Ryan Carney

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	A. BUILDING <u>00</u>		
			B. WING	B. WING		
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			IAYSVILLE ROAD		
CEDARH	IURST OF FORT W	AYNE		WAYNE, IN 46815		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
R 0000						
Bldg. 00	This visit was for th IN00391020.	e Investigation of Complaint	R 0000			
	_	020 - Substantiated. State to the allegations are cited at 10.				
	Survey date: Octobe	er 4, 2022				
	Facility number: 01	4576				
	Residential Census:	54				
	These State Residen	itial Findings are cited in				
	accordance with 410	•				
	Quality review com	pleted October 6, 2022				
R 0088	410 IAC 16.2-5-1.3	3(c)(1-2)(d)(1-2)				
	Administration and	Management -				
Bldg. 00	Noncompliance					
	c) The licensee sh					
	. ,	ninistrator with either a:				
	. , .	e care facility administrator				
	•	d by IC 25-19-1-5(c); or				
	* *	e facility administrator				
		d by IC 25-19-1-5(d); and				
	(2) delegate to tha					
	authority to organize and implement the day-to-day operations of the facility.					
		ons of the facility. hall notify the director:				
	• •	working days of a vacancy				
	in the administrate					
		d license number of the				
	replacement admi					
		and record review the facility	R 0088	§ POC – On 10/13/22 the cha	ange 11/01/2022	
	failed to ensure the	facility had a licensed		of administrator form was		
			1			
		/IDER/SUPPLIER REPRESENTATIVE'S SI		TITLE	(X6) DATE	
Ryan Carn	ev		Executive	e Director	10/29/2022	

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.

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 1 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. WING 10/04/2		/2022		
		l	<u> </u>	STREET /	ADDRESS CITY STATE 718 COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	₹	STREET ADDRESS, CITY, STATE, ZIP COD  9210 MAYSVILLE ROAD				
CEDARH	IURST OF FORT W	VAYNE			NAYNE, IN 46815		
OLDAM		V/ \	FORT WATINE, IIV 40010				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL					COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		strator. 54 residents resided in			completed and sent to email		
	the facility.				address,		
					ltcproviderservices@isdh.in.go	ov to	
	Findings include:				name Jim Clindaniel as the		
	D	de a Administrativa de 1º			licensed administrator for the		
		the Administrator's license was			community. Additionally, on		
	-	Regional Director of Nursing			9/1/22 Jim Clindaniel was cha	-	
	(DON) on 10/4/22	at 1:12 PW.			to the licensed administrator of	i tne	
	In an interview and	10/4/22 at 2:14 PM, the			community within the Indiana		
	Regional DON indi				State Department of Health		
	_	on 8/30/22 and Regional staff			gateway site.  § Mr. Clindaniel has been on-	cita	
		legional DON indicated the			providing direct oversight of th		
	Regional staff did r				community October 10, 2022		
	_	ise. The Regional DON also			October 20, 2022. When not		
		y did not have a specific policy			directly on-site, a regional sup	port	
	but followed state g				supervisor is and will be on-sit	-	
	• • • • • • •				daily to provide community		
	This State citation i	is related to Complaint			oversight and reports all		
	IN00391020.	1			communication to licensed		
					administrator, Jim Clindaniel		
					through a daily report address	ing	
					the overall operations of the d	-	
					Mr. Clindaniel will then	-	
					communicate any follow up		
					required regarding his review	of the	
					daily report provided to him.		
					Additionally, Cedarhurst prov	ides	
					support oversight for operation	าร	
					and clinical services through t	he	
					use of, and on-site presence of		
					Regional Director of Operation		
					and Regional Director of Nurs	ing	
					regularly.		
					§ The community's quality		
					assurance program consists of		
					following department manage		
					· Executive Director, Director	tor	
					of Nursing, Resident Care		
					Manager, Environmental Serv	ices	

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 2 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI 10/04		
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COI IAYSVILLE ROAD	)	
CEDARH	IURST OF FORT W	VAYNE	FORT	WAYNE, IN 46815		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
				Director, Director of Dinir Services, Business Office Manager, Life Enrichmer Director, and Director of The quality assurance promeeting is held weekly for 6 months. During the assurance meetings, an review all aspects of the community's updates will communicated with the liadministrator for his review comments. The on-site edirector will also communicated all updates from the assurance program to Jin Clindaniel as the licensed administrator to ensure a and updates are in composite with ISDH regulations. The process will remain in efficient of 6 months in order maintain and sustain 100 maintain and sustain 100 meeting the	esect for a ler to	
R 0121 Bldg. 00	410 IAC 16.2-5-1. Personnel - Nonc	ompliance				
Diug. 00	employee of a fact contact. The screen skin test, using the PPD), unless a procan be documented recorded in millimed date given, date madministered. The following:  (1) At the time of (1) month prior to annually thereafted.	n shall be required for each cility prior to resident en shall include a tuberculin e Mantoux method (5 TU, reviously positive reaction ed. The result shall be reters of induration with the ead, and by whom e facility must assure the employment, or within one employment, and at least er, employees and nonpaid ties shall be screened for				

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 3 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
			B. WING 10/04/2022				
		1	STREE	T ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	₹					
CEDABL	IURST OF FORT W	/AVNE	9210 MAYSVILLE ROAD FORT WAYNE, IN 46815				
CEDARI	IURSI OF FORT W	VATINE	FOR	WATNE, IN 40815			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	tuberculosis. The	first tuberculin skin test					
	must be read prio	r to the employee starting					
	work. For health o	care workers who have not					
		d negative tuberculin skin					
	test result during t	the preceding twelve (12)					
		line tuberculin skin testing					
	1	e two-step method. If the					
		ve, a second test should be					
	1 '	) to three (3) weeks after the					
	1	quency of repeat testing will					
	depend on the ris	k of infection with					
	tuberculosis.						
		who have a positive					
		n test shall be required to					
	1	y and other physical and					
	I -	nations in order to complete					
	a diagnosis.						
	1 ' '	all maintain a health record					
		that includes reports of all					
	1	ed health screenings.					
	1 ' '	with symptoms or signs of					
		ymptoms suggestive of					
		s, including, but not limited					
	_	night sweats, and weight					
	1	permitted to work until					
	tuberculosis is rul	eu out.	D 0121	S. The Director of Number 22	d one 11/01/2022		
	Rased on intervious	and record review the facility	R 0121	§ The Director of Nursing and of the TB certified LPN emplo			
		f 6 employees received a 2 step		can and will be providing all T	- I		
		eening skin test. (CNA 2, CNA		screens for all new staff going			
	3).	cennig skin test. (CIVA 2, CIVA		forward. Should one or both of			
	- J.			these TB certified employees			
	Findings include:			(DON and LPN) be unavailab			
	- mamas morado.			then the community will rely of			
	CNA 2 was interviewed on 10/4/22 at 1:40 PM.			relationship with its Occupation			
		ne had been working the floor		Health partner, Parkview Hea			
		scheduled to receive her 1st		complete these new hire TB			
	step TB screening s			screens.			
	- Servening S			§ Additionally, in an effort to			
	The Employee Reco	ords form and Employee		correct any staff who may be	out		
	l	and zamploy co	1	1 3311331 arry stair write may be			

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 4 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDII	4G <u>00</u>		COMPLETED	
			B. WING			10/04/2022	
		<u> </u>	CTI	DEET ADDRESS CITY	Z STATE ZID COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		REET ADDRESS, CITY 10 MAYSVILLE F			
CEDABL	IURST OF FORT W	/AVNE					
CEDARI	iuksi ur fuki w	VATINE	۲۷	PRT WAYNE, IN 4	10013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVID	DER'S PLAN OF CORRECTION	(X:	5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	IX (EACH CORR CROSS-REFER	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA	TE COMPLI	ETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA		DEFICIENCY)	DAT	Έ
		ded by the Regional Director		of compliar	nce, the community	will	
	of Nursing (DON)	on 10/4/22 at 3:50 PM. The		audit the st	taff files in place an	d	
	forms indicated CN	JA 2's start date was 9/7/22 and		provide the	e appropriate TB sc	reens	
	1st step TB screening	ng was completed on 10/4/22.		for any stat	ff who have one or	both	
		icated CNA 3 started 8/17/22		steps outst	tanding and be		
	_	t step TB screening on 8/15/22,		<u>completed</u>	on or before Nover	<u>nber</u>	
	but had not received	d a 2nd step.		<u>1, 2022.</u>			
				· The c	ommunity's leaders	hip	
		10/4/22 at 4:30 PM, the			artment managers)		
	_	icated employees should have			scheduled meeting		
		tep TB test prior to working the			d in an effort to		
		ep should be completed within		effectively	monitor the TB		
	14 days of the 1st s	tep.			process and ensure		
					reoccur, the leader	•	
	A policy, undated,			_	II add a review of th		
	_	rovided by the Regional DON			for the week along v		
		PM. The policy indicated "it is			ınity's current new l	nire	
		v the direction of state			et that tracks all		
	regulations in relati	on to TB screening."			ment screenings a	nd	
				completion			
	_	relates to Complaint		I -	nmunity's quality		
	IN00391020.				program consists of		
				_	epartment manage		
					utive Director, Direc	tor	
				_	Resident Care		
				_	Environmental Serv	ices	
					irector of Dining		
					Business Office		
					_ife Enrichment		
					nd Director of Sales	•	
				1	uality assurance	, l	
				1 ' -	eeting is held week	-	
					period of 6 months,		
				1	and all new hires f		
				I	is week. The comm	uriity	
				I	n ongoing new hire		
				I -	et that will track all		
					ment screenings a	iiu	
				·	progress which		
	I			includes th	e new hire's TB	[	

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 5 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED  B. WING 10/04/2022					
NAME OF PROVIDER OR SUPPLIER  CEDARHURST OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD  9210 MAYSVILLE ROAD  FORT WAYNE, IN 46815				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				screening and completion date. This quality assurance will occured weekly and the completion percentage will be 100% and it reviewed weekly by the license administrator to ensure compliance is met.	oe De		
R 0410 Bldg. 00	completed within the admission or upon forty-eight (48) to a result shall be reconsidered induration with the by whom administe (f) For residents whom administed to the tuberculin should employ the first step is negative performed within on after the first test. It testing will depend with tuberculosis.  (g) All residents who to the tuberculin should a chest x-ray	Noncompliance berculin skin test shall be aree (3) months prior to admission and read at seventy-two (72) hours. The arded in millimeters of date given, date read, and areed and read.					
	failed to ensure 3 of	and record review the facility 12 residents received a 2 step ening skin test. (Resident K, t M).	R 0410	§ The Director of Nursing and of the TB certified LPN employ can and will be providing all TI screens for all new residents p to admission. Should one or b of these TB certified employee (DON and LPN) be unavailable.	vees 3 prior poth		

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 6 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

NAMILOF PROVIDER OR SUPPLIER  CEDARHURST OF FORT WAYNE  REGIA TORY OR SUPPLIER  (EACH DEPICIONY MIST BE PRECEDED BY FULL PROPERLY MIST BE PRECEDED BY FULL PROGRAM TO MIST BE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING			
CEDARHURST OF FORT WAYNE   SUMMARY STATEMENTO DEPICUINCE:   DRIVERS   CACH DEPICE CONTROL OF PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECEDING IN THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PRECED BY FULL REGULATORY OR LSC IDENTIFY IN THE REGULATORY OR LS	NAME OF P	ROVIDER OR SUPPLIEF	1			
Resident K's record was reviewed on 10/4/22 at 4:59 PM. Resident L's record indicated the resident received a 1st step TB screening test.  Resident M's record did not indicated the resident received a 2st step TB screening test on 9/12/22. The record did not indicated the resident received a 2st step TB screening.  Resident M's record was reviewed on 10/4/22 at 4:59 PM. Resident M's record indicated the resident received a 2nd step TB screening test on 9/12/22. The record did not indicated the resident received a 2nd step TB screening.  Resident M's record was reviewed on 10/4/22 at 4:59 PM. Resident M's record indicated the resident received a 2nd step TB screening.  Resident M's record did not indicated Resident M received a 2nd step TB screening.  In an interview on 10/4/22 at 4:59 PM, the Regional Director of Nursing (DON) indicated residents should receive the 1st step TB screening prior to or the day of admission. The Regional DON also indicated residents should receive their 2nd step 1d days after the 1st step was completed. The Regional DON also indicated the facility did not have a specific policy but followed state guidance.  This State finding relates to Complaint IN00391020.  This State finding relates to Complaint IN00391020.  PAGENTAL TAG  TAG  TAG  THE REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  THE REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  THE REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  THE Headerstate PROPREATE Relationship with the residents' primary care physician to complete the relationship with the residents' primary care physician to complete the relationship with the residents' primary care physician to complete these TB screening the teating the physician to complete these TB screens prior to admission.  S Additionally, will rely on its relationship with the residents' primary care physician to complete these TB screens prior to admission.  S Additionally, will rely on its relationship with the residents' primary care physician to complete these TB screens prior to admissi	CEDARH	CEDARHURST OF FORT WAYNE				
Resident K's record was reviewed on 10/4/22 at 4:59 PM. Resident L's record indicated the resident L's record was reviewed on 10/4/22 at 4:59 PM. Resident L's record indicated the resident received a 1 st step TB screening test on 9/12/22. The record did not indicate Resident L received a 2nd step TB screening test on 9/12/22. The record was reviewed on 10/4/22 at 4:59 PM. Resident M's record indicated the resident received a 1st step TB screening test on 9/9/22. The record did not indicated the resident received a 1st step TB screening test on 9/9/22. The record did not indicated the resident received a 1st step TB screening test on 9/9/22. The record did not indicated the resident received a 1st step TB screening test on 9/9/22. The record did not indicated the resident received a 1st step TB screening test on 9/9/22. The record did not indicated the resident received a 1st step TB screening (DoNs) indicated residents should receive the 1st step TB screening prior to or the day of admission. The Regional Director of Nursing (DoNs) indicated the facility did not have a specific policy but followed state guidance.  This State finding relates to Complaint IN00391020.  Resident K's record indicated the community will audit the residents on the day of admission. § Additionally, in an effort to complete these TB screens prior to admission. § Additionally, in an effort to comment by will audit to exident shound a propriet to admission. § Additionally, in an effort to comment in a displaying the resident from any currently be out of compliance, the community will audit the resident from appropriate TB screens prior to admission. § Additionally, in an effort to comment in a displaying the resident from appropriate TB screens prior to admission. § Additionally, in an effort to community will audit the resident from appropriate TB screens prior to start should receive the state of the fellow propriet on or both steps outstanding and be completed on or before November 1, 2022.  The community will audit the resident files	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	1.70	Resident K's record 4:59 PM. Resident resident had not rec test.  Resident L's record 4:59 PM. Resident resident received a 9/12/22. The record received a 2nd step  Resident M's record 4:59 PM. Resident resident received a 9/9/22. The record received a 2nd step  In an interview on received a 2nd step  In an interview on Regional Director or residents should rec screening prior to o Regional DON also receive their 2nd ste was completed. The the facility did not b followed state guide  This State finding re-	was reviewed on 10/4/22 at K's record indicated the eived a 2 step TB screening  was reviewed on 10/4/22 at L's record indicated the 1st step TB screening test on 1 did not indicate Resident L TB screening.  I was reviewed on 10/4?22 at M's record indicated the 1st step TB screening test on 10/4?22 at M's record indicated the 1st step TB screening test on 10/4/22 at 4:59 PM, the of Nursing (DON) indicated review the 1st step TB red the day of admission. The 1 indicated residents should the p 14 days after the 1st step to Regional DON also indicated have a specific policy but ance.		then the community will rely relationship with the residen primary care physician to complete these TB screens to admission.  § Additionally, in an effort to correct any residents who me currently be out of compliant community will audit the resifiles in place and provide the appropriate TB screens for a staff who have one or both so outstanding and be completed or before November 1, 2022.  The community's leaded team (department managers a regularly scheduled meeting weekly and in an effort to effectively monitor the new resident's TB screening product and other residency requirer to ensure that it does not reduce the leadership meeting will a review of the new residents week, to track all pre-resident documentation required as week, to track all pre-resident	on its ts'  prior  ay ce, the ident e any steps ed on ership e) host ng  cess ments, occur, add a for the ncy vell as ition y  s of the iers: ector rvices

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 7 of 8

PRINTED: 10/31/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  10/04/2022	
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF FORT WAYNE			9210 M	ADDRESS, CITY, STATE, ZIP COD MAYSVILLE ROAD WAYNE, IN 46815		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  meet weekly for a period of 6 months and will effectively more all new resident's TB screening process and other residency requirements by utilizing an a form which the DON and Executive Director will review ensure that it does not reoccut The quality assurance meeting further add a review of the neresidents for the week, to trace pre-residency documentation required as well as screening their completion progress. The process will be for a period of months to maintain and sustand 100% compliance. If any area found to be missing, the DON complete the TB screening process again and document	onitor ag  udit  to  ur. g will w ck all s and is 6 in as are	(X5) COMPLETION DATE
				100% compliance.		

State Form Event ID: 8XIK11 Facility ID: 014576 If continuation sheet Page 8 of 8