STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155829	A. BUILDING 01 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(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
K 0000 Bldg. 01	A Life Safety Code and Preoccupancy survey for the following was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Building Renovation: - 200 Wing - Remodeling of part of the wing into a locked unit. The locked wing includes thirteen resident rooms to accommodate 14 residents, a resident lounge, a janitor's closet, a nurse's station, restrooms, a soiled laundry, and an activity / dining area. This project also includes a gated courtyard to the northwest of the locked wing, with access through the dining / activities room. *Note* The means of egress from the rest of the 200 hall may require accessing the locked unit. Survey Date: 02/23/24 Facility Number: 013499 Provider Number: 155829 AIM Number: 201285490 At this Life Safety Code and Preoccupancy survey, The Springs at Lafayette was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code, (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the	K 0000	The submission of this plan of correction does not indicate an admission by The Springs of Lafayette that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of The Springs of Lafayette. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Weaver	Executive Director	03/07/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	corridors, and all resident rooms with hard wired smoke detectors. The facility has a capacity of 70 and had a census of 60 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/29/24			
K 0200 SS=E Bldg. 01	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Based on observation and interview, the facility failed to ensure 1 of 1 door to the newly renovated locked unit was fully installed with all hardware. This deficient practice could affect any residents, staff, or visitors when using the entry doors to the unit. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:24 a.m., the three-hour rated double door set used to enter the locked unit was missing a screw in the center hinge of the left door as you enter the locked unit. Based on interview at the time of observation, the Executive Director stated that he would have the Senior Director of Construction	K 0200	The Director of Plant Operations replaced the missing screw in the center hinge of the left door as you enter the locked unit. The Director of Plant Operations was educated by the Executive Director on Means of Egress requirements – Other 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-Tags but are deficient. The Director of Plant Operations will complete single inspection of the facility verifying that all door hardware is installed correctly of the newly renovated wing. If missing hardware has been identified, these locations will have	03/08/2024

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	have someone add the screw into the hinge of the door as soon as he could. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		hardware installed immediately. This audit will be followed by a semi-annual audit of the newly renovated wing. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect any residents, staff, or visitors when using the entry doors to the unit.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 2 corridors within the unit. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of	K 0211	The director of Plant Operations removed the items that were being stored in the corridor immediately outside resident rooms #221 and #223 (a) large three-drawer dresser with cut for mini-refrigerator (b) a large dresser with four drawers (c) miscellaneous boxes an assorted trash items (d) a bedside table. The Director of Plant Operations was educated by the Executive	03/08/2024

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	wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 13 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:47 a.m., the following items were being stored in the corridor immediately outside resident rooms #221 and #223: a) a large three-drawer dresser with a cut-out for a mini-refrigerator b) a large dresser with four drawers. c) miscellaneous boxes and assorted trash items. d) a bedside table Based on interview with the Executive Director at the time of the observation, he acknowledged the items in the corridor and added that he would have them removed as soon as possible. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		Director on Means of Egress – General. Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2. through 18/19.2.11. 18.2.2, 19.2.1, 7.1.10.1 The Director of Plant Operations will audit each corridor 1 X per day X 30 days followed by 1 X per week X 8 weeks. Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect approximately 14 residents, 4 staff, and 2 visitors.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not			

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	be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard			

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	contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 2 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as many as 16 residents, 4 staff and 2 visitors needing to use the locked unit as an exit in the event of an emergency. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life	K 0222	The Director of Plant Operations has posted the code for the keypad located at entrance of new unit. The Director of Plant Operations and maintenance staff has been educated by the Executive Director on maintaining the posting of the entry door to the new unit. Doors within a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless otherwise permitted in accordance with 19.2.2.2.5.2 The Director of Plant Operations will perform monthly review X6. Results of these reviews will be	03/08/2024

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	Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:22 a.m., the entry doors to the new locked unit were marked as a facility exit, were magnetically locked and could be opened by entering a four-digit code, but the code was not posted at the door. Based on interview at the time of the observations, the Executive Director stated the aforementioned locked unit doors were indeed marked as exit, could be opened by entering a four-digit code, but the code was not posted adding that he would have the code posted as soon as he could. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		presented by Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect as many as 14 residents, 4 staff, and 2 visitors needing to use the locked unit as an exit in the event of an emergency.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign	K 0293	The Director of Plant Operations installed signage of not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads 'NO EXIT" The Director of Plant Operations	03/08/2024

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	that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 13 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:26 a.m., the door to the courtyard located in the activity / dining room was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the Executive Director stated the door to the courtyard is not an exit to the public way and acknowledged that the aforementioned door to the courtyard did not have a NO EXIT sign posted. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		was educated by the Executive Director on K293 – Exit Signage, NFPA 101, 2012 Existing. Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also serve by the emergency lighting system 19.2.10.1 The Director of Plant Operations will conduct audit of corridor for proper signage “No Exit” for leading to the exterior of corridor. 1 x per week x 3 months. Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 14 residents, 4 staff, and 2 visitors.	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as	K 0521	The Senior Director of Construction contacted HVAC	03/08/2024

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	a portion of a return air system serving adjoining rooms for 66 of 75 rooms. LSC 9.2.1 requires air conditioning, heating, ventilating, ductwork, and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long-term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. . This deficient practice could affect 13 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:26 a.m., air returns could not be found throughout the renovated space. Based on interview at the time of the observations, the Senior Director of Construction acknowledged the renovated area did not have return air installed and was indeed using the corridor to provide return air to the air conditioning and ventilating systems stating that he would look into the matter immediately. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		contractor to add air returns the renovated space. The Director of Plant Operations was educated by the Executive Director on NFPA 90A, Section 4.3.12.1.1 egress corridors in nursing and long-term care facilities shall not be used as a portion of a supply, return, or echaust air system serving the adjourning areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. The Director of Plant Operations will audit air returns 1 X per week X 4 weeks. Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 14 residents, 4 staff, and 2 visitors.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens			

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	Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, it could not be assured 13 of 13 rooms did not use extension cords, including power strips, used in patient care vicinities met UL 1363A or UL60601-1. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This	K 0920	The Director of Plant Operations as disconnected the outlet and USB features to all thirteen resident sleeping rooms with lamps that had a powered outlet attached to it. The Director of Plant Operations was educated by the Executive Director on K-920 – Electrical Equipment – Power Cords and extension Cords. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions	03/08/2024

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	deficient practice could affect 13 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:30 a.m., all thirteen resident sleeping rooms had a lamp that had a powered outlet attached to it. This lamp outlet is an extension cord and is not allowed to be used within a healthcare facility sleeping room area also known as the patient care vicinity. Based on interview at the time of observation, the Senior Director of Construction acknowledged that these lamp outlets were extension cords and stated that he would do something about them as soon as possible. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		of 10.2.4, 10.2.3.6 (NFPA 99), 10.2.4 (NFPA99), 400-8 (NFPA 70), TIA 12-5. The Director of Plant Operations and Executive Director will verify non approved devices are not in use on the newly renovated unit once per week X 3 months followed by once per month X 3. Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 14 residents, 4 staff, and 2 visitors.	
K 9999 Bldg. 01	1) 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(u)(1) The nurses' station must be equipped to receive resident calls through a communication	K 9999	**Immediate Intervention (1)** The Director of Plant Operations has re-installed the call light extension with the call button that was not plugged into the wall mounted box and was missing. The Director of Plant Operations was educated by the Executive Director on State Rule 3.1-19(b) 2) 3.1-19 Environment and	03/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155829	A. BUILDING 01 B. WING	02/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(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
	system from the resident rooms. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide access for nurse call lights in 1 of 13 resident sleeping rooms. This deficient practice could affect 1 resident. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:48 a.m., there was a box for a call light mounted on the wall at the head of the bed, but the call light extension with the call button was not plugged into the wall mounted box and was missing. Based on an interview with the Executive Director at the time of the observation, he stated that he was unaware of the missing call light cord and would have one located and plugged in as soon as he could. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b) 2) 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(a)(m)(1) The facility must provide each		Physical Standards 3.1-19(a) The Facility must designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. 3.1-19(a)(m)(1) The Facility must provide each resident a separate bed of proper size and height for the convenience of the resident. The Director of Plant Operations will conduct a single audit in each of the 13 sleeping rooms on the newly renovated for the complete install of call light cords. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 1 resident. **Immediate Intervention (2)** The Director of Plant has located the missing bedframe for room #228 and removed the mattress from the box and completely assembled the resident bed. The Director of Plant Operations was educated by the Executive Director on State Rule 3.1-19(b) 2) 3.1-19 Environment and Physical Standards 3.1-19(a) The Facility must design, constructed, equipped, and maintained to protect the health and safety of residents,	

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	resident a separate bed of proper size and height for the convenience of the resident. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide a resident bed in 1 of 13 resident sleeping rooms. Findings include: Based on observations made during a tour of the facility with the facility Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction, on 02/23/24 at 10:56 a.m., resident room # 228 had a mattress, still in the box and plastic wrapped within it, but there was no bedframe for the mattress. Based on an interview at the time of the observation, the Executive Director stated that he did not know where the bedframe was located but would find it and have it placed in room #228 as soon as possible. This item was discussed at the exit conference with the Executive Director, the Life Enrichment / Legacy Support person, and the Senior Director of Construction on 02/23/24 at 12:10 p.m. 3.1-19(b)		personnel, and the public. 3.1-19(a)(m)(1) The Facility must provide each resident a separate bed of proper size and height for the convenience of the resident. The Director of Plant Operations will conduct a single audit in each of the 13 sleeping rooms on the newly renovated for the complete assembly of the resident beds. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. This deficient practice could affect 1 resident.	