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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELMCROFT OF FORT HARRISON	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

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R 0000 Bldg. 00	This visit was a State Residential Licensure Survey. Survey dates: May 23 and 24, 2019 Facility number: 014109 Residential Census: 49 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 3, 2019	R 0000	Allegation of Substantial Compliance Elmcroft of Fort Harrison has or will have substantially corrected the alleged deficiencies and achieved substantial compliance on or before the date specified herein. The Plan of Correction constitutes Elmcroft of Fort Harrison's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before June 18, 2019. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with Indiana state requirements for health facilities found at 410 IAC 16.2, Elmcroft of Fort Harrison (herein after referred to as "community") has taken or will take the actions set forth in this plan of correction.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention,			

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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	safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.			
	Based on interview and record review the facility failed assure yearly resident's rights training was provided for 1 of 6 employees reviewed. (Certified Nursing Assistant 10) Findings include: The personnel file for Certified Nursing Assistant	R 0120	The identified employee not having met the annual in-service training for Resident Rights completed her training on 06-10-2019. All employee files have been audited by Business Office Coordinator on 06-14-2019 and no other concerns identified.	06/18/2019

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	10 was reviewed on 5/24/2019 at 1:40 p.m. The record indicated the most recent resident rights training was completed 12/07/2017. During an interview on 5/24/2019 at 2:12 p.m., the Executive Director indicated Certified Nursing Assistant 10 did not have documentation of completing resident rights training in 2018.		The Business Office Coordinator or her designee will complete monthly audits for three months of all employee files to ensure compliance with required annual in-service education. The Business Office Coordinator or designee will bring audit results to monthly Quality Assurance meetings. Quality Assurance committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the			

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	first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on record review and interview, the facility failed to ensure the screening/testing for tuberculosis was completed for 1 of 5 employee files reviewed. (Licensed Practical Nurse 6) Finding includes: The Personnel Records were reviewed on 5/24/19 at 11:00 a.m., the following was not included: Licensed Practical Nurse (LPN) 6 hired on 3/19/19, lacked the second step tuberculosis (TB, a bacteria) screening/testing within the 1 to 3 weeks after the first step tuberculosis screening/testing. LPN 6 had the first step TB given on 3/19/19 at 3 p.m. and a second step TB on 5/2/19 at 11 a.m. Interview with the Director of Nursing on 5/24/19 at 11:41 a.m., indicated, she was unable to provide documentation the above employee had completed the required two step TB screening/testing within the 1 to 3 week time frame between first and second steps.	R 0121	The identified employee missing the required 2nd step TB test had received their second step on 05-24-2019, which was not timely. All employee files audited by Business Office Coordinator on 06-14-2019 to ensure timely compliance with 1st and 2nd step TB tests for employees. No other concerns identified. The Director of Nursing and Business Office Coordinator received education from Executive Director on 06-14-2019 for compliance with Indiana Regulations regarding TB screenings for all new employees. The Business Office Coordinator will conduct monthly audits for three months of all new employee files to ensure compliance with TB	06/18/2019

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	A TB Testing of Associates policy received on 5/24/19 from ED stated, "....A tuberculin skin test is not required if the associate can produce documentation that he/she has had a tuberculin skin test within 12 month prior to their current employment. For all other associates whose INITIAL (sic) skin test shows less than 10 millimeter on induration, a two step skin test is required within 7 days after hire but not to exceed 14 days apart...".		screenings for all employees. Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation and interview, the facility failed to provide a functional and sanitary environment by having miscellaneous trash on the ground around the outside of the dumpster, and not ensuring the trash receptacles in the kitchen remained covered when not in use. This had the potential to affect 49 of 49 residents in the facility for dumpster and kitchen. (Assisted Living) Findings include: 1. On 5/24/19 at 10: 32 a.m., during the Environmental Tour with the Maintenance Director (MD) and Executive Director ED) the following was observed: The area immediately surrounding the dumpster was littered with multiple white, disposable cloth	R 0155	The trash surrounding the dumpster was immediately cleared away following the environmental tour and the two trash cans in kitchen were replaced on 5-24-2019. All staff in-serviced on proper disposal of trash into dumpster and maintaining a clean area in the surrounding area by Dietary Manager on 06-11-2019. Dietary staff in-serviced regarding proper food storage and sanitation on 06-11-2019 by Dietary Manager. Maintenance Supervisor will audit area surrounding the dumpster once weekly for 8 weeks to ensure compliance with a neat and tidy area.	06/18/2019

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	wipes; orange plastic bags; facial tissues; cup lids; straws, two medication cups, ripped sugar packets; and lids to nutritional drinks. An interview with the MD, at the time of the observation, indicated the area was in need of cleaning and all trash should be contained within the dumpster. 2. A tour of the kitchen was conducted on 5/23/19 at 2:00 p.m. with Cook 5. The trash receptacle near the dishwasher was not covered and not in use. There was food debris, plastic, and paper towel easily observed inside the receptacle. The receptacle lid had 2 flopping doors, inverted, inside the receptacle, that did not flop upward. The doors had matted food debris on them. Another identical trash receptacle was located near the 2 compartment sink. Only 1 of the 2 flopping receptacle lid doors was inverted, inside the receptacle, and did not flop upward. Trash and debris were easily observed inside the receptacle. A gnat was observed flying nearby. An observation of the kitchen was conducted on 5/24/19 at 11:40 a.m. The trash receptacle near the dishwasher had been replaced with a larger trash receptacle. An interview was conducted with Cook 5 at this time. She indicated the other trash receptacle was broken.		Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate.	
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.			

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	(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 observation, interview, and record review, the facility failed to ensure completion of an evaluation of a resident's ability to self administer medications for 1 of 5 residents whose physician's orders were reviewed. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 5/24/19 at 10:00 a.m. The diagnoses for Resident 6 included, but were not limited to, diabetic neuropathy and fibromyalgia. The 4/4/19 physician's order for Resident 6 read, "Volteran gel 1% apply to bilat [bilateral] knees TID [three times daily] - may keep at bedside [MKAB.]" The May, 2019 MAR (medication administration record) read, "Volteran gel 1% Apply to bilat knees TID. MKAB." There were no facility staff signatures on the MAR to indicate the facility applied the medication. There was no evaluation of Resident 6's ability to self administer medications in her clinical record. An interview was conducted with the WD (Wellness Director) and NP (Nurse Practitioner) 9 on 5/24/19 at 10:40 a.m. NP 9 indicated she saw the Volteran gel in Resident 6's room approximately 2 weeks ago. The Wellness	R 0216	The self- administration of meds assessment for Resident #6 was completed immediately upon being made aware of missed assessment. An audit was conducted on 05-28-2019 by the Nursing Director of all residents that are self- administering meds and no other concerns identified. Nursing Director has completed in-service education to all licensed staff on 05-24-2019 policy and screenings for self-administering medications Nursing Director or her designee will complete audits on residents with orders to self-administer medication monthly for three months. Quality Assurance Committee to review during QA meetings and provide recommendations for continued monitoring as appropriate	06/18/2019

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	Director reviewed Resident 6's clinical record and indicated she was unable to locate a self administration assessment for Resident 6's Volteran gel. An observation of Resident 6's apartment was made with the WD, in the presence of Resident 6, on 5/24/19 at 11:05 a.m. The WD looked through Resident 6's belongings in her living room, kitchen, bedroom, and bathroom, and was unable to locate the Volteran gel. An interview was conducted with Resident 6 on 5/24/19 at 11:05 a.m. She indicated she applied the Volteran gel everyday and stated, "I just used it before my walk today." On 5/24/19, at 11:10 a.m., after exiting Resident 6's apartment, the WD indicated Resident 6 could be forgetful sometimes, but she was cognitively intact. The Resident Self Administration of Medication and Storage policy was provided by the Executive Director on 5/24/19 at 2:16 p.m. It read, "The resident will be evaluated by Resident Services Director (RSD)/designee using the Self Administration Screening deeming the resident capable of self-administration per [name of facility] self-administration policy requirements, regardless of physician approval."			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.			
	Based on interview and record review, the facility failed to ensure blood sugar readings were taken and insulin was administered, as ordered, for 2 of	R 0240	Physician and residents notified by licensed staff of missed accucheks on 05-24-2019.	06/18/2019

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	5 residents whose physician's orders were reviewed. (Residents 4 and 6) Findings include: 1. The clinical record for Resident 4 was reviewed on 5/23/19 at 2:30 p.m. The diagnoses for Resident 4 included, but were not limited to, diabetes. The 4/19/19 service plan for Resident 4 indicated staff was to assist with his medications due to noncompliance of medications and blood sugar checks. The May, 2019 physician's orders indicated for Resident 4's blood sugar to be checked 4 times daily and to administer sliding scale Novolog for blood sugar readings as follows: 151-200 = 2 Units 201-250 = 4 Units 251-300 = 6 Units 301-350 = 8 Units 351-400 = 10 Units The May, 2019 blood sugar logs and MAR (medication administration record) indicated a reading of 200 at breakfast on 5/2/19 with no sliding scale insulin administered, a reading of 236 at dinner on 5/4/19 with 2 Units administered, a reading of 263 at dinner on 5/8/19 with 2 Units administered, a reading of 209 at breakfast on 5/10/19 with 2 Units administered, and a reading of 170 at dinner on 5/10/19 with no Units administered. An interview was conducted with the Wellness Director on 5/23/19 at 3:31 p.m. She reviewed Resident 4's clinical record and indicated she had		Resident #4and #6 were seen by Nurse Practitioner 06-11-2019 for follow-up. No concerns identified. Nursing Director completed an audit on 05-24-2019 of all residents receiving accucheks/insulin medication and no other concerns identified. Nursing Director completed in-service education for all licensed staff regarding documentation and completion of accucheks and administration of sliding scale insulin on 06-14-2019. Nursing Director or her designee will complete weekly audits for 8 weeks to ensure compliance with Physician orders and documentation for accucheks and insulin orders. Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate	

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	no information to indicate the sliding scale insulin was administered, as ordered, on the above dates and times. 2. The clinical record for Resident 6 was reviewed on 5/24/19 at 10:00 a.m. The diagnoses for Resident 6 included, but were not limited to, diabetes. The 5/7/19 physician's order indicated for blood sugar checks to be done every morning and at bedtime. The order read, "Please record all results in blood sugar log in medication book so I can review." The May, 2019 blood sugar log did not have readings for the following dates and times: 5/8/19 at bedtime 5/9/19 at bedtime 5/11/19 at bedtime 5/12/19 at bedtime 5/13/19 in the morning The May, 2019 MAR (medication administration record) did not have blood sugar readings for the above dates and times either. An interview was conducted with the Wellness Director on 5/24/19 at 12:17 p.m. She indicated the blood sugar readings should have been recorded on the log. The Medication Administration policy was provided by the Executive Director on 5/24/19 at 2:16 p.m. It read, "It is policy of [name of facility] that all medications be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional."			

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to ensure food was properly stored and proper hand hygiene was maintained in the kitchen with the potential to affect 46 of 46 residents in the facility. Findings include: A tour of the kitchen was conducted on 5/23/19 at 2:00 p.m. with Cook 5. A pair of white ear phone plugs was resting on a food prep (preparation) counter. A cup of juice was also on this counter. The shelf above the prep counter held a large white plastic bottle of seasoning salt, with salt resting all around the neck of the bottle. There were 4 bottles of food coloring on the shelf with splatter around the necks and sides of the bottles. There were 3 clean dessert cups and 2 plastic cups on this shelf. Cook 5 indicated the earphones should not be stored on the prep counter, and the cup of juice belonged to one of the employees. Cook 5 indicated they barely used the food coloring, as half of the items on the shelf belonged to the activity department. The dry storage area of the kitchen contained a large bottle of molasses on a top rack of a multi rack unit. The bottle had product around the neck, top and sides of the bottle. A gnat was flying near the multi rack unit.	R 0273	Personal items found in prep counter were immediately removed following discovery. Staff member re-educated on need to store said items in lockers or break room on 06-11-2019. Cook #5 re-educated on Infection Control and Hand-washing policy on 06-11-2019 by Dietary Manager. Dietary Manager and staff completed deep cleaning of kitchen on 06-11-2019. Staff in-serviced on Food storage and handling, Infection Control and hand-washing policy by Dietary Manager on 06-11-2019. Dietary Manager or her designee will audit kitchen and prep areas once weekly for 8 weeks to ensure compliance with kitchen and prep areas are clean and sanitary. Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate	06/18/2019

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	A pan of pizza rolls and a pan with 2 cooked beef roasts were resting on top of the oven, uncovered. A pan of sausage with peppers, covered with plastic wrap, was also resting on top of the oven. The plastic wrap had a golf ball sized hole in the corner, exposing the food to air. Cook 5 indicated the pizza rolls were for one of the residents; the beef was going to be shredded, and the sausage with peppers was for dinner. The walk in refrigerator contained 14 carafes of ice water, uncovered, on a rolling cart. Cook 5 indicated they kept the carafes uncovered to prevent them from breaking. The walk in freezer had mixed vegetables spilled all over the floor. Cook 5 coughed into the air 3 times and once into her hand during the tour. She did not use hand hygiene after coughing. A second tour of the kitchen was conducted on 5/24/19 at 11:40 a.m. The white earphones were now on the shelf above the prep counter, next to the spices. The 3 dessert cups remained on the shelf. There was less vegetables on the freezer floor, but vegetables remained underneath the racks in the freezer. Cook 5 indicated the freezer floor was swept daily and as needed. The Food Storage, Handling & Labeling policy was provided by Consultant 7 on 5/24/19 at 1:30 p.m. It read, "Ensure that all storage areas are clean, organized, and maintained....All cooked foods, open containers, salads, desserts and fruits are to be securely covered, labeled and dated....Storage areas are cleaned and organized daily. Storage areas are protected from vermin, rodents and insects....Always securely cover food			

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ELMCROFT OF FORT HARRISON	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

(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
	item." The Employee Hand Washing policy was provided by Consultant 7 on 5/24/19 at 1:30 p.m. It read, "Employees must wash hands under the following circumstances: ...After blowing nose, coughing or sneezing."			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.			
	Based on observation, record review, and interview, the facility failed to ensure over-the-counter medications were labeled with the Physician's name for 2 of 5 residents observed during medication administration. (Residents 3 and 51) Findings include: 1. On 5/24/19 at 8:40 a.m., LPN 4 was observed preparing medications for Resident 3. The LPN administered 0.25 milliliters (ml) of cannabidiol (CBD) oil (a hemp extract) directly underneath residents tongue. The medications was an over-the-counter medication. The Physician's name was not listed on the bottle. 2. On 5/24/19 at 9:47 a.m., with DON, during the medication storage observation, a bottle of aspirin, 81 mg tablets was observed stored in a drawer for Resident 51. The resident was to receive 81 mg of Aspirin, by mouth daily. The medication was provided over-the-counter (OTC).	R 0302	The identified OTC drugs were updated immediately upon finding to reflect compliance with Indiana State Regulations. Nursing Director completed audit on 05-28-2019 of all OTC medications, and no other concerns identified. Nursing Director completed in-service education on 05-23-2019 to all Licensed staff on the appropriate labeling of all OTC medications. Nursing Director or her Designee will complete weekly audits of OTC medications for compliance with labeling for a total of 8 weeks. Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as	06/18/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The Physician's name was not listed on the bottle. In an interview with the DON, at the same time as the observation, she indicated she was unaware of OTC medication labeling requirements and thought they (the facility) should not label medications because only a pharmacy can label medications.		appropriate	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.			
	Based on interview and record review, the facility failed utilize a resident transfer form and to ensure resident transfer form included condition on transfer, date of chest x-ray and skin test for tuberculosis for 2 of 2 closed records reviewed. (Resident 22 and 52) Findings include: 1. The clinical record for Resident 22 was reviewed on 5/23/2019 at 2:10 p.m. The diagnosis for	R 0354	The Transfer/Discharge form was updated immediately to reflect the missing information for compliance with Indiana Regulations. Nursing Director completed in-service education on 05-23-2019 to all Licensed staff regarding updated Transfer/Discharge forms. Nursing Director or her Designee will complete audits of future	06/18/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/24/2019

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	Resident 22 included, but were not limited to, hypertension and weakness. The clinical record contained a nursing note dated 5/09/2019 at 3:00 a.m., indicating Resident 22 had been transferred to an acute care hospital on 5/08/2019. The clinical record did not contain a transfer form or information about what records were sent with Resident 22 to the acute care hospital. During an interview on 5/23/2019 at 3:00 p.m., the Wellness Director indicated that transfer forms were not usually utilized when a resident was sent to the hospital. The facility would normally send a copy of the MAR (Medication Administration Record), recent labs, face sheet, Power of Attorney paperwork and Physicians orders. There is no notation in the clinical record that those items were sent with Resident 22. 2. The clinical record for Resident 52 was reviewed on 5/23/2019 at 2:30 p.m. The diagnosis for Resident 52 included, but were not limited to, hypertension and high cholesterol. The clinical record contained a transfer and discharge record dated 3/30/2019, indicating Resident 52 was discharged to an assisted living facility. The transfer and discharge record did not include information about Resident 52's most recent Tuberculin skin test results, Chest X-Ray results and current condition upon discharge from the facility. During an interview on 5/23/2019 at 3:15 p.m., the Director of Wellness indicated the transfer and		discharges for a total of three months to verify compliance. Quality Assurance Committee to review audits during QA meetings and will provide recommendations for continued monitoring as appropriate	

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	discharge record did not contain the chest X ray, Tuberculin skin test results or the current condition of Resident 52 upon discharge. On 5/23/2019 at 3:30 p.m., the Executive Director provided the Transfer and Discharge Policy, dated 3/24/2016, which reads as follows: " Policy: It is the policy of Elmcroft that resident transfers and discharges will be conducted in accordance with resident rights, physician's orders, and in such a manner as to maintain continuity of care for the resident..."			