

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2020
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00315967.</p> <p>Complaint IN00315967 - Substantiated. Federal/State deficiencies related to the allegations are cited at F623 and F660.</p> <p>Survey dates: January 6 & 7, 2020</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Census Bed Type: SNF/NF: 71 Total: 71</p> <p>Census Payor Type: Medicare: 9 Medicaid: 55 Other: 7 Total: 71</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed on January 13, 2020.</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit.</p>	
F 0623 SS=D Bldg. 00	<p>483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of</p>			

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	<p>this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p>			
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	<p>§483.15(c)(8) Notice in advance of facility closure</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>Based on interview and record review, the facility failed to ensure a 30 day notice of discharge was provided to a resident and the local Ombudsman was notified of a facility initiated transfer for 1 of 4 residents reviewed for discharge. (Resident D)</p> <p>Finding includes:</p> <p>On 1/6/2020 at 10:35 A.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted to the facility on 7/9/19 and was re-admitted after hospital stays, on 9/16/19 and 12/28/19. The resident's diagnoses included, but were not limited to: heart failure, hypertension, bipolar disorder, binge eating disorder and diabetes</p> <p>The Minimum Data Set (MDS) Quarterly Assessment, dated 12/20/19, indicated the residents Brief Interview for Mental Status (BIMS) score was 15 -normal cognition. The assessment recorded the resident was eating and transferring-independently, used a walker, was always continent of bowel/bladder, had no falls, no skin issues, was receiving insulin injections and had no active discharge plan.</p>	F 0623	<p>F623 Notice of Requirements Before Transfer/Discharge</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: ED or designee will educate Social Services Director (SSD) and all Nurses on the transfer discharge form and bed hold policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: Nursing will complete a transfer discharge form and bed hold policy form and send with all resident that are transferred out of the building. A copy of the completed forms will be made and retained in the resident's medical record. SSD to audit residents who have transferred out and will notify ombudsman of transfer/discharge if it was missed.</p>	02/06/2020

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	<p>The resident's care plans indicated there was no discharge plan of care.</p> <p>An Indiana Summary of Findings - Preadmission Screening and Resident Review (PASRR) form, dated 7/15/19, indicated Resident D had qualified for 90 days of nursing home care. The form stated "...You may choose nursing facility care now but should return to a setting in the community (for example, home or a residential setting) once your medical condition improves." The form was located in the resident's medical record.</p> <p>A form titled, "PASRR Level II Outcome", dated 10/3/19, indicated the resident had a short term approval, effective 9/28/19 with an end date of 12/27/19.</p> <p>A 30 day notice of discharge was not available for review.</p> <p>A Progress Note, dated 12/22/19 at 1:18 P.M., indicated the resident complained of shortness of breath, stated his was unable to catch his breath and feels like he has "fluid on him". The resident had a history of Congestive Heart Failure (CHF) with noncompliance to fluid and diet restriction. Resident had a weight gain of 4 pounds in 72 hours. The resident was observed to have shortness of breath, his lungs sounds had crackle sounds in the lung bases and his vital signs were within normal limits. The resident requested to be sent to the local Emergency Room (ER) to be checked out. The resident's physician was contacted and resident was sent to the ER via ambulance at 1:30 P.M.</p> <p>A form titled, "Notice of Level of Care Determination", dated 12/27/19, indicated the resident was receiving the notification because he</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ED or designee educated the Interdisciplinary team on the discharge policy and process. SSD or designee will keep a log of all individuals that are transferred out including emails to the State Ombudsman. During morning start up meeting, team will review residents that transferred out of the building and compare to log to ensure compliance.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur: ED or designee will review log 5 x week for 6 months. Results of audits will be reviewed in QAPI monthly x 6 months and finding no trends will be reviewed again in QAPI as needed</p> <p>By what date the systemic changes will be completed by 2/6/2020.</p>	

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

PRINTED: 01/30/2020

FORM APPROVED

OMB NO. 0938-039

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	<p>had received a Level of Care screen on 12/27/19. The form indicated the resident received the screen as he was seeking to enter or continue to stay in a Medicaid certified nursing facility. The form indicated the resident was not eligible for admission or a continued stay in a nursing facility.</p> <p>A time line of the re-admission of Resident D was received from the Social Service Director (SSD), on 1/6/2020. The time-line indicated she had received a call from the hospital's discharge planner, on 12/28/19 at 11:54 A.M. The hospital discharge planner stated the hospital planned to discharge the resident back to the facility even though the resident had received an evaluation regarding his level of care status and was denied to have long term care services. The SSD asked for the hospital to keep him over the weekend, which they denied at 4:59 P.M. On 12/28/19 at 9:22 P.M. the SSD was notified, by a nurse at the facility that Resident D was dropped off at the facility via a cab. He had a voucher to go to a homeless shelter, but instead he came to the facility.</p> <p>A Progress Note, dated 12/28/19 at 11:01 P.M., indicated Resident D walked into the facility, using a walker, handed the nurse his discharge papers from local hospital and stated he was kicked out of the hospital and did not have anywhere to go except to return to the facility, where his belongings were. Management was made aware of the situation and they told the nurse to re-admit resident back into the facility.</p> <p>A Progress Note titled "Discharge Planning, dated 12/31/20 at 12:50 P.M., indicated the resident, his physician, Power of Attorney and local Ombudsman were all aware the resident no longer met Level of Care for placement in a nursing home</p>			

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	<p>and needed alternate placement. The Note indicated the following: "...He was admitted to the hospital on 12/22/2019 and discharged 12/28/2019 via cab to the homeless shelter. Instead of going to the homeless shelter, he came back to the facility at approximately 10:00pm. [Name of Resident D] stated he did not want to go to the homeless shelter so asked the cab driver to drop him off here. Both ED [Executive Director] and I spoke with [name of resident] explaining that he no longer meets level of care and therefore needs to find other placement. He stated he understood and was thankful for our help. I called the homeless shelters [names of shelters] and they currently have no beds available. At the request of his friend [name of friend], I called [name of assisted living facility] for possible admission there. Referral paperwork has been sent. [Name of SSD at assisted living facility] stated she will call with a decision as soon as she can. In the meantime, the facility will pay for [name of resident] to go to a hotel for three days [name and address of hotel] All discharge paperwork has been completed. All notices of LOC [Level of Care] denial sent with [name of resident]. All of his meds [medications] and scripts from the hospital have been sent with him as well...."</p> <p>A time line, received from the SSD indicated on 12/30/19 at 2:15 P.M. and at 4:45 P.M., the resident's physician's office was contacted.</p> <p>A time line, received from the SSD, indicated on 12/31/19 at 9:15 A.M., the resident's physician was contacted. A message was left with the physician's receptionist for discharge orders. On 12/31/19 at 12:30 P.M., the Medical Director was contacted and he gave the order to discharge the resident from the facility.</p>			

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	<p>A Physician's Order, dated 12/31/19, indicated the resident may be discharged to the hotel.</p> <p>A time line, received from the SSD, indicated on 12/30/19 at 3:41 P.M., the local Ombudsman was called and informed of the situation and at 3:55 P.M. the State Ombudsman was contacted and a message was left on her voice mail.</p> <p>A time line, received from the SSD, indicated on 12/31/19 at 11:11 A.M., SSD spoke with Assisted Living facility and sent a referral with the resident's permission. At 2:07 P.M., the assist living facility indicated they would see the resident on 1/2/20 for a possible admission to their facility.</p> <p>A Progress Note, dated 12/31/19 at 4:19 P.M., indicated the following: "...Discharge discussed with resident, paperwork reviewed, f/u [follow up] appts. [appointments] scheduled and MD [Medical Doctor] notified of discharge. Resident will return to p/u [pick up] belongings at a later date. Resident medications reviewed with 3 day supply sent with resident at time of discharge... Resident voiced understanding. No concerns at this time. POA [Power of Attorney] aware of discharge...."</p> <p>During an interview via the telephone, on 1/6/19 at 11:34 A.M. the Power of Attorney (POA) for Resident D indicated the Social Worker from the facility told the hospital Resident D could not return to the facility due to medicaid not paying for his care. The hospital discharged him and gave him a cab voucher to go to a homeless shelter. The resident sat outside the hospital with no where to go, so the POA told him to not go to shelter, which the hospital suggested, but to return to the facility, as his personal belongings</p>			

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	<p>where still there. The POA indicated the resident was currently at an assisted living facility. The POA doesn't believe the resident was given a 30 day notice prior to discharge and he never received one either.</p> <p>On 1/6/20 at 1:47 P.M., and interview was conducted with the Executive Director (ED) and the Social Service Director (SSD). The SSD indicated Resident D had Medicaid, as a payer source, as long as he was meeting the Level of Care for a long term stay. His stay ended on 12/27/19. The SSD indicated no 30 day notice was developed, as the resident had no payor source and was notified back in October via the PASRR Level II notice, that his services would end. The SSD indicated they had no documentation indicating the resident had received the notice. She indicated the notice was sent, in the mail, to him and facility received a copy of this notice. Both the ED and the SSD indicated the facility had not informed the resident of the 12/27/19 discharge, while he was in the hospital. The SSD indicated she had contacted the hospital to see if they could get the resident qualified for another short term Level II approval. The SSD indicated the resident brought the denial with him, from the hospital, when he arrived at the facility. The ED indicated resident just showed up at facility. The hospital discharged him and gave him a voucher for a cab. He had no where to go, so he had the cab drop him off at the facility. The facility let him stay and readmitted him. On Monday morning the resident and the Power of Attorney (POA) was notified of denial, of Level of Care, in a long term setting. The SSD sought alternative placement, including homeless shelters, as resident had no home to return to and had no income. On Tuesday the 31st the resident was discharged to a hotel, which the facility paid for. Both the ED and SSD</p>			

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	<p>indicated they did not give the resident a 30 day notice of his upcoming discharge on 12/27/19, nor after his readmission, after his hospital stay, to the facility.</p> <p>During an interview, on 1/6/20 at 3:25 P.M., the ED indicated she was advised by the facility's legal team to discharge the resident instead of letting him remain, in the facility, until the transfer to the assisted living facility was completed.</p> <p>During an interview, on 1/7/20 at 9:15 A.M., the SSD indicated prior to the resident's hospitalization she had not attempted to find the resident an alternative placement. The idea of the assist living facility was the resident's POA's idea, after his re-admission on 12/28/19. She pursued and set up a time for them to visit him at the hotel for possible admission.</p> <p>During an interview, on 1/7/20 at 3:00 P.M., the local Ombudsman indicated she was not notified of Resident D's discharge prior to the date of 12/27/19, nor was she notified of the discharge to a hotel prior to him being relocated there.</p> <p>On 1/6/20 at 11:00 A.M., the Corporate Nurse (acting Director of Nursing) provided a policy titled "Admission, Readmission, Bed Hold, and Transfer/Discharge", dated 1/22/18, and indicated the policy was the one currently used by the facility. The policy indicated "...Before the facility transfers or discharges a resident, the facility must-</p> <p>*Notify the resident and the resident's representative (s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. A copy of the notice must be sent to a representative of the Office of the State Long-Term Care</p>			

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F 0660 SS=D Bldg. 00	<p>Ombudsman...Discharge of Hospitalized Resident *In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility must send a notice of discharge to the resident and resident's representative, and must also send a copy of the discharge to a representative of the Office of the State LTC [Long Term Care] Ombudsman...."</p> <p>This Federal tag relates to complaint IN00315967.</p> <p>3.1-12(a)(6)(A)</p> <p>483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident's or</p>			

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	<p>caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p> <p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p> <p>(vi) Address the resident's goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2020
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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	<p>applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>Based on interview and record review, the facility failed to ensure a resident had a discharge plan of care for 1 of 4 residents reviewed for discharge. (Resident D)</p> <p>Finding includes:</p> <p>On 1/6/20 at 10:35 A.M., a review of the clinical record for Resident D was conducted. The record indicated the resident was admitted to the facility on 7/9/19 and was re-admitted after hospital stays, on 9/16/19 and 12/28/19. The resident's diagnoses included, but were not limited to: heart failure, hypertension, bipolar disorder, binge eating disorder and diabetes</p> <p>The Minimum Data Set (MDS) Quarterly Assessment, dated 12/20/19, indicated the residents Brief Interview for Mental Status (BIMS) score was 15 -normal cognition and he had no active discharge plan to return to the community.</p> <p>The resident's care plans indicated there was no discharge plan of care.</p> <p>During an interview, on 1/7/20 at 10:05 A.M., the MDS Coordinator indicated she completed</p>	F 0660	<p>F660 Discharge Planning Process</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> Resident was discharged from facility on 12/31/19. <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <ul style="list-style-type: none"> Social Services Director (SSD) or designee will ensure all short-term current residents have a discharge plan that is documented in the residents comprehensive care plan. An audit of short-term residents will be conducted and those found not in compliance will be corrected. <p>What measures will be put into</p>	02/06/2020

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	<p>section C regarding the resident's cognition score but did not complete section Q, which had to do with the resident's discharge, nor would she have developed a discharge plan of care. She indicated section Q was completed by the Social Service Director (SSD), who would be in charge of completing a discharge care plan for the resident.</p> <p>On 1/7/19 at 10:25 A.M., the SSD provided a copy of the resident's care plans, which did not include a care plan for discharge. The SSD indicated she had not attempted to acquire other placement options for the resident, in the month, prior to his days of service coming to an end on 12/27/19. She could not indicate why she completed section Q of the MDS indicating the resident did not want to talk about his possibility of leaving the facility and had no active discharge plan occurring for the resident to return to the community.</p> <p>This Federal tag relates to complaint IN00315967.</p> <p>3.1-12(a)(18)</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> · SSD or designee will ensure a discharge care plan is added within 72 hours of admission and will update as needed. · SSD will implement Discharge Summary Form to ensure successful discharge. · ED or designee will in-service IDT and nursing staff on the discharge process. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> · SSD or designee will log all current residents on discharge care plan audit tool and add residents as they admit. · ED will review for compliance of discharge forms and audit tool weekly for 3 months then monthly for 3 months. · Results of audits will be reviewed in QAPI monthly x 6 months and finding no trends will be reviewed again in QAPI as needed <p>By what date the systemic changes will be completed by 2/6/2020.</p>	