This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00288101 and Complaint IN00286794.

Complaint IN00288101 - Substantiated-State deficiencies related to the allegation is cited at R0052.

Complaint IN00286794 - Substantiated-No deficiencies related to the allegation are cited.

Survey dates: March 6th and March 7th, 2019

Facility number: 012141

Residential Census: 72

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality Review completed on March 15, 2019.

R 0052

Residents' Rights - Offense

(v) Residents have the right to be free from:

(1) sexual abuse;
(2) physical abuse;
(3) mental abuse;
(4) corporal punishment;
(5) neglect; and
(6) involuntary seclusion.

Based on observation, interview and record review the facility failed to ensure prompt response time to the emergency door alarm on a secured memory care unit for 1 of 3 records reviewed and this deficient practice has the potential to affect 19 out of 72 residents who

A. With respect to the specific resident/situation cited:

Executive Director/designee retrained Reminiscence Care

03/15/2019
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION

**Date Survey Completed:** 03/07/2019

**Name of Provider or Supplier:** SUNRISE ON OLD MERIDIAN

**Street Address, City, State, Zip Code:** 12130 OLD MERIDIAN ST, CARMEL, IN 46032

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>(X4) Prefix</th>
<th>(X4) Tag</th>
<th>Summary Statement of Deficiency</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>resident in the facility. (Resident B)</td>
<td></td>
<td></td>
<td></td>
<td>Managers on responding to door alarms.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Finding includes:</td>
<td></td>
<td></td>
<td></td>
<td>B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>During a walk through observation of the facility, on 03/06/18 beginning at 9:30 a.m., with Maintenance Employee 1 and the Facility Maintenance Director, the second floor Memory Care emergency door was activated and the alarm sounded audibly at 9:40 a.m.</td>
<td></td>
<td></td>
<td></td>
<td>19 residents living in the Reminiscence neighborhood have the potential to be affected by this identified concern. No other residents are affected by this potential concern.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>At 9:46 a.m. the Maintenance Director (MD) indicated he was concerned with the lack of response. He indicated the alarm sent a message to the staff via pager and someone should have responded.</td>
<td></td>
<td></td>
<td></td>
<td>C. With respect to what systemic measures have been put into place to address the stated concern:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>At 9:46 a.m. the MD stopped the alarm and rearmed the emergency door.</td>
<td></td>
<td></td>
<td></td>
<td>Executive Director/designee re-trained Team Members on the Elopement and Missing resident policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>At 9:48 a.m. Certified Nursing Assistant 2 (CNA 2) was found around the corner from the door. The MD verified the alarm signal was sent to CNA 2's pager. At that time, she indicated she had not responded to the alarm because she did not think there had been an emergency. CNA 2 indicated she had not been aware of what was happening at the end of the hall by the emergency door, as she had been unable view the area. The MD indicated CNA 2 should have investigated the alarm.</td>
<td></td>
<td></td>
<td></td>
<td>The Executive Director/Designee will conduct Elopement drills weekly along with random alarm testing for the first 90 days and monthly ongoing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The record for Resident B was reviewed on 03/06/19 at 10:31 a.m. Diagnoses included, but were not limited to, Alzheimer's disease (dementia) and hypertension (high blood pressure).</td>
<td></td>
<td></td>
<td></td>
<td>D. With respect to how the plan of correction will be monitored:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A facility incident report for 02/22/19, provided by the Facility Administrator on 03/07/19 at 11:20 a.m., indicated Resident B was found in the first floor employee break room after pushing open the</td>
<td></td>
<td></td>
<td></td>
<td>The Executive Director or designee is responsible to ensure</td>
<td></td>
</tr>
</tbody>
</table>

State Form | Event ID: 55T511 | Facility ID: 012141 | If continuation sheet | Page 2 of 16
doors on the Memory Care Unit and leaving the unit unsupervised.

A facility incident report for 02/25/19, provided by the Facility Administrator on 03/07/19 at 11:20 a.m., indicated Resident B had exited the Memory Care unit and was found on another floor of the facility.

A facility document provided by the Facility Administrator, on 03/07/19 at 11:08 a.m., titled "Elopement and Missing Residents", indicated, "...Team members are responsible to respond immediately to all alarms to investigate the reason for the alarm ...The team member ...closest ...to the door will immediately respond ...observe the area around the alarming door to determine whether a resident has exited the building unsupervised. This includes opening the alarming door and visually scanning the ...area ...."

This residential tag relates to Complaint IN00288101.

### Summary Statement of Deficiency

410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual 's medication and treatment records that indicate the:

- (A) time;
- (B) name of medication or treatment;
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

| A. BUILDING | 00 |
| B. WING | |

**DATE SURVEY COMPLETED**

| 03/07/2019 |

**NAME OF PROVIDER OR SUPPLIER**

SUNRISE ON OLD MERIDIAN

12130 OLD MERIDIAN ST

CARMEL, IN 46032

**STREET ADDRESS, CITY, STATE, ZIP CODE**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX TAG</td>
<td>R 0243 (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on observation, interview and record review the facility failed to follow a physician's order to administer medication accurately for 1 of 5 residents reviewed for medication administration. (Resident 7) Finding includes:</td>
</tr>
<tr>
<td></td>
<td>During a medication pass with Qualified Medication Assistant (QMA) 3 on 03/06/2019 at 3:15 p.m., he was observed attempting to give Resident 7's Hyoscyamine 0.125 milligrams (mg) (a medication used to treat bladder spasms) with the instructions to swallow the medication with water. A physician's order, dated 07/22/2016, indicated &quot;Hyoscyamine 0.125 mg tab SL (sublingual - under the tongue). Give 1 tablet sublingually two times a day for bladder spasms.&quot; During an interview at that time, QMA 3 indicated he should have followed the physician's directions and instructed the resident to place the medication under his tongue to dissolve. An undated document titled &quot;The Community Medication Oversight Program,&quot; provided by the Director of Nursing on 03/07/2019 at 12:08 p.m., indicated &quot;...A medication error is defined as any event in which the 'rights' of medication administration are not followed ...Right Route ....&quot;</td>
</tr>
<tr>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>04/05/2019</td>
</tr>
<tr>
<td>(X5) COMPLETION DATE</td>
<td></td>
</tr>
</tbody>
</table>

**CROSS-REFERENCED TO THE APPROPRIATE**

| CARMEL, IN 46032 | |

**Event ID:** 55T511  **Facility ID:** 012141  **If continuation sheet:** Page 4 of 16
**Qualified Medication Aides and Wellness Nurses receive annual training regarding medication administration by the Resident Care Director/designee.**

Qualified Medication Aides are observed performing a medication pass annually and as needed by the Resident Care Director/designee.

**D. With respect to how the plan of correction will be monitored:**

The RCD/Nurse Designee will conduct weekly and random audits of 2 medication pass observations for the next 90 days.

The Executive Director or designee is responsible for compliance with the plan of correction by verifying completion of retraining and new hire training, reviewing results of weekly audits for the next 90 days.

The ED/designee conducts random spot checks of compliance with medication pass for 90 days. This will be tracked and trended in monthly QAPI Meeting over the next 90 days.
### Summary Statement of Deficiency

**Finding Includes:**

- The medical record for Resident 2 was reviewed on 03/07/2019 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, hypertension, hypothyroidism and depressive disorder.

**Corrective Action:**

- Based on interview and record review the facility has failed to ensure administration of a PRN (as needed) medication was approved by a licensed nurse prior to being administered by a QMA (Qualified Medication Aide) for 1 of 7 records reviewed for PRN medications administered by a QMA. (Resident 2)

**Provider's Plan of Correction**

- Qualified medication aides and Licensed Nurses have been re-trained by the Resident Care Director/designee regarding authorization and documentation of PRN medication administration.

**A. With respect to the specific resident/situation cited:**

- 04/05/2019

**State Form Event ID:** 55T511

**Facility ID:** 012141

**Page 6 of 16**
A physician's order dated 02/13/2018, indicated the resident could receive 650 mg (milligrams) of Tylenol every 4 hours as needed for pain.

The MAR (medication administration record) for February 2019, indicated the resident received Tylenol 650 mg from a QMA on 02/05, 02/06, 02/18, 02/20 and 02/24/2019.

Progress notes reviewed for the month of February had no indication documented the QMA had notified the licensed nurse to received authorization prior to administering the medication.

During an interview with the Director of Nursing on 03/07/2019 at 12:10 p.m., she indicated QMA's are to obtain and document authorization from a licensed nurse prior to giving any PRN medication.

An undated document titled, "Qualified Medication Aide Scope of Practice," provided by the Director of Nursing on 03/07/2019 at 12:08 p.m., indicated "(11) Administer previously ordered (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty.... If authorization is obtained...the QMA must...Document in the resident record that the facility nurse was contacted, symptoms were described, and permission was granted to administer the medication, including time of contact.... Ensure that the resident's record is cosigned by the licensed nurse who gave permission...."

B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

Resident Care Director/designee reviewed resident records and 63 residents have the potential to be affected by this identified concern. No other residents are affected by this potential concern.

C. With respect to what systemic measures have been put into place to address the stated concern:

Qualified medication aides and Licensed Nurses have been re-trained by the Resident Care Director/designee regarding authorization and documentation of PRN medication administration.

Qualified Medication Aides and Wellness Nurses receive annual training regarding PRN Medication Administration by the Resident Care Director/designee.
Resident EMARs are audited monthly and as needed by the Resident Care Director/designee.

D. With respect to how the plan of correction will be monitored:

The RCD/Nurse Designee will conduct weekly audits of 5 EMARs for PRN authorization and documentation. This will be audited for the next 90 days.

The Executive Director or designee is responsible for compliance with the plan of correction by verifying completion of retraining and new hire training of the QMA and Licensed Nurse team members, reviewing results of weekly audits for the next 90 days.

The ED/designee conducts random spot checks of compliance with the EMAR audits for 90 days. This will be tracked and trended in monthly QAPI.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER**

**MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**DATE SURVEY COMPLETED**

03/07/2019

**NAME OF PROVIDER OR SUPPLIER**

SUNRISE ON OLD MERIDIAN

**STREET ADDRESS, CITY, STATE, ZIP CODE**

12130 OLD MERIDIAN ST
CARMEL, IN 46032

**SUMMARY STATEMENT OF DEFICIENCY**

-EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION-

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| R 0300 | Bldg. 00 | 410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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. Based on observation, interview and record review the facility failed to ensure an expired medication was discarded in a timely manor for 1 of 1 medication storage room observed. (Resident 7)
Finding includes:  
During an observation of the medication room with the Director of Nursing on 03/06/2019 at 10:05 a.m., Preparation H suppositories for Resident 7 were observed with an expiration date of 01/2018. The record for Resident 7 was reviewed on 03/06/2019 at 3:40 p.m. Diagnoses included, but were not limited to, muscle weakness, hypertension and hemorrhoids.  
A physician's order dated 08/30/2015 indicated the resident could receive Preparation H suppositories for hemorrhoids as needed. | R 0300 | A. With respect to the specific resident/situation cited:  
Resident Care Director/designee removed and disposed expired medications.  
B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:  
62 residents have the potential to be affected by this identified concern. No other residents are affected by this potential concern. | 04/05/2019 |

Meeting over the next 90 days with the ED/designee oversight. The ED/designee is responsible to ensure opportunities identified for improvement are corrected.
During an interview with the Director of Nursing on 03/06/2019 at 3:45 p.m. she indicated the expired medication should have been removed from the refrigerator and disposed of immediately.

An undated document titled "The Community Medication Oversight Program," provided by the Director of Nursing on 03/07/2019 at 12:08 p.m., indicated "...Medication carts...are checked weekly for expired medications....All medications are disposed of or destroyed promptly....In general medications are considered...safe to use until the manufacturer's expiration date printed on the label...."

C. With respect to what systemic measures have been put into place to address the stated concern:

The Resident Care Director/Nurse designee retrained all QMA's and Wellness Nurses on storage of medications policy.

The RCD/Nurse Designee conducts weekly audits of all the medication carts and refrigerators.

D. With respect to how the plan of correction will be monitored:

The Executive Director or designee is responsible to ensure compliance with the plan of correction by verifying completion of retraining and new hire training of the QMA team members and Wellness nurses and reviewing results of the weekly audits for the next 90 days. This will be tracked and trended in monthly QAPI Meeting over next 90 days. The ED/designee is responsible to ensure opportunities identified for improvement are corrected.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>R 0301</td>
<td>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review the facility failed to have accurate pharmacy labels on prescription medications for 2 of 5 residents observed for medication administration. (Resident 7 and Resident 8) Findings include: During a medication administration pass with</td>
<td>R 0301</td>
<td>A. With respect to the specific resident/situation cited: 04/05/2019</td>
<td></td>
</tr>
<tr>
<td>Bldg. 00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Resident Care Director/designee immediately had new labels placed on medication cards for R7 and R8.
Qualified Medication Assistant 3 (QMA 3) on 03/06/2019 at 3:15 p.m., the following was observed:

1. Resident 7’s was observed receiving Donepezil HCL 10 milligram (mg) tablet (a medication used to help with dementia). The medication had a pharmacy label indicating "Donepezil HCL 10 mg tablet, give 1 tablet by mouth daily at bed time."

The record for Resident 7 was reviewed on 03/6/2019 at 3:40 p.m. Diagnoses included, but were not limited to, muscle weakness, hypertension and dementia.

A physician's order, dated 12/04/2018, indicated "Donepezil HCL 10 mg tablet, give 1 tablet by mouth one time a day...."

2. Resident 8 was observed receiving Simvastatin 40 mg tablet (a medication used to help control high cholesterol). The medication had a pharmacy label indicating "Simvastatin 40 mg tablet, give 1 tablet by mouth at bed time."

The record for Resident 8 was reviewed on 03/6/2019 at 3:40 p.m. Diagnoses included, but were not limited to Diabetes Mellitus and hyperlipidemia.

A physician's order, dated 03/01/2018, indicated "Simvastatin tablet 40 mg, give 1 tablet by mouth once a day for cholesterol control."

During an interview with QMA 3 on 03/06/2019 at 4:00 p.m., he indicated he should have placed a change of directions label on both prescriptions.

A current policy titled "Packaging And Labeling" dated 01/01/2005 and revised on 11/03/2006.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. BUILDING</td>
<td>B. WING</td>
<td>03/07/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUNRISE ON OLD MERIDIAN</td>
<td>12130 OLD MERIDIAN ST CARMEL, IN 46032</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td>ID</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
</tbody>
</table>

provided by the Director of Nursing on 03/07/2019 at 11:31 a.m., indicated "...Directions changed refer to chart sticker shall be placed on the medication container label indicating there has been a change in the order affecting the administration of the medication...."

Resident Care Director/designee.

D. With respect to how the plan of correction will be monitored:

The RCD/Nurse Designee will conduct weekly audits of 3 resident's Physician orders and medication labels to ensure they match. This will be audited weekly for the next 90 days.

The Executive Director or designee is responsible to ensure compliance with the plan of correction by verifying completion of retraining and new hire training of the QMA’s and Wellness nurses and reviewing results of the weekly audits for the next 90 days. This will be tracked and trended in monthly QAPI Meeting over next 90 days. The ED/designee is responsible to ensure opportunities identified for improvement are corrected.

R 0409 410 IAC 16.2-5-12(d) Infection Control - Noncompliance

Event ID: 55T511 Facility ID: 012141 If continuation sheet
Bldg. 00

(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.

Based on interview and record review the facility failed to ensure that each resident had a health assessment prior to admission and that a statement showing that the resident was free of a communicable disease was documented for 4 out of 7 residents that were reviewed for annual health statements. (Resident 6, B, 2 and 3)

Findings include:

1. The record review for Resident 6 was reviewed on 3/6/19 at 12:06 p.m. Diagnoses included, but were not limited to, Parkinson's disease, delusional disorders and dementia with Lewi Bodies.

   Resident 6's record did not contain a physician signed annual health statement.

2. The record for Resident B was reviewed on 03/06/19 at 10:31 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and hypertension.

   Resident B's record did not contain a physician signed annual health statement.

3. The record for Resident 2 was reviewed on 03/06/2019 at 3:30 p.m. Diagnoses included, but were not limited to, dementia, hypertension and hypothyroidism.

   Resident 2's record did not contain a physician signed annual health statement.

A. With respect to the specific resident/situation cited:

   R 0409

   R6, R8, R2, and R3 have a current Health assessment signed by a Physician indicating free from infectious disease

B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:

   The Resident Care Director/Nurse designee reviewed resident files for annual Health assessments requirements.

   Resident files have been updated with required annual health assessment.

C. With respect to what systemic measures have been put into place to address the stated concern:
### Statement of Deficiencies and Plan of Correction

**State:** IN

**Name of Provider or Supplier:** SUNRISE ON OLD MERIDIAN

**Address:** 12130 OLD MERIDIAN ST

**City, State, Zip Code:** CARMEL, IN 46032

**Identification Number:** MULTIPLE CONSTRUCTION

**Type:** BUILDING: 00, WING: 00

**Date Survey completed:** 03/07/2019

#### Summary Statement of Deficiency

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Regulatory or LSC Identifying Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>4. The record for Resident 3 was reviewed on 03/06/2019 at 3:45 p.m. Diagnoses included, but were not limited to, chronic fatigue and hypertension. Resident 3's record did not contain a physician signed annual health statement. During an interview with ED on 3/6/19 at 11:58 a.m., she indicated that the facility used the TB (Tuberculin Test) as their documentation for an annual health statement. She also clarified with corporate that they will need to institute a policy going forward for documenting that the resident is free of communicable diseases. During an interview with the Director of Nursing on 03/07/2019 at 12:00 p.m., she indicated the facility did not have physician signed annual health statements and referred to the resident's annual screening for Tuberculosis for documentation of annual health assessments.</td>
</tr>
</tbody>
</table>

**Prefix:** RESIDENT CARE DIRECTOR/NURSE DESIGNEE RE-TRAINED WELLNESS NURSES REGARDING REQUIREMENTS OF ANNUAL HEALTH ASSESSMENTS.

**Tag:** ANNUAL HEALTH ASSESSMENT COMPLETION IS TRACKED IN ELECTRONIC HEALTH RECORD BY WELLNESS NURSES.

**Completion Date:**

**Plan of Correction:**

- Resident Care Director/Nurse designee re-trained Wellness Nurses regarding requirements of annual health assessments.
- Annual health assessment completion is tracked in Electronic Health Record by Wellness nurses.
- **D. With respect to how the plan of correction will be monitored:**
  - The RCD/Nurse Designee will conduct a review of all new move-ins to ensure health assessment is completed. The RCD/Nurse Designee will review 3 current residents weekly to ensure annual health assessment is completed. This will be audited weekly for the next 90 days.
  - The Executive Director or designee is responsible to ensure compliance with the plan of correction by verifying completion of retraining and new hire training of the Wellness nurses and reviewing results of the weekly audits for the next 90 days. This will be tracked and trended in monthly QAPI Meeting over next 90 days. The ED/designee is responsible to ensure
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>REGULATORY OR LSC IDENTIFYING INFORMATION</td>
<td>TAG</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
</tbody>
</table>

opportunities identified for improvement are corrected.