		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/13/2025	
	ROVIDER OR SUPPLIER			2300 PA	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN DD, IN 46036		
(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 Date: 03/13/ Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this EP survey, Efound not in compli Preparedness Requi Medicaid Participat CFR 483.73. The facility has 85 of the survey, the cens Quality Review con	225 20372 55522 89060 Elwood Health and Living was ance with Emergency rements for Medicare and ing Providers and Suppliers, 42 certified beds. At the time of us was 67.	E 00	000	Submission of this plan of correction shall not constitute to be construed as an admission Elwood Health and Living that allegations in the survey report accurate or reflect accurately the provisions of care and services the residents at Elwood Health and Living. The facility request the following plan of correction considered its allegation of compliance.	by the t are the s to	
E 0006 SS=F Bldg	Plan Based on All Based on record rev failed to maintain at Plan (EPP) that was documented, facility risk assessment, util including missing re strategies for addres identified by the risl with 42 CFR 483.73	Hazards Risk Assessment iew and interview, the facility in Emergency Preparedness (1) based on and includes a y-based and community-based izing an all-hazards approach, esidents and (2) included sing emergency events assessment in accordance (a) (1) and 42 CFR 483.73(a) (2). ce could affect all occupants.	E 00	006	What corrective action(s) will be accomplished for those reside found to have been affected by deficient practice: 1. 1.) A Kaiser Permanente Hazard and Vulnerability Assessment tool was complete with current facility information 2. 2.) All policies were reviet to ensure there were policies to cover hazards for the facility. How other residents having the	nts y the ed i. wed	03/28/2025
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

(X6) DATE

Penny Broshar Administrator 03/25/2025

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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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE C A. BUILDING B. WING	construction =-	(X3) DATE SURVEY COMPLETED 03/13/2025			
	PROVIDER OR SUPPLIEI D HEALTH AND LIV		STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ITION (X5) LD BE COMPLETION DATE			
IAU	Based on records re and the Maintenance a.m., the EPP did lift facility, but no door regarding a docume community-based re all-hazards approace the time of record representation of a all-hazards approace. This finding was re	eview with the Administrator the Director on 03/13/25 at 10:11 st the top four hazards for the tumentation could be found tented facility-based and tisk assessment utilizing an the Based on an interview at the eview, the Maintenance		potential to be affected by same deficient practice widentified and what correct action(s) will be taken: All occupants could have affected by this deficient process. The Kaiser Perman Hazard and Vulnerability Assessment tool was conwith current facility inform 2. 2.) All policies were not on the facility and the puplace and what systemic will be made to ensure the deficient practice does not the Kaiser Permanente Hand Vulnerability Assessment be updated annually when the facility and the facil	the ill be stive been practice. ente inpleted ation. reviewed sies to lity. It into changes at the it recur: Hazard in the ived. The is and in and will in place ty is at in the in the is at the in will be Hazard			

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/13/2025	
155522		199922	B. W			03/13/	2025
	PROVIDER OR SUPPLIE D HEALTH AND LIV			2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN DD, IN 46036		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	ATE	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Licensure Survey v Department of Hea 483.90(a). Survey Date: 03/13 Facility Number: 0 Provider Number: AIM Number: 100	00372 155522	K 0	000	be updated annually when the Emergency Plan is reviewed. Maintenance Director will schedule the annual review ar will, with coordination from the Administrator, ensure that the hazards and vulnerabilities assessment is completed and presented to the IDT team and ensure there are policies in platfor each hazard that facility is risk for. All findings will be discussed in QAPI. QAPI team will discuss the need for further actions or to help develop policand procedures if one is not currently in place. Submission of this plan of correction shall not constitute be construed as an admission Elwood Health and Living that allegations in the survey report accurate or reflect accurately provisions of care and service the residents at Elwood Health and Living. The facility request the following plan of correction considered its allegation of compliance.	The nd e d will acce at mer icies or h by t the rt are the es to h ests	DATE
	was found not in co for Participation M Subpart 483.90(a), 2012 Edition of the Association (NFPA	John March Medicard, 42 CFR Life Safety From Fire and the National Fire Protection A) 101, Life Safety Code (LSC), and Health Care Occupancies and			,p		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155522	B. WING 03/13/2025			2025		
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
					ARKVIEW LN			
ELWOOL	D HEALTH AND LIV	ING		ELWOC	DD, IN 46036			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PR		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
K 0211 SS=E Bldg. 01	Type V (000) construction The facility has a findetection in the correction and has bat detectors in all residing facility is partly propropane generator. 85 and had a census All areas where resimples were sprinklered. A services were sprinklered. A services were sprink storage building. Quality Review common NFPA 101 Means of Egress - (#1) Based on obsering facility failed to main through 1 of 8 exits LSC section 7.2.1.4 Assembly Requirem in a means of egress pivoted-swinging ty be capable of swing full required width constalled. (#2) Based on obsering facility failed to ensimple were continuously in obstructions or important case of fire or other case of fire or ot	rvation and interview, the intain the means of egress egresses in accordance with .1 Swinging-Type Door nent states any door assembly is shall be of the side-hinged or ape, and shall be installed to ing from any position to the of the opening in which it is avation and interview, the ture 1 of 5 means of egress maintained free of all ediments to full instant use in	K 02	211	What corrective action(s) will be accomplished for those resider found to have been affected by deficient practice: 1.) Exit door #6 was repaired we survey was still in progress. The deficient practice could have affected 25 residents on the 30 hall. 2.) 300 hall linen cart was remistrement the hall and a new cart we purchased to keep linens in the shower rooms on each hall. The deficient practice could have affected 25 residents on the 30 hall. How other residents having the potential to be affected by the	nts y the while nis oved as e his	03/28/2025	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 03/13/2025			
NAME OF PROVIDER OR SUPPLIER ELWOOD HEALTH AND LIVING			STREET ADDRESS, CITY, STATE, ZIP COD 2300 PARKVIEW LN ELWOOD, IN 46036					
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: (#1) Based on an observation with the Maintenance Director on 03/13/25 at 12:10 p.m., exit door #6 on the 300- hall did not open when tested due to the push-bar not working. On the door there was a handwritten sign stating, "Do not use door, Broken." The 300-hall did have other exits nearby less than 200 ft. away. Based on an interview at the time of observation, the Maintenance Director stated the exit door would not open due to the push-bar was broken, did		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO TH	DATE COMPLETION DATE Will be ective potential ficient serviced ag work aware of rect in a potential ficient				
	training was need f work order if an ex (#2) Based on an of Maintenance Direct the 300-hall there we stored in the hall do an interview at the Maintenance Direct was stored in the 30 would have to find cart.	tor on 03/13/25 at 12:15 p.m., in was a clean linen cart that was uring all three shifts. Based on time of observations, the tor stated the clean linen cart 00-hall during all shifts and a new storage place for the reviewed with the Maintenance Director during		practice. All linen carts were more than 33 gallons have removed from the halls a linen carts were purchas keep linens in the showed each unit. All staff were if on this change on 3/25/2 What measures will be place and what systemic will be made to ensure the deficient practice does in 1. 1.) Maintenance Dirround facility weekly to each that all exits remain in go and will document results audit will be reviewed by Administrator weekly to ecompliance. 2. 2.) Housekeeping a Laundry Supervisor will reacility weekly to ensure linen carts are stocked a shower rooms. This audit reviewed by the Administ weekly to ensure compliance.	ve been and new ed to er room on n-serviced es. but into c changes nat the ot recur: rector will ensure bod repair s. This the ensure and round the that all nd in the it will be trator			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155522		A. BUILDING B. WING	01	COMPLETED 03/13/2025	
	PROVIDER OR SUPPLIER D HEALTH AND LIV		2300 P	ADDRESS, CITY, STATE, ZIP COD ARKVIEW LN OD, IN 46036	_
(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)	(X5) COMPLETION DATE
K 0533	NEDA 404			How the corrective action(s) we monitored to ensure the defici practice will not recur, IE what quality assurance program will put into place: 1. 1.) Maintenance Director audit each exit door weekly durounding and turn in results to Administrator for review. Results audit will be discussed in QAPI. Audit will continue for or quarter or until 100% compliance is reached, Maintenance Director may receive to reduce or discontinue this at 2. 2.) Housekeeping/Laund Supervisor will audit each hall weekly during rounding and turesults to Administrator for reviewlessed in QAPI. Audit will continue for one quarter or un 100% compliance is reached. Once 100% compliance is reached. Once 100% compliance is reached. Once 100% compliance is reached. Supervisor may request to record discontinue this audit.	ent in libe will uring ults of ne nce quest udit. ry urn in riew. til
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heati				
	failed to ensure 1 of provided with intake outside for rooms of This deficient practi rich with carbon mo	on and interview, the facility I laundry rooms was the combustion air from the containing fuel fired equipment. The could create an atmosphere the could which could cause too staff in the laundry room.	K 0522	What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice: Maintenance Director remove vent fan in the laundry room an added a section of flue to allow direct air from the outside to will accomplished.	nts y the d a nd

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	COMP	SURVEY LETED B/2025
	PROVIDER OR SUPPLIER		2300 P	ADDRESS, CITY, STATE, ZIP CO ARKVIEW LN OD, IN 46036	OD	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	EECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
IAU	Based on an observ Director on 03/13/2 room contained a fu water heater withou This condition does the room. Based on observation, the Ma fresh air intake was equipment was new and an electrical wa	ation with the Maintenance 5 at 12:39 p.m., the laundry tel-fired dryer and a fuel-fired t a fresh air intake to the room. not allow fresh air to enter an interview at the time of intenance Director stated the not located, and the fuel fired er replacing an electrical dryer	IAG	into the laundry room. Toom staff could have be affected by this deficient. How other residents had potential to be affected same deficient practice identified and what correction(s) will be taken: No residents were affected deficient practice, howel laundry room staff could affected. The Maintenan Director removed a vental laundry room and adder of flue to allow direct air outside to vent into the room. What measures will be place and what systemic will be made to ensure deficient practice does affected. The Maintenance Directed all areas in the facility the gas source for a direct at the laundry room and the mechanical room in die only two areas that use source. The dietary meroom was in compliance a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to serve for a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to the oany power source (IE en gas) should occur in the the Maintenance Direct observe for a direct air vent to the oany power source.	rhe laundry leen at practice. Ving the by the will be rective cted by this ever, all dhave been noce at fan in the da section from the laundry put into ic changes that the not recur: stor audited hat use a lair vent. The tary are the a gas chanical e as it has butdoors. If lectric to be facility, or will event to	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>01</u>		COMPLETED		
155522		B. WING		03/13/2025		
			-			
NAME OF P	ROVIDER OR SUPPLIER	L		ET ADDRESS, CITY, STATE, ZIP COD		
FLWOOF		VINIC		PARKVIEW LN		
ELWOOL	D HEALTH AND LIV	TING	ELVV	OOD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
K 0741 SS=F Bldg. 01	NFPA 101 Smoking Regulati	ons		How the corrective action(s) we monitored to ensure the defici practice will not recur, IE what quality assurance program will put into place: If any construction occurs in the facility, the Maintenance Direct will inspect the area for any changes in power source that would require a direct air vent Results from this inspection we be taken to QAPI for one quart or until 100% compliance is reached. Once 100% compliates reached, Maintenance Direct may request to reduce this autor discontinue it at that time.	tent t tl be he ctor fill rter nce ctor	
	interview, the facili non-smoking polici could affect staff ar residents using the residents include: Based on observation building on 03/13/2 Maintenance Direct property was eviden butts on the ground the building and 5 caround the service review at 1:10 p.m	on, records review, and ty failed to enforce 1 of 1 es. This deficient practice ound the service exit and all main entrance. ons upon entrance to the 5 at 9:00 a.m. and with the or at 12:27 p.m., smoking on at due to at least 30 cigarette around the main entrance to igarette butts on the ground hall exit. Based on records, the smoking policy stated wed on the facility's property.	K 0741	What corrective action(s) will I accomplished for those reside found to have been affected by deficient practice: This deficient practice could he affected staff around the service exit and all residents using the main entrance. All discarded cigarettes were removed. No smoking signs were added to each exit in the facility. Communication was sent out families via Cliniconex (an automated message system) 3/14/25, reminding all families Elwood Health and Living is a tobacco free campus and ther	ents by the lave lace to all on to that	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155522	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE COMPL 03/13/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	?		ADDRESS, CITY, STATE, ZIP CO)D	
ELWOOI	D HEALTH AND LIV	/ING		PARKVIEW LN OD, IN 46036		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL D LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION
PREFIX TAG	REGULATORY OF Based on an intervi and records review, stated the facility is confirmed there wa the cigarette butts of entrance and the ser	ew at the time of observation the Maintenance Director a non-smoking campus and s smoking on property due to on the ground outside the main	PREFIX TAG	should be no smoking of premises. Staff was also on the Communication Point Click Care that the was a tobacco free care 3/14/25. An ashtray will provided near the main for all visitors to properly of smoking materials premisering the facility. States also re-educated on the policy at the 3/25/25 In-How other residents has potential to be affected same deficient practice identified and what correction(s) will be taken: /bAll residents have the potential to be affected deficient practice. All discarded cigarettes were moved. No smoking were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were moved. No smoking were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were moved. No smoking were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were moved. No smoking were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were added to each experience in the potential to be affected deficient practice. All discarded cigarettes were added to each experience in the potential to be affected and the communication properies. Staff was all reminded on the Communication page. Click Care that the faction at obacco free campus 3/14/25. An ashtray will provided near the main entrance for all visitors properly disposed of states.	on the oreminded page on the facility inpus on the entrance by disposed for to the entrance of	DATE

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPL	ETED
155522		155522	B. WI	NG		03/13/	2025
		1	<u> </u>				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					ARKVIEW LN		
ELWOOI	D HEALTH AND LI	VING		ELWOO	DD, IN 46036		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	materials prior to entering the facility. Staff were also re-educated on the smoking policy at the 3/25/25 In-service. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director with audit the grounds weekly to ensure compliance. Results audits will be submitted to the Administrator. If noncompliance is noted, education will be provided to those not following the facility policy. If noncompliance continues, visitors could have their visitation restricted from this facility. If staff is noted being noncompliant, disciplinary actions will result how the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be printo place: The Maintenance Director will bring results from this audit QAPI to discuss with IDT members. Once one quarter 100% compliance has been reached, Maintenance Director.	e ce. to ll of ne lt. the ut ll to or or	DATE
					may request for this audit to reduced or discontinued.		

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