STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155510	A. BUILDING 00 B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CENTURY VILLA HEALTH CARE	705 N MERIDIAN ST GREENTOWN, IN 46936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 12, 13, 14, 15, 16 and 19, 2022. Facility number: 000549 Provider number: 155510 AIM number: 100267470 Census Bed Type: SNF/NF: 59 SNF: 7 Residential: 35 Total: 101 Census Payor Type: Medicare: 9 Medicaid: 32 Other: 25 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/21/22.	F 0000	This Plan of Correction constitutes Century Villa Health Care and Rehabilitation's written allegation of compliance for the alleged deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Century Villa Health Care and Rehabilitation respectfully requests a desk review for this Plan of Correction.	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:			

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

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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	§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on record review and interview the facility failed to submit an updated Preadmission Screening and Resident Review (PASARR) after a new diagnosis of mental illness was identified for 1 of 1 residents reviewed for PASARR. (Resident 2) Finding includes: Resident 2's clinical record was reviewed on 9/14/22 at 1:02 p.m. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance, other recurrent depressive disorders, and delusional disorders. A level one PASARR was completed on 2/25/22 with no mental illness diagnoses listed and resulted in no recommendations for a level two PASARR. A Nursing Progress Note, dated 5/16/22 at 3:55 p.m., indicated the resident was transported to a psychiatric hospital. A Nursing Progress Note, dated 5/31/22 at 11:00 a.m., indicated the resident returned from the psychiatric hospital.	F 0644	*F-644 Coordination of PASSAR and Assessment* 1. corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 had a Level 1 PASSAR completed 2-25-22 at another SNF. Level II assessment was completed 9-19-22 and was an exclusion, so the Level II was not needed. 2. How other residents having the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken: An audit has been completed for all residents to determine if a new Level I or Level II PASSAR needs to be completed. 3. What measures will be put in place and what systematic changes will be mad to ensure that deficient practice does not occur: Social Services, BOM, and	10/07/2022

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	A Nursing Progress Note, dated 5/31/22 at 3:27 p.m., indicated the Psychiatric Nurse Practitioner (NP) evaluated the resident and added the diagnosis of delusional disorders. During an interview, on 9/15/22 at 9:58 a.m., the Social Services Director (SSD) indicated the Minimum Data Set (MDS) assessment coordinator typically completed the PASARR. She indicated the PASARR should have been submitted with the identification of the delusional disorders and would check with the MDS coordinator. During an interview, on 9/15/22 at 10:00 a.m., the SSD indicated an updated PASARR with the diagnoses of delusional disorders had not been submitted and should have been. A current facility policy with an effective date of 6/25/17, titled "PASARR (Preadmission Screening and Resident Review)" and provided by the Director of Nursing (DON) on 9/16/22 at 2:51 p.m., indicated " ...It is the policy of the facility to coordinate the assessment process with the preadmission screening and annual resident review (PASARR) program under Medicaid in Subpart C to the extent practicable to avoid duplicative testing and effort. This includes incorporating the recommendations from the PASARR level ll determination and evaluation in the residents' assessment, care plan, and transition of care; and referring all level ll residents and all residents with new or evident conditions related to Level ll review upon significant change in status assessment ..." 3.1-16(d)		Clinical Interdisciplinary team have been re-educated on PASSAR guidelines to ensure any resident with newly evident or possible serious mental disorder, intellectual disability of a related condition for Level II resident review upon status assessment. 4. How the corrective action(s) will be monitored to ensure the deficient practice will recur, i.e., what quality assurance program will be put in place and by what date the systematic changes for each will be completed: SSD will work with Psych NP and DON to ensure all residents and applicable Levels are identified on a daily basis when new admit arrives, then reviewed on monthly GDR meeting, and report to QAPI. Areas of concern will be addressed immediately. Findings will be reported to Executive Director with each occurrence and the Quality Assurance Performance Improvement Committee monthly. 5. compliance: October 7, 2022	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure a resident, who had an order for daily weights to monitor for congestive heart failure, received daily weights and/or an alternative method for assessment of heart disease for 1 of 5 residents reviewed for hospitalization. (Resident 31). Finding includes: Resident 31's clinical record was reviewed on 9/16/22 at 9:40 a.m. Current diagnoses included, but were not limited to, chronic diastolic congestive heart failure, acute and chronic respiratory failure with hypercapnia, atherosclerotic heart disease of native coronary artery without angina pectoris, and hypertensive heart, and chronic kidney disease with heart failure. The resident had a current 4/26/22 physician's order to obtain a daily weight and notify the physician of a weight gain of greater than 3 pounds in one day and/or greater than 5 pounds in a week in order to monitor for congestive heart failure. The resident had a current care plan problem/need	F 0684	F-684 Quality of Care 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #31 Physician was notified during the course of the survey in regards to residents daily weight order and new order received to discontinue daily weights. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Clinical team audited all residents that required weights per their diagnosis or by physician's request and ensured the group that needs to be monitored daily, weekly, and monthly. 3. What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur: All residents on weight program	10/07/2022

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	regarding "The resident has Congestive Heart Failure [CHF]." This problem originated, 9/9/2021. Approaches to this problem included, but were not limited to, "Monitor/document/report PRN [as needed] any s/sx [signs and symptoms] of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB [shortness of breath] upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation." A 9/4/22, hospital discharge summary indicated the resident was admitted to the hospital on 9/3/22. The discharge summary included but was not limited to the following: "Problem focused hospital course: ... chest radiograph showing cardiomegaly, and pulmonary venous congestion....Chronic diastolic CHF...The heart is enlarged and there is pulmonary venous congestion..." Review of the resident's weight record for July 1 2022 to September 12, 2022 (a 74 day period of time) indicated the following: The resident did not have documented refusal or documented weights for 31 of 74 days 7/1/22, 7/4/22, 7/5/22, 7/7/22, 7/13/22, 7/14/22, 7/15/22, 7/17/22, 7/18/22, 7/19/22, 7/21/22, 7/23/22, 7/25/22, 7/26/22, 7/28/22, 7/29/22, 7/31/22, 8/2/22, 8/4/22, 8/8/22, 8/9/22, 8/11/22, 8/14/22, 8/15/22, 8/18/22, 8/19/22, 8/20/22, 8/21/22, 8/23/22, 8/7/22, and 9/12/22. During an interview on 9/16/22 at 3:33 p.m., the Director of Nursing (DON) indicated the resident often refused to be weighed because she found getting out on bed to be painful. The staff had		are audited and up to date. All are referenced in weekly NAR meeting. Any resident that is identified as refusing weights will be referred to physician thru Clinical team to designate whether daily weights or other change may be needed. Licensed nurses have been re-educated on facility Policy & Procedure related to Physician Notification on prescribed treatment refusal. 4. How the corrective measure will be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put in place and by what date the systematic changes for each deficiency will be completed: A Performance Improvement Tool has been developed that will monitor compliance with residents prescribed order refusals. PI tool will be completed Monday through Friday for 2 weeks, then weekly for 4 weeks the monthly for 3 months. Areas of concern will be addressed immediately. Finding will be reported to Executive Director with each occurrence and the Quality Assurance Performance Improvement Committee monthly. Date of compliance: October 7, 2022	

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	been lax in documenting the resident's refusals. The facility had informed the physician of the resident's refusal on this day. The physician had discontinued the daily weights on this date (9/16/22). She indicated the facility had not evaluated and identified other alternative methods to assess the resident for congestive heart failure. 3.1-37			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable			

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	an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to provide ordered medications for 1 of 10 residents reviewed for medication use. (Resident 65) Finding includes: During an observation, on 9/12/22 at 2:05 p.m., Resident 65 was sitting in his recliner in his room with his eyes closed. He did not respond to his name. In an interview at the time of the observation, the resident's wife indicated he had times when he was so tired, he barely opened his eyes. The resident's clinical record was reviewed on 9/13/22 at 1:18 p.m. Diagnoses included, but were not limited to, somnolence. A Nursing Progress Note, dated 9/2/22 at 6:36 p.m., indicated the physician saw the resident on rounds and ordered methylphenidate (stimulant) 5 milligrams (mg) daily. A Nursing Progress Note, dated 9/3/22 at 11:56 a.m., indicated methylphenidate was not given because of waiting on delivery. A Nursing Progress Note, dated 9/5/22 at 8:10 a.m., indicated methylphenidate was not given because the medication was not available. A Nursing Progress Note, dated 9/7/22 at 10:20 a.m., indicated methylphenidate was not given	F 0755	F755 Pharmacy Services/Procedures/Pharmacists/ Records 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #65 has been addressed and no adverse effect related to delay in medication delivery. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with medication changes could be affected. Clinical team went thru each resident med list to ensure that correct medications were listed, ordered, and being given to residents at facility. 3. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been re-educated on Facility Policy & Procedure related to medication availability and the steps to take when a medication is not available. 4. How the corrective action(s)	10/07/2022

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	because the medication was not available A Nursing Progress Note, dated 9/8/22 at 9:07 a.m., indicated methylphenidate was not given because it was not in the facility or in the emergency drug kit (EDK). A Nursing Progress Note, dated 9/9/22 at 8:39 a.m., indicated methylphenidate was not given because the medication was not available. The Nursing Progress Notes lacked documentation of notification of the physician or pharmacy of the unavailability of methylphenidate. During an interview, on 9/13/22 at 3:35 p.m., the Director of Nursing (DON) indicated she would investigate why methylphenidate was unavailable to be administered to the resident until 9/10/22. During an interview, on 9/13/22 at 3:53 p.m., the DON indicated the administration of the methylphenidate was delayed because a written script for the medication was not given to the pharmacy by the physician. The Nurse Practitioner (NP) wrote the script for the methylphenidate. The pharmacy sent the medication once the script was received. During an interview, on 9/15/22 at 2:39 p.m., Licensed Practical Nurse (LPN) 2 indicated when a resident's medication was unavailable, she would look through the resident's back up medications. Next, she would check the EDK. Then, she would notify the pharmacy and the physician. During an interview, on 9/16/22 at 12:07 p.m., Registered Nurse (RN) 3 indicated when a medication was unavailable in the medication cart,		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place and by what date the systemic changes for each deficiency will be completed: Daily review of prescription log in PCC will be completed to include validation that any new order written has had the medication delivered. This will be an ongoing part of morning meeting. Areas of concern will be addressed immediately with physician and pharmacy. Findings will be reported to Executive Director with each or any occurrence and the Quality Assurance Performance Improvement Committee monthly. Date of compliance: October 7	

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	she checked the EDK. Next, she would notify the pharmacy to get an emergency delivery if the medication was needed emergently. Then, she would notify the physician or NP. A current facility policy with an effective date of 6/21/17, titled "Medication Administration and provided by the DON on 9/16/22 at 11:54 a.m., indicated " ... If a medication is unavailable, contact the pharmacy and document accordingly ..." 3.1-25(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 19, 2022 Facility number: 000549 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/21/22.	R 0000	This Plan of Correction constitutes Century Villa Health Care and Rehabilitation's written allegation of compliance for the alleged deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. Century Villa Health Care and Rehabilitation respectfully requests a desk review for this Plan of Correction.	
R 0117 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			

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	unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the 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 a minimum of one awake staff member certified in first aid was on site for 21 of 24 shifts reviewed for staffing sufficiency. This had the potential to affect the 35 residents residing in the facility. Finding includes: The staffing schedule for September 11, 2022 through September 24, 2022, provided by the Assisted Living Director on 9/15/22 with the entrance conference paperwork, was reviewed on 9/19/22 at 11:01 a.m. The schedule lacked a listing of third shift staff and lacked a first aid certified employee for 21 of 24 shifts. During an interview, on 9/19/22 at 10:37 a.m.,	R 0117	R-117 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: An audit has been completed of employee files to determine the need for completion of first aide course.	10/28/2022

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	Licensed Practical Nurse (LPN) 4 indicated the connected nursing home portion of the building provided any needed care during the third shift. She indicated the residents' call buttons rang to the nursing station of the skilled nursing portion of the building. During an interview, on 9/19/22 at 11:57 a.m., the Executive Director indicated he believed when basic lifesaving (BLS) CPR was provided, first aid was also provided. During an interview, on 9/19/22 at 1:49 p.m., the Director of Nursing (DON) of the skilled nursing portion of the building was unable to provide additional first aid certifications. During an interview, on 9/19/22 at 4:52 p.m., the DON indicated she was unable to locate a policy on first aid certifications.		3. What measures will be put into Place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed nurses, and Certified nurse aides are scheduled to attend First Aide class by October 28, 2022. A first aide class will be offered quarterly to ensure both licensed and certified employees have first aide class on night shift assignment sheets. 4. How the corrective action(s) will Be monitored to ensure the deficient Practice will not recur, i.e., what Quality assurance program will be put Into place: Human Resource Director will track Classes and completions for all Licensed Nurses and certified nurse aides, monitored quarterly and updated as needed per new hires. Findings will be reported to the Executive Director with each Occurrence and the Quality Assurance Performance Improvement Committee Monthly. 5. Date of compliance: 10-28-22	

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R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to assess a resident for self-administration of medication for 1 of 3 residents reviewed for self-administration of medication. (Resident 4) Finding includes: Resident 4's clinical record was reviewed on 9/19/22 at 2:52 p.m. A Mini-Mental State Exam (MMSE) was completed on 7/18/22. She scored a 24 out of 30. According to the Alzheimer's Association website, https://www.alz.org/alzheimers-dementia/diagnosis/medical_tests/, a score of 24 suggests mild dementia. The resident's medication administration record for September 2022 indicated the resident	R 0216	R-216 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: An audit has been completed of all residents that presently self-administer medications. 3. What measures will be put into place and what systemic changes	10/07/2022

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	155510	A. BUILDING 00 B. WING	09/19/2022

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	self-administered medication. The resident's record lacked an evaluation for self-administration of medication. During an interview, on 9/19/22 at 4:05 p.m., the Assisted Living Director indicated she had the nurse do the evaluation recently but was uncertain where the documentation was located. During an interview, on 9/19/22 at 4:08 p.m., the Director indicated she had called the nurse to ask where the evaluation was located. The Director was unable to locate the self-administration of medication evaluation. A current policy with a revised date of 9/2017, titled "Orders for Self-Administration of Medications" and provided by the Director of Nursing on 9/19/22 at 4:52 p.m., indicated " ...the staff and physician will evaluate and define a resident/patient's decision-making capacity ..."		will be made to ensure that the deficient practice does not recur: Medication Self-Administer tracking tool with due dates put into place. Assisted Living Director/designee will inform Charge Nurse when due, Charge Nurse will give completed form to Assisted Living Director/designee to scan into PCC under Misc. 4. How the corrective action(s) will Be monitored to ensure the deficient Practice will not recur, i.e., what Quality assurance program will be put Into place: When quarterly Personal Care Level Of Service Assessment is due, the Medication Self-administration Evaluation will be due at the same time. Charge Nurse will be responsible for giving completed evaluation to the Assisted Living Director/designee to upload to PCC and to update the Medication	

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			Self-Administer Evaluation tracking tool. Areas of concern will be addressed immediately. Findings will be reported to the Executive Director with each occurrence and the Quality Assurance Performance Improvement Committee Monthly. 5. Date of compliance: 10-7-2022	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview and record review, the facility failed to ensure a system was in place to analyze patterns of infections for 35 of 35 residents residing in the facility. Finding includes:	R 0407	R-407 1. What corrective action(s) will be accomplished for those residents	10/07/2022

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	During an interview, on 9/19/22 at 9:39 a.m., the Assisted Living Director and Licensed Practical Nurse (LPN) 4 indicated they did not track infections except for COVID-19. They did not have documentation of current or previous resident infections or antibiotic use. If they had several infectious symptoms on a residential hall, they would immediately test for COVID-19 and quarantine the symptomatic residents. LPN 4 indicated she would also notify the nurse practitioner whether the residents tested positive or negative for COVID-19 and about the symptoms. She indicated they did not keep a log of infections. Review of a facility document, titled "Order Listing Report" and provided by the Assisted Living Director on 9/19/22 at 1:42 p.m., indicated two residents were currently taking antibiotics for urinary tract infections, which indicated the potential for spread of an infectious organism. During an interview, on 9/19/22 at 5:04 p.m., the Executive Director indicated he did not have a policy for the surveillance or tracking of infections for the facility.		found to have been affected by the deficient practice: No residents were affected. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: An audit of all residents on an Antibiotic will be completed. 3. What measures will be put into Place and what systemic changes will be made to ensure that the deficient practice does not recur: R407 (cont) Antibiotic tracking tool identifying residents that are currently on an antibiotic and the reason will be put into place to analyze patterns of known infectious symptoms. Potential Infection Tracking Tool put in place in conjunction with the Antibiotic tracking tool to identify locations of potential spread of Infection,	

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			and to monitor if there are any trends in those locations. Nursing will document using the tools listed above and a copy will be given to the Assisted Living Director/designee who will then report any communicable diseases to public health authorities. 4. How the corrective action(s) will Be monitored to ensure the deficient Practice will not recur, i.e., what Quality assurance program will be put Into place: Orientation and in-service education on infection prevention and control, including universal precautions will be completed monthly for 3 months, then every 3 months thereafter. Areas of concern will be addressed	

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			immediately. Findings will be reported to the Executive Director with each occurrence and the Quality Assurance Performance Improvement Committee Monthly. 5. Date of compliance: 10-7-22	