STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155582	A. BUILDING 00 B. WING	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF WAKARUSA SKILLED NURSING FACILITY, THE	300 N WASHINGTON ST WAKARUSA, IN 46573

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 26, 27, 28, and April 1, 2 and 3, 2024 Facility number: 000521 Provider number: 155582 AIM number: 100266980 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 1 Medicaid: 48 Other: 46 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/10/24.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 05/14/2024. The facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

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

Roberta Scott Shull | Executive Director | 04/26/2024

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	physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

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	Based on observation, interview, and record review, the facility failed to notify the Physician of weight gain per the parameters in the physician orders, for 1 of 1 reviewed for edema. (Resident 60) Finding includes: During an observation and interview on 3/26/2024 at 10:36 A.M., Resident 60 indicated she has had a problem with her legs for a while, her legs were observed to be elevated and wrapped with ace wraps. A record review for Resident 60 was completed on 4/1/2024 at 9:35 A.M. Diagnoses included, but were not limited to: Parkinson's Disease, type 2 diabetes, chronic systolic congestive heart failure and cardiomyopathy. A Physician's Order, dated 10/23/2024, indicated but not limited to: daily weight after voiding, before breakfast and medication daily. Notify the doctor of 2 pound gain in 1 day and 4 pound gain in 5 days. A Care Plan for diuretic therapy, dated 12/7/2023, included but not limited to: monitor weight, report changes to physician and report increased edema. The Treatment Administration Record (TAR), dated 3/1/ 2024 to 3/31/2024, indicated the 3/13/2024 weight was 210.2 pounds and the 3/14/2024 weight was 212.4 pounds, a 2.2 pound increase in one day. The TAR, dated 3/1/2024 to 3/31/2024, indicated the weights were as follows: 3/25/2024-213.8, 3/26/2024- 214.4, 3/27/2024-214, 3/28/2024-217.2,	F 0580	=”” bit=””> It is the policy of this facility to Notify Physician of Weight Gains per parameters in the physician orders. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Physician was notified of residents 60’s weight concern on 4/22/2024 by the DON. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents’ weights were reviewed x 90 by NP on 4/22/2024. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced nursing staff on notification of physician and/or nurse practitioner on weights outside of the parameter on physician orders on 04/30/2022 . Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The DON/Designee will monitor physician orders with weight	05/06/2024

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	3/29/2024-218.8 pounds, which reflected an increase of 5 pounds in five days. During an interview on 4/2/2024 at 10:24 A.M., the Director of Nursing indicated the documentation for notifying the physician of a weight gain should be in the progress notes, unless staff did a change in condition. She did not see in the electronic medical record where the nurse notified the physician of the weight gain on 3/14/2024 or on 3/29/2024. On 4/2/2024 at 12:30 P.M., the DON provided a policy titled, "Physician Notification of Resident Change of Condition," undated, and indicated the policy was the one used by the facility. The policy indicated "...It is the intent of the facility for the attending physician to be notified of a change in a resident's condition by licensed personnel as warranted. Physician notification. Make an entry into Nurse's notes regarding condition/physician notification and change in physician's orders....." 3.1-5(a)(2)		parameters for notification of weight changes outside the parameters 5 times a week x 4 weeks, then 3 times a week for 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will stop. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date the systemic changes for each deficient will be completed.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide necessary ADL (activities of daily living) services related to nail care, facial hair removal, and showers, for 2 of 3 residents reviewed for ADL care. (Residents 1 & 82) Findings include:	F 0677	It is the policy of this facility to provide nail care, facial hair removal and showers. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # #1 was provided a	05/06/2024

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	1. An interview was conducted on 3/27/2024 at 1:39 P.M. Resident 1 indicated he was not receiving his showers, and he did not refuse to have a shower provided. A record review was completed on 3/28/2024 at 1:13 P.M. Diagnoses included, but were not limited to: epilepsy, diabetes mellitus type 2, and major depressive disorder. An Annual Minimum Data Set (MDS) assessment was completed on 1/21/2024. The assessment indicated Resident 1 was cognitively intact. He was dependent on bathing tasks. A Care Plan, dated 2/21/2023, indicated Resident 1 had a self-care deficit and required assistance with ADLs to maintain the highest possible level of functioning. An intervention dated, 2/21/2023, indicated Resident 1 usually required extensive assistance and one person support for bathing. A record of the bathing documentation in the electronic medical record indicated the following from 2/28/2024-4/1/2024: 3/5/2024 8:51 A.M. shower 3/5/2024 9:43 P.M. shower 3/8/2024 8:41 A.M. shower 3/12/2024 2:59 P.M. shower 3/15/2024 1:10 P.M. shower 3/26/2024 9:06 A.M. shower 3/30/2044 4:11 A.M. refused On 4/2/2024 at 9:51 A.M., the shower sheets from the unit were received from the Director of Nursing. Shower sheets for Resident 1 indicated a shower was provided on 3/5/2024, 3/8/2024, 3/12/2024, 3/15/2024, 3/26/2024. There were no shower sheet documentation sheets for 3/19/2024,		shower on 4/5/2024 by the aide and Resident # 82 nails were cleaned and trimmed and facial hair removed on 4/3/2024 by the aide. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: An audit was completed for residents for showers, nail care and facial hair on 04/22/2024 by the DON/Designee at any concerns were addressed immediately. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The DON/Designee in-serviced the nursing staff on providing showers per resident's preference, nail care and removal of facial hair per resident's preference on 4/25/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The DON/Designee will audit 10 random residents a week for 4 weeks for showers, nail care and removal of facial hair, then 5 random residents a week x 4	

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	3/22/2024.3/29/2024. A document, titled. " ICF Showers" was provided. The document indicated Resident 1 was to receive a shower on Tuesdays and Fridays on day shift. During an interview on 4/2/2024 at 10:11 A.M., the Executive Director indicated the facility completed shower sheets, but it was not part of the facility policy to do so. She indicated all the shower sheets were provided to the surveyor for Resident 1's unit. The staff were required to document showers in the electronic medical record. During an interview on 4/2/2024 at 10:46 A.M., the Director of Nursing indicated showers were scheduled twice a week, and the staff had a shower schedule they should follow. If a shower was not given, it should be charted as refused. A policy was provided on 4/3/2024 at 12:42 P.M., The policy was provided by the Executive Director, and titled, "Skin Observation/Assessment". The policy indicated, " ...It is the policy of the facility to ensure each resident is provided with showers and or baths to maintain proper hygiene as well as comfort ...."2. During an observation and interview on 3/27/2024 at 11:41 A.M., Resident 82 was in her bed. She had long fingernails on both hands with a brown substance under them, and facial hair under her chin. She indicated the staff had not offered to assist with trimming her nails or shaving the hair under her chin. She had done it at home and preferred it to be done. During an observation on 3/28/2024 at 3:06 P.M., the resident was in the common area visiting her spouse, her nails were long with brown substance under them and facial hair remained under her		week, then 5 random residents a month x 4 months. If the facility is within 95% compliance at the end of the 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date the systemic changes for each deficient will be completed.	

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	chin. During an observation on 4/1/2024 at 10:00 A.M. and 4/2/2024 at 9:09 A.M., the resident's fingernails were still long with brown substance under them, and facial hair remained under her chin. A record review for Resident 82 was completed on 3/28/2024 at 10:19 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, non-pressure chronic ulcer of the right heel and rheumatoid arthritis, unspecified. A Quarterly Minimum Data Set (MDS) assessment, dated 3/14/2024, indicated impairment on one side of the upper body. A Self Care Deficit Care Plan, initiated on 1/28/2024, indicated that she required extensive assistance of one person with activities of daily living for personal hygiene and bathing. During an interview on 4/1/2024 at 1:44 P.M., CNA 2 indicated when she gave a shower, it depended on what a resident could do for themselves. She would undress them, test the temperature of the water, wash their hair and continue to wash from the top of the body down. She would assist the resident to dry off, apply lotion and dress them. During an interview on 4/1/2024 at 1:51 P.M., CNA 3 indicated when he provided A.M., care he knocked on the door and introduced himself and asked if they were ready to get up. He would assist with changing them, dressing, brushing teeth and would ask if they wanted to sit in their room until breakfast. If he provided a shower, he would ask if they wanted one first. He would			

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	obtain supplies, spray the shower chair then lock up the chemical. He started with washing the hair, face, arms, back, legs and feet. Then he got them dressed, combed their hair and reported any skin issues to the nurse, documented on a skin sheet, and then in the electronic medical record that a shower was done. During an interview on 4/2/2024 at 9:13 A.M., CNA 4 indicated that when he provided A.M. care, he did a partial bed bath, brushed teeth and every day activities of daily living. When he provided a shower, he obtained clothing and supplies and assisted with washing their back. legs and anything they needed help with. During an interview on 4/2/2024 at 9:19 A.M., CNA 5 indicated when she provided A.M. care, she washed their face, hands, armpits, completed peri-care, dressed them, brushed their teeth, combed their hair and took them to the bathroom. Then she made the bed, cleaned up the room, then transported them to breakfast . If she gave a shower, she obtained supplies and clothing, then sanitized the shower chair. She washed their hair then the body, dried them off then applied lotion, deodorant, and clean clothes. If they could answer, she would brush their teeth and shave them. On 4/2/2024 at 10:14 A.M. the Director of Nursing (DON) provided a policy titled, "Activities of Daily Living," undated, and indicated the policy is the one currently used by the facility. The policy indicated "...Residents are given routine daily care and HS care by a CNA or Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL is provided throughout the day, evening and night as care planned and/or as needed. ADL care is coordinated between the			

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	resident and the care givers with emphasis on resident preference as much as possible. Prior to entrance to the resident's room to perform ADL care, the staff will knock on the door, announce themselves and request permission to enter. ADL care of the resident includes: Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care as well as encouraging participation in physical, social and recreational activities....." On 4/2/2024 at 12:30 P.M. the DON provided a policy titled, "Shaving the Resident," dated 1/1/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...To remove facial hair and improve the resident's appearance and morale....." 3.1-38(3)(A) 3.1-38(3)(D) 3.1-38(3)(E) 3.1-38(b)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to supervise a resident with severe cognitive deficits and wandering behaviors to prevent the resident from exiting the	F 0689	Per 2567 no POC required past non compliance	05/06/2024

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	facility door and falling for 1 of 1 resident reviewed for elopement. (Resident 86) The deficient practice was corrected by 3/22/2024, prior to the start of the survey, and was therefore past noncompliance. The facility thoroughly investigated the incident and implemented immediate corrective action including reeducation of staff regarding safety checks, the wanderguard system and key pad locks, having the company check the alarm system and turn the volume up on the system, and ensuring the frequency of checks on all key pad door locks and alarms were increased. Finding includes: On 4/2/2024 at 10:24 A.M., the Administrator presented a Facility Reported Incident for review. The incident, which occurred on 3/21/24 at 7:29 P.M., indicated Resident 86 had pushed the rehabilitation unit door open and had gained access to the assisted living entrance and facility parking lot. The resident fell just outside the door leading to the facility parking lot and was brought back into the building by a staff member at 7:38 P.M. The resident was placed on 15 minute safety checks. The Administrator, responsible party, and physician were notified. The initial investigation indicated Resident 86, who was wearing a wander guard, had wheeled himself to a closed unit and opened the door to the outside, the alarm was not heard by staff. During an interview, on 4/2/24 at 10:24 A.M., the Administrator indicated Resident 86 resided on the healthcare unit and had stood up from his wheelchair and exited the building out of the rehabilitation unit exit doors and the exit door leading into the parking lot. The rehabilitation exit			

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	door connected to a small hallway with two other doorways used by assisted living residents to visit the healthcare units and also to access the outside for their pets and the parking lot. The resident had been wearing a wanderguard (a bracelet which alarms when residents go through alarmed door) , but the audible alarm was not loud enough to hear at the nurses' station. The facility camera footage showed the resident pushing the rehabilitation exit door open. The facility thought the rehabilitation exit door was not shut correctly, maybe due to other doors and air pressure, and did not lock correctly. The facility checked the exit doors and the alarm/wanderguard system and there were no issues noted. The door was currently being checked hourly, the alarm volume was turned up, and the resident was placed on 15 minute checks after the incident. The Administrator indicated the resident normally utilized a wheelchair and required 2-3 people to ambulate. On 4/2/24 at 11:12 A.M., the resident was observed outside of his room sitting with other residents. The resident had a wander guard security alarm on his right wrist. The resident was seated in his wheelchair. On 4/3/24 at 10:24 A.M., a record review was completed for Resident 86. The residents diagnoses included, but were not limited to: Neurocognitive disorder with Lewy Bodies, hallucinations, altered mental status and muscle weakness. An Admission Minimum Data (MDS) Assessment, dated 3/11/24, indicated the resident was severely cognitively impaired and utilized a wheelchair for mobility.			

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	A Progress Note, dated 3/21/24 at 8:43 P.M., indicated Resident 86 was found outside on the ground by a visitor. The resident was assessed for any pain, assisted into a wheelchair, and brought inside. Neuro checks were initiated and abrasions were noted to the right cheek and chin. An Elopement Risk Assessment, dated 3/5/24, indicated the resident did not have any wandering behavior or exit seeking behavior and his risk of elopement score was 7. A Wandering Risk Scale Assessment, dated 3/5/24, indicated the resident was at risk to wander and scored a 9. The March TAR (Treatment Administration Record) indicated the wander alert system had been checked off every night shift by a nurse and was documented by the nurse's initials. A Care Plan, dated 3/6/24, included the following "...I have the potential for elopement cognitive loss, often seeking family, Wander guard is placed on Resident 86 right wrist...." The interventions included, but were not limited to: " check function of sensor daily, check placement of sensor every shift, Wanderguard sensor bracelet applied ..." The facility's Elopement Book included pictures and face sheets of 11 residents who wore a wander guard, which included Resident 86. The Director of Nursing indicated these residents were the residents who were currently at high risk for elopement or had wandering behaviors. During an interview, on 4/3/24 at 12:48 P.M., LPN 9 indicated on the evening Resident 86 was found outside, she was charting and was informed a resident was outside. She indicated the resident			

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	155582	A. BUILDING 00 B. WING	04/03/2024

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	was brought inside the facility and he was assessed by his nurse. She also completed a head count for all residents in the building. During an interview, on 4/3/24 at 1:05 P.M., RN 10 indicated she did not hear any alarms and had not seen Resident 86 attempt to exit before. During an interview, on 4/3/24 at 1:10 P.M., CNA 5 indicated she had not seen Resident 86 attempting to leave. She indicated he did wear a wanderguard bracelet. During an interview, on 4/3/24 at 1:13 P.M., the Social Services Assistant indicated she placed the wanderguard on Resident 86 when his assessment triggered him to be at risk upon admission. On 4/2/24 at 2:25 P.M., the ED provided a policy titled, "Missing Resident/Elopement", no date, and indicated the policy was the one currently used by the facility and staff were being in-serviced on. The policy indicated "...It is the policy of the facility to provide a safe and secure environment for all residents. In the event of resident elopement, the facility will implement its policies and procedures immediately to locate the resident in a timely manner. The facility will assure safety and security of all residents. To establish policies and procedures in the event of a missing resident. To educate and maintain staff awareness of the importance of resident safety and security. Elopement response team will be activated...." 3.1-45(a)(2)			
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits			

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	§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. Based on record review and interview, the facility failed to provide medical doctor visits every 60 days as required, for 1 of 2 residents reviewed for nutrition. (Resident 21) Finding includes: A record review was completed on 3/28/2024 at 9:11 A.M. Diagnoses included, but were not limited to: protein-calorie malnutrition, mild cognitive impairment and localized edema. A Quarterly Minimum Data Set (MDS) assessment, dated 2/21/2024, indicated Resident 21 had a weight loss of five percent or more in the past month or ten percent or more in the past six months and had severe cognitive impairment. The facility Nurse Practitioner (NP) had	F 0712	It is the policy of this facility to provide medical doctor visits every 60 days. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 21 was seen by physician on 03/20/2024. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All resident physician visits were reviewed x 90 days and scheduled per regulation. Medical Records completed audit on 4/24/2024. All	05/06/2024

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	documented visits on 10/30/2023, 12/18/2023, 1/25/2024, 2/27/2024, and 3/26/2024. The Medical Doctor had documented visits on 5/24/2023 and 3/20/2024. The insurance Nurse Practitioner had documented visits on 2/27/2024 and 3/21/2024. During an interview on 4/1/2024 at 2:08 P.M., the Executive Director indicated that the Medical Director was "really big about fraud", and felt if the Nurse Practitioner had seen the resident, then he did not need to, even for the 60-day or alternating regulatory visits. The Nurse Practitioner was not an employee of the Medical Director, but an employee of the facility. She indicated the Medical Director did not document if he was in agreement with the NP assessments. On 4/1/2024 at 2:30 P.M., the Executive Director indicated the Medical Director signed the Care Summary monthly and would oversee the care of the nurse practitioner in this way, and the Nurse Practitioner signed the monthly orders. She indicated this information came from the Director of Nursing. On 4/1/2024 at 2:44 P.M., the Director of Nursing and the Executive Director indicated the Medical Director followed a list for visits provided by the Medical Records Supervisor, which was given to him weekly on Wednesdays. The list was rotated every other month between the House Nurse Practitioner, Insurance Nurse Practitioner, and the Medical Director. During an interview on 4/1/2024 at 2:50 P.M., the Medical Records Supervisor indicated she notified the Nurse Practitioner and Medical		visits are current. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: Medical Records will monitor all new admissions to be seen by physician upon admit and then will alternate with NP; so that all residents are seen by Physician not greater than 60 days. The Administrator in-serviced the physicians and nurse practitioners on requirements of physician visits, timeliness, and alternating visits with nurse practitioner on 05/01/2024 and 05/02/2024 respectfully. The Administrator in-serviced medical records on requirements of timely physician visits and alternating visits with medical doctor and nurse practitioner 04/29/2024. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: Medical Records/Designee will audit 10 random residents, new admissions, and re-admissions for timely physician/nurse practitioner visits weekly x 4 weeks, then 5 random residents, new admission, and re-admissions weekly x 4 weeks, then 5 random residents, new admissions, and re-admissions monthly x 4 months. If the facility is within	

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	Director as to when the residents needed to be examined. She indicated the Medical Director preferred the Nurse Practitioner to complete acute visits. She indicated the facility did not want to overbill the residents, especially those who were private pay. She indicated it was a fair statement to state the Medical Director did not see the residents in the 60 day time frame alternating with the Nurse Practitioner. During an interview on 4/2/2024 at 10:31 A.M., the Director of Nursing reviewed the medical record for the Medical Directors visits, and indicated she only found visits for May 2023 and March 20, 2024. All other visits were with the house Nurse Practitioner and insurance Nurse Practitioner. A policy was provided on 4/3/2024 at 12:42 P.M. The policy was provided by the Executive Director, and was titled, "Medical Records". The policy indicated, " ...Physician Visits and Progress Notes ... At a minimum, residents are seen by a physician within 30 days of admission, every 30 days for the first 90 days after admission, and then at least every 60 days thereafter. A physician visit is considered timely if it occurs within 10 days of the date the visit was required or as otherwise stipulated by state rules ...The physician can designate certain tasks to a non-physician practitioner such as a nurse practitioner, clinical nurse specialist or physician assistant at allowed by state scope of practice ...." 3.1-22(d)(1)		95% compliance at the end of the 6 months, monitoring will stop. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date the systemic changes for each deficient will be completed.	