STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	08/26/2016

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ALTENHEIM HEALTH & LIVING COMMUNITY	3525 E HANNA AVE INDIANAPOLIS, IN 46237

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00205017. Complaint IN00205017 - Unsubstantiated due to lack of evidence. Survey dates: August 18, 19, 22, 23, 24, 25, and 26, 2016. Facility number: 000103 Provider number: 155194 AIM number: 100290000 Census bed type: SNF: 21 SNF/NF: 47 Residential: 46 Total: 114 Census payor type: Medicare: 21 Medicaid: 30 Other: 17 Total: 68 These deficiencies reflect State findings	F 0000	This plan of correction is to serve Altenheim Family FirstSenior Living's credible allegation of compliance. Submission of this plan ofcorrection does not constitute an admission by Altenheim Family First SeniorLiving or its management company that the allegations contained in the surveyreport are a true and accurate portrayal of the provision of nursing care andother services in this facility. Nor does this submission constitute an agreementor admission of the survey allegations. We would like to respectfully requestpaper compliance for Altenheim Family First Senior Living's Recertification andState Licensure Survey and Residential Licensure Survey.	

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

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	cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on September 02, 2016.			
F 0246 SS=D Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review, observation, and interview, the facility failed to ensure a resident was aware of the call light cord location to ensure it was available if the resident needed to contact staff for assistance. (Resident #10). Findings include: Resident #10's clinical record was reviewed on 8/24/16 at 1:00 p.m. Diagnoses included, but were not limited to, contracture of left hand. (A contracture is stiffness in your muscles or joints that restricts normal movement) On 8/19/16 at 1:00 p.m., Resident #10 was observed with the left 3 fingers, on	F 0246	*Altenheim Family First Senior Livingwould like to respectfully request a face-to-face Informal Dispute Resolution of F246. Thebasis of the findings was in reference to resident #10 being unable to reachher call light and was unaware of the call light location on three occurrences.During each of the three occurrences resident was lying in bed and call lightwas clipped to resident's pillow and within resident's reach. Altenheim FamilyFirst Senior Living's Accommodation of Needs Policy states "Staff shall arrangetoiletries and personal items so that they are in easy reach of the resident".The facility did follow the policy and ensure resident's call light was*	09/16/2016

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	the left hand closed halfway. Resident #10 indicated she was unable to open the 3 fingers outward all the way. The Quarterly Minimum Data Set (MDS) Assessment dated 7/29/16, assessed Resident #10 as scoring a 11 out of 15 on the Brief Interview for Mental Status (BIMs) assessment (11 out of 15, indicated moderate cognitive impairment). On 8/19/16 at 9:56 a.m., Resident #10 was observed lying in bed. The call light was positioned to the left side of the pillow. When asked to demonstrate use of the call light, Resident #10 responded, "I can't reach it." On 8/23/16 at 3:00 p.m., Resident #10 was observed lying in bed. The call light was clipped to the bottom left corner of the pillow case. When asked where the call light was located, Resident #10 indicated, " I don't know where it is." On 8/24/16 at 10:46 a.m., Resident #10 was observed lying in bed. The call light was clipped to the top right corner of the pillow case. When asked to turn the call light on, Resident #10 indicated, "I don't know where it is." During an interview on 8/24/16 at 11:58		*withinreach. Resident #10 has a BIMS of 11 out of 15. Altenheim Family First SeniorLiving would like to respectfully request that F246 be removed from the 2567.* **1. What corrective Actions will be accomplished for those residents found to have been affected bythe deficient practice?** Call light is placed within resident #10's reach and view while resident is in room. 2. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents residing in the Skilled Nursing Facility have the potential to be affected by thealleged deficient practice. Director of Nursing/Designee will do a random audit of 10 rooms daily to ensure resident call light was in resident view and resident isaware of location. **3. What measures will be put into place or what systematic changes will be made to ensure that thedeficient practice does not occur?** Director of Nursing/Designee will do random audit of 10 rooms daily to ensure resident call lights are in resident's view and resident's are aware of location. Facility staff will be educated by Director of Nursing/Designee by September 16, 2016 on ensuring resident's call lights are within resident view and residents are aware of call	

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	a.m., Licensed Practical Nurse (LPN) #3 indicated Resident #10 cognitively knows how to use the call light. LPN #3 indicated that due to Resident #10's left hand contracture, the call light is usually pinned to the front of Resident #10's shirt or blanket." On 8/24/26 at 1:30 p.m., the Director of Nursing (DON) provided a policy revised in October, 2009, titled "Quality of Life - Accommodation of Needs" and indicated it was the policy currently used by the facility. The policy indicated, "...Staff shall arrange toiletries and personal items so that they are in easy reach of the resident...." 3.1-3(v)(1)		light location. **4. How will the corrective actions be monitored to ensure the deficient practice will not recur, and what quality assurance program.** Daily Call Light audits will be completed weekly X 4,monthly x 2, the quarterly there after until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee weekly until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	
F 0250 SS=D Bldg. 00	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure Social Service followed through on a resident's need for dentures for 1 of 2 residents reviewed for dental services. (Resident #76)	F 0250	**1. What correctiveActions will be accomplished for those residents found to have been affected bythe deficient practice?** Resident #76 received dentures on 7/12/16. 2. **How will otherresidents having the potential to be affected by the**	09/16/2016

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	Findings include: The clinical record of Resident #76 was reviewed on 8/23/16 at 10:24 a.m. Diagnoses for the resident included, but were not limited to, dysphagia (difficulty swallowing). A care plan created 7/15/15, and deemed current by the Director of Nursing (DON), indicated Resident #76 had consented to receive dental services from the facility dental provider. The goal was, "Resident will have ancillary services needs met." Approaches included, "dental to consult as needed." Disciplines responsible were Nursing and Social Services. Review of a dental exam summary, dated 11/2/15, indicated Resident #76 did not have any teeth, would like dentures, and impressions for dentures would be taken at the next visit. A dental exam summary dated 12/23/15 indicated, "Tooth Notes...pt [patient] seen 11-2-15...Impressions after [payor source] approval. A dental exam summary, dated 6/2/16, indicated impressions for dentures were taken on that day.		**same deficient practice byidentified and what corrective action will be taken?** All residentsresiding in the Skilled Nursing Facility requesting dentures have the potentialto be affected by the alleged deficient practice. Social Services Director/Designee will do a house wide audit of resident's records to ensure timely follow up for dental needs by September 16, 2016. **3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not occur?** Social Services Director/Designee will do a house wideaudit of resident's records to ensure timely follow up for dental needs bySeptember 16, 2016. Social Services staff will be educated by the SocialServices Consultant by September 16, 2016 on timely follow up to resident's dental needs. IDT will review all Dental Services recommendations for each resident on the next business day to ensure timely follow up is completed for resident's dental needs Social Services Director/Designee will complete Dental Services CQI Audit to verify timely follow up on residents' dental needs weekly x 4, monthly x 2, and quarterly thereafter **4. How will thecorrective actions be monitored to ensure**	

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	A Denture Delivery Form, dated 7/12/16, indicated the dentures were delivered to Resident #76. An undated communication from the dental provider, received from the Director of Nursing on 8/23/16 at 2:00 p.m., indicated, "On November 2, 2015 the denture case started for [Resident #76]; the case was submitted to [payor source] on November 3 2015 and the prior authorization was approved on November 10 2015. The case manager who was responsible for this case did not let the scheduling team know that impressions were needed to move forward with the fabrication process; that was not done until May 5 2016. The impressions were received into our lab on June 6 2016 and the dentures were fabricated June 27 2016 and delivered on July 12, 2016..." An undated communication from the dental provider, received from the Acting Administrator on 8/23/16 at 2:15, indicated, "During an examination on 11/2/15, our Dentist, [name of dentist] determined [Resident #76] has a need for, and would benefit from complete upper and lower dentures. The resident didn't receive a denture delivery until 7/12/16. [Name of dental provider] takes full responsible for the length of time took to		**the deficient practice will notrecur, and what quality assurance program.** Social Services Director/Designee will complete Dental Services CQI Audit to verify timely follow up on residents' dental needs weekly x 4, monthly x 2, and quarterly thereafter The results of these audits will be reviewed weekly x 4,monthly x 2, then quarterly thereafter by the Quality Assurance Committee untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	

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	fabricate dentures for the resident. Poor communication between our Utilization and Scheduling departments resulted in the resident not being scheduled for impressions until May 2016. This is why the resident case took seven months to complete..." On 8/26/16, the DON indicated Social Services should have been tracking Resident #76's need for dentures as determined on 11/2/15, and followed up on the progress toward obtaining the dentures so that he would have received them prior to July 12, 2016 (8 months after initial determination of his need for dentures). 3.1-34(a)			
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.			

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	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) Assessments were coded accurately for a resident with significant weight loss (Resident #46) and a resident receiving an anticoagulant medication (Resident #14). Findings include: 1. The clinical record of Resident #46 was reviewed on 8/22/16 at 2:46 p.m.	F 0278	**What correctiveactions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #46 and Resident #17 had a corrected MDS submitted during the survey process. **How will other residentshaving the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** All residents have the potential to be affected by the same alleged	09/16/2016

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	Diagnoses for the resident included, but were not limited to, gastroesophageal reflux disease and congestive heart failure. A recapitulated physician order for August, 2016, with an original order date of 1/5/16, indicated Resident #146 was to receive a regular diet with no added salt, and thin liquids. No order for a weight loss regimen was found in the resident's record. A review of Resident #46's weights indicated: 2/3/16 weight = 223 lbs (pounds) 5/5/16 weight = 204 lbs This was a significant weight loss in 3 months of 8.5%. An Interdisciplinary Team (IDT) note dated 5/13/16, indicated Resident #46's current weight was 204 lbs. No documentation to indicate the resident was on a weight loss regimen. An IDT note dated 5/25/16 indicated the resident's current weight was 200.6 lbs. This was a significant weight loss of 10% in 3-4 months. No documentation to indicate the resident was on a weight loss regimen.		deficient practice. All Current residents will have their most recent MDS reviewed for accuracy of weight loss and anticoagulant coding by the MDS Personnel by September 16, 2016. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education will be provided to MDS Personnel regarding correct coding of the MDS for weight loss and anticoagulant coding by MDS Consultant/Designee by September 16, 2016. MDS Coordinator/Designee will audit accuracy of anticoagulant coding and weight loss coding daily Monday through Friday, usingthe MDS accuracy audit tool on the assessment prior to any MDS being submitted. **How will the corrective actions be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?** Daily MDS accuracy audits for anticoagulant coding and weight loss coding will be completed weekly x 4, monthly x 2, and then quarterly thereafter until 100% compliance is met. The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as	

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	A quarterly Minimum Data Set(MDS) assessment, dated 6/15/16, with a look back period between 6/9/16 and 6/15/16, was coded "0" which indicated Resident #46 had not lost "5% or more in the last month, or... 10% in the last 6 months." On 8/22/16 at 4:26 p.m., the Director of Nursing indicated the Registered Dietician had coded the K0300 section of the 6/15/16, MDS on Weight Loss incorrectly at a 1, Yes on physician-prescribed weight loss regimen. The correct coding should have been 2, "Yes, not on a physician prescribed weight-loss regimen." The 6/15/16 MDS was signed by LPN #6 verifying accuracy, and RN #7 verifying assessment completion. 2. The clinical record review for Resident #14 was completed on 8/22/16 at 11:01 a.m. Diagnoses included, but were not limited to, atrial fibrillation (an abnormal heartbeat). An Annual MDS assessment Section N0410E completed on 3/19/16, assessed Resident #14 as not receiving an anticoagulant medication. A review of the Medication		needed, if compliance is below 100%.	

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	Administration Record (MAR) dated 3/13/16 through 3/19/16, for Resident #14 for 7 days prior to the Annual MDS assessment, indicated Resident #14 received warfarin (an anticoagulant medication) daily from 3/13/16 through 3/19/16. During an interview on 8/24/16 at 10:59 a.m., the MDS Coordinator indicated the Annual MDS dated 3/19/16 for Resident #14 was coded incorrectly. The MDS Coordinator indicated Section N0410E should have indicated that Resident #14 received an anticoagulant medication for 7 days during the assessment period. The 3/19/16, Annual MDS assessment was signed by LPN #4 verifying accuracy, and RN #5 verifying assessment completion. The Resident Assessment Instrument Comprehensive User Manual, Version 3.0, copy right 2009, page 477 indicated, " **...N0410E, Anticoagulant (warfarin):** Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period...." 3.1-31(d)			

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F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review the facility failed to develop a Care Plan for a resident assessed with urinary incontinence for 1 of 3 residents reviewed for urinary incontinence. (Resident #111) Findings include: 08/22/2016 2:44 p.m., during record review, indicated diagnosis which included but not limited to muscle weakness, difficulty in walking, cognitive communication deficit, hypertension, and	F 0279	**F279 – DevelopComprehensive Care Plan** **What corrective actionswill be accomplished for those resident found to have been affected by thedeficient practice?** Resident #111 MDS record was reviewed and urinaryincontinence care plan was initiated during the survey process. **How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action will be taken**. All residents have the potentialto be affected by the same alleged deficient practice.	09/16/2016

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	chronic obstructive pulmonary disease. Medications included, but not limited to metroprolol tartrate. Point Of Care History indicated incontinent episodes: 8/20/2016 at 12:16 a.m., 8/17/2016 at 9:39 p.m., 7/27/2016 at 10:10 a.m., 7/26/2016 at 3:29 p.m., 7/19/2016 at 3:39 p.m., 7/16/16 at 2:01 a.m. and 9:34 a.m., 7/9/2016 at 1:33 p.m., 7/5/2016 at 10:14 p.m., 7/3/2016 at 12:04 a.m., 6/21/2016 at 2:41 p.m., 5/24/16 at 1:16 a.m., 5/15/2016 at 2:27 p.m. Resident #111's clinical record lacked documentation of a care plan to address incontinence. 8/22/2016 at 2:00 p.m., Director Of Nursing indicated she would look for care plan for incontinence for Resident #111. 8/23/2016 at 10:30 a.m., Director Of Nursing indicated she continues to look for care plan for incontinence for Resident #111. 8/24/2016 at 9:10 a.m., Director Of		All Current residents will have their mostrecent MDS reviewed for accuracy of urinary incontinence and care planinitiated as indicated. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Education will be provided to MDSpersonnel regarding comprehensive care plan needed for urinary incontinence bythe MDS Consultant/Designee by September 16, 2016. MDS coordinator/designee will audit accuracy of urinaryincontinence care plan initiation with comprehensive assessments with the MDS accuracyaudit tool by September 16, 2016. **How will the correctiveactions will be monitored to ensure the deficient practice will not recur and whatquality assurance program will be put into place?** Daily MDS accuracy audits for urinary incontinence and initiatinga comprehensive urinary incontinence care plan will be completed weekly x 4,monthly x 2, and then quarterly thereafter, until 100% compliance is met. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	

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	Nursing indicated she is going to look for care plan for incontinence for Resident #111. 8/24/2016 at 11:30 a.m., Director Of Nursing indicated an incontinence care plan had not developed and one would be developed today. 3.1-35(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interview, the facility failed to ensure urinary catheter drainage bags and tubing were maintained in a manner to prevent urinary tract infection for 2 of 2 residents observed for care of urinary catheter drainage bags and tubing. (Residents #38 & #155) Findings include:	F 0315	**1. What correctiveActions will be accomplished for those residents found to have been affected bythe deficient practice?** Resident #38's Catheter Tubing is not touching the floor. Resident #155's Catheter Tubing is positioned to allow free flow. 2. **How will otherresidents having the potential to be affected by the same deficient practice byidentified and what**	09/16/2016

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	1. Resident #38's clinical record was reviewed on 8/24/16 at 1:30 p.m. Diagnoses included, but were not limited to, obstructive uropathy (condition when urine flow is blocked). A recapitulated physician's order for August, 2016, with an original order date of 5/25/16, indicated Resident #38 had a suprapubic catheter (a tube which drains urine from the bladder). A care plan dated 9/28/15 and current through September, 2016, indicated a problem of, "Resident has a suprapubic urinary catheter...." Approaches included, "Do not allow tubing or any part of the drainage system to touch the floor." On 8/22/16 at 10:43 a.m., Resident #38 was observed sitting in a wheelchair in the hallway, with catheter tubing resting on the floor. On 8/22/16 at 5:13 p.m., Resident #38 was observed sitting in a wheelchair in the dining room, with catheter tubing and drainage bag resting on the floor. On 8/23/16 at 8:15 p.m., Certified Nursing Assistant (CNA) #8 was observed to help Resident #38 transfer from the wheelchair to bed. During the		**corrective action will be taken?** All residents residing in the Skilled Nursing Facility with a catheterhave the potential to be affected by this alleged deficient practice. Director of Nursing/Designee will review all residents with cathetersto ensure their tubing is not touching the floor by September 16, 2016. Director Nursing/Designee will review all residents with catheters toensure tubing is positioned to allow free flow by September 16, 2016. **3. What measures willbe put into place or what systematic changes will be made to ensure that thedeficient practice does not occur?** Director of Nursing/Designee will review residents with catheters each shift daily to ensure their tubing is not touching the floor Director Nursing/Designee will review all resident with catheters each shift daily to ensure tubing is positioned to allow free flow Nursing staff will be educated by the Director ofNursing/Designee by September 16, 2016 on ensuring tubing does not touch thefloor and that it is positioned to allow free flow. **4. How will thecorrective actions be monitored to ensure the deficient practice will notrecur, and what quality assurance program.** Catheter Tubing Audit will completed by Director of NursingServices/Designee	

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	transfer, CNA #8 placed the catheter bag on the floor and pulled it across the floor under the wheelchair and laid it on the floor, before hanging it on the side of the bed. On 8/24/16 at 2:52 p.m., the Director of Nursing (DON), indicated catheter tubing and drainage bags should not touch the floor. 2. The clinical record review for Resident #155 was completed on 8/22/16 at 3:18 p.m. Diagnoses included, but were not limited to, pressure area of sacral region (area near bottom of spine and palliative care (care to improve quality of life). A recapitulated physician's order for August, 2016, with an original start date of 8/19/16, indicated Resident #155 had an indwelling urinary catheter. On 8/22/16 at 10:35 a.m., Resident #155 was observed lying in bed with the catheter drainage tubing positioned in an upward looped position to prevent free flow of urine through the tube toward the drainage bag. On 8/23/16 at 9:30 a.m., Resident #155 was observed lying on their right side, with the catheter drainage tube resting		weekly x 4, monthly x 2, and quarterly thereafter untilcompliance is at 100%. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	

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	under Resident #155's right leg, leaving a red indentation. On 8/22/16 at 2:17 p.m., Resident #155 was observed lying on their right side, with catheter tubing positioned in an upward looped position to prevent free flow of urine through the tube toward the drainage bag. On 8/24/16 at 9:34 a.m., Resident #155 was observed lying on their right side, with catheter tubing positioned in an upward looped position to prevent free flow of urine through the tube toward the drainage bag. On 8/24/16 at 2:52 p.m., the DON indicated catheter tubing should not be under Resident #155's leg, and the tubing should hang down to the drainage bag without being in a looped position. On 8/24/16 at 1:30 p.m., the DON provided a policy revised in September, 2015, titled, "Emptying a Urinary Drainage Bag" and indicated it was the policy currently used by the facility. The policy indicated, "...Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage...." The policy lacked information on placement of drainage tubing to allow for free flow of urine from the bladder to the			

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	drainage bag. 3.1-41(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure hazardous chemicals were locked in patient areas as indicated by facility policy for 15 of 22 residents in 1 of 1 shower rooms observed. Findings include: On 8/22/2016 at 10:30 a.m., During initial tour on Hall (A), observed an unlocked shower room with cabinet (with lock) on wall. The door on the cabinet was easily opened. The cabinet contained a 1 gallon container of Turbo Clean. The label on Turbo Clean indicated, wear gloves, if ingested call MD (Medical Director), drink plenty of water and induce vomiting if necessary, a 1/2 gallon container of CID-A-LII Disinfectant Cleaner with label that	F 0323	**1. What correctiveActions will be accomplished for those residents found to have been affected bythe deficient practice?** The cabinet lock in the shower room on A Hall has been replaced and islocked. 2. **How will otherresidents having the potential to be affected by the same deficient practice byidentified and what corrective action will be taken?** All residents residing inthe Skilled Nursing Facility have the potential to be affected. Administrator/Designee will educate Maintenance Director andMaintenance Assistant on ensuring the shower rooms are free of accident hazards. Nursing Facility Staff will be educated by the Director ofNursing/Designee by September	09/16/2016

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	indicated, irreversible eye damage and skin burns, harmful if swallowed, and one 7.5 ounce Clean and Free Body Wash with a label that indicated may cause eye damage. On 8/22/2015 at 10:45 a.m., During interview with the Associate Administrator (AA) indicated, the AA indicated the cabinet should have been locked. On 8/24/2016 at 9:55 a.m., The Director Of Nursing provided the policy, Physical Plant, dated 12/2011, and indicated the policy was current. A review of the policy indicated, "Basic Safety Rules: The following basic safety rules and tips highlight many areas of safety practices. Some of the rules may apply to your job duties and some may not, but you need to know them so that you can recognize an unsafe situation and report it. These are basic rules and will be followed up with more detail later in this chapter. ....Never leave open chemical unattended or unlocked in patient areas." On 8/24/2016 at 11:15 a.m., Director Of Nursing provided Census Detail by Level of Care dated 8/24/2016. The census indicated, 15 out of 22 residents, on Hall (A) self ambulate.		16, 2016 on ensuring the cabinets in the showerrooms are properly locked and that if the locks are not in tact to notify theMaintenance Director/Designee. **3. What measures willbe put into place or what systematic changes will be made to ensure that thedeficient practice does not occur?** Maintenance Director/Designee will audit cabinets in shower roomsdaily to ensure they are properly locked and intact. Administrator/Designee will educate Maintenance Director andMaintenance Assistant by September 16, 2016 on ensuring the shower rooms arefree of accident hazards. Nursing Facility Staff will be educated by the Director ofNursing/Designee by September 16, 2016 on cabinets in the shower rooms areproperly locked and that if the locks are not in tact to notify the MaintenanceDirector/Designee. **4. How will thecorrective actions be monitored to ensure the deficient practice will notrecur, and what quality assurance program.** Locked Cabinet/Hazardous Chemical Audit will be completedby the Maintenance Director/Designee weekly x 4, monthly x 2, and quarterlythereafter until compliance is at 100% The results of these audits will be	

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	3.1-45(a)(1)		reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 0431 SS=D Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976			

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	and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure a vial of tuberculin (a method used to diagnose silent [latent] tuberculosis [TB] infection), was dated when opened as indicated by facility policy in 1 of 1 medication storage areas observed. Findings Include: On 8/24/16 at 9:10 a.m., during medication storage task, observed an opened vial of tuberculin in the medication storage unit refrigerator (Therapy Department medication storage room). The vial currently being used for injection, was not dated when opened. On 8/24/16 at 9:20 a.m., During interview with Associate Director (AD), AD indicated it (tuberculin vial) should have been labeled with an opened date. On 8/24/2016 at 9:43 a.m., The Director of Nursing provided a policy, Drug Storage (undated), and indicated it was the current policy being used by facility. "Drug Storage policy indicated, ...7. Insulin and PPD (tuberculin) vaccine and other multi-dose vials requiring	F 0431	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** The undated open vialof Tuberculin was discarded. **How will other residentshaving the potential to be affected by the same deficient practice be identifiedand what corrective action will be taken?** All residents have the potential to be affected by thealleged deficient practice. Medications stored in medication room refrigeratorswill be audited to ensure multi dose vials were dated with date opened bySeptember 16, 2016 by DON/Designee **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Licensed Nursing staff will be educated on dating multi dosevials upon opening by SDC/Designee by September 16, 2016. The Multi Dose Medication Date Opened Audit will becompleted daily by the DON/Designee. **How the correctiveactions will be monitored to ensure the deficient practice will not recur and whatquality assurance program will**	09/16/2016

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	refrigeration need to be dated when opened. All vials should be discarded within 28 days of the open date." 3.1-25(j)		**be put into place?** The Multi Dose Medication Date Opened Audit will becompleted weekly x 4, monthly x 2, and quarterly thereafter until compliance is100%. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 safe, sanitary, and comfortable environment for residents, in that the facility was found have live ants and an unkept environment. Findings include: 1. On 8/19/16 at approximately 10:00 a.m., in resident room #1092, Resident #37 requested the surveyor open the top drawer of her nightstand. When the top drawer was opened it was noted that there was an abundance of ants crawling in, out, and around the things in the top	F 0465	**What correctiveactions will be accomplished for those resident found to have been affected bythe deficient practice?** Resident #37room was deep cleaned. Resident #37'slight fixture was cleaned. Dining room on the Long Term Care Unit was deepcleaned, including windowsills. Room#1071's bathroom floor was repaired. Room#1088's bathroom floor was repaired. Room # 1092's ceiling was cleaned, lightfixture was cleaned, and floor was repaired. Eco Lab completed treatment	09/16/2016

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	drawer of the resident's nightstand. Resident #37 indicated she had mentioned the ants to staff several times starting roughly four days prior, to the current observation. It was also observed that there were stains above the resident's bed. Something was splattered on the ceiling. There were also dead bugs in the light fixture cover located inside the resident's room near the door to enter and exit the room. 2. On 8/19/16 at approximately 11:00 a.m., the dining room was observed. e dinning room was also utilized as an activity room. Inside the entrance into the dinning room there was a card table set up for residents to assemble puzzles. The table had small black insects crawling on it. The windows along the left side of the room had soiled windowsills. The windowsills were covered with dirt, dust, debris, and dead insects. 3. On 8/24/16 at 11:00 a.m., during environmental tour, resident room #1071 was observed. Resident's bathroom had eight (8) small holes in the floor in front of toilet. Holes were approximate a half inch in diameter and were discolored and black. They also appeared to be filled		forpests on the Long Term Care Unit, including resident rooms and dining room. **How will other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action will be taken**. All residents residing on theLong Term Care Unit have the potential to be affected by the same allegeddeficient practice. Resident rooms onLong Term Care Unit were audited by Maintenance/Housekeeping/Design ee for floorrepairs needed and cleanliness of room and light fixtures. Dining room on Long Term Care Unit wascleaned including window sills and Eco Lab completed treatment for pests. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Education will be completed withhousekeeping staff on proper cleaning of resident rooms and resident diningroom. September 16, 2016. Maintenance staff will be educated onmonitoring and repairing flooring by September 16, 2016. Administrator/Designee will complete 10 random room auditsweekly on Long Term Care Unit for cleanliness of rooms, light fixtures, diningrooms, and repairs	

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	with an unknown black substance. 4. On 8/24/16 at 11:00 a.m., during environmental tour, resident room #1088 was observed. The floor cove had about a four inch section missing from the outer left side of the bathroom door. There was a noticeable discoloration where the piece was missing. 5. On 8/24/16 at 11:00 a.m., during environmental tour, resident room #1092 was observed. There was a discolored splatter stain in the ceiling. There were dead insects in the light fixture cover located inside the resident's room near the door to enter and exit the room. There was also section of floor cove missing on the left side of the room. 3.1-19(f)		needed. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, whatquality assurance program will be put into place?** The Environmental/Resident Room Audit will be completed byAdministrator/designee weekly x 4, monthly x 2, and quarterly thereafter until100% compliance is met. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 0469 SS=E Bldg. 00	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program for 47 of 47 residents who resided on the A/B wing.	F 0469	**What correctiveactions will be accomplished for those resident found to have been affected bythe deficient practice?** Resident #37'sroom was deep cleaned. Dining room on theLong Term Care Unit was deep cleaned,	09/16/2016

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	Findings include: 1. On 08/19/2016 at approximately 10:00 a.m., in resident room #1092, Resident #37 requested that the surveyor open the top drawer of her nightstand. When the top drawer was opened it was noted that there was an abundance of ants crawling in, out, and around the things in the top drawer of the resident's nightstand. Resident #37 indicated that she had mentioned it to staff several times, with the last time being roughly four days prior to the current observation On 8/19/16 at 9:52 a.m., the Interim Administrator indicated it was her belief that part of the issue was caused by the fact the resident had so much food in her nightstand. She indicated Resident #37 had filed a complaint on July 11th, of ants in her room. Maintenance was called to spray at that time. She was unaware of any other complaints from the resident. The administrator was unable to provide documentation for follow up after the July 7th complaint. 2. On 8/19/16 at approximately 11:00 a.m., the dining room was observed. Dinning room also utilized as an activity room. Inside the entrance into the dinning room there was a card table set up for residents to assemble puzzles. The table		including window sills. Eco lab treated dining room on the Long TermCare Unit and resident #37's previous room. **How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action will be taken**. All residents residing on theLong Term Care Unit have the potential to be affected by the same allegeddeficient practice. Resident rooms on theLong Term Care Unit were audited by Maintenance/Housekeeping/designe e forpresence of pests. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Education will be completed withhousekeeping staff on proper cleaning of resident rooms and resident diningroom by Housekeeping Supervisor by September 16, 2016. Administrator/Designee will complete 10 random room auditsweekly on Long Term Care Unit for cleanliness of rooms, light fixtures, diningrooms and repairs needed **How the correctiveactions will be monitored to ensure the deficient practice will not recur, whatquality assurance program will be put into place?** The Environmental/Resident Room Audit will be completed	

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	155196	A. BUILDING 00 B. WING	08/26/2016

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	had small black insects crawling on it. The windows along the left side of the room had soiled windowsills. The windowsills were covered with dirt, dust, debris, and dead insects. 3. On 8/18/16 at 4:00 p.m., observed two small black ants crawling on the card table used by residents to put puzzle together. The table was located in the back, on the left side of the room, from entry door. There were 12 dead black ants along the windowsills, on the right side of room from entry door. This room was used for meal service and activities for residents. On 8/24/16 at 4:30 p.m., the Interim Administrator provided EcoLab invoices dated 4/11/16, 5/11/16, 6/14/16, 7/28/16, 8/5/16, 8/18/16, all invoices indicated, " Target Pest: Ants." 3.1-19(f)(4)		byAdministrator/designee weekly x 4, monthly x 2, and quarterly thereafter until100% compliance is met. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not	F 9999	**What correctiveactions will be accomplished for those resident found to have been affected bythe deficient practice?** No specificresident was affected by the alleged deficient practice. Activity staff #1 completed required	09/16/2016

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	limited to, the following: (1) Residents' Rights (u) In addition to the required inservice hours in subsection (1), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility staff received the required 3 hours of annual training for dementia, annual training for resident rights, and annual training for abuse for 2 of 5 employee files reviewed for annual inservices. (Activity Staff #1 and Cook #2) Findings include: Employee Files were reviewed on 8/19/16 at 10:15 a.m. with the following findings:		ResidentRights, Alzheimer's and Dementia, and Abuse training. Cook #2 completed required Alzheimer's and Dementiatraining. **How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective action will be taken**. All residents have the potentialto be affected by the same alleged deficient practice. Facility staff will be in-serviced on completing therequired annual education by SDC/Designee by September 16, 2016 House wideaudit will be completed by the SDC/Designee to verify staff completed ResidentRights, Alzheimer's and dementia, and Abuse training have been completed forthe year by September 16, 2016. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Facility staff will be in-serviced on completing therequired annual education including, Resident Rights, Alzheimer's and Dementia, and Abuse training. The Education Audit will be completed by SDC/Designee weeklyto verify staff has completed required annual education. **How the correctiveactions will be monitored to ensure the deficient practice will not recur, whatquality assurance program will be put into**	

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	1. Activity Staff #1 was hired on 7/1/13. a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016. b. A Resident's Rights training was documented 4/7/15. No other Resident's Rights training was documented until 8/23/16 (4 days after employee records were reviewed). c. An Abuse training was documented 4/7/15. No other Abuse training was documented until 8/23/16 (4 days after employee records were reviewed). 2. Cook #2 was hired on 3/4/14. a. Three hours of dementia training was documented in 2014. No dementia training was documented in 2015 or 2016. b. A Resident's Rights training was documented 3/4/14. No other Resident's Rights training was documented in the employee file. c. An Abuse training was documented on 8/12/15. No other Abuse training was documented in the employee file.		**place?** The Education Audit will be completed by SDC/Designee weeklyx 4, monthly x 2, and quarterly thereafter until 100% compliance is met. The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	

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	On 8/23/16 at 3:56 p.m., the Acting Administrator provided an undated policy titled, "Ongoing Training" and indicated it was the current policy used by the facility. The policy indicated, "All associates will be required to complete a minimum of two (2) courses each month in the CarDon University System. Courses will be assigned in the following subject matters throughout the year: Resident's Rights and Abuse Prevention...Alzheimer's/Dementia (minimum three one-hour courses per year)...."			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 46 Residential Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5. Q.R. completed by 14466 on September 02, 2016.	R 0000	This plan of correction is to serve Altenheim Family FirstSenior Living's credible allegation of compliance. Submission of this plan ofcorrection does not constitute an admission by Altenheim Family First SeniorLiving or its management company that the allegations contained in the surveyreport are a true and accurate portrayal of the provision of nursing care andother services in this facility. Nor does this submission constitute an agreementor admission of the survey allegations. We would like to respectfully requestpaper	

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			compliance for Altenheim Family First Senior Living's Recertification andState Licensure Survey and Residential Licensure Survey.	
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, 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.			

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	The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure nursing staff received the required 3 hours of annual training for dementia, annual training for resident rights, and annual training for abuse for 3 of 5 employee files reviewed (Licensed Practical Nurse (LPN) #1, Certified Nursing Assistant (CNA) #2, and Registered Nurse (RN) #3) Findings include: Employee files were reviewed on 8/19/16 at 10:15 a.m. with the following findings: 1. LPN #1 was hired on 5/1/2010. a. Three hours of dementia training was documented in 2014. No other dementia training was documented until 1 hour was completed on 8/23/16 (4 days after employee files were reviewed). b. A Resident's Rights training was documented on 2/12/14. The next Resident's Rights training was documented on 8/22/16 (3 days after employee records were reviewed). c. An Abuse training was documented on 7/24/14. No other Abuse training was documented until 8/22/16 (3 days after	R 0120	**What correctiveactions will be accomplished for those residents found to have been affected bythe deficient practice?** No specificresident was affected by the alleged deficient practice. Activity staff #1 completed required ResidentRights, Alzheimer's and Dementia, and Abuse training. Cook #2 completed required Alzheimer's and Dementiatraining. **How will other residentshaving the potential to be affected by the same deficient practice be identifiedand what corrective action will be taken?** All residents have the potentialto be affected by the same alleged deficient practice. Facility staff will be In-serviced by SDC/Designee by September 16, 2016 oncompleting the required annual education. House wide audit will be completed by SDC/Designee to verify staffcompleted Resident Rights, Alzheimer's and Dementia, and Abuse Training yearlyby September 16, 2016. **What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur?** Facility staff will be in-serviced oncompleting the required annual education including, Resident Rights, required Alzheimer'sand Dementia , and Abuse training by SDC/Designee	09/16/2016

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	employee records were reviewed). 2. CNA #2 was hired on 7/1/15. a. A Resident's Rights training was documented on 7/2/15. No other Resident's Rights training documentation was found in CNA #2's employee file. b. An Abuse training was documented on 7/2/15. No other Abuse training was documented until 8/23/16 (4 days after employee records were reviewed). 3. RN #3 was hired on 12/20/11. a. A Resident's Rights training was documented on 2/5/14. No other Resident's Rights training was documented in RN #3's employee file. On 8/23/16 at 3:56 p.m., the Acting Administrator provided an undated policy titled, "Ongoing Training" and indicated it was the current policy used by the facility. The policy indicated, "All associates will be required to complete a minimum of two (2) courses each month in the CarDon University System. Courses will be assigned in the following subject matters throughout the year: Resident's Rights and Abuse Prevention...Alzheimer's/Dementia (minimum three one-hour courses per		by September 16, 2016. The Education Audit will be completed by SDC/Designee weeklyto verify staff has completed required annual education. **How will the correctiveactions be monitored to ensure the deficient practice will not recur, and whatquality assurance program will be put into place?** The Education Audit will be completed by SDC/Designee weeklyx 4, monthly x 2, and quarterly thereafter until 100% compliance is met. *The results of these audits will be reviewed by the QualityAssurance Committee weekly x 4, monthly times 2, and quarterly thereafter untilcompliance is at 100%. Frequency and duration of reviews will be increased asneeded, if compliance is below 100%.	

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	year)...."			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: During environmental tour on 8/26/16 at 11:00 a.m. the following was observed: 1. In resident apartment #3313, the carpet had scrapes of paper and needed to be swept. The bathroom had a small plastic container sitting on the floor between the shower ad toilet over flowing with soiled wash clothes. The interior surface of the sink and shower had discolored film. During an interview on 8/25/16 at 2:30 p.m., Resident #48 indicated he was upset because it had been 2 weeks since his apartment had been cleaned and linens had been changed on his bed. Resident #48 indicated they are suppose to clean and change the sheets weekly.	R 0144	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Room 3313 has been deep cleaned by housekeeping, including carpet and bathroom. Room 3315 has been deep cleaned by housekeeping, including carpet and bathroom. Room 2113 has been deep cleaned by housekeeping, including carpet and bathroom. **How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?** Housekeeping Supervisor has audited all rooms in Residential to ensure the carpet is swept and free of stains, the bathrooms are clean, and the rooms are free of odor. All residents residing in Residential have the potential to be affected by the same alleged deficient practice. Facility Housekeeping Supervisor has been in-serviced by Housekeeping Supervisor on how to properly clean the Residential Apartments. Facility	09/16/2016

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	2. In resident apartment #3315, the apartment carpet had multiple color stains and was heavily soiled, contained scraps of paper, and needed to be swept. In the bathroom, the sink and shower had a discolored film, on the toilet seat there was brown substance smeared in two places, there was a worn discolored place approximately 1" (inch) by 3", and the interior of toilet was soiled. During an interview on 8/26/16 at 11:30 a.m., Resident #48 indicated she had to sleep on soiled linens for two weeks and they had not cleaned her apartment. She Indicated she had trouble seeing but she could tell it was in need of cleaning. 3. In resident apartment #2113, there was a foul odor extending to the hallway, the carpet soiled with scraps of paper,and multiple clumps of black hair. The black hair was floating in the air as you walked through the apartment.		Housekeeping staff in-serviced by Administrator on how to properly clean the Residential Apartments. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Administrator/Designee will complete 10 random room audits weekly on the Residential Unit for cleanliness of carpet, bathroom, and toensure room is free of odor. Facility Housekeeping Supervisor will be in-serviced by Housekeeping Supervisor on how to properly clean the Residential Apartments by September 16,2016. Facility Housekeeping staff will be in-serviced by Administrator on how to properly clean the Residential Apartments by September16, 2016. **How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place?** Administrator/Designee will complete 10 random for cleanliness of floor, bathroom, and to ensure the room is free of odor. The results of these audits will be reviewed by the Quality Assurance Committee weekly x 4, monthly times 2, and quarterly thereafter until compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.	