DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 155292 B. WING		(X3) DATE S COMPLI 03/11/2	ETED			
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE			2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST IAPOLIS, IN 46220	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT 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)	TE	(X5) COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42 Survey Dates: 03/11 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency I American Village w Emergency Prepare Medicare and Medicand Suppliers, 42 C	20189 55292 67330 Preparedness survey, vas found in compliance with dness Requirements for caid Participating Providers FR 483.73. certified beds. At the time of us was 123.	E 00	000	This Plan of correction constituthis facility's written allegation compliance for the deficienciecited. The submission of this pof correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspect report. American Village respectfully requests consideration for a desk review this plan of correction.	of s olan on	
K 0000							•
Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/11/25 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 At this Life Safety Code survey, American Village was found not in compliance with Requirements K 0000 This Plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. American Village respectfully requests consideration for a desk review of this plan of correction.		of s olan on				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Gina Couch **Executive Director** 03/24/2025

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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TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155292	B. WING		03/11/2025	
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE		2026 E	ADDRESS, CITY, STATE, ZIP COD EAST 54TH ST NAPOLIS, IN 46220			
(V4) ID	CUMMADV	CTATEMENT OF DEFICIENCIE	ID	<u> </u>	(V5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
TAG		Medicare/Medicaid, 42 CFR	TAG		DATE	
	•	Life Safety from Fire and the				
		National Fire Protection				
) 101, Life Safety Code (LSC),				
		g Health Care Occupancies and				
	410 IAC 16.2.	· ·				
	American Village c	onsists of two wings, Harrison				
	Hall which is one st	tory and Washington Manor				
	which is two stories	s. This facility was determined				
	to be of Type III (2)	11) construction and was fully				
	_	st wing of the second floor of				
	_	houses the Moving Forward				
	_	The facility has a fire alarm				
	-	detection on all levels in the				
		areas open to the corridor. The				
		operated smoke detectors in 59				
	-	ing rooms. The facility has				
		rd wired to the facility's				
	-	23 of 82 resident sleeping has a capacity of 150 and had a				
		e time of this survey.				
	census of 123 at the	time of this survey.				
	All areas where resi	idents have customary access				
		all areas providing facility				
	•	klered except for a detached				
	storage and repair s	•				
	Quality Review con	mpleted on 03/14/25				
K 0321	NFPA 101					
SS=E	Hazardous Areas	- Enclosure				
Bldg. 01	i iazaiuuus Aieas	- LIIOOSUIE				
Diag. 01	Rased on observation	on and interview, the facility	K 0321	K321 – Hazardous Areas -	04/04/2025	
		f 9 hazardous areas such as a	K 0321	Enclosure	04/04/2023	
		dry rooms were separated from		What corrective action(s) wi	ıı	
		oke resistant partitions and		be accomplished for those	"	
		be self-closing or automatic		residents found to have bee	n	
		ce with LSC 7.2.1.8. This		affected by the deficient	"	
	-	ould affect as many as 4 staff.		practice		
	1	,		" """"		

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	NT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 03/11/2025
	PROVIDER OR SUPPLIE	R	2026 E	ADDRESS, CITY, STATE, ZIP COD AST 54TH ST JAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIE	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 CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DEBE COMPLETION PRIATE DATE
TAG	Findings include: Based on observation Maintenance Direct on 03/11/25 at 12:: Laundry room was device but the door into the door frame times. When swing approximately a or and the door jam of Based on interview Maintenance Direct door to the aforem hazardous area, fail into the door frame. This finding was referenced.	stor during a tour of the facility 35 p.m., the corridor door to the a equipped with a self-closing refailed to fully close and latch when tested three separate ging to close, the door left ne-inch gap between the door on the latching side of the door. We at the time of observation, the stor acknowledged the corridor centioned laundry room, a led to self-close and fully latch exceptions.	TAG	The laundry room corridor has been adjusting and full closes along with latches. How other residents having potential to be affected by same deficient practice widentified and what correct action(s) will be taken. No residents were affected alleged deficient practice. Laundry staff have the potential be affected by the alleged practice. What measures will be purplace or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director educated on 3/24/25 by the ED/Designee regarding the laundry room corridor door separated from other corridors moke resistant doors fully closing and latching. A maintenance audit tool we completed to ensure the la room corridor door to fully and latch. How the corrective action will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be into place The POC QAPI To be utilized by ED/designee x 4 weeks, monthly x 6 mo and quarterly thereafter for year with results reported to	door ly ng the y the ill be ctive by the ential to deficient it into ce to be dor by vill be undry close u(s) re the e put ool will weekly nths, rone

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ENTERS FOR	MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>01</u>	COMPLETED
		155292	B. WING		03/11/2025
NAME OF P	ROVIDER OR SUPPLIE	R	STREET .	ADDRESS, CITY, STATE, ZIP COD	
TWINE OF T	ROVIDER OR SOLVER.			AST 54TH ST	
AMERICA	AN VILLAGE		INDIAN	IAPOLIS, IN 46220	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				Quality Assurance and	
				Performance Improvement	
				Committee overseen by the	
				Executive Director	
				• If a threshold of 95% i	
				not achieved, an action plan w	'III
				be developed to ensure	
				compliance.	
K 0353	NFPA 101				
SS=E Bldg. 01	_	- Maintenance and Testing			
Diag. 01	Based on observati	on, and interview; the facility	K 0353	K353 Sprinkler System –	04/04/2025
		of 1 sprinkler heads behind the	K 0555	Maintenance and Testing	04/04/2023
		ers covered with lint were		What corrective action(s) wil	
		l in accordance with NFPA 25.		be accomplished for those	
	_	d for the Inspection, Testing,		residents found to have beer	ı
		f Water-Based Fire Protection		affected by the deficient	
	Systems, 2011 Edit	tion, Section 5.2.1.1.1 states		practice	
	sprinklers shall not	show signs of leakage; shall		The sprinkler head behind the	
	be free of corrosion	n, foreign materials, paint, and		laundry room dryers has been	
		and shall be installed in the		cleaned and free of lint.	
		(e.g., upright, pendent, or		How other residents having t	he
	· ·	nore, at 5.2.1.1.2 any sprinkler		potential to be affected by th	
	_	any of the following shall be		same deficient practice will be	
	replaced:			identified and what correctiv	e
	(1) Leakage			action(s) will be taken.	
	(2) Corrosion(3) Physical Damage(4) Loss of fluid in the glass bulb heat responsive			No residents were affected by	the
				alleged deficient practice.	al to
	element	the glass but heat responsive		Laundry staff have the potentia	
	(5) Loading			be affected by the alleged defi practice.	CICIIL
		painted by the sprinkler		What measures will be put in	to
	manufacturer.	painted by the spiniklei		place or what systemic	
		sprinklers that are loaded with		changes will be made to	
		to clean sprinklers with		ensure that the deficient	
		by a vacuum provided that the		practice does not recur	
	_	t touch the sprinkler.		The Maintenance Director has	

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staff.

This deficient practice could affect as many as 4

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been educated on 3/24/25 by the

ED/Designee regarding sprinkler

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[XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN VILLAGE			2026 E	ADDRESS, CITY, STATE, ZIP COD EAST 54TH ST NAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT 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)	DATE
	Findings include: Based on observations made with the Maintenance Director during a tour of the facility on 03/11/25 at 12:35 p.m., the sprinkler head located behind the Laundry room dryers was completely covered with lint. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler head was loaded with lint adding that he would have one of his team clean the area behind the dryers and blow off the sprinkler head immediately. This finding was reviewed with the Field Maintenance Supervisor and the Maintenance Director at the exit conference. 3.1-19(b)			heads being inspected and fre lint. A maintenance audit tool will is completed monthly to ensure sprinkler heads are inspected free of lint and debris. How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality assurance program will be pinto place The POC QAPI Tool will be utilized by ED/designee week 4 weeks, monthly x 6 months, quarterly thereafter for one ye with results reported to the Quastrance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant.	the and the ut be ly x and ar uality seen bt be
K 0374 SS=E Bldg. 01	Based on observation failed to ensure 1 of would restrict the mr 20 minutes. LSC 19 barriers shall compl 8.5.4.1 requires door the opening leaving necessary for proper	Iding Spaces - Smoke on and interview, the facility of sets of smoke barrier doors dovement of smoke for at least of 3.7.8 requires doors in smoke by with LSC Section 8.5.4. LSC ors in smoke barrier shall close only the minimum clearance or operation. This deficient t as many as 42 residents, 6	K 0374	K374 Subdivision of Building Spaces – Smoke Barrier Door What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The smoke barrier doors near to resident room #101 has been cleared of a moveable food cannot be affected by the same deficient practice will be same deficient practice will be same deficient practice.	est en art. the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/11/2025 155292 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2026 EAST 54TH ST INDIANAPOLIS, IN 46220 AMERICAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Based on observations made with the identified and what corrective Maintenance Director during a tour of the facility action(s) will be taken on 03/11/25 at 12:35 p.m., the set of smoke barrier No residents were affected by the doors nearest to resident room # 101 on Harrison alleged deficient practice. hall was obstructed by a food cart. Based on All residents, visitors and staff interview at the time of observation, the have the potential to be affected Maintenance Director acknowledged these smoke by the alleged deficient practice. barrier doors as being obstructed from fully closing and added that staff knew better than to What measures will be put into leave items obstructing the barrier doors. place or what systemic changes will be made to This finding was reviewed with the Field ensure that the deficient Maintenance Supervisor and the Maintenance practice does not recur Director at the exit conference. The Maintenance Director educated on 3/24/25 by 3.1-19(b) ED/Designee regarding smoke barrier doors not to be obstructed and to be able to fully close. A maintenance audit tool will be completed to ensure the smoke barrier doors are clear of obstruction and able to fully close. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director If a threshold of 95% is not achieved, an action plan will be

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developed to ensure compliance.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155292	(X2) MUL' A. BUILI B. WING	DING	01	(X3) DATE : COMPL 03/11/	ETED
	PROVIDER OR SUPPLIER		12	2026 EA	DDRESS, CITY, STATE, ZIP COD ST 54TH ST APOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	failed to conduct questimes under varying shift for 4 of 4 quar could affect all reside facility. Findings include: Based on review of documentation entity Conduct a Fire Drill Maintenance Direct a.m. on 03/11/25, the a.m.) fire drills come and 08/31/24 and 1 respectively, 5:37 a p.m.: were all conductions, and were resinterview at the time Maintenance Direct aforementioned this conducted at unexpections. This finding was residued.	triew and interview, the facility arterly fire drills at unexpected a conditions on the second ters. This deficient practice dents, staff and visitors in the staff and visitors in the dents, staff and visitors in the staff and visitors in the dents, staff and visitors in the dents, staff and visitors in the dents den	K 071	2	K712 – Fire Drills What corrective action(s) wibe accomplished for those residents found to have bee affected by the deficient practice The fire drill schedule has bee modified so that the fire drills be at varied times and under varying conditions. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken. No residents were affected by alleged deficient practice. All residents, visitors and staff have the potential to be affected by the alleged deficient practice by the alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur The Maintenance Director had been educated on 3/24/25 by ED/Designee in ensuring the drills are conducted at varied times and under varying conditions. How the corrective action(s) will be monitored to ensure deficient practice will not recur, ie., what quality	n en will the he be ye y the fted ce. nto s the fire	04/04/2025

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CENTERSIO	WINEDICHNE & MEDIC	THE SERVICES			ONID 110: 0700 007
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155292	B. WING		03/11/2025
			STREET	ADDRESS, CITY, STATE, ZIP COD	<u></u>
NAME OF	PROVIDER OR SUPPLIEF	8		AST 54TH ST	
AMERIC	AN VILLAGE			NAPOLIS, IN 46220	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and	Trash Containers	K 0754	assurance program will be p into place The POC QAPI Tool will I utilized by ED/designee week 4 weeks, monthly x 6 months, quarterly thereafter for one ye with results reported to the Quassurance and Performance Improvement Committee over by the Executive Director If a threshold of 95% is not achieved, an action plan will be developed to ensure compliant	be ly x , and ear uality rseen oe
	failed to ensure 4 or receptacles in the cogallons in capacity This deficient pract residents, 6 staff and compartment. Findings include: Based on observation Maintenance Direct on 03/11/25 betwee 2:15 p.m., the followa) there was a large a large 40-gallon trathe corridor outside b) there was a large a large 40-gallon trathe corridor outside Based on interview	or during a tour of the facility on the hours of 12:15 p.m. and wing was noted: 40-gallon soiled linen cart and ash container being stored in resident room #414.	K 0/34	Containers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice The soiled linen carts have been placed in a room protected as hazardous area. How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken No residents were affected by alleged deficient practice. All residents, visitors and staff have the potential to be affect by the alleged deficient practice.	n een a the ne be ve / the f led ce

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the capacity of the receptacles and the fact that

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place or what systemic

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 01		COMPLETED	
		155292			03/11/2025	
		1.53252			30,11,2320	
NAME OF P	ROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
				AST 54TH ST		
AMERIC	AN VILLAGE		INDIAN	IAPOLIS, IN 46220		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	they were all being	stored within a 64 square foot		changes will be made to		
	area.			ensure that the deficient		
				practice does not recur		
	This finding was re	viewed with the Field		Maintenance Director,		
	Maintenance Super	visor and the Maintenance		housekeeping and nursing st		
	Director at the exit	conference.		have been educated on 3/19	/25 by	
				ED regarding facilities praction	ce of	
	3.1-19(b)			not using trash or soiled liner	n	
				containers larger than 32 gal	lons	
				in a 64 foot area.		
				A maintenance audit tool will		
				completed to ensure there ar		
				trash or soiled linen containe		
				larger than 32 gallons in a 64	l foot	
				area.		
				How the corrective action(s	•	
				will be monitored to ensure	the	
				deficient practice will not		
				recur, ie., what quality		
				assurance program will be	put	
				into place	ho	
				The POC QAPI Tool will utilized by ED/designee weel		
				4 weeks, monthly x 6 months	•	
				quarterly thereafter for one ye		
				with results reported to the Q		
				Assurance and Performance	· I	
				Improvement Committee over		
				by the Executive Director	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
				If a threshold of 95% is r	not	
				achieved, an action plan will		
				developed to ensure complia		

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