STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 13, 14, 15, 16, and 19, 2024. Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 6 Medicaid: 48 Other: 16 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 23, 2024.	F 0000	9-2-2024 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Recertification and State Licensure Survey Chateau Rehabilitation and Healthcare Center 6006 Brandy Chase Cove Fort Wayne, IN 46815-7601 Survey Event ID 76HB11 Dear Ms. Buroker: On August 19, 2024, a Recertification and State Licensure Survey was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. This letter is our formal request for a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction. Please feel free to call me with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monique Augustine	HFA	08/30/2024

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			any further questions at 1 (260) -486-3001. Respectfully submitted, Monique L. Augustine Health Facility Administrator	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation interview, and record review the facility failed to ensure fall interventions were recorded and communicated for 1 of 6 residents reviewed (Resident 67). Findings include: Resident 67's record was reviewed on 8/13/24 at 11:48 AM. Diagnoses included Alzheimer's disease, major depressive disorder, and unilateral primary osteoarthritis, right hip. Resident 67's current quarterly Minimum Data Set (MDS) dated 7/31/24 indicated his Basic Interview for Mental Status (BIMS) score was not conducted as he was rarely if ever able to make himself understood. The MDS indicated Resident 67 required assistance with activities of daily living and had fallen since admission to the	F 0689	F 689D Free of Accidents/Hazards/Supervision/Devices The facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	09/02/2024

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	facility. An admission fall risk assessment dated 5/17/24 indicated Resident 67 had fall risk factors including disorientation, 1-2 falls in the past 3 months, incontinence, decreased muscular coordination, use of medications that had side effects including drowsiness and dizziness, recent medication changes, and diagnoses predisposing a fall risk. A document titled Initial Occurrence Note dated 5/18/24 at 4:43 PM indicated Resident 67 was found lying on the floor after being seen walking toward the garden room. No fall interventions were recorded at the time of the fall. An interdisciplinary team (IDT) note dated 5/20/24 at 5:01 PM indicated an intervention of orienting Resident 67 to surroundings should be added. An IDT note dated 5/21/24 at 12:58 PM indicated an intervention of ensuring non-skid footing was in place. A document titled Initial Occurrence Note dated 6/23/24 at 6:40 AM indicated Resident 67 fell. No description of the fall or interventions added were available for review. A document titled Initial Occurrence Note dated 6/30/24 at 10:00 AM indicated Resident 67 was standing in the dining room with his hands on the back of a chair when he suddenly fell to the left landing on his left shoulder and arm. An intervention was assisting the Resident 67 to bed and lowering the bed to the floor. An IDT note dated 7/1/24 indicated staff should ensure proper footing when ambulating.		1.) What corrective actions will be accomplished for those residents found to have been affected by the practice? • Resident #67 was assessed, and care plan interventions updated along with Kardex. 2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken: • Any resident has the potential to be affected. • An audit was conducted to determine care plan interventions were in place and reflective on the Kardex. 3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. • Care Plans will be reviewed to determine interventions are appropriate for these residents identified to be at risk for falls. • DON /designee will audit falls for residents weekly to determine compliance with the fall prevention. • Identified issues will be addressed through re-education. • Staff educated in components of F689 and the prevention of Accidents and Hazards/ Supervision, to include intervention implementation and care plan and Kardex updating. • Identified concerns will be addressed with 1-1 education. • Nursing staff will be educated on	

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	A document titled Initial Occurrence Note dated 7/5/24 at 7:53 AM staff heard a noise in the dining room and found Resident 67 on the floor. An IDT note dated 7/8/24 at 4:25 PM indicated staff was educated on keeping the area bright, ensure toileting is completed, and offering snacks at bedtime. A document titled Initial Occurrence Note dated 7/26/24 at 5:00 PM indicated Resident 67 was walking in the dining room when he bent over to pick something up, lost his balance and fell. An IDT note dated 7/29/24 at 10:44 AM indicated staff should assist resident when bending over to pick items up off the floor. A document titled Initial Occurrence Note dated 8/9/24 at 2:30 PM indicated Resident 67 was found sitting on the floor of another resident's room. The intervention initiated was to assist the resident to lie down in his room. An IDT note dated 8/12/24 at 1:36 PM indicated Physical and Occupational therapy were initiated for weakness. During an observation and interview on 8/15/24 at 11:57 AM, Certified Nurse Aide (CNA) 11 indicated staff instructions for care of each resident were found in a book marked ADLS (activities of daily living), located in a cabinet in the pantry area of the dementia unit dining room. The book included printed care plan forms with care plan goal dates of 2022. The Dementia Care Director (DCD) indicated most of the care plans in the book were for residents no longer residing on the unit. She did not know why the book had not		fall prevention upon hire and at least annually and prn. 4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place. • The DON or designee will audit residents with falls weekly to determine compliance with the care plan fall interventions, prevention, and Kardex. • The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 100% compliance or greater is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Correction 9-2-2024	

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	been updated. Resident 67's care plan was not found in the book. CNA 11 and the Dementia Care Director were not aware of any other place instructions for care for CNAs were located and accessible to the CNA staff. A document titled Visual Bedside Kardex provided by the Assistant Director of Nursing on 8/15/24 at 12:28 PM indicated Resident 67 had safety precautions including encouraging him to lay in his bed and not in the middle of the floor or sidewalk. A mat to the floor beside the bed while in bed was an additional intervention. No other interventions were listed. Resident 67's current Care plan titled ...at risk for impaired safety/injury ...indicated the resident had a problem of a risk for falls, with a goal date of 9/16/24. Interventions included the following: 1. Distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, book, etc. 2. Encourage resident to avoid secured doorways to avoid injury when staff are entering and exiting unit; periodically re-evaluate need for secured unit. 3. Keep bed in lowest position 4. Mat to floor at bedside while in bed. 5. Refer to psychiatrist/psychologist/behavior specialist. No additional interventions were listed. During an interview on 3/18/24 at 3:18 PM, the Director of Nursing (DON) indicated a new intervention should be put in place immediately after post fall care (vital signs, assessments, first aid, if applicable) has been provided for a resident			

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	who had fallen. Interventions should be passed on verbally in report, added to the care plan and the Kardex (document for CNAs detailing individual care interventions). A current policy, undated, titled Falls Management and Fall Risk provided by the Chief Nursing Officer indicated each resident will have a person-centered fall care plan. The fall care plan should be reviewed at a minimum of quarterly, post fall, annually and with significant changes. The policy indicated the fall care plan should address both prevention of falls as well as when applicable, specific interventions in response to a fall occurrence. The policy indicated staff should implement additional or different interventions. 3.1-45(a)(2)			
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or			

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	university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in			

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	food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. Based on record review and interview the facility failed to ensure the qualified/registered dietician was licensed in Indiana. This deficient practice had the potential to affect 70 of 70 residents in the facility who received dietary services. Findings include: The employee records were reviewed on 8/18/24 at 11:40 AM. The employee records indicated Registered Dietician (RD) 6 was hired by the facility on 6/1/2024. Review of the Indiana Professional Licensing Agency website on 8/19/24 at 11:53 AM indicated, effective 7/1/2019, Dieticians would receive licensures instead of certifications through the Medical Licensing Board of Indiana.	F 0801	F 801 F Qualified Dietary Staff ' The facility respectively requests a desk review for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1.) What corrective actions will be accomplished for those residents	09/02/2024

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	RD 6's undated resume indicated she provided Dietician coverage for Long Term Care/Rehabilitation facilities as needed remotely through a nationwide dietician staffing service since 4/2024. The RD 6's resume indicated she was a RD/Licensed Dietician/Nutritionist in the states of North Carolina, South Carolina, and Florida. On 8/19/24 at 11:55 AM the Indiana Professional Licensing Agency website, 2024, was used to search for and verify RD 6's license. No current Indiana Registered Dietician license was found for RD 6. In an interview on 8/19/24 at 11:45 AM, the Administrator indicated according to federal regulations the facility's registered dietician must be licensed or certified as a dietitian or nutrition professional by the State in which the services are performed unless the State does not provide certification or licensure. A current policy titled, " Food and Nutritional Services", dated 11/2021, provided by the Director of Nursing on 8/19/24 at 12:18 PM, indicated a qualified dietician or other clinically qualified nutrition professional was one who ...was licensed or certified as a dietician/nutritional professional in the State their services were performed unless the State does not provide certification or licensure. No current Indiana Registered Dietician license was provided for RD 6 by survey exit.		found to have been affected by the practice? • No Resident was identified. 2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken: • Any resident has the potential to be affected. • The administrator contacted the contract company to ensure that there is a qualified/registered Dietician in Indiana that is providing services to the facility. 3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. • The contracted company will notify the administrator with any personnel changes with the staff who are providing services to the facility. • The administrator or designee will review any changes with the consulting dietary company to ensure the Dietician license is valid in Indiana. 4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place. • The Administrator or designee will audit monthly to determine compliance with the license for the dietician. • The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or	

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			until an average of 100% compliance or greater is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Date of Correction 9-2-2024	
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 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:			

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	(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 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 corrective 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			

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	its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure a shared glucometer was cleaned between uses for 3 of 12 residents reviewed (Resident 19, Resident 29, and Resident 30). Findings include: During a medication pass observation on 8/16/24 at 8:37 AM, Licensed Practical Nurse (LPN) 9 removed a glucometer (handheld device designed to measure blood glucose levels), lancet (small needle designed to poke the skin to produce a drop of blood), a test strip, and an alcohol swab from the top drawer of the medicine cart on the 300-hall of the C-wing. LPN 9 entered the room of Resident 19, cleaned her finger with an alcohol swab, obtained a drop of blood, applied it to the test strip inserted in the glucometer and obtained a reading. After the test, LPN 9 placed the glucometer in the top drawer of the cart, completed her documentation, and proceeded to prepare medications for the next resident who required medicine at that time. The glucometer was not cleaned before or after use. Upon completion of the medication pass observation, the medicine cart for the 300 hall of the C-wing was inspected. The glucometer in the top right drawer was the only glucometer in the cart. LPN 9 indicated that glucometer was used for all the residents on the 300- hall requiring blood glucose monitoring. She indicated it should be cleaned with a disinfectant wipe for 3 minutes before and after each use. She thought another employee had cleaned it earlier and did not give a reason for not cleaning it after use.	F 0880	F880 D Infection Prevention and Control. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • Immediate In-servicing initiated for facility licensed nursing staff per the Director of Nursing/Infection Preventionist on Infection Control/ Glucometer Cleaning and Disinfecting. • Residents #19, #29 and #30 were assessed, and plan of care reviewed. • LPN #9 received immediate 1-1 education on infection control and glucometer cleaning practices per Director of Nursing / IP/and Executive Director. 2)How the facility identified other residents: • Any residents residing in the facility that received glucometer checks per LPN #9 has the	09/02/2024

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	A document titled Glucometers, provided by the Director of Nursing on 8/16/24 at 12:32 PM indicated Resident 19, Resident 29, and Resident 30 used the glucometer in the 300-hall medication cart. Resident 19's record was reviewed on 8/16/24 at 1:04 PM. Diagnoses included type 2 diabetes without complications, chronic kidney disease, stage 4, and hypothyroidism. Resident 19's current significant change Minimum Data Set (MDS) dated 5/14/24 indicated her Basic Interview for Mental Status (BIMS) score was 7 (cognitively impaired). Physician orders dated 5/9/24 indicated Resident 19's blood sugar should be checked twice daily. Resident 29's record was reviewed on 8/16/24 at 12:02 PM. Diagnoses included type 2 diabetes without complications, end stage renal disease, and acute respiratory failure, unspecified whether hypoxia or hypercapnia. Resident 29's current quarterly Minimum Data Set (MDS) dated 7/11/24 indicated her Basic Interview for Mental Status (BIMS) score was 13 (cognitively intact). Physician's orders dated 3/5/22 indicated a glucometer check should be performed twice daily. Resident 30's record was reviewed on 8/16/24 at 11:28 AM. Diagnoses included type 2 diabetes mellitus with diabetic neuropathy, end stage renal disease, acute on chronic diastolic (congestive) heart failure.		potential to be affected. • No adverse outcomes identified. No other resident was identified to have been affected • An audit was conducted to identify those residents that receive glucometer checks. 3) Measures put into place/ System changes: • In servicing was provided by the Director of Nursing/IP/Designee to ensure nursing staff are educated and competent on infection control practices related to glucometer testing. • Nursing staff completed glucometer competencies. • New nursing employees will complete this competency during orientation. • Any resident that received glucometer check was provided with individual glucometers, stored individually with identifying name placed on meter and container. • Weekly audits and observations per Nursing management on correct infection control procedures for glucometer cleaning and disinfecting. 4) How the corrective actions will be monitored: • The responsible party for this plan of correction is the Director of Nursing /Infection Preventionist with Executive Director oversight. • The results of audits will be reviewed in scheduled morning/clinical meetings and Quality Assurance Meeting	

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	155249	A. BUILDING 00 B. WING	08/19/2024

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	Resident 30's current quarterly Minimum Data Set (MDS) dated 7/11/24 indicated his Basic Interview for Mental Status (BIMS) score was 14 (cognitively intact). Physician orders dated 5/23/24 indicated blood glucose readings were needed to determine need for insulin coverage at mealtimes. In an interview on 8/16/24 at 10:19 AM, the Administrator indicated the glucometer should be cleaned before and after each use to prevent cross contamination. A current policy dated 6/11/24 provided by the Administrator on 8/16/24 at 9:46 AM indicated blood glucometers intended for reuse are cleaned and disinfected between use with a disinfectant. An undated document titled Medical and Commercial Disinfecting wipes provided by the Administrator indicated a wipe must keep the device thoroughly wet for 2 minutes to ensure disinfection. 3.1-18(a)		monthly for 6 months or until 100% compliance is achieved x3 consecutive months. • The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 9-2-2024	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review the facility failed to ensure flooring panels were complete and intact for 1 of 24 residents reviewed (Resident 11). Findings include:	F 0921	F 921 D Safe/Functional/Sanitary/Comfortable Environ The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of	09/02/2024

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	During an observation on 8/13/24 at 9:51 AM, an approximately 15 inch by 30 inch area of floor paneling was missing in front of the heating unit and near the end of Resident 11's bed. One floor panel was lying loose across a small portion of the uncovered area. Resident 11's record was reviewed on 8/14/24 at 9:49 AM. Diagnoses included multiple sclerosis, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and type 2 diabetes mellitus without complications. Resident 11's current quarterly Minimum Data Set (MDS) dated 7/24/24 indicated her Basic Interview for Mental Status (BIMS) score was 4 (cognitively impaired). During an observation and interview on 8/13/24 at 12:16 PM, Registered Nurse (RN) 4, and Certified Nurse Aide (CNA) 5 and CNA 6 indicated they were not aware of the floor damage until that observation. CNA 5 indicated it likely just happened since one piece of flooring was lying in the middle of the patch of missing flooring. She was unable to identify where the other missing floor panels were located and indicated the additional damage must have happened at an earlier time. She indicated floor damage should be reported to maintenance immediately. During an observation and interview, on 8/13/24 at 12:18 PM, Maintenance 3 indicated this was the first he heard of floor damage. During an interview on 8/13/24 at 1:34 PM, the Administrator indicated floor damage should be reported through the facility maintenance system as soon as the damage is found. She indicated she		compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified: • Identified area of missing paneling in front of the heating unit in resident 11's room was repaired. • Resident was not adversely affected 2)How the facility identified other resident: • No resident was identified to have been affected related to identification of needed facility repair. • Facility wide walk through was completed by Administrator, Maintenance Director, to identify flooring issues. 3)Measures put into place/ System changes: • Maintenance added any identified needed facility repairs to Preventative Maintenance Log and with Administrator assistance prioritized repairs • Preventative Maintenance log will be reviewed and initialed weekly	

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	was not aware the floor panels were missing until today. A Document titled Point Click Care Dashboard, dated 8/13/24, provided by the Administrator on 8/13/24 at 3:10 PM indicated staff should use an application called tells to generate a work order to notify maintenance staff of any concerns. She indicated this system was the facility's current method of communication regarding maintenance issues and there were no additional facility policies available for review. 3.1-19(a)(4)		for completed repairs. • New identified area of needed repairs was placed on a repair schedule. • Educated staff to complete generate a work order through utilization of TELLS application • Angel Rounds will be completed 5 times weekly to identify any areas needing repair and review in scheduled stand-up meetings. 4)How the corrective actions will be monitored: • The responsible party for this plan of correction is the joint effort of the Executive and Maintenance Director. • Completed Angel rounds will serve as the facilities audit tool for identification of facility needed repairs. • Identified areas requiring repair are placed on a Preventative Maintenance log for follow up. • TELLS reports will be reviewed weekly per maintenance Director and Executive Director. • The results of these audits will be reviewed in QAPI monthly for 6 months and or until 90% compliance is achieved for 3 consecutive months. • The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5)Date of compliance: 9-2-2024	

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