STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

(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 the Investigation of Complaints IN00408291, IN00408359, IN00408615, and IN00408745. Complaint IN00408291- No deficiencies related to the allegations are cited. Complaint IN00408359- No deficiencies related to the allegations are cited. Complaint IN00408615- No deficiencies related to the allegations are cited. Complaint IN00408745- No deficiencies related to the allegations are cited. Survey Dates: May 18, 19, 22, 23, and 24, 2023 Facility Number: 000476 Provider Number: 155446 AIM Number; 100290870 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 6 Medicaid: 66 Other: 11 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed May 26, 2023	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a Post Survey Desk Review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Blackburn	RN, Regional Nurse Consultant	06/12/2023

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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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 interview and record review the facility failed to ensure adequate supervision to prevent accidents for 2 of 4 residents reviewed. (Resident 3 & Resident 4) Findings include: 1. Resident 3's record was reviewed on 5/22/23 at 10:03 AM. Diagnoses included repeated falls, impulse disorder, and vascular dementia. A review of Resident 3's current admission MDS indicated their BIMS (Basic Interview for Mental Status) score was 5 (severely impaired). A review of Resident 3's current care plan dated 5/22/23 at 1:06 PM titled risk for falls or fall related injury indicated the resident had a problem of falls with injury with a goal date of 6/30/2023. Interventions included: dycem (padding to help stabilize objects, hold objects firmly in place, or to provide a better grip) to wheelchair, assist with toileting, assist with transfers, therapy to evaluate and treat for positioning, keep call light and frequently used personal items within reach, and encourage and assist to wear appropriate nonskid footwear. The care plan was not updated after Resident 3's falls.	F 0689	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility is unable to correct the alleged deficient practice of no assessments documented after fall and no neurological assessments for Res #3. Resident #3's fall care plan was reviewed and updated as needed. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All resident's resident in the facility have the potential to be affected by the alleged deficient practice. A review of nursing progress notes and risk management was completed on all residents for the last 60 days for any documented falls. Fall care plans updated as needed for residents.	06/12/2023

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	A review of Resident 3's incident note dated 5/8/23 at 9:55 PM indicated staff reported resident had transferred self and was found on the floor, resident was sitting on buttocks on the floor in the doorway to the bathroom. No injuries were noted at the time of the incident. There were no assessments documented after the fall. A review of Resident 3's progress note dated 5/9/23 at 09:50 AM indicated staff were brought to the room and observed edema (swelling) and misalignment of the right lower extremity. Per the Nurse Practitioners' order, Resident 3 was sent to Emergency Room for evaluation. A review of a fall follow-up note dated 5/18/23 at 1:50 PM indicated staff found Resident 3 on floor in a supine position lying on footrests of wheelchair with the wheelchair tilted forward. There were no neurological assessments completed for Resident 3 post fall. In an interview on 5/22/23 at 10:38 AM, RN 9 indicated when a resident falls a general head to toe assessment would be performed, and when a fall is unwitnessed or a resident hits their head then neurological assessments should be done alongside a progress note. In an interview on 5/23/23 at 8:00 AM, the DON (Director of Nursing) indicated a fall should be immediately reported to a nurse, an assessment performed, and protocol followed. 2. Resident 4's record was reviewed on 5/22/23 at 9:15 AM. Diagnoses included: acquired absence of right leg below knee (amputation below right knee), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur. Policy and Procedure reviewed with no changes needed. DNS/Designee will review all progress notes and risk management in morning clinical meeting to ensure fall documentation is complete. Nurse Consultant will review weekly for compliance. All licensed staff educated on proper documentation and follow up regarding falls and Fall policy and procedure by DNS/Designee by 6-12-23. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. Audits will be performed each business day X3 months, then 3X's a week X3 months, then weekly X3 months and then QA committee will adjust audits accordingly. Results of audits will be discussed at monthly Quality Assurance meetings. If 100% threshold is not met, then an action plan will be developed. The QA Committee will be adjust audits based on findings.	

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	side (paralysis affecting left side of body following a stroke), and generalized anxiety. A review of Resident 4's current quarterly MDS indicated their BIMS score was 11 (moderately impaired). The MDS indicated the resident required extensive assistance in bed mobility and transferring. Resident 4 was determined unable to walk on their own and required only supervision when in the wheelchair. A review of Resident 4's current care plan titled risk for falls or fall related injury due to impaired cognition and impaired mobility indicated the resident had a problem of falls with injury with a goal date of 8/02/23. Interventions included: encourage to participate in activities to promote exercise, physical activity for strengthening and improved mobility, encourage and assist to wear appropriate nonskid footwear, keep call light and frequently used personal items within reach, keep pathways clear and well lit, Occupational Therapy to eval for wheelchair positioning, therapy to screen quarterly and as needed, notify therapy of changes in gait or balance and therapy to treat as ordered, assist with toileting, and assist with transfers. A review of progress notes dated 03/26/23 at 2:24 AM indicated Resident 4 fell and hit the toilet on 03/25/23. A faint discoloration on the left outer eye was noted. On 03/26/23 at 3:29 AM a progress note indicated there were no notes regarding any fall. On 03/27/23 at 2:32 PM a progress note indicated Resident 4 was unable to stand and "flopped" back onto bed upon assistance getting up. Upon further assessment the LUE (left upper extremity, left arm) was flaccid, speech and smile were			

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	normal, and left pupil was nonreactive. The Nurse Practitioner was notified, and Resident 4 was sent to the Emergency Room. There was no indication Resident 4 had fall prevention measures in place. A current fall management policy dated 01/2023 provided by the RNC (Regional Nurse Consultant) on 5/23/23 at 2:28 PM indicated a neurological assessment would be initiated on all unwitnessed falls: every 15 minutes for 1 hour then every 30 minutes for 1 hour, then every 1 hour for four hours, then every 4 hours for 24 hours, then every 8 hours for 72 hours. 3.1-45(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review the facility failed to ensure care of dialysis access site for 3 of 7 residents reviewed. (Resident 3, Resident 11, and Resident 72). Findings include: 1)During an interview on 5/18/23 at 1:36PM, Resident 3's POA (Power of Attorney), indicated the facility did not care for Resident 3's dialysis fistula. The POA indicated he had required a repair of his dialysis fistula. The POA indicated there was a lack of care to fistula before and after the repair.	F 0698	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility is unable to correct the documentation and assessments for Res #3. Orders for dialysis to assess site added and care plan updated for Res #11 during survey. The facility is unable to correct the documentation prior to 5-23-23. Orders for dialysis to assess site added for Resident #72.	06/12/2023

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	Resident 3's record was reviewed, on 5/19/23 at 2:16PM. The review indicated his diagnoses included intellectual difficulties, dependent on renal dialysis, and end stage renal disease. Resident 3's comprehensive MDS (Minimal Data Set) assessment, completed on 5/16/23, had the following findings: Section C- Cognitive Patterns had documented a BIMS (Brief Interview of Mental Status) indicated a score of 5. The score of 5 indicated moderate cognitive impairment. Section E-Behaviors indicated he had physical behaviors towards others and himself. Section O-Special Treatments, Procedures, and Programs-indicated he received dialysis. Resident 3's physician orders were reviewed on 5/19/23 at 3:15PM. An order for dialysis fistula right arm to check for thrill and bruit, swelling, pain, change in temperature, and bleeding every shift began on 2/13/23. An order for Meropenem-Sodium Chloride (an antibiotic) intravenous solution daily from 5/4/23 to 5/13/23 was noted. Resident 3's MAR indicated there was no documentation for the following dates and times in April 2023: 4/1/23 day shift 4/2/23 evening shift 4/3/23 evening shift 4/4/23 evening and night shift 4/7/23 night shift 4/9/23 night shift 4/13/23 evening shift 4/14/23 day shift 4/23/23 day and evening shift 4/24/23 night shift 4/25/23 night shift		2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents who received dialysis services have the potential to be affected by the alleged deficient practice. An audit of all current residents receiving dialysis services have been audited for orders and care plan completion and any corrections made. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. Policy and Procedure reviewed with no changes needed. DNS/Designee will review all dialysis residents each business day to ensure completion of dialysis assessments and documentation. All new dialysis admissions will be audited on next business day to ensure orders are entered for dialysis site assessment and completion of dialysis care plan. Nurse Consultant will review weekly for compliance. All licensed staff educated on proper documentation and assessment of dialysis sites and completion of documentation by DNS by 6-12-23. 4. How the corrective action will be monitored to ensure the	

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	4/26/23 day shift 4/27/23 night shift 4/28/23 day and night shift 4/29/23 night shift 4/30/23 day and evening shift Resident 3's hospital discharge paperwork dated 5/13/23 was reviewed. Resident 3 went to the hospital on 4/16/23 and had a repair to right arm fistula. Resident 3 was discharged back to the facility on 4/21/23. Hospital discharge record indicated on 4/27/23 Resident 3 returned with pus coming from right arm fistula where there were still a couple of staples remaining . Resident 3's progress note dated 4/26/23 at 10:21AM indicated the facility nurse was notified by the dialysis nurse; dialysis would not be done due to Resident 3's fistula having drainage. The Th progress note indicated the dialysis nurse was attempting to get Resident 3 into a radiology clinic. The progress note indicated if the dialysis nurse was not able to get Resident 3 into clinic, the nephrologist wanted him sent to emergency room. There were no further progress notes on this date to indicate why resident was not sent to hospital or an assessment of fistula. A nursing progress note on 4/27/23 at 4:30PM indicated there was a miscommunication between the dialysis nurse and radiology. Radiology indicated they did not receive the referral the dialysis nurse sent. The DON received physician orders for Resident 3 for an oral antibiotic and to have Resident 3 sent to emergency room for a temporary port placement for dialysis. In an interview with RN 6 on 5/23/23 at 10:38 AM,		deficient practice will not recure, ie,. what quality assurance program will be put into place. Audits will be performed each business day X3 months, then 3 X's a week X3 months, then weekly X3 months. Results of audits will be discussed at monthly Quality Assurance meetings. If 100% threshold is not met, then an action plan will be developed. The QA Committee will adjust audits based on findings.	

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	she indicated to know when something was done and to show physician ordered treatments had been completed; they were to be signed off on the MAR. She indicated any unusual findings would require a progress note and any concerns were to be communicated to the DON, the POA, and the physician. 2. Resident 11's Record was reviewed on 5/19/23 at 2:40 PM. Diagnoses included dependence on renal dialysis, and end stage renal disease. A review of Resident 11's current admission Minimum Data Set Assessment (MDS), indicated his Brief Interview for Mental Status (BIMS) score was 13 (cognitively intact). The MDS indicated Resident 11 was receiving dialysis. A copy of Resident 11's current physician orders was provided by the Regional Nurse Consultant (RNC) on 5/24/23 at 8:30 AM. A review of a physician order, dated 5/16/23, indicated Resident 11 received hemodialysis (a treatment to filter wastes and water from the blood) 3 times a week (Monday, Wednesday, and Friday) at the (name of company) in house dialysis center. A review of a physician order, dated 5/23/23, indicated Resident 11 had a left upper arm dialysis AV fistula (an access made by joining an artery with a vein in the arm to be used for dialysis) with checks to be completed every shift for thrill (vibration at the fistula site) and bruit (sound heard when placing a stethoscope on a fistula site), swelling, pain, change in temperature, and/or bleeding. There was no order to assess Resident 11's dialysis fistula site prior to 5/23/23. A review of Resident 11's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated May 2023,			

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	indicated Resident 11's AV fistula was assessed for thrill and bruit, swelling, pain, change in temperature, and/or bleeding on the 5/23/23 night shift. There was no documentation on the MAR and TAR to indicate an assessment of Resident 11's AV fistula was completed prior to 5/23/23 night shift. A review of Resident 11's progress notes, dated 5/1/23 9:46 AM to 5/22/23 2:09 PM, indicated there was no documentation indicating an assessment of Resident 11's AV fistula for thrill and bruit, swelling, pain, change in temperature, and/or bleeding had been completed. A review of Resident 11's care plans was completed. A current care plan, dated 4/6/23, indicated Resident 11 had potential for nutritional risk related to end stage renal disease with hemodialysis, type 2 diabetes mellitus, history of diverticulitis, and depression. The goal indicated Resident 11 would not exhibit significant weight change through the next review. The interventions did not include assessment of Resident 11's AV fistula site. There were no other care plans addressing Resident 11's dialysis or AV fistula. 3. Resident 72's record was reviewed on 5/23/23 at 11:10 AM. Diagnoses included acute kidney failure, and dependence on renal dialysis. A review of Resident 72's current quarterly MDS indicated his BIMS score was 14 (cognitively intact). The MDS indicated Resident 72 received dialysis. A copy of Resident 72's current physician orders was provided by the RNC on 5/23/23 at 3:18 PM. A review of a physician order, dated 5/15/23,			

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	indicated Resident 72 received hemodialysis 3 times a week (Monday, Wednesday, and Friday) at the (name of company) in house dialysis center. There was no order to assess Resident 72's perm catheter (a catheter inserted into a blood vessel in the neck or upper chest to be used for short term dialysis) site. A review of Resident 72's MAR and TAR, dated May 2023, was completed. The MAR and TAR indicated there was no documentation indicating an assessment of Resident 72's perm catheter site was completed. A review of 72's progress notes, dated 5/1/23 10:11 PM to 5/22/23 10:10 AM, indicated there was no documentation indicating an assessment of Resident 72's perm catheter site was completed. A review of Resident 72's care plans was completed. A care plan, dated 1/27/23, indicated Resident 72 required dialysis due to renal failure. The goal was Resident 72 would be free from complications related to dialysis. The interventions included dressing change per medical doctor order, notify dialysis of changes in Resident 72's condition or abnormal findings related to the access site, observe for signs of infection to Resident 72's right chest port access site: redness, swelling, warmth or drainage, observe for signs of the following: bleeding, hemorrhage (massive bleeding), bacteremia (infection in the blood), septic shock (widespread infection causing organ failure and low blood pressure), document abnormal findings and notify the medical doctor and dialysis. In an interview on 5/23/23 at 2:38 PM, LPN 8 indicated an assessment of a resident's dialysis access site was completed every shift and before			

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	and after dialysis. An assessment of a dialysis fistula site included checking for bruit and thrill, observing for anything unusual, edema (swelling), bleeding, assuring the dressing was clean and dry, and assuring the resident was not picking at the site. An assessment of a perm catheter site included assessing for signs of infection and assuring the dressing was clean and dry. Documentation of the dialysis access site was completed in the computer on the MAR and TAR or in a progress note. LPN 8 indicated, when a resident receiving dialysis had no order for assessment and care of a dialysis access site, the Director of Nursing (DON) would be notified to place the order. LPN 8 indicated when a problem with the dialysis site was observed, the resident's vital signs would be taken, and the Nurse Practitioner would be notified. This would be documented in a progress note. In an interview on 5/23/23 at 3:01 PM, the DON indicated an assessment of a dialysis access site was to be completed every shift. The assessment of a fistula included checking for bruit and thrill and assessing the site. The assessment of a perm catheter site included assessing the site and assuring the dressing was intact. Documentation was done on the MAR and TAR or in a nurse's progress note. The NP was to be notified of any problems. The DON indicated residents on dialysis should have an order for assessment and care of their dialysis access site. A current policy, titled Dialysis Care, dated July 2020, was provided by the RNC on 5/18/23 at 1:36 PM. The policy indicated residents requiring dialysis would receive services consistent with their plan of care. The policy indicated the facility would assure each resident requiring dialysis received such services consistent with			

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	professional standards. " ...Continued assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at an off-site dialysis center ...Assessment of the resident before, during, and after dialysis treatments ..." The procedure indicated "1. Physician orders will be received at time of admission specific to the resident including access site care, current schedule, exchanges (if applicable) and any orders related to the resident's specific dialysis needs. 2. For residents receiving treatment at an off-site facility the following will be completed: Assess and document vital signs upon return. Assess access sites and ensure dressings are clean, dry, and intact if applicable. Assess bruit and thrill if applicable ...." A current policy, titled Hemodialysis Access Care, dated September 2010, was provided by the RNC on 5/18/23 at 1:36 PM. The policy indicated " ...Care of AVF's (Arterio-Venous Fistula) and AVG's (Arterio-Venous Grafts-fistula using a synthetic or animal derived tubing to connect the artery and vein) ...3. Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots). 4. To prevent infection and/or clots: a Keep the access site clean at all times ... d. Check for signs of infection (warmth, redness, tenderness, or edema) at the access site when performing routine care and at regular intervals ... g. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. h. Check patency of the site at regular intervals. Palpate the site to feel the "thrill" or use a stethoscope to hear the "whoosh" or "bruit" of the blood flow through the access ... Care immediately following dialysis treatment indicated ... "2. If the dressing becomes wet, dirty,			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

(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
	or not intact, the dressing shall be changed by a licensed nurse trained in this procedure ...3. Mild bleeding from the site post dialysis can be expected. Apply pressure to the insertion site and contact the dialysis center for instructions. 4. If there is major bleeding from the site post dialysis, apply pressure to the insertion site and contact emergency services and the dialysis center. Verify the clamps are closed on the lumens. This is a medical emergency. Do not leave the resident alone until emergency services arrive ...Care of Central Dialysis Catheters ...1. The central catheter site must be kept clean and dry at all times ...5. Those caring for the catheter site must wear a mask and gloves when doing so. Dressing changes, if ordered, should be done using sterile technique ... Documentation: The general medical nurse should document in the resident's medical record every shift as follows: 1. Location of the catheter. 2. Condition of the dressing (interventions if needed). 3. If dialysis was done during the shift. 4. Any part of the report from the dialysis nurse post-dialysis being given. 5. Observations post-dialysis ...." A current procedure, titled Wound Care, dated October 2010, was provided by the RNC on 5/18/23 at 1:36 PM. The policy indicated the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. Preparation included "1. Verify there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. Documentation included "The following should be recorded in the resident's medical record: 1. The type of wound care given ...5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound ...8. Any problems or			

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	complaints made by the resident related to the procedure ...Reporting included "1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice ...." 3.1-37(a)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview the facility failed to ensure a clean homelike environment for 1 of 3 residents reviewed. (Resident 61). Findings include: During an interview on 5/18/23 at 9:18AM, Resident 61 indicated her room was dirty and she requested it to be cleaned several times. During an observation in room 11, on 5/18/23 at 9:18AM, there were 2 empty pop bottles, 6 plastic medication dose cups, and 10 used alcohol wipe pads around and under bed observed. The 10 alcohol wipes had dark red spots, the size of a pencil, on them. Resident 61 indicated they were from when they checked her blood sugars at bedside. Resident 61 indicated staff took her blood sugar three times per day. During an interview, on 5/18/23 at 9:46AM, QMA 7 (Qualified Medication Aid) indicated there should not be trash on floor and under bed in residents' rooms. The QMA indicated she observed 2 empty pop bottles, 6 empty medication	F 0921	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Resident #61's room was immediately cleaned by the QMA and then housekeeping followed up and cleaned the room. Resident has since discharged home from the facility. 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. All residents have the potential to be affected byt he alleged deficient practice. A whole house audit on all resident rooms completed to verify that they are clean. 3. What measures will be put into place and what systemic changes will be made to ensure that the	06/12/2023

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	cups, and 10 used alcohol wipe pads. The QMA was observed sweeping Resident 61's side of the room on 5/18/23 at 9:50AM. Resident 61's record review began on 5/23/23 at 8:15AM. Resident 61 diagnosis included chronic obstructive pulmonary disease, type 2 diabetes, and heart failure. Resident 61's comprehensive MDS (Minimum Data Set) assessment indicated the following; Section C for cognitive patterns indicated a BIMS (Brief Interview of Mental Status) score of 15. The score of 15 indicated no cognitive impairment. The RNC (Regional Nurse Consultant) provided, on 5/23/23 at 9:23 AM, a copy of the cleaning schedule for Resident 61's room. The cleaning schedule indicated the room was to be dust swept and damp mopped. The housekeeper was unavailable for an interview. In an interview, on 5/23/23 at 9:26AM, the RNC indicated they did not have a policy for maintaining a clean environment. 3.1-483.10 (I)(2)		deficient practice does not recur. Protocol reviewed with no changes needed. Administrator/Designee will verify 5 rooms a day are cleaned without any debris on the floor. Administrator educated housekeeping supervisor and supervisor educated on protocol for daily room cleaning on 6-10-23. 4. How the corrective action will be monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place. Audits will be performed each business day X4 months, then 3X's a week X3 months, then weekly X3 months. Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA Committee will adjust audits based on findings.	