STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE CITY PLACE	425 CHINWORTH CT WARSAW, IN 46580

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: Feburary 23 & 24, 2022 Facility number: 011389 Residential Census: 25 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/3/22.	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to			

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

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	familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure twelve fire drills were conducted yearly and at least every six months hold fire and disaster drill in conjunction with the local fire department. This has the potential to affect 25 Residents residing at the facility. Finding includes: On 2/23/2022 at 10:39 A.M., the Administrator indicated that they did not do all the required fire drills and hold fire and disaster drill with the local fire department. On 2/23/2022 at 10:55 A.M., the Administrator indicated they do not have a fire drill policy but follow the state guidelines. During an interview on 2/23/2022, at 11:19 A.M., the Maintenance Director indicated that she started in late August. She started doing fire drills in October and had one with the local fire department in January.	R 0092	**R 092 Administration and Management – Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** /p> **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of fire drills for the last 12 months was completed on 3/16/2022 by the Executive Director (ED) to ensuretwelve fire drills were conducted yearly and at least every six months hold fire and disaster drill in conjunction with the local fire department. Results review with the Regional Director of Facilities Management (RDFM) and schedule created for	03/26/2022

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			drill completion for the remainder of 2022. A fire and disaster drill was completed on 3/16/2022 by the MT in conjunction with the local fire department. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** /p> **4 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:** Effective 3/28/22, the ED or designee will complete an audit of fire drill logs monthly times 3 months to ensuretwelve fire drills are conducted yearly and at least every six months hold fire and disaster drill in conjunction with the local fire department. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	
R 0121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance			

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Bldg. 00	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			

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	Based on record review and interview, the facility failed to provide annual tuberculosis screening for 2 of 5 employee records reviewed. and health screening for 1 of 5 employee records reviewed for employee health. (Employee 6 & 7) Finding includes: On 2/23/2022, at 10:30 A.M., employee records were requested and provided. At 12:07 P.M., documents not provided during the initial review were requested. During the review of employee records, the facility could not provide documentation for Employee 6 receiving an employee health screening. Employee 6 began employment on 8/12/2019. In addition, Employee 6 and Employee 7 did not receive annual tuberculosis screening for the year of 2021. Employee 6 last tuberculosis screening was performed on 12/28/2020. Employee 7 last tuberculosis screening was performed 10/26/2020. During an interview on 2/23/2022 at 3:05 P.M., the Administrator indicated Employee 6 and 7 should have received an annual tuberculosis screening in 2021. A policy was requested on 2/23/2022 at 2:17 P.M. The Administrator indicated that the State regulations were followed regarding employee health and tuberculosis screenings. A policy was requested and not provided.	R 0121	**R 121 Personnel - Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** /p> /p> 2 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of employee health screens and annual tuberculosis screens was completed 3/11/2022 by the Executive Director (ED) to ensure current employees received a health screen and annual tuberculosis screening. Results reviewed by CSM and concerns identified were corrected. 3 **What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: The CSM was reeducated on 3/10/2022 by the Regional Director of Care Services (RDCS) on the need to provide annual tuberculosis screening to	03/26/2022

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			employees and a health screening for new employees prior to resident contact and per states requirements. Licensed nursing staff were reeducated on 3/16/2022 by the CSM on the need to provide annual tuberculosis screening to employees and a health screening for new employees prior to resident contact and per states requirements. 4 **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:** Effective 3/28/22, the CSM or designee will complete an audit of employee health screens and annual tuberculosis screens to ensure annual tuberculosis screening for employees and health screening for new employees prior to resident contact and per states requirements are completed. The audit will occur weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	

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			5 By what date the systemic changes will be completed Completion date: 3/26/2022	
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview and record review, the facility failed to ensure physician's order were followed for 1 of 6 residents observed for medication administration. (Resident H) Finding includes: Medication administration observation began on 2/23/2022 at 11:20 A.M. At 11:30 A.M., Employee 3 administer Resident H's medications that included a pill and Diclofenac Sodium cream (Volteran). Employee 3 was observed squeezing an undetermined amount of the cream into her gloved hand and then applying the cream to Resident H's right shoulder/upper arm region. During an interview on 2/23/2022 at 11:34 A.M., Employee 3 indicated she should have measured the amount of gel administered per the measuring device provided by the manufacturer. The device provides measurement for 2 grams and 4 grams administration. Employee 3 pulled	R 0243	**R 243 Health Services - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** **/p>** **/p>** **/p>** **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** A medication pass observation was completed on 3/15/2022 by the CSM on the need to ensuregels are labeled with an open date and physician orders	03/26/2022

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	the measuring device out of the Diclofenac Sodium gel box. It was adhered to the manufacturer's education. No open date was on the box of the Diclofenac Sodium gel. On 2/23/2020 at 1:25 P.M. a clinical record review of Resident H was conducted. Diagnosis included, but were not limited to: hypertension, osteoarthritis, hypothyroidism and osteoporosis. Resident H admitted to the facility on 8/30/21. A Physician's Order, dated 11/4/2021, indicated Diclofenac Sodium 1% apply 2 grams topically four times a day to the right shoulder and upper arm. On 2/23/2022 at 3:32 P.M., the Administrator provided a policy entitled, "Medication Administration". The policy indicated, " ...The six "right" of medication and treatments administration will be observed every time a medication is administered-right resident, right medication, right dose, right form and route, right time, right documentation ...."		are followed, including proper measuring of gel medication. No concerns identified. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was reeducated by the Regional Director of Care Services on 3/10/2022 on the need to ensuregels are labeled with an open date and physician orders are followed, including proper measuring of gel medication. Current staff who pass medications were reeducated by the CSM on 3/16/2022 on the need to ensuregels are labeled with an open date and physician orders are followed, including proper measuring of gel medication. **4 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:** b> to ensure physician orders are followed, including proper measuring of gel medications and gel medications are labeled with an open date. The observations will occur 3 times per week for 4 weeks, 2 times per week for 4 weeks, then weekly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will	

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			determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure authorizations for as needed medications administered by a qualified medication aide were documented in the medical record in 1 of 5 residents reviewed for medications. (Resident F) Finding includes: A clinical record was reviewed on 2/23/2022 at 3:35 P.M., and indicated Resident F diagnoses included, but not limited to: Parkinson's disease, hypertension, and prosthetic heart valve. Resident F's Physician Orders, dated 11/10/2021, indicated she was receiving Tylenol ES 1000 mg (milligrams) 2 caplets every 6 hours	R 0246	**R 246 Health Services - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident F was assessed for injury and adverse drug reaction on 3/16/2022 by Care Services Manager (CSM). None noted. The QMA was reeducated on 3/15/2022 by the CSM on the need to ensure authorizations for as needed medications administered by a qualified	03/26/2022

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	as needed for pain. A Medication Administration Record dated, 2/2022, indicated Resident F had received the pain medication on 2/14/2022 which was administered by a QMA (qualified medication aide). Resident F's Physician Orders, dated 1/5/2022, indicated she was receiving Norco (a narcotic) 10/325 mg (milligrams) 1 tablet every 4-6 hours as needed. A Medication Administration Record dated, 2/2022, indicated Resident F had received the narcotic medication on 2/22/2022 which was administered by a QMA. During an interview, on 2/23/2022 at 4:42 P.M, the Director of Nursing indicated that the as needed Tylenol and Norco were administered for pain by a QMA, the documentation should have been on the back of the Medication Administration Record, and had not been authorized by a nurse. During an interview, on 2/24/2022 at 9:24 A.M., the Director of Nursing indicated that the documentation for the as needed medication would not be documented anywhere else. She indicated they do not have a policy but follow the Qualified Medication Scope of Practice. On 2/24/2022 at 9:25 A.M., the Director of Nursing provided a scope of practice titled, "Qualified Medication Aide Scope of Practice", undated, and indicated it was the one currently used by the facility. The scope of practice indicated "... (11) Administer previously ordered pro re nata (PRN) medication only if		medication aide are documented in the medical record. **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** /p> **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was reeducated on 3/10/2022 by the Regional Director of Care Services (RDCS) on the need to ensure authorizations for as needed medications administered by a qualified medication aide are documented in the medical record. No additional QMA's currently providing services to the community. **4 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:** /p> **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	

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	authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to provide sanitary food service to 12 of 20 residents observed for food delivery service. Finding includes: On 12/23/2022 from12:10 P.M. through 12:25 P.M., dining room food service was observed in the main dining room. Employee 8 was observed to have her thumb beyond the rim of the plate when serving the residents' main plate. During an interview on 12/23/2022 at 12:26 P.M., Employee 8 indicated her thumb should not be over the edge of the plate being served.	R 0273	**R 273 Food and Nutritional Services - Deficiency** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Employee 8 was reeducated on 3/14/2022 by the Executive Director (ED) on the need to provide sanitary food service. **2 How the facility will identify other residents having the potential to be affected by the**	03/26/2022

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	On 2/23/2022 at 3:32 P.M., the Administrator provided a policy entitled, "Serving the Meal". The policy did not address sanitary handling during food service.		**same deficient practice and what corrective action will be taken:** The ED completed an observational audit of meal service on 3/16/2022 to ensure sanitary food service is provided. Concerns identified were corrected. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** Current staff were reeducated on 3/16/2022 by the ED to ensure sanitary food service is provided. **4 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:** ="" p="">\ **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference.			

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	(3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure that all the required information was provided in the Emergency Information File for 4 out of 5 records reviewed. (Residents B, C, D, F) Findings include: 1. On 2/23/2022 at 2:25 P.M. a clinical record review of Resident C was conducted. Diagnosis included, but not limited to: dyslipidemia and cardiomyopathy. Resident C was admitted to the facility on 5/31/2017. A review of the Emergency Information File indicated that an advance directive was not included. During an interview on 2/23/2022 at 2:34 P.M., the Director of Nursing indicated that an advance directive should have been available in the Emergency Information File. 2. On 2/23//2022 at 3:00 P.M., a clinical record review of Resident D was conducted. Diagnoses included, but not limited to: atrial fibrillation, arthritis, hypertension, congestive heart failure, coronary heart disease, vertigo, benign prostatic	R 0356	**R 356 Clinical Records - Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The emergency information file for resident C was updated with an advanced directive on 3/16/2022 by the Care Services Manager (CSM). The emergency information file for resident D was updated with an advance directive and resident information sheet including, funeral home and hospital preference on 3/16/2022 by the CSM. The emergency information file for resident F was updated with an advance directive and resident information sheet including, funeral home preference on 3/16/2022 by the CSM. Resident B no longer resides in the community effective 3/10/2022	03/26/2022

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		A. BUILDING 00 B. WING	02/24/2022

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	hypertrophy, and depression. Resident D was admitted to the facility on 11/30/2020. A review of the Emergency File indicated that an advance directive, a resident information sheet including: funeral home and hospital was not in the Emergency Information File. During an interview on 2/23/2022 at 3:25 P.M., The Director of Nursing indicated that an advance directive, funeral home and hospital should have been available in the Emergency Information File. 3. On 2/23/2022 at 3:40 P.M., a clinical record review of Resident F was conducted. Diagnoses included, but not limited to: Parkinson's disease, hypertension and prosthetic heart valve. Resident F was admitted to the facility on 11/3/2021 A review of the Emergency Information File indicated that an advance directive, a resident information sheet including: funeral home was not in the Emergency Information File. During an interview on 2/23/2022 at 4:19 P.M., the Director of Nursing indicated that an advance directive and the funeral home should have been available in the Emergency Information File.4. On 2/23/2022 at 1:39 P.M., a clinical record review of Resident B was conducted. Diagnosis included, but were not limited to: diabetes mellitus, Parkinson's disease and osteoarthritis. Resident B was admitted to the facility on 1/28/2021. A review of the Emergency Information File indicated that an advance directive, a resident information sheet including:		**2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of emergency information files for current residents was completed on 3/13/2022 by the Administrative Coordinator to ensure all required information is provided in the emergency information file. Results reviewed by the Executive Director and concerns identified will be corrected by 3/26/2022. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was reeducated on 3/10/2022 by the Regional Director Clinical Services (RDCS) on the need to ensure an emergency information file for each residents is complete with the required information. **4 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:** Effective 3/28/22, the CSM or designee will audit emergency files weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4	

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	the resident's name, sex, room, phone number, and date of birth were not in the Emergency Information File. Also, not included in the Emergency Information File were the hospital preference, legal representatives, resident's physician, emergency contacts, and photograph. During an interview on 12/23/2022 at 2:40 P.M., the Director of Nursing indicated the required information should be available in the Emergency Information File. On 2/23/2022 at 2:17 P.M., a policy for Emergency Information was requested and one was not provided. The administrator indicated the facility followed the state regulation.		weeks to ensure required information is included in the emergency information file. Results will be discussed in monthly QI meeting. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going. **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	
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			

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	a diagnosis. Based on record review and interview, the facility failed to ensure resident received timely Mantoux Tuberculosis screenings for 2 of 7 records reviewed. (Resident B & G) Findings include: 1. On 2/23/2022 at 2:45 P.M., a clinical record review for Resident G was conducted. Diagnoses included, but not limited to: dementia, major depression and schizophrenia. Resident G was admitted to the facility on 9/23/2021. A Tuberculosis Testing and Vaccine Consents and Records form for Resident G indicated she received a Mantoux (skin test for tuberculosis) 1st step on 9/23/2021 and read on 9/26/2021 with negative results. This form lacked the documentation to show a 2nd step Mantoux had been administered to Resident G. During an interview on 2/23/2022 at 3:15 P.M., the Director if Nursing indicated that Resident G should have had a second step administered 1 to 3 weeks after the first step. 2. On 2/23/2020 at 1:39 P.M. a clinical record review of Resident B was conducted. Diagnosis included, but were not limited to: diabetes mellitus, Parkinson's disease and osteoarthritis. Resident B was admitted to the facility on 1/28/2021. An initial tuberculosis screening test was performed on 1/28/2022. The tuberculosis test was read on 1/30/2022 with a negative result documented. No time was indicated for administration or reading. A second Mantoux was not administered. During an interview on 2/23/2022 at 3:05 P.M.,	R 0410	**R 410 Infection Control - Noncompliance** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B no longer resides in the community effective 3/10/2022 Resident G no longer resides in the community effective 1/31/2022 **2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** An audit of resident Mantoux Tuberculosis screenings was completed on 3/16/2022 by the Executive Director (ED) to ensure residents receive timely Mantoux Tuberculosis screenings. Audit reviewed and concerns identified were corrected. **3 What measure will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** The CSM was reeducated on 3/10/2022 by the Regional Director of Care Services (RDCS) on the need to ensure residents	03/26/2022

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	the Administrator indicated Resident B should have received a second step tuberculosis test. A policy was requested on 2/23/2022 at 2:17 P.M. The Administrator indicated that the State regulations were followed regarding resident tuberculosis screenings. A policy was requested and not provided.		receive timely Mantoux Tuberculosis screenings. Licensed nursing staff were reeducated 3/16/2022 by the CSM on the need to ensure residents receive timely Mantoux Tuberculosis screenings. **4 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:** Effective 3/28/22, the CSM or designee will audit resident Mantoux Tuberculosis to ensure residents receive timely Mantoux Tuberculosis screenings. The audit will occur weekly for 4 weeks, biweekly for 4 weeks, then monthly for 4 weeks. Results will be reviewed at monthly QI meeting. The QI Committee will determine if continued interviews are necessary based on 3 consecutive months of compliance. Monitoring will be on-going. I will do this audit more frequently and trend down like your other audits, this will help identify any residents out of compliance quicker **5 By what date the systemic changes will be completed** Completion date: 3/26/2022	