STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE OF CASTLETON	8480 CRAIG ST INDIANAPOLIS, IN 46250

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R 000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: March 4 & 5, 2015 Facility number: 009894 Provider number: 009894 AIM number: N/A Survey team: Michelle Hosteter, RN-TC Gloria Bond, RN Sandra Nolder, RN Census bed type: Residential: 125 Census payor type: Other: 125 Sample: 13 These findings are cited in accordance with 410 IAC 16.2-5. Quality Review was completed by Tammy Alley RN on March 10, 2015.	R 000	This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or the proposed administrative penalty (with right to correct) on the community. Rather, it is submitted as confirmation of our ongoing efforts to comply with all statutory and regulatory requirements. In this document, we have outlined specific actions in response to each allegation or finding. We have not presented all contrary factual or legal arguments, nor have we identified all mitigating factors.	
R 092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire			

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

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	and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct fire drills quarterly on all shifts and a fire and disaster drill in conjunction with the fire department at least every six months. This had the potential to affect 125 of 125 residents residing in the facility. Findings include: The "Fire Drill Report" documentation logs were reviewed on 3/4/15 at 10:45 a.m. The "Fire Drill Report" documentation logs indicated a fire drill was completed on 4/30/14, then another	R 092	**1.Corrective Action for affected/cited resident:** **There was no negative outcome with residents identified during survey process failure to complete fire drills.** **1.How to Identify Other Residents/Associates with potential for similar events:** **No other residents were effected by failure to complete fire drills.** **1.Systemic Changes you will make:** **The maintenance supervisor was educated on the process**	03/31/2015

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	was not completed until 1/17/15. The "Fire Drill Report" documentation logs had no documentation of a fire and disaster drill being completed at least every six months in conjunction with the fire department. A "Focus Action Plan" provided by the Executive Director (ED) on 3/4/15 at 10:45 a.m., indicated the "Issues/Concerns: fire drills quarterly on all shifts not being done. No documentation [sic]...." During an interview on 3/4/15 at 11:00 a.m., the ED indicated no fire drills had been completed from April 2014 to January 2015, and no fire and disaster drills with the fire department had been attempted throughout the last year.		**of fire drills and maintaining records.** **1.Monitoring Q.A. plan:** **A Fire Drill Audit Tool for the community has been developed and the ED or Designee will monitor and ensure fire drills be conducted on each shift quarterly. Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive** ***Director***	
R 117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the			

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	specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and first aid certified staff member in the facility available for residents at all times. This had the potential to affect all 125 of 125 residents currently living in the facility. Findings include: The record review of employee records, including CPR and First Aid certifications, was completed on 3/5/2015 at 12:30 p.m. During an interview on 3/5/15 at 12:30 p.m., the Health Wellness Director indicated all the names of the staff with CPR and First Aid certification had been	R 117	**1.Corrective Action for affected/cited resident:** **Audit was completed to ensure nurses on duty have CPR and First Aid Certification.** **1.How to Identify Other Residents/Associates with potential for similar events:** **No other residents have been affected by this deficiency as evidenced by no negative outcomes identified.** **1.Systemic Changes you will make:** **All nurses have been certified in CPR and First Aid. All new nurses hired will be CPR and First Aid Certified prior to being placed on duty.** **1.Monitoring Q.A. plan** **The HWD will perform an**	03/31/2015

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	provided. The record of the nursing staff schedule as worked, for the past two weeks, was provided by the Health Wellness Director on 3/5/15 at 12:30 p.m. The record of the employees with CPR and First Aid certification and the record of the nursing staff schedule as worked were compared and the following was found: On 2/15/15, for the 10 p.m., to 6 a.m., shift, no staff had current CPR and First Aid certification. On 2/19/15, for the 10 p.m., to 6 a.m., shift, no staff had current CPR and First Aid certification. On 2/23/15, for the 10 p.m., to 6 a.m., shift, no staff had current CPR and First Aid certification. On 2/28/15, for the 10 p.m., to 6 a.m., shift, no staff had current CPR and First Aid certification. As of exit on 3/5/2015 at 1 p.m., no other information was provided by the facility.		**audit of all nurses monthly to ensure they are currently certified in CPR and First Aid. Nurses that are not certified will be taken off the schedule and not allow to work till rectified. Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	
R 214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to			

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	admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure a semiannual evaluation was completed for 1 of 11 residents and failed to ensure a change of condition evaluation was completed for 2 of 11 residents reviewed for updated evaluations for individual needs. (Residents #38, #105 and #68) Findings include: 1. Resident #38's record was reviewed on 3/4/15 at 2:43 p.m. Diagnoses included, but were not limited to, acute pancreatitis, diabetes mellitus and a history of chronic pancreatitis. The last "Risk Identification Assessment" found in Resident #38's record was dated 4/17/14. During an interview on 3/5/15 at 10:18 a.m., the Heath Wellness Director (HWD) indicated the "Risk Identification Assessment" was the Evaluation she used for the semi-annual evaluations. She indicated the Evaluation of needs were to be updated semi-annually and Resident #38's had not been.	R 214	**1. Corrective Action for affected/cited resident** **There was no negative outcome with the resident identified during the survey process. Residents #38, #68 & #105 assessments has been updated related to their current conditions.** **1.How to Identify Other Residents/Associates with potential for similar events:** **A complete audit of medical records has been completed to ensure all other resident's assessments are current and updated related to their current conditions.** **1.Systemic Changes you will make:** **A complete audit of medical records has been completed to ensure all other resident's assessments are current and updated related to their current conditions.**	03/31/2015

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	2. Resident #105's record was reviewed on 3/4/15 at 12:42 p.m. Diagnoses included, but were not limited to, diabetes mellitus, pacemaker, and urinary tract infections. The last "Risk Identification Assessment" found in Resident #105's record was dated 11/4/14. The resident had a Physician order dated 2/5/15, which indicated "Anchored Foley Cath-dx [diagnosis] UTI [urinary tract infection] Nursing to: 1) Empty cath bag [sign for and] clean [sign for every] AM, [sign for every]] PM [sign for and] PRN [as needed] 2) Report [sign for changes] to MD [sign for and] family re: [regarding] urine color, appearance. 3) Apply clean cath bag [sign for every] AM [sign for and] PM. 4) Applciation [sic] of bags performed per facility policy." During an interview on 3/5/15 at 10:18 a.m., the HWD indicated the "Risk Identification Assessment" was the Evaluation she used for Change of Condition Evaluations. She indicated the Evaluation of needs were to be updated after a Change of Condition of a resident with a catheter and Resident #105's had not been. 4. On 3/4/2015 at 11:15 a.m., Resident		**1.Monitoring Q.A. plan** **The HWD will audit all residents records weekly to ensure all assessments are current related to resident's condition for change of condition or that assessments are completed upon admission and every 6 months. This process will be include identification of residents with change in condition.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	

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	#68's record was reviewed. Diagnoses, included, but were not limited to, diabetes, history of a stroke, and high blood pressure. The resident's interdisciplinary progress notes indicated on 2/22/15 at 2:17 p.m., the resident called nursing because his, " (L)[left] foot swelling...foot swollen up to knee Family was called Resident was taken to [name of hospital]." The resident's interdisciplinary progress notes indicated the resident returned on 2/26/15. The interdisciplinary progress notes for 2/26/15 at 10 p.m., indicated, "...Res[resident] stated he had his (L) [left] 5th digit of his foot amputated on 2/24/15. (L) foot has drsg[dressing] on it & a special boot. Res states a nrse[sic] from [name of hospital] will be coming daily to do the drsg[dressing] [symbol for change] to his (L) toe...." The record lacked any re-admission type evaluation of the resident. During an interview on 3/5/15 at 10:10 a.m., the Health Wellness Director indicated there were no new evaluation of needs assessment forms filled out for this resident.			

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R 217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure service plans were completed for a Change of Condition in a timely manner for 1 of 11 residents (Resident #105) and failed to ensure the service plans were signed and updated for 2 of 11 residents reviewed for service plans. (Residents #38, and	R 217	**1. Corrective Action for affected/cited resident** **There was no negative outcome with the resident identified during the survey process. Residents #38, #68 & #105 assessments has been updated related to their current conditions and have been reviewed**	04/05/2015

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	#68) Findings include: 1. Resident #105's record was reviewed on 3/4/15 at 12:42 p.m. Diagnoses included, but were not limited to, diabetes mellitus, pacemaker, and urinary tract infections. The last "PERSONALized Assisted Living Respect for Individual Preferences" found in the resident's record was dated 11/4/14, and signed and dated by the resident on 11/16/14. This service plan indicated under the "Bathroom Assistance" area "Resident does not require bathroom assistance. Resident is incontinent of bladder. Resident or designee will monitor and maintain inventory, order and supply incontinence products. Comments: Pull ups or panty inserts. States she wears rubber pants to bed to protect bedding." The resident had a Physician order dated 2/5/15, which indicated "Anchored Foley Cath-dx [diagnosis] UTI [urinary tract infection] Nursing to: 1) Empty cath bag [sign for and] clean [sign for every] AM, [sign for every]] PM [sign for and] PRN [as needed] 2) Report [sign for changes] to MD [sign for and] family re: [regarding] urine color, appearance. 3)		**and signed by residents or legal representative.** **1.How to Identify Other Residents/Associates with potential for similar events:** **A complete audit of medical records has been completed to ensure all other resident's assessments are current and updated related to their current conditions and have been signed by the resident or legal representative.** **1.Systemic Changes you will make:** **A complete audit of medical records will be completed weekly by the HWD to ensure all other resident's assessments are current and updated related to their current conditions and have been reviewed and signed by the resident or legal representative.** **1.Monitoring Q.A. plan**	

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	Apply clean cath bag [sign for every] AM [sign for and] PM. 4) Applciation [sic] of bags performed per facility policy." During an interview on 3/4/15 at 1:05 p.m., the Health Wellness Director (HWD) indicated the "PERSONALized Assisted Living Respect for Individual Preferences" was the resident's individual Service Plan. She indicated the last Service Plan that had been completed and signed by the resident was 11/4/14 and it had not addressed her catheter needs. 2. Resident #38's record was reviewed on 3/4/15 at 2:43 p.m. Diagnoses included, but were not limited to, acute pancreatitis, diabetes mellitus and a history of chronic pancreatitis. The last "PERSONALized Assisted Living Respect for Individual Preferences" found in the resident's record was dated 4/17/14, and signed and dated by HWD on 4/17/14, but lacked a signature or date from the resident or the resident's legal representative. During an interview on 3/4/15 at 3:55 p.m., the HWD indicated the "PERSONALized Assisted Living Respect for Individual Preferences" was the resident's individual Service Plan. The HWD indicated the resident		**A complete audit of medical records will be completed weekly by the HWD to ensure all other resident's assessments are current and updated related to their current conditions and have been reviewed and signed by the resident or legal representative.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	

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	"always" had an updated Service Plan in the computer, but he had not had one in his chart that was signed and dated. She indicated the resident had not signed the Service Plan on 4/17/14. 3. On 3/4/2015 at 11:15 a.m., Resident #68's record was reviewed. Diagnoses, included, but were not limited to, diabetes, history of a stroke, high blood pressure and recent left foot 5th digit amputation surgery. During an interview on 3/4/15 at 3:10 p.m., the Health Wellness Director printed what she indicated was the resident's only service plan. The resident's service plan was dated 2/12/2015. The document lacked the resident or legal representative's signature. During an interview on 3/4/15 at 3:15 p.m., the Health Wellness Director indicated she has not been able to have all the service plans signed by the residents. During an interview on 3/4/15 at 3:45 p.m., the resident indicated he was not clear on the services he was to be provided. He indicated he had not seen his service plan nor signed it.			

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R 241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review the facility failed to follow a physician's order in regards to a change in the status of a medication resulting in the resident receiving additional doses of a medication that were not ordered. (Resident #50) Findings include: On 3/5/15 at 11:15 a.m., the record review for Resident #50 was completed. Diagnoses included, but were not limited to, congestive heart failure, benign prostatic hypertrophy, and weakness. The Physician's Order dated 2/13/15 indicated, "...Loratadine [an allergy medication] 10 milligrams by mouth daily [PRN] [skin itching T.O. [telephone order] [nurse practitioner name] (handwritten below on the same physician's order sheet] 2/18/15- please note change to prescription as frequency of daily as needed skin itching/rash...."	R 241	**1. Corrective Action for affected/cited resident:** **The order for Loratadine for resident #50 has been clarified with the physician and documentation has been corrected to reflect the correct order. There was no harm to resident #50 related to this medication error.** **1.How to Identify Other Residents/Associates with potential for similar events:** **An audit of all physician orders related to medication was completed by pharmacy to ensure no other medication discrepancies have occurred. No other residents were affected by this event.** **1.Systemic Changes you will make:** **The HWD will double check all**	03/31/2015

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	signed by LPN #2 with no date and signed by Nurse Practitioner 2/18/15. The nurses notes dated 2/13/15 indicated,"...Resident went to dermatologist today seen NP [name of nurse Practitioner] received new order Loratadine 10 milligrams every day per phone. Noted in Medication Administration Record [MAR] & faxed to pharmacy. Daughter aware...." signed by LPN #2 on 2/13/15. The February MAR indicated February 14 through February 28, 2015 the resident had received Loratadine 10 milligrams daily. On 3/4/15 at 4:00 p.m., the Health and Wellness Director indicated there was an error as the medication should have been changed to as needed and it was not.		**physician orders every day while on duty to ensure orders are clear and correctly transcribed as ordered by the doctor. If orders are not clear or concise the HWD will follow up with the doctor for clarification. Nurses were inserviced medication administration to include order transcription.** **1.Monitoring Q.A. plan:** **The HWD will audit all medication order daily as orders are written and monthly during rewriting process. Medication errors will be tracked per policy and procedure.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	
R 273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.			

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		A. BUILDING 00 B. WING	03/05/2015

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	Based on observation, interview and record review, the facility failed to ensure a sanitary environment in the dry storage area and freezer floor area of the kitchen and failed to ensure a cook had hair covered effectively. This deficiency had the potential to affect 125 of 125 residents currently receiving food from the kitchen. Findings include: During an initial tour of the kitchen on 3/4/15 at 9:50 a.m., the dry storage area was observed with a pile of dark residue underneath one of the shelves. The Director of Dining Services indicated at the time he was not sure what had spilled under the shelves. During a kitchen observation on 3/4/15 at 11:30 p.m., Cook #3, while taking food temperatures, was observed with uncovered hair that fell in the front and side of her face. During a kitchen observation on 3/5/15 at 9:40 a.m., the floor of the walk in freezer was observed to have debris of labels and food residue frozen on it and an unidentified wrapped food item was on the floor.	R 273	**1. Corrective Action for affected/cited resident:** **Kitchen Staff cleaned the dry storage and freezer area immediately once identified. The cook not wearing hair covered was corrected upon identification and placed a hair cover on immediately after.** **1.How to Identify Other Residents/Associates with potential for similar events:** **The kitchen was inspected by the ED to ensure sanitation and that anyone in the kitchen is wearing appropriate head covers.** **1.Systemic Changes you will make:** **The Director of Dining Services monitor the kitchen daily using a Kitchen Sanitation Checklist to ensure all areas are maintained in accordance with state and local sanitation and safe food handling standards. To include all staff is wearing appropriate head covers while in the kitchen.** **1.Monitoring Q.A. plan:**	03/31/2015

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	The Executive Chef during an interview, at this time, indicated the floor needed to be cleaned and proceeded to dispose of the unidentified object on the floor. A policy titled "2013 Dining Services Operating Standards" was provided by the Director of Dining Services on 3/5/15 at 9:45 a.m. The record indicated, "All spills shall be cleaned up immediately and if needed the area shall be properly cleaned and sanitized...." The Indiana, "Retail Food Establishment Sanitation Requirements" manual indicated, "Effectiveness of hair restraint...food employees shall wear hair restraints, such as hats, hair coverings or nets,...that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment,...."		**Audits will be reviewed monthly to find trends through QA directed by the ED to ensure correction through education and monitoring.** **Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.**	
R 354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical			

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	limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure inter-facility transfer documentation was completely documented for 1 of 1 residents reviewed for inter-facility transfers. (Resident #68) Findings include: On 3/4/2015 at 11:15 a.m., Resident #68's record was reviewed. Diagnoses, included, but were not limited to, diabetes, history of a stroke, high blood pressure and recent left foot 5th digit amputation surgery. The resident's interdisciplinary progress notes dated 2/22/15 at 2:17 p.m., indicated the resident called nursing because his, " (L)[left] foot swelling...foot swollen up to knee Family was called Resident was taken to [name of hospital]. The resident's record lacked a transfer form. During an interview on 3/5/15 at 10:15	R 354	**1. Corrective Action for affected/cited resident: The order for Loratadine for resident #50 has been clarified with the physician and documentation has been corrected to reflect the correct order. There was no harm to resident #50 related to this medication error. 2. How to Identify Other Residents/Associates with potential for similar events: An audit of all physician orders related to medication was completed by pharmacy to ensure no other medication discrepancies have occurred. No other residents were affected by this event. 3. Systemic Changes you will make: The HWD will double check all physician orders every day while on duty to ensure orders are clear and correctly transcribed as ordered by the doctor. If orders are not clear or concise the HWD will follow up with the doctor for clarification. Nurses were inserviced medication administration to include order**	03/31/2015

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	a.m., the Health Wellness Director indicated there was no transfer form. She indicated one should have been filled out.		**transcription. 4. Monitoring Q.A. plan: The HWD will audit all medication order daily as orders are written and monthly during rewriting process. Medication errors will be tracked per policy and procedure. Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.** **1. Corrective Action for affected/cited resident: Kitchen Staff cleaned the dry storage and freezer area immediately once identified. The cook not wearing hair covered was corrected upon identification and placed a hair cover on immediately after.** **2. How to Identify Other Residents/Associates with potential for similar events: The kitchen was inspected by the ED to ensure sanitation and that anyone in the kitchen is wearing appropriate head covers. 3. Systemic Changes you will make: The Director of Dining Services monitor the kitchen daily using a Kitchen Sanitation Checklist to ensure all areas are maintained in accordance with state and local sanitation and safe food handling standards. To include all staff is wearing**	

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			appropriate head covers while in the kitchen. 4. Monitoring Q.A. plan: Audits will be reviewed monthly to find trends through QA directed by the ED to ensure correction through education and monitoring. Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings. 1. Corrective Action for affected/cited resident: There was no negative outcome with resident transferred without a Transfer Form. 2. How to Identify Other Residents/Associates with potential for similar events: HWD completed audit of residents transferred inter-facility to ensure transfer forms were used. There were no negative outcomes found during the audit. 3. Systemic Changes you will make: The HWD will monitor (audit) daily while on duty to ensure Transfer Forms are being completed and sent with resident transferred inter-facility. If found incomplete these will completed and sent to the other facility. Nurses have been inserviced on the	

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			importance and completion of Transfer Forms for inter-facility transfers. 4. Monitoring Q.A. plan: Daily audit of Transfer Forms will be monitored monthly using the QA processing to detect trends and needs for further education needs. Audit outcomes will be reviewed at upcoming Quality Assurance Meetings. The Executive *Director* will be responsible for directing additional action, based on audit findings.	