received education regarding drug storage policy. Education will be provided upon hire and annually. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? DON or designee with audit the medication carts to ensure insulin pens and other medications are dated 5 days a week for 4 weeks, weekly x 12 weeks and monthly x 8 months.	

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents were assessed for tuberculosis within 90 days of being admitted to the facility for 2 of 3 residents reviewed for tuberculin testing. (Resident's 27 and 31) Findings include: A. Resident 27's clinical record was reviewed on 5/21/21 at 10:32 a.m. Diagnoses included, but were not limited to, Parkinson's disease and depressive episodes. The resident had admitted to the facility on 2/2/21. The clinical record did not include a tuberculosis risk assessment or a tuberculin skin test to	R 0410	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Tuberculosis skin tests were completed for residents 27 and 31** **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**	06/11/2021

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	determine the resident's tuberculosis status. B. Resident 31's clinical record was reviewed on 5/21/21 at 11:56 a.m. Diagnoses included, but were not limited to, diabetes mellitus type 2, chronic obstructive pulmonary disease, and chronic kidney disease. The resident had admitted to the facility on 11/15/20. The clinical record did not include a tuberculosis risk assessment or a tuberculin skin test to determine the resident's tuberculosis status. During an interview on 5/21/21 at 2:16 p.m., the DON indicated neither resident had a tuberculosis risk assessment or a tuberculin skin test done. During the Public Health Emergency of COVID-19, a waiver was in place on tuberculin skin tests for residents newly admitted to the facility that indicated residential care facilities are no longer required to complete a tuberculin skin test test for residents within three (3) months prior to admission but must do so within ninety (90) days of admission. During an interview on 5/21/21 at 2:45 p.m., the Administrator indicated the facility does not have a policy related to assessing newly admitted residents for tuberculosis, and they follow State regulations.		**Residents who admitted during the Public Health Emergency of COVID-19 have the potential to be affected. All residents were audited to ensure they have a tuberculosis risk assessment or tuberculosis skin test completed.** **What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur?** **The Interim Unit Manager was educated that tuberculin skin tests must be completed within 90 days of admission during the COVID-19 public health emergency.** **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** DON or designee will audit 5 random residents to ensure tuberculosis skin tests are on file weekly x 12 weeks, then monthly for 6 months.	