| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 9975 | A. BUILDING _____ B. WING _____ | 12/22/2021 |

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| SOUTH MEADOWS RESIDENTIAL CARE HOME | 13495 STONEY BROOK DR, RENO, NEVADA ,89511 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual survey conducted at your facility on 12/21/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Groups beds for elderly and disabled persons, and/or Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and four employee files were reviewed. The facility received a grade of C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified: | 0000 | | |
| 0026 SS= D | Contents of License - Multiple Types - NAC 449.190 License: Contents; issuance of more than one type. 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the Bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services.<br><br>Inspector Comments: Based on clinical record review and interview, the facility | 0026 | 1. **The correction of the specific finding for those residents found to have been affected by the deficient practice:** The facility applied for a mental | 03/14/2022 |

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| | failed to obtain an endorsement for Mental Illness (MI) and admitted and retained a resident with a MI diagnosis (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/12/20, with a diagnosis of schizoaffective disorder. A History and Physical dated 05/17/21, documented Resident #1 had a diagnosis of other schizoaffective disorders on 08/08/20. The facility lacked an MI endorsement to admit and retain residents with MI. On 12/22/21 at 12:55, the Owner confirmed the facility was not endorsed for MI. Severity: 2 Scope: 1 | | illness endorsement on March-12-2022 (see attachment 7, application of the mental illness endorsement), and the requirement of the mental illness application will be completed and submitted to the licensing unit by March 14, 2022 (See attachment 8, the certificate of the mental illness training for all for the employees).<br><br>2. **What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur:** This deficient practice will not recur because the facility applied and submitted all of the document to complete the application on March 14, 2022 for the mental illness endorsement.<br><br>3. **The facility will identify other residents having the potential to be affected** by reviewing all of the medical records of the diagnosis closely for all residents.<br><br>4. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur–**The facility plans to monitor the performance to make sure that solutions are | |

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| | | | sustained by continuing to have the mental illness endorsement. The facility submitted all the required document and the facility will follow up with the licensing department to ensure that correction is achieved and sustained. We are ensuring that this plan of having the mental illness endorsement is implemented, and the corrective action evaluated for the effectiveness as proven by the submission and completion all requirements (see the attachment 7-8)<br><br>5. **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of the correction is implemented.<br><br>6. **The date of the corrective action is completed:** As of March-14-2022 the corrective action was completed.<br><br>a. On March-12-2022: The facility submitted/paid for the mental illness endorsement (see supporting document attachment 7).<br><br>b. March-14-2022, the completion of the mental illness training. (see the | |

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| | | | supporting document, attachment 8). | |
| 0178 SS= E | Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.<br><br>Inspector Comments: Based on observation and interview the facility failed to ensure the interior premises were maintained. Findings include: On 12/22/21 at 9:54 AM, the hall closet outside Room 6 had double sliding doors off their track. The Caregiver tried to put the doors back on the track; however, was unable. On 12/22/21 at 9:54 AM, the Caregiver acknowledged the doors were broken. Severity: 2 Scope: 3 | 0178 | 1. **The correction of the specific finding:** The facility failed to ensure the interior premises were maintained, the hall closet outside Room#6 had double sliding doors off their track. After Dec 22, 2021, the facility decided to remove the door and turn it into a seating area for the residents (See the attachment 1 for Tag 0178).<br><br>2. **This systematic changes will be put into place to make sure the deficient practice doesn't recur:** The sliding doors won't be off the track again because the area is now turned into a seating area with no door. For any future interior or exterior of the facility that is broken, we will post a sign to notify work in progress.<br><br>*3.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The manager/administrator will | 01/05/2022 |

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| | | | take immediate action or contact the repairman to come right away. However, when it depends on an outside contractor, sometimes the work could be delayed. However, we will post a notice for any delay of the repair in the area needing repair.<br><br>4. The manager/administrator will be responsible for ensuring the plan of correction is implemented.<br><br>5. As of Jan 5, 2022 the plan of corrective action was completed. | |
| 0250 SS= E | Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition.<br><br>Inspector Comments: Based on observation and interview the facility failed to ensure outdated food was discarded. Findings include: On 12/22/21 at 9:41 AM, a container of grated parmesan cheese, expired on 12/06/21, was in the pantry. On 12/22/21 at 9:41 AM, the Caregiver confirmed the parmesan cheese was expired and verbalized the food should be | 0250 | 1. **The correction of the specific finding:** To correct the specific finding, parmesan cheese was discarded at the time of discovery.<br><br>2. **These systematic changes will be put into place to make sure the deficient practice doesn't recur:** This deficient practice occurred due ordering food supplies in | 12/22/2021 |

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| | discarded. Severity: 2 Scope: 3 | | bulk. The system changes for this deficient practice is that the manager will not order too many parmesan cheese containers again. We will purchase just enough to supply the residents for a month and within the range of expiration.-<br><br>3. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The manager/administrator will monitor check storage monthly and keep less food in storage.<br><br>4. **The manager/administrator** will be responsible to monitor for all expired food products and to ensure the plan of correction is implemented.<br><br>5. On Dec 22, 2021 the plan of corrective action was completed by discarding the expired grated parmesan cheese container. The action | |

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| | | | is done with no attachment. The grated parmesan cheese was removed and discarded immediately at time of discovery. | |
| 0859 SS= D | Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician.<br><br>Inspector Comments: Based on clinical record review and interview, the facility failed to ensure 2 of 10 residents received a physical examination upon admission and annually thereafter (Resident #3 and #2). Findings include: Resident #3 Resident #3 was admitted on 03/15/20 with diagnoses including bipolar disorder, hypertension, and sleep apnea. Resident #3's record contained an initial physician examination dated 03/15/20. The resident's record contained documentation of an annual physical examination on 05/19/21, 14 months after the previous physical examination. Resident #2 Resident #2 was admitted to the facility on 07/22/20, with diagnoses including hypertension, dementia, and stroke. Resident #2's History and Physical was dated 07/23/20. On 12/22/21 at 1:03 PM, the Owner confirmed Resident #2's History and Physical was not completed upon admission and the Resident #3's annual physical examination was late. Severity: 2 Scope: 1 | 0859 | 1. **The correction of the specific finding:** To correct the deficiency: the facility provided these following physician examinations on the following dates: 3-15-2020, 11-15-2020 and 5-19-2021 (see support document attachment 1- tag 0859, contained only the first page with date of the three of physician examinations).<br><br>For Resident #2: The facility failed to provide the completion of the physical examination upon admission. (see support document attachment 2- tag 0859 Dated as 6-24-2020). The facility failed to re-ensure that all of the documents were in place. To correction this citation, we requested the primary care provider to re-fax the completed history and physical examinations the date prior to 07/22/20. The physical examination dated 6-18-2020 was faxed to us. (see the attachment 3-tag 0859 the physical examination dated as 6-18-2020). | 03/14/2022 |

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| | | | 2. **These systematic changes will be put into place to make sure the deficient practice doesn't recur:** Employees were re-trained on the documentation and will pay more attention to detail. To re-ensure that circumstances don't happen again, the staff was re-trained for 8 hours, and the certification of completion was issued to re-ensure that this type of insufficient practice will not happen again. Also, the manager retrained the employees to re-ensure that all pages of every document are submitted at the time of admission and/or to retain in the record.<br><br>*3.* **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The manager/administrator will monitor the admission documentation closely and make sure the documents are kept organized monthly. We take this action seriously; the manager has emphasized and trained employees every month since Jan 5, 2022. Also, to monitor and re-ensure this type of deficient practice shall not recur for this deficient practice, we | |

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| | | | created a log system that will monitor the time-line of the documentation (see template of the log system of the physician examination, attachment 4-tag 0859) and it acts as a cover page of this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur.<br>4. **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of the correction is implemented.<br>5. As of March-14-2022 the corrective action was completed. The employees were re-trained, and the certificate is issued on Jan-05 -2022 | |
| 0874 SS= F | Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator.<br><br>Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure a medication profile review performed by a physician, | 0874 | 1. **The correction of the specific finding:** The facility failed to ensure a medication profile review performed by a physician, pharmacist, or registered nurse was initialed by the Administrator. To correct this deficient practice, the designee of the administrator initialed the medication Review (see all of | 01/05/2022 |

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| | pharmacist, or registered nurse was initialed by the Administrator at least once every six months for 8 of 10 residing in the facility for longer than six months (Resident #3, #7, #9, #10, #1, #2, #4, and #6). Findings include: Resident #3 Resident #3 was admitted on 03/15/20, with diagnoses including bipolar disorder, hypertension, and sleep apnea. Resident #3's file contained medication reviews dated 05/19/21 and 11/08/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #7 Resident #7 was admitted on 06/11/21, with diagnoses including dementia, hypertension, and chronic kidney disease. Resident #7's file contained a medication review dated 11/08/21; however, the review lacked documented evidence of the Administrator's initials. Resident #9 Resident #9 was admitted on 02/02/20, with diagnoses including dementia and high blood pressure. Resident #9's file contained medication reviews dated 05/19/21 and 10/19/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #10 Resident #10 was admitted on 07/09/20, with diagnoses including dementia, chronic obstructive pulmonary disease, hypertension, and hypothyroidism. Resident #10's file contained medication reviews dated 05/19/21 and 11/08/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #1 Resident #1 was admitted on 08/12/20, with diagnoses including dementia, anxiety disorder, and schizoaffective disorder. Resident #1's file contained medication reviews dated 05/19/21 and 11/08/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #2 Resident #2 was admitted on 07/22/20, with diagnoses including hypertension, hyperlipidemia, and stroke. Resident #2's file contained medication reviews dated 05/19/21 and 11/08/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #4 Resident #4 was admitted on 11/29/20, with diagnoses including dementia, depression, and osteoporosis. Resident #4's file contained medication | | the attachments #1-8 ).<br><br>2. **This systematic changes will be put into place to make sure the deficient practice doesn't recur:** The administrator or her designee will initial all of the medication reviews from the primary care provider promptly from now forward.<br><br>3. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The manager/administrator will monitor and initial the medication reviews immediately after it is reviewed by the primary care provider every 6 months. To monitor and re-ensure this type of deficient practice will not recur for the medication review, we created a log system that will monitor the time-line of the documentation (see template of the log system of the Medication Review, attachment 9-tag 0874) and it acts as a cover page for this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur. | |

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| | reviews dated 05/19/21 and 11/08/21; however, the reviews lacked documented evidence of the Administrator's initials. Resident #6 Resident #6 was admitted on 08/14/21, with diagnoses including dementia, Alzheimer's Disease, major depressive disorder, and diabetes mellitus type two. Resident #6's file contained medication reviews dated 11/08/21; however, the review lacked documented evidence of the Administrator's initials. On 12/22/21 at 1:00 PM, the Owner verbalized the medication profile reviews were not initialed by the Administrator. Severity: 2 Scope: 3 | | 4. **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of correction is implemented.<br><br>5. As of Jan-05-2022 the corrective action was completed. The medication reviews were reviewed and signed by administrator (Attachment 2 -tag 0874, the certification of the designee). | |
| 0885 SS= D | Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744.<br><br>Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure discontinued medications were destroyed for 1 of 10 residents (Resident #5). Findings include: Resident #5 was admitted to the facility on 05/22/21, with a diagnosis of dementia with psychotic features. On 12/22/21, Resident #5's available medications included Diphenhydramine. Resident #5's record contained a physician order dated 12/20/21, to discontinue the Diphenhydramine. The December 2021 Medication Administration Record (MAR) documented the Diphenhydramine had been discontinued. On 12/22/21 in the | 0885 | 1. **The correction of the specific finding:** The facility failed to destroy the Discontinued Diphenhydramine dated on 12/20/21, however Medication Administration Record (MAR) documented the Diphenhydramine had been discontinued.<br><br>2. **This systematic changes will be put into place to make sure the deficient practice doesn't recur:** When medication is discontinued, it shall be destroyed ASAP that is our policy. The manager retrained all employees to make sure the D/C medication is removed and discarded right away after the D/C order was discontinued on the MAR. Also, all | 12/22/2021 |

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| | afternoon, the Medication Technician verbalized the medication should have been destroyed when the physician order to discontinue the medication was received. Severity: 2 Scope: 1 | | employees shall pay closer attention to detail, so that the deficient practice doesn't recur.<br>3. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** To make sure to destroy the medication ASAP after receiving the order and to document it on the MAR at the same time.<br>4. **The manager and the administrator** will be the responsible person to ensure and re-ensure the plan of the correction is implemented.<br>5. As of Dec-22-2022 the corrective action was completed/the medication was destroyed. | |
| 0933 SS= D | Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (d) A statement from the resident ' s physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which | 0933 | 1. **The correction of the specific finding:** The facility failed to obtain a Standard Physician's Assessment and Physician Placement Determination upon admission for Resident #6. The only physician examination for Resident #6 prior to admission was on 6-21-2021. It was a telehealth appointment, therefore there is no temperature and system | 03/08/2022 |

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| | 9975 | A. BUILDING _____ B. WING _____ | 12/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SOUTH MEADOWS RESIDENTIAL CARE HOME | 13495 STONEY BROOK DR, RENO, NEVADA ,89511 |

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| | those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services.<br><br>Inspector Comments: Based on interview and clinical record review, the facility failed to obtain a Standard Physician's Assessment and Physician Placement Determination upon admission for 1 of 10 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/14/21, with diagnosis including dementia, Alzheimer's, and major depressive disorder. Resident #6's Physician Placement Determination was dated 08/23/21. On 12/22/21 at 1:55 PM, the Owner confirmed Resident #6's Physician Placement Determination was not completed upon admission. Severity: 2 Scope:1 | | check (see supporting documents, Attachment 1-tag 0933 the only telehealth physician examination on 6-21-21 upon admission).<br>Resident #6: The resident's record contained a standard placement determination after their admission. **We will ensure that the placement forms are submitted to the facility upon admission.**<br><br>2. **These systematic changes will be put into place to make sure the deficient practice doesn't recur:** The facility acknowledges and ensures that this type of citation will not happen again. Both the Standard Physician's Assessment and Physician Placement Determination will be required upon admission as a part of the admission package.<br><br>3. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur—**The facility will monitor closely to make sure all documents are submitted upon admission. Also, The facility will have a log template for placement determination form, and physician examination as part of our monitor system (see | |

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| | | | template of the log system of the physician examination, Attachment 2_tag 0933_the log system), and it acts as a cover page of this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur.<br><br>4. **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of correction is implemented.<br><br>5. As of 12-22-2021 the corrective action was completed, and the placement forms were part of required documentation upon admission. | |
| 0938 SS= D | Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare | 0938 | 1. **The correction of the specific finding:** The facility failed to ensure an Activities of Daily Living (ADL's) Assessment was accessible upon admission. There are ADL assessments on file as stated here 8-6-2020, 1-2-2021. (See attachment 1 for all ADL dated on August 6 2020 and Jan-2-2021). It is our responsibility to show the documents we have onsite. | 01/05/2022 |

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| | such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year.<br><br>Inspector Comments: Based on interview and clinical record review, the facility failed to ensure an Activities of Daily Living (ADL's) Assessment was completed upon admission for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted on 08/12/20, with diagnosis including schizoaffective disorder, anxiety disorder, and dementia. Resident #1's annual ADL Assessment was dated 01/02/21, five months after the ADL Assessment was due to be completed. On 12/22/21 at 1:10 PM, the Owner confirmed the ADL Assessment for Resident #1 was completed late. Severity: 2 Scope: 1 | | The training will ensure that this type of deficiency will not happen again.<br><br>2. **These systematic changes will be put into place to make sure the deficient practice doesn't recur:** The facility will have a log system both electronically and paper onsite to re-ensure that this type of deficiency will not happen again.<br><br>3. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** We will have a log template for all ADLs date (see the attachment 2-tag 1938_log system), and it acts as a cover page for this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur. All employees were re-trained to monitor and understand the documentation and system throughout.<br><br>4. **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of correction is implemented.<br><br>5. As of Jan-05-2022 the | |

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| | | | corrective action was completed, and All ADLs for all residents were reviewed by the manager | |
| 1700 SS= D | Annual Assessment of History of Each Resident<br><br>Inspector Comments: Based on interview and record review, the Administrator failed to ensure a resident with a diagnosis of dementia had a standard placement determination completed by a provider prior to admission to the facility to ensure the facility would have been able to provide the appropriate level of care in 4 of 10 residents (Resident #6, #7, #9, and #10). Findings include: Resident #6 Resident #6 was admitted to the facility on 08/14/21, with diagnosis including dementia, Alzheimer's, and major depressive disorder. Resident #6's Standard Physician's Assessment was dated 08/23/21. Resident #7 Resident #7 was admitted to the facility on 06/11/21, with diagnoses including dementia, hypertension, and chronic kidney disease. The resident's record contained a standard placement determination dated 06/15/21, four days after the resident was admitted. Resident #9 Resident #9 was admitted to the facility on 02/02/20, with diagnoses including dementia and high blood pressure. The resident's record contained a standard placement determination dated 06/01/20, four months after the resident was admitted. Resident #10 Resident #10 was admitted to the facility on 07/09/20, with diagnoses including dementia, chronic obstructive pulmonary disease, hypertension, and hypothyroidism. The resident's record contained a standard placement determination dated 08/06/20, 28 days after the resident was admitted. On 12/22/21 at 12:51 PM, the facility Owner confirmed the standard placement determinations had not been completed prior to admitting the residents to the facility. Severity: 2 Scope: 2 | 1700 | 1. **The correction of the specific finding:** The facility failed to ensure a resident with a diagnosis of dementia had a standard placement determination completed by a primary provider upon admission.<br><br>o Resident #6, #7, #9 and #10: The resident's record contained a standard placement determination after their admission. **The facility will ensure that the placement forms are submitted to the facility upon admission.** We understand how important it is to make sure that the Alzheimer's residents are safe for themselves and others in a non-Alzheimer's facility. We will do anything we can to comply with the requirement.<br><br>**2. These systematic changes will be put into place to make sure the deficient practice doesn't recur:** The placement forms will be required upon admission. The facility acknowledges and | 03/08/2022 |

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| | | | ensures that this type of citation will not happen again. We will have a log template for placement determination form (see the attachment 3-tag 1700_Log system), and it acts as a cover page for this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur.<br><br>• **How the corrective action(s) will be monitored to ensure the deficient practice will not recur.** The requirement of the placement forms will be part of required documentation upon admission package. We will have a log template for placement determination form (see the attachment 3-tag 1700_Log system), and it acts as a cover page for this tab of the documentation. This log system will be monitored to make sure this type of deficient practice will not recur.<br><br>• **The manager and the administrator** will be the responsible persons to ensure and re-ensure the plan of the correction is implemented.<br><br>• As of Dec-22-2022 the | |

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| | | | corrective action was completed, and the placement forms are part of required documentation upon admission moving forward. | |