STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155323	A. BUILDING 00 B. WING	08/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKEVIEW VILLAGE SENIOR LIVING	410 TIOGA RD MONTICELLO, IN 47960

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 29, 30 and 31, 2018 Facility number: 000216 Provider number: 155323 AIM number: 100267580 Census Bed Type: SNF/NF: 29 Total: 29 Census Payor Type: Medicare: 4 Medicaid: 23 Other: 2 Total: 29 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/5/18.	F 0000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under state and federal law. Please accept this Plan of Correction as our credible allegation of compliance. Provider desires to request a desk review in lieu of a re-visit due to monitoring in place to substantiate the allegation of compliance. Christopher J. Schiavone, HFA Administrator	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review, the facility failed to provide showers per resident preference to a resident who required total assistance with activities of daily living (ADL's) for 1 of 1 residents reviewed for choices. (Resident 20)	F 0677	1. A shower was provided immediately for resident 20. Resident preferences were again discussed with the resident with no significant changes indicated at this time.	09/28/2018

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

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	Finding includes: Interview with Resident 20, on 8/2718 at 3:15 p.m., indicated she was suppose to get 2 showers a week, but sometimes did not get any showers. Interview with Resident 20, on 8/31/18 at 10:10 a.m., indicated she was getting showers "half the time." Resident 20's record was reviewed on 8/29/18 at 3:15 p.m. Diagnoses included, but were not limited to, obesity, spina bifida (spine and spinal cord do not form correctly at birth), hypertension (high blood pressure), asthma, irregular heart rhythm, and mild intellectual disabilities. A Significant Change Minimum Data Set (MDS) assessment, dated 7/19/18, indicated Resident 20 was totally dependant on bathing with a 2 person assist and was cognitively intact. A "Daily Preference" form was completed 6/14/18 and indicated showers 2 x (times) a week on Tuesday and Fridays, in the evenings. The "Resident Care Record" indicated Resident 20 received "PB" - Partial Bathing, in the evenings on August 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, and 30 and a shower on August 24. Interview with CNA 1 on 8/31/18 at 8:57 a.m., indicated Shower Sheets are completed and given to the Nurse. Interview with the Director of Nursing (DON) on 8/31/18 8:58 a.m., indicated shower sheets are completed and reviewed. If the resident refuses bathing, the CNA marked refused on the sheet.		2. No other Residents were affected, however, as all residents have the potential to be affected, the following corrective actions shall be taken. 3. All residents were assessed to assure proper shower schedules in place. Resident preferences were again discussed with all residents, with no significant changes made. Nursing staff were re-educated on shower policy for all residents. 4. The shower policy and procedure was reviewed with no changes. All nursing staff was re-educated on the proper procedure and importance of showers for all residents and what to do should a Resident refuse their shower. The DON and/or designee will assess 5 residents' showers and care 5 x / week x 4 weeks, 3 x /week x 4 weeks then weekly thereafter. Should any concerns be noted, immediate corrective action will be taken. 5. The results of these reviews and any corrective action will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective actions will be completed on or before September 28, 2018.	

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	Interview with the Nurse Consultant on 8/31/18 at 10:17 a.m., indicated there was only 1 shower sheet dated August 24. If the resident refused, there should have been a behavior note and there were none for August. 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure a cognitively impaired resident was provided with the preferred activities of choice to meet the resident's interests for 1 of 1 residents reviewed for activities. (Resident 7) Finding includes: On 8/27/18 at 2:46 p.m., Resident 7 was sitting in a wheelchair in an open area by the nurses station. A radio was sitting on a table by the resident but was not on. There were no other residents around the area. On 8/28/18 at 2:01 p.m., Resident 7 was sitting in a wheelchair in an open area by the nurses station. The radio next to the resident was not on and no	F 0679	1. Resident 7 was immediately assessed, and family interviewed to assure resident was provided with preferred activities of choice to meet her individual interests. 2. All residents were reviewed, with input from family members, if applicable, to assure they are provided with preferred activities of choice to meet their individual needs. No other Residents were identified as affected. 3. The Activity Director was re-educated by the Administrator on 9/5/2018 pertaining to working with residents on preferred activities to meet their individual needs in addition to one on one	09/28/2018

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	other residents were around the area. On 8/29/18 at 2:15 p.m., Resident 7 was sitting in a wheelchair in an open area by the nurses station. The radio next to the resident was not on and no other residents were around the area. Record review for Resident 7 was completed on 8/28/18 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 6/13/18, indicated the resident was cognitively impaired. The activity preference indicated it was very important to have music she liked. The Activity Assessment Significant Change, dated 6/27/18, indicated the resident liked to listen to gospel and country music. She enjoyed talking and conversing with friends, family and staff. The resident was to have 1 on 1 with activities staff two times a week. Interview with the Activity Director on 8/29/18 at 2:17 p.m., indicated she hasn't documented 1 on 1 activity visits with the resident since March 2018. The resident use to listen to music but doesn't like to listen to it anymore. They haven't tried it again recently. She indicated it was hard for her because she was the only person at the facility for activities. 3.1-33(a)		documentation. The resident and/or family interviews were reviewed and activities implemented to meet the resident's interests. The Activity Director and/or designee will monitor 5 residents daily on scheduled days of work to ensure activities of interest are being followed utilizing the monitoring tools daily times 4 weeks, then weekly times four weeks then every two weeks times two months, then quarterly thereafter to assure residents activities are implemented to meet the resident individual interests. Should any concerns be noted, immediate corrective action will be taken. 4. The results of this monitoring, and any corrective action will be reviewed by the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective measures will be completed on or before September 28, 2018.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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	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, record review, and interview, the facility failed to ensure adequate supervision for a resident who was at risk for elopement related to an inaccurate elopement assessment for 1 of 1 residents reviewed for unsafe wandering/elopement. (Resident 7) Finding includes: On 8/27/18 at 11:27 a.m., Resident 7 was observed in her wheelchair by a side door of the employee entrance. The resident was pushing on the door and stating she wanted to go out. A staff member wheeled the resident away from the door to an open area by the nurses station. On 8/29/18 at 10:56 a.m., Resident 7 was observed in her wheelchair at the end of the hall. The resident was pushing on a door that leads out of the facility. The resident was saying, "come on, open the back door" " I want to leave". A CNA wheeled the resident away from the door. Record review for Resident 7 was completed on 8/28/18 at 11:25 a.m. Diagnoses included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 6/13/18, indicated the resident was cognitively impaired.	F 0689	1. Resident 7 was re evaluated for Elopement risk. 2. All residents were re evaluated for elopement risk with no further concerns noted. No other Residents were affected. 3. The Elopement risk policy and procedure was reviewed with no changes made. All staff was re-educated by the Administrator on 9/26/2018 pertaining to the Elopement Risk policy and specific procedures to follow if a resident is identified as exhibiting exit -seeking behaviors. The Social Services designee will review residents with exit seeking behaviors on a daily basis on scheduled days of work to ensure adequate supervision and assistance to prevent unsafe wandering/elopement. The SSD and/or designee will utilize the monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until compliance is obtained and maintained. 4. The results of this monitoring, and any corrective action will be reviewed by the	09/28/2018

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	A Nursing Note, dated 6/28/18, indicated the resident had asked several staff members to help her pack her bags so she could go home. A Nursing Note, dated 7/2/18, indicated the resident was confused throughout the shift. She was pushing on the exit door insisting she needed to leave. An Elopement Risk Assessment, dated 8/18/18, indicated the resident had the ability to move about the facility independently. The resident did not express a desire to leave the facility or exhibit exit seeking behaviors. The resident was not at risk for elopement. Interview with CNA 3 on 8/29/18 at 11:00 a.m., indicated the resident had been going to the doors a lot more lately trying to leave. She indicated the resident would say she wanted to go get an apartment. Interview with the Director of Nursing and the Social Service Director on 8/29/18 at 11:18 a.m., indicated the resident had voiced wanting to leave the facility since she had been there but had not made any attempts. If the resident had been going to the doors lately, staff should have told them so they could assess the resident for a risk for elopement. 3.1-45(a)(2)		facility's monthly QA meetings on an ongoing basis for a minimum of six month and the frequency of monitoring will be increased or decreased according to findings. The above corrective measures will be completed on or before September 28, 2018.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview the facility failed to monitor and assess pain for a cognitively impaired resident for 1 of 1 resident reviewed for pain management. (Resident 24) Finding includes: During an observation on 8/27/18 at 11:21 a.m., Resident 24 took out her lower dentures, pointed to the bottom right area and complained of pain to the bottom right, lower tooth area to the Activities Director. The Activity Director asked the resident if she had just eaten candy, the resident replied yes and the Activities Director said that is why it hurts. During an observation on 8/28/18 at 9:04 a.m., Resident 24 went to LPN 1, pointed to her right lower jaw area and complained that her tooth hurt. LPN 1 asked the resident if she had brushed her teeth today, the resident did not answer and walked away. LPN 1 did not further assess, nor look in to the resident's mouth. Resident 24's record was reviewed on 8/29/18 at 11:19 a.m. Diagnoses included , but were not limited to, Alzheimer's disease, mixed receptive-expressive language disorder (has problems expressing their needs), intellectual disabilities. The Quarterly Minimum Data Set (MDS) assessment, dated 7/24/18, indicated the resident was cognitively impaired. The current Physician Order Summary indicated to assess pain every shift and if present, refer to the	F 0697	1. Resident 24 was immediately assessed for pain and was noted to have a red, inflamed area with a white area in the middle, on the inside of Residents 24's cheek. 2. Resident 24 had no negative outcome as a result, as the physician was notified on 8/29/18 by the Director of Nursing and new treatment orders were initiated. All Residents were reviewed with no other Resident being identified to have been experiencing pain. No other Residents were affected. 3. The pain assessment policy and procedure was reviewed with no changes. All staff was re-educated on the proper procedure and importance of reporting pain for all residents and what to do should a Resident report they are in pain. The DON and/or designee will assess 5 residents' pain 5 x / week x 4 weeks, 3 x /week x 4 weeks then weekly thereafter. Should any concerns be noted, immediate corrective action will be taken. 4. The results of these reviews and any corrective action will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective actions will	09/28/2018

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	PRN (as needed) flow sheet. Tylenol 325 mg (milligrams) every 8 hours as needed for pain or fever. The Medication Administration Record indicated the resident was assessed for pain on 8/28/18 and did not have any pain all 3 shifts. The Nurse Progress Notes lacked documentation of the resident's pain. An updated care plan, dated 8/16/18, indicated the resident requires special attention to oral care, an intervention was to observe for oral/dental problems such as dryness, ulceration, cracking, bleeding. Interview with the Activities Director, on 8/28/18 at 8/28/18 at 4:10 p.m., indicated she always says something hurts, and she should have told the Nurse to assess the resident. Interview with the Director of Nursing (DON), on 8/29/18 at 10:41 a.m., indicated she always complains that something hurts. On 8/29/18 at 10:43 a.m., the DON assessed the resident's mouth and found a small, red inflamed area with a white area in the middle, on the inside of the resident's right cheek. 3.1-37(a)		be completed on or before September 28, 2018	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and	F 0759	1. Residents' 27 and 10 had no	09/28/2018

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	interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 8 residents observed during 3 medication pass observations. 2 errors in medications were observed during 33 opportunities for errors in medication administration. This resulted in a medication error rate of 6.06%. (Residents 27 & 10) Findings include: 1. During a medication administration observation on 8/28/18 at 5:00 p.m., LPN 2 prepared Resident 27's medications, which included an insulin pen. The LPN turned the dial on the insulin pen to 5 and then proceeded to administer the insulin to the resident's left arm. The LPN did not prime the pen and do an airshot (procedure to eliminate air from the needle and ensure the correct amount of insulin is given) before administering the insulin from the insulin pen. Record review for Resident 27 was completed on 8/28/18 at 5:26 p.m. The August 2018 Physician Order Summary (POS) indicated an order for lantus (insulin) pen, to prime and inject 5 units every day. Interview with LPN 2 on 8/28/18 at 5:09 p.m., indicated she doesn't do an airshot before each administration and an airshot is only needed the first time you open the pen. Interview with the Director of Nursing on 8/28/18 at 5:11 p.m., indicated they should do an airshot before administering the insulin each time. The insulin pen manufacturing instructions, provided by the facility on 8/30/18, indicated, "...Giving the airshot before each injection. Before each injection, small amounts of air may collect in		adverse reactions. LPN 2 was re-educated on the use of the insulin pen as well as the necessity of monitoring the residents pulse prior to giving certain cardiac or antihypertensive medication. The physician for residents' 10 and 27 were notified with no new orders received. 2. Residents receiving insulin via insulin pen and residents receiving cardiac meds/antihypertensive meds charts were reviewed to assure correct administration and monitoring were complete with no concerns noted. Nursing staff were re-educated on medication administration with a special focus on use of insulin pen and monitoring pulse prior to giving certain cardiac/antihypertensive medication. 3. The medication administration policy was reviewed with no changes necessary. Nursing staff re-educated as above. The DON and/or designee will monitor nursing staff giving insulin injections via insulin pen, and monitoring pulse prior to giving cardiac meds per order for 3 residents 5 x per week x 4 weeks, 2 x per week x 4 weeks, and weekly x 4 weeks then quarterly thereafter to assure proper insulin administration via insulin pen and monitoring of pulse as necessary prior to giving cardiac medications as ordered.	

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	the cartridge during normal use. To avoid injection of air and to ensure you take the right dose of insulin...." 2. During a medication administration observation on 8/28/18 at 5:13 p.m., LPN 2 prepared Resident 10's medications, which included metoprolol succinate (blood pressure medication). The medication card indicated to hold the medication if the heart rate is less than 50. The LPN walked into the resident's room and administered the resident's medication without checking the resident's heart rate. Record review for Resident 10 was completed on 8/28/18 at 5:31 p.m. The August 2018 POS indicated an order for metoprolol succinate. Give 25 mg (milligrams) three times a day. Hold if the heart rate is less than 50. Interview with LPN 2 on 8/28/18 at 5:19 p.m., indicated she did not check the resident's heart rate before administering the medication but she should have. A policy titled, "Medication Administration" and received as current from the facility on 8/29/18, indicated, "...20. Always take pulse and B/P as indicated if ordered prior to giving certain cardiac or antihypertensive drugs...." 3.1-48(c)(1)		4. The results of these reviews and any corrective action will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective actions will be completed on or before September 28, 2018.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and			

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

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	the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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 its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during a dressing change for a resident with a pressure ulcer for 1 of 2 residents reviewed for pressure ulcer care. (Resident 9) Finding includes: During an observation of Resident 9's dressing change on 8/29/18 at 10:08 a.m. with LPN 1 and LPN 5, the resident was positioned onto her left side and the old undated dressing was removed. LPN 1 cleansed the sacral (tailbone area) wound	F 0880	1. Resident 9 was not affected. LPN 1 and 5 were re-educated on proper dressing change and infection control procedures such as glove use and hand washing. 2. Residents with wounds have the potential to be affected. All residents with wounds have been assessed for signs and symptoms of infection, with no concerns noted. 3. The infection control policy and the dressing change policy have been reviewed with no	09/28/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155323	A. BUILDING 00 B. WING	08/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAKEVIEW VILLAGE SENIOR LIVING	410 TIOGA RD MONTICELLO, IN 47960

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	and then applied the new dressing of silver alginate with the same gloved hands and then placed a bandage that covered the silver alginate. Then LPN 1 applied a skin protectant on the resident's buttock with the same gloved hands. Interview with LPN 1 after the completion of the dressing change, indicated she had no excuse, she had forgotten to change her gloves. It is an every day dressing change, so the bandage does not need to be dated. Policy titled, "Dressing-Clean Technique," was provided by the Nurse Consultant on 8/29/18 at 11:13 a.m. This current policy indicated, "...Procedure...2. Removed soiled dressing and discard into designated waste receptacle. 3. Remove gloves, wash hands, and put on a pair of clean gloves...." 3.1-18(a) 3.1-18(l)		changes indicated. Nursing staff have been re-educated on proper dressing change procedure with a special focus on glove use and hand washing. The DON/designee will monitor dressing changes daily 5 x per week x 4 weeks, 2 x per week x 4 weeks, and weekly x 4 weeks then quarterly thereafter to assure proper dressing change procedure. 4. The results of these reviews and any corrective action will be reviewed during the facility's monthly QA meetings on an ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective actions will be completed on or before September 28, 2018.	
F 0921 SS=E 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 and interview, the facility failed to maintain a functional, safe and homelike environment related to yellowed discolored pull cords in the bathroom, exposed toilet screws, strong urine smell in the bathroom, and discolored floor tiles in 3 of 4 hallways. (Hallway A, Hallway C and Hallway D) Findings include: During the Environmental Tour on 8/30/18 from	F 0921	1.) All items identified in the 2567 statement of deficiencies have been repaired or replaced - A5 bathroom pull cord replaced immediately - A5 bathroom toilet flange bowl caps were installed immediately - A1 bathroom tiles that surrounded the toilet has been cleaned and repaired immediately.	09/28/2018

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	11:00 a.m.-11:19 a.m., with the Administrator, the Director of Maintenance, the Housekeeping/Laundry Supervisor, and the Regional Consultant, the following was observed: 1. A Hallway: a. Room 5's bathroom pull cord had a yellow discoloration, the flange bowl caps were missing on toilet with exposed screws. There was one resident who resided in this room. b. Room 1's bathroom floor tiles that surrounded the toilet, had yellow and brown discolorations, there were missing flange bowl caps and exposed rusted screws on toilet base, and the bathroom walls were mainly blue with random pink patched areas. There was one resident who resided in this room. 2. C Hallway: a. On Room 2's floor near the bed in use, there were worn non-skid floor strips. There was one resident who resided in this room. 3. D Hallway: a. On Room 3's bathroom wall, there were four screws sticking out above the toilet, a strong urine smell in the bathroom, and brown discolored tiles around toilet. There were two resident who shared this bathroom. Interview with Administrator at the end of the tour, indicated the above was in need of repair or cleaning. 3.1-19(e)		A1 toilet flange bowl caps were installed immediately - The random pink patched areas have been painted blue to match the rest of the bathroom - C2 had the non-skid strips removed - D3 bathroom walls had the screws removed, patched and painted. The bathroom was deep cleaned and no urine odor has been identified - D3 bathroom tiles have been replaced 2.) As all residents/rooms have the potential to be affected, the following corrective actions were taken. 3.) A facility wide inspection was completed on 9/13/18 by the facility Administrator to identify any further discolored bathroom call cords, missing toilet flange bowl caps, discolored floor tiles, worn non-skid strips with any concerns addresses/corrected. The facility Administrator or his designee will complete weekly facility tours to inspect areas of the facility to identify any discolored tile, missing toilet bowl flange caps and any discolored bathroom pull cords. Theses tours and audits will continue weekly for 4 weeks then bi-weekly for 4 weeks, then monthly for 6 months. 4.) The results of these tours and any corrective action will be reviewed during the facility's monthly QA meetings on an	

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			ongoing basis for a minimum of six months and the frequency of monitoring will be increased or decreased according to findings. The above corrective actions will be completed on or before September 28, 2018.	