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	345049	A. BUILDING _____ B. WING _____	C 06/23/2022

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 6/20/22 through 6/23/22. The facility was in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WH3E11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/20/22 through 6/23/22. Event ID #WH3E11. The following intakes were investigated: NC00189454, NC00188893, NC00188764, NC00188101, NC00188110, NC00186026, NC00185909, and NC00187536. 3 of the 30 complaint allegations were substantiated.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete Minimum Data Set (MDS) assessments in the areas of dialysis and weight status for 1 of 32 sampled residents reviewed for MDS accuracy (Resident #78). Findings included: a. Resident #78 was admitted to the facility on 4/16/22 with multiple diagnoses that included end-stage renal disease dependent on hemodialysis and stroke.	F 641	1. Facility failed to accurately code dialysis and weight status of resident reviewed for MDS accuracy. MDS assessments in the areas of dialysis and weight status were corrected and submitted on 6/23/22 for resident #78. 2. An audit of last two weeks of assessments for accuracy for weights and dialysis was completed by the DON/Designee on 7/15/22 with any concern noted addressed. Re-education on ensuring accuracy of assessments was completed with the Interdisciplinary	7/15/22

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

Electronically Signed | 07/18/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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F 641	Continued From page 1 Review of Resident #78's care plan revealed she was receiving dialysis therapy related to end stage renal failure. The goal was for no complications from dialysis. Interventions included to send Resident #78 on Tuesdays, Thursdays, and Saturdays to an outside dialysis center. The quarterly MDS assessment dated 5/19/22 noted Resident #78 did not receive dialysis treatment while a resident. An interview with the MDS Coordinator was conducted on 6/23/22 at 7:57 AM. The MDS Coordinator revealed dialysis was not included for Resident #78 and it was a mistake. She stated dialysis while a resident should have been included. An interview was conducted with the Director of Nursing (DON) on 6/23/22 at 2:16 PM. She stated her expectation for MDS assessments was that all information in the medical record be timely and accurate. During an interview with the Administrator on 6/23/22 at 3:09 PM, she stated her expectation was that all assessments be completed accurately. b. Resident #78 was admitted to the facility on 4/16/22 with multiple diagnoses that included severe protein calorie malnutrition, dysphagia, and anemia. Review of Resident #78's care plan revealed she was at risk for decreased nutritional status and dehydration related to end stage renal disease, protein calorie malnutrition, need for	F 641	Team by the DON/Designee on 6/30/22. All employees who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Education to be added to new employee orientation on ensuring accuracy of assessments. Audits will be conducted on 10% of assessments by the DON/Designee on accuracy of assessments. Audits weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 641	Continued From page 2	F 641		

supplemental tube feeding, underweight, need for mechanically altered diet and thickened liquids, need for fortified foods, and need for protein supplement. One of the goals was no significant weight changes. Interventions included monitor weight as ordered, assist with meals as needed, diet as ordered, monitor diet tolerance, monitor all intake, and provide supplements as ordered.

Review of Resident #78's weight history revealed a significant weight loss of 16.2% (19 pounds) within 1 month. The following weight measurements were included:
- 4/17/22: 117 pounds
- 5/5/22: 93.4 pounds
- 5/16/22: 98 pounds

The quarterly MDS assessment dated 5/19/22 noted Resident #78's weight value was 117 pounds and significant weight loss was not noted.

An interview with the MDS Coordinator was conducted on 6/23/22 at 7:57 AM. The MDS Coordinator revealed the Registered Dietitian (RD) completed the nutrition section of the MDS, and she did not double check the entries of the providers who completed the other sections. She stated the weight should have been updated with the most recent value and significant weight loss should have been noted as yes.

During an interview with the RD on 6/23/22 at 12:55 PM, she revealed the weight value and weight loss sections of the MDS were not accurate in the 5/19/22 quarterly assessment. The RD stated when she completed Resident #78's nutrition assessment on 5/17/22, the digital form in the medical record auto-populated the weight from 4/17/22, which was 117 pounds. The

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F 641	Continued From page 3 RD stated she had looked at all vital signs, including weight history, and only the 4/17/22 weight was posted. She indicated the weights from 5/5 and 5/16 were not entered into the medical record at that time. An interview was conducted with the Director of Nursing (DON) on 6/23/22 at 2:16 PM. She revealed she was the only one that entered weight values into the medical record for all residents. She could not recall when the weights for Resident #78 were entered in May 2022. The DON stated her expectation for MDS assessments was that all information in the medical record be timely and accurate. During an interview with the Administrator on 6/23/22 at 3:09 PM, she stated her expectation was that all assessments be completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and	F 656		7/1/22

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F 656	Continued From page 4 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to develop a care plan for 1 of 1 resident reviewed for indwelling urinary catheter. (Resident #16) The findings included: Resident # 16 was admitted to the facility on 10/1/21 with diagnoses that included hydronephrosis with renal and ureteral calculous obstruction.	F 656	1. Facility failed to develop and maintain an active care plan for a Resident #16 with an indwelling catheter. Care plan was developed for Resident #16on 6/23/22. 2. An audit of all residents with an indwelling catheter to ensure an active care plan was completed by the SDC on 6/27/22 with no concerns noted. Re-education was completed with all staff on developing and implementing person centered care plans by the DON/Designee	

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F 656	Continued From page 5 Review of Resident #16's Comprehensive Care Plan dated 10/2/21 and last revised 4/21/22 revealed no information or interventions for an indwelling catheter. A review of the physician's order revealed an order dated: 10/7/2021 Leg Strap on and drainage bag covered in privacy bag at all times 10/7/2021 Monitor Catheter for blockage/leakage if present document & notify physician every shift 5/2/2022 Flush foley catheter with 60 mL of NS every 8 hours 6/8/2022 Exchange foley catheter q 4 weeks one time a day every 28 day(s) for chronic foley Review of the most recent Minimum Data Set (MDS) assessment dated 4/5/22 revealed Resident #16 was cognitively intact and had an indwelling catheter. An interview was conducted with MDS nurse on 6/23/22 at 12:36 PM. The MDS nurse stated Resident #16's catheter care plan was accidentally resolved on 11/23/21. The MDS nurse further stated that she usually caught the care plans if they were accidentally resolved. The MDS nurse stated that there was not a system to identify when care plans were accidentally resolved. An interview was conducted with the Director of Nursing (DON) on 6/23/22 at 1:18 PM. The DON stated that Resident #16 should have had a catheter care plan in place.	F 656	on 6/30/22. All employees who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Audits will be conducted on residents with indwelling catheter by the DON/Designee on accuracy of care plan. Audits weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		7/1/22

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F 690	Continued From page 6 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and physician assistant interviews, the facility failed to obtain a physician order for an indwelling	F 690	1. Facility failed to obtain a physician order for an indwelling urinary catheter for Resident #73. Physician order for an	

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F 690	Continued From page 7 urinary catheter for 1 of 4 resident reviewed for catheter (Resident #73). Findings included: Resident #73 was admitted to the facility on 11/11/11 with diagnoses which included neuromuscular dysfunction of the bladder, and a stage 4 pressure ulcer to sacrum. Record review of the Minimum Data Set (MDS) Significant Change Assessment dated 5/02/22 revealed Resident #73 had an indwelling urinary catheter. Record review of the care plan with review date of 5/28/22 revealed Resident #73 had an indwelling urinary catheter. During an observation on 6/20/22 at 12:51 pm Resident #73 was observed with an indwelling urinary catheter. Record review of Resident #73 ' s active physician orders revealed no order for indwelling urinary catheter. During an interview on 6/22/22 at 4:20 pm Nurse #1 revealed Resident #73 had an indwelling urinary catheter and the catheter required a physician order. Nurse #1 stated the indwelling urinary catheter orders were entered as an order set when order was received from the physician or from the admission orders. She stated the catheter was changed when leaking or clogged and catheter care was completed every shift by the nurse or aide. Nurse #1 was unable to state why the physician order for the indwelling urinary catheter was not in place for Resident #73.	F 690	indwelling urinary catheter for Resident #73 was obtained on 6/22/22. 2. An audit of all residents with an indwelling catheter to ensure a physicians order was obtained was completed by the SDC on 6/27/22 with no concern noted. Re-education was completed with all licensed staff on obtaining a physicians order for an indwelling urinary catheter by the SDC/Designee on 6/30/22. Licensed staff who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Audits will be conducted on indwelling catheters by the DON/Designee to ensure a physician's order for an indwelling catheter was obtained. Audits weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 690	Continued From page 8 During an interview on 6/22/22 at 4:39 pm the Director of Nursing (DON) revealed a physician order was required for Resident #73 ' s indwelling urinary catheter. The DON stated Resident #73 had the indwelling urinary catheter for a long time and was unable to state why the physician order was not in place. She reported Resident #73 had a recent hospitalization and the order was not reactivated when she returned to the facility on 4/25/22. The DON stated admission orders were reviewed during the clinical meeting, but she was unable to state why the physician order was missed for Resident #73 ' s indwelling urinary catheter. During an interview on 6/23/22 at 10:59 am the Physician Assistant (PA) revealed Resident #73 required an indwelling urinary catheter for the diagnoses of bladder dysfunction and her stage 4 pressure wound. The PA stated the nurse would enter the orders for the indwelling based on the facility protocol when a resident had an indwelling urinary catheter. The PA was unable to state why the Nurse did not enter the order or notify her when an order was required for Resident #73 ' s indwelling urinary catheter. During an interview on 6/23/22 at 12:43 pm the Administrator revealed the physician order was expected to be in place for Resident #73 ' s indwelling urinary catheter.	F 690		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in	F 694		7/1/22

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F 694	Continued From page 9 accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: The facility failed to implement its intermittent infusion policy when staff reconnected the infusion tubing end back into the infusion therapy line for 2 of 4 residents reviewed for intravenous therapy. (Resident #108, Resident #85) The findings included: Review of the policy for "Administration of an Intermittent Infusion" last updated 6/21/21 read in part "licensed nurses must adhere to Aseptic Non-Touch Technique for all infusion-related procedures as a critical aspect of infection prevention." The policy further stated "when infusion is complete close the clamp and disconnect the administration set from needleless connector. Place a new sterile end cap on end of administration set." On 6/21/22 at 12:10 PM an observation was conducted of nurse #10. Nurse #10 disconnected Resident # 85's administration set from the needleless connector and plugged the end of the administration set back into the infusion line. An interview was conducted with Nurse #10 on 6/21/22 at 12:18 PM. Nurse #10 stated that intravenous medications usually came with a bag of end caps to cover the end of the Infusion line. Nurse # 10 stated that she had not seen any caps on her medication cart. An observation was conducted of the 300 Hall medication room on 6/22/22 at 1:15 PM with the	F 694	1. Facility failed to implement its intermittent infusion policy when staff reconnected the infusion tubing end back into the infusion therapy line for Resident # 108 and Resident #85. Nurse #10 was re-educated by the SDC on utilizing the infusion tubing end back (leur lock end caps) when the infusion tubing is disconnected on 6/21/22. The infusion tubing end back (leur lock end caps) were provided for utilization for Resident #108 and Resident #85 by the SDC on 6/21/22. 2. An audit of all residents with intermittent infusion to ensure utilization of the infusion tubing end back (leur lock end caps) when the infusion tubing is disconnected was completed by the SDC on 6/22/22 with no concern noted. Re-education was completed with all licensed staff on intermittent infusion to ensure utilization of the infusion tubing end back (leur lock end caps) when the infusion tubing is disconnected by the SDC/Designee on 6/30/22. Licensed staff who have not been re-educated by the end of theday 7/1/22 will be in-serviced before their next scheduled shift. 3. Audits will be conducted on all residents with intermittent indwelling catheters by the DON/Designee to ensure a physician’s order for an indwelling catheter was obtained. Audits weekly X 4	

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F 694	Continued From page 10 Staff Development Coordinator (SDC) present. A bag of white Leur lock end caps with Resident #108's name and a bag of white Leur lock end caps for Resident #85 were sitting on the top shelf in the 300 Hall Medication room. The SDC stated that the staff were supposed to place the end caps on the disconnected infusion tubing when not in use. An interview was conducted with the DON on 6/22/22 at 1:44 PM. The DON stated that the staff should have been using the end caps to protect the ends of intravenous tubing.	F 694	weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and physician assistant interviews, the facility failed to obtain a physician order and failed to clarify a physician order for the use of supplemental oxygen for 2 of 3 residents reviewed for oxygen (Resident #7 and #92). Findings included: 1. Resident #7 was admitted to the facility on 6/28/20 with a diagnosis of asthma.	F 695	1. Facility failed to obtain a physician order for and failed to clarify a physician's order for the use of supplemental oxygen for Resident #7 and #92. Physician order for supplemental oxygen for Resident #7 and clarification of physician order for supplemental oxygen was obtained for Resident #92 was obtained on 6/27/22 by the SDC. 2. An audit of all residents with	7/1/22

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F 695	Continued From page 11 Record review of the care plan last updated on 7/08/21 revealed Resident #7 had a care plan for oxygen therapy related to diagnosis of asthma which included the intervention to provide oxygen settings per order. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 3/14/22 revealed Resident #7 was coded for oxygen use. Record review of active physician orders revealed Resident #7 did not have a physician order for oxygen. During observations on 6/20/22 at 12:46 pm and 6/21/22 at 8:35 am Resident #7 had oxygen via nasal canula (NC) at 3 liters per minute (L/min). During an interview on 6/22/22 at 4:20 pm Nurse #1 revealed a physician order was required for oxygen but was unable to state why the order was not in place for Resident #7. During an interview on 6/22/22 at 5:06 pm the Director of Nursing (DON) revealed Resident #7 required a physician order for the oxygen. The DON reported physician orders were reviewed during clinical meeting, but she was unable to state how the oxygen order was missed for Resident #7. During an interview on 6/23/22 the Administrator revealed she expected physician orders to be in place for Resident #7 ' s oxygen. 2. Resident #92 was admitted to the facility on 9/19/16 with diagnoses which included chronic obstructive pulmonary disease (COPD), asthma,	F 695	supplemental oxygen to ensure a physicians order including the flow rate was obtained was completed by the SDC on 6/27/22 with areas of concern noted addressed. Re-education was completed with all licensed staff on obtaining a physicians order with flow rate for residents with supplemental oxygen by the SDC/Designee on 6/30/22. Licensed staff who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Audits will be conducted on residents utilizing supplemental oxygen by the SDC/Designee to ensure a physician's order including flow rate. Audits weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 695	Continued From page 12	F 695		

and respiratory failure.

Record review of Resident #92 ' s care plan dated 9/08/21 revealed a care plan in place for oxygen therapy related to impaired gas exchange with an intervention to administer oxygen as ordered.

A physician order dated 5/02/22 for PRN (as needed) oxygen via nasal canula (NC) to maintain oxygen (O2) levels greater than or equal to 90% one time a day. The order did not have the dosage of liters of oxygen to be administered.

Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 5/31/22 revealed Resident #92 was coded for oxygen use.

During observations on 6/20/22 at 11:00 am, 6/21/22 at 8:45 am, and 6/22/22 at 12:20 pm Resident #92 had oxygen at 2 liters per minute (L/min) via NC.

During an interview on 6/22/22 at 12:40 pm Nurse #2 revealed that the physician order for oxygen was required to have the L/min of oxygen that was to be administered. Nurse #2 was unable to state why the order did not have the oxygen liters that were to be administered to Resident #92.

During an interview on 6/22/22 at 5:07 pm the Director of Nursing (DON) confirmed the physician order for Resident #92 ' s oxygen did not have the amount of liters that was to be administered. She stated the order was required to have the amount of oxygen to be delivered. The DON reported the order was entered by the Physician Assistant (PA) and the nurse would have confirmed the order. The DON stated that physician orders were reviewed in the clinical

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F 695	Continued From page 13 meeting but was unable to state why the oxygen order for Resident #92 did not have the liters of oxygen to be administered. During an interview on 6/23/22 at 10:56 am the Physician Assistant (PA) revealed the physician order was required to have the L/min of oxygen for Resident #92. The PA stated the nurse was expected to contact her for a clarification of the physician order for Resident #92 ' s oxygen. During an interview on 6/23/22 the Administrator revealed she expected the physician orders to be reviewed by nursing staff to ensure the physician orders were complete.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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	F 761		7/1/22

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F 761	Continued From page 14 Control Act of 1976 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to monitor and report out of range temperatures for 1 of 1 medication refrigerators (300 Hall medication refrigerator) . The findings included: An observation was conducted of the 300 Hall medication room on 6/22/22 at 1:15 PM with the Staff Development Coordinator (SDC) present. Review of the temperature chart for the month of June revealed the temperature had not been recorded on 6/18/22 and 6/19/22. On 6/16/22 the refrigerator temperature was documented at 34 degrees Fahrenheit and on 6/17/22 the refrigerator temperature was documented at 34 degrees Fahrenheit. There was no documentation of corrective action for 6/16/22 and 6/17/22 when temperatures were out of range. An interview was conducted with the SDC on 6/22/22 at 1:25 PM. The SDC stated it was the night shift nurses' responsibility to check and document the medication refrigerator temperature. The SDC stated that the medication refrigerator should be in the range of 36 to 46 degrees Fahrenheit. On 6/22/22 at 1:44 PM an interview was conducted with the Director of Nursing. The DON stated that refrigerator checks, and temperatures	F 761	1. Facility failed to monitor and report out of range temperatures for 1 of 1 medication refrigerators (300 Hall medication refrigerator). 300 hall medication refrigerator temperature was checked by the SDC on 6/22/22. 2. An audit of all medication refrigerators was completed by the Administrator on 6/30/22 with no concern noted. Re-education was completed with all licensed staff on monitoring and reporting temperatures and documenting intervention if temperature is out of range by SDC/Designee on 6/30/22. Licensed staff who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Audits will be conducted on all medication room refrigerators by the DON/Designee to ensure a monitoring and reporting temperatures with intervention documented if temperature is out of range. Audits 5x per week for 2 weeks, weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the	

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F 761	Continued From page 15 were assigned to the night shift nurse. The Don stated that the checks were to be recorded daily.	F 761	Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to 1) maintain food service equipment without a debris build up on 1 of 4 pieces of cookline equipment (top convection oven) observed for cleanliness, 2) failed to allow food plates, dessert bowls, cups, and covers to air dry prior to assemblage and stacking for two of three observations, and 3) the facility failed to discard bread stored for use with signs of	F 812	1. Facility failed to monitor 1) maintain food service equipment without debris build up on 1 of 4 pieces of cookline equipment (top convection oven) observed for cleanliness, 2) failed to allow food plates, dessert bowls, cups and covers to air dry prior to assemblage and stacking for two of three observations, and 3) the facility failed to discard bread	7/1/22

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F 812	Continued From page 16 spoilage. These practices had the potential to affect all residents. Findings Included: 1. Observations of the kitchen conducted on 6/20/22 at 10:39 AM, 6/21/22 at 10:05 AM, and 6/22/22 at 11:25 AM revealed a buildup of grease on the inside doors, both the right and left sides, and bottom of the top convection oven. An interview and observation were conducted with the interim Certified Dietary Manager (CDM) on 6/22/22 at 11:26 AM. The interim CDM stated the oven needed to be cleaned and was unsure of the last time it was cleaned. She indicated the convection oven was now included on the cleaning log. An interview was conducted with the Administrator on 6/23/22 at 4:27 PM. She stated her expectation was for kitchen staff to follow the cleaning schedule and clean the oven after each shift if spillage and deep cleaned weekly. 2. An observation of the kitchen was conducted on 6/20/22, which started at 10:22 AM. During the observation, 24 of 24 plastic drink cups were observed to have been stacked in a nesting manner with moisture between the cups on a prep table in the dish area. An observation of the kitchen during tray line was conducted on 6/22/22, which started at 11:04 AM. During the observation, 65 of 72 plate covers, 42 of 45 dessert bowls, 1 of 2 lip plates, and 6 of 6 observed plates were found to have been stacked in a nesting manner with moisture between the items. The interim CDM stated the plates, bowls,	F 812	stored for use with signs of spoilage. The Interim Certified Dietary Manager (CDM)/designee ensured the top convection oven was cleaned on 6/22/22, rewashed identified food plates, dessert bowls, cups and covers and allowed to air dry prior to assemblage and stacking on 6/22/22, discarded the bread with signs of spoilage on 6/20/22. 2. The Certified Dietary Manager/designee 1) observed all cookline equipment for cleanliness, 2) food plates, dessert bowls, cups and covers were observed to ensure they were air dried prior to assemblage and stacking, 3) all other bread to ensure no signs of spoilage was completed with no concerns noted on 6/23/22. Re-education was completed with dietary staff to ensure 1) all cookline equipment is cleaned per the cleaning schedule and as needed, 2) food plates, dessert bowls, cups and covers are air dried prior to assemblage and stacking, 3) bread is discarded if signs of spoilage/mold on SDC/Designee on 6/30/22. Dietary staff who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Education to be added to new employee orientation with dietary staff to ensure 1) all cookline equipment is cleaned per the cleaning schedule and as needed, 2) food plates, dessert bowls, cups and covers are air dried prior to assemblage and stacking, 3) bread is discarded if signs of spoilage/mold. Audits	

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F 812	Continued From page 17 and covers should all have been allowed to air dry prior to being stacked in preparation for meals to be plated. The interim CDM then directed the dietary staff to rewash all the plates, covers, dessert bowls, and lip plate. Plastic wrap was used to cover the meal plates and bases during tray line. Dessert bowls were not used for the vegetables, and they were placed directly on to the meal plate. During an interview with the interim CDM on 6/23/22 at 9:06 AM, she stated her expectation was for there to be no wet-nested dishes in the kitchen. If there were any, she would expect staff to pull them aside and run them through dishwasher and air dry. The interim CDM further indicated that all dishes on the tray line should be fully air dried prior to usage. An interview was conducted with the Administrator on 6/23/22 at 4:27 PM. She stated her expectation was that all dietary staff allow all dishes to air dry before stacked and ready for use. 3. An observation of the kitchen was conducted on 6/20/22, which started at 10:22 AM. During the observation, 1 loaf of white bread displayed signs of mold, which was immediately discarded by the interim CDM. During an interview with the interim CDM on 6/23/22 at 9:06 AM, she stated her expectation was that bread be pulled from the freezer and then dated. The interim CDM further stated the bread should be checked daily per policy and should be discarded if not used in 3 days. An interview was conducted with the	F 812	will be conducted by the CDM/Designee to ensure a 1) cookline equipment is clean without debris buildup, 2) food plates, dessert bowls, cups and covers are air dried prior to assemblage and stacking, 3) bread does not have signs of spoilage 5x per week for 2 weeks, weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 812	Continued From page 18 Administrator on 6/23/22 at 4:27 PM. She stated her expectation was that all dietary staff follow the bread policy reiterated by the interim CDM.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		7/15/22

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F 842	Continued From page 19 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to maintain accurate records of wound care treatment for 2 of 33 residents' medical records reviewed (Residents #78 and #260).	F 842	1. Facility failed to maintain accurate records of wound care treatment for Residents #78 and #260. Resident #78 no longer resides at the facility. Resident #78s Treatment Administration Record (TAR) was reviewed for last 14 days on	

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F 842	Continued From page 20 Findings included: 1. Resident #78 was admitted to the facility on 4/16/22 with diagnoses that included pressure ulcer stage 3. A physician order dated 4/20/22 - 5/5/22 for sacrum cleanse with normal saline or wound cleanser, apply silver alginate to wound bed every day and as needed when soiled, and cover with bordered gauze dressing every day shift for wound care. Record review of the Treatment Administrator Record (TAR) for the month of April 2022 revealed daily wound care treatment was left blank for the following dates: 4/21, 4/23, 4/24, 4/26, 4/27, and 4/29. Record review of the Treatment Administrator Record (TAR) for the month of May 2022 revealed daily wound care treatment was left blank for the following dates: 5/1, 5/2, 5/3, and 5/4. An interview was conducted with the Wound Nurse (WN) on 6/22/22 at 4:43 PM. She revealed that she covered all wound care from 8:30 AM - 5:00 PM Monday - Friday and sometimes on Saturdays. The WN indicated which ever staff member performed wound treatment would have signed the TAR. She stated she did not know there were dates missing on the April/May 2022 TAR for wound care of Resident #78. The WN indicated she usually signed the TAR at the end of the day or in between treatments. When she was not in the facility, she stated the floor nurse, or another other nurse would be assigned to wound care.	F 842	7/15/22 with no concerns noted. Resident #260 was discharged from the facility prior to the survey. On 6/23/22 the Administrator/designee conducted one on one re-education with Nurse #3, Nurse #4, Treatment Nurse and Director of Nursing regarding signing the treatment administration record as soon as treatments are completed. 2. An audit of last two weeks of treatment administration record ensuring accurate record of completion of wound care was completed by the DON/Designee on 7/15/22 with any concerns noted addressed. Re-education was completed with licensed staff on ensuring the medical record is complete and accurate by the SDC/Designee on 6/30/22. Licensed staff who have not been re-educated by the end of the day 7/1/22 will be in-serviced before their next scheduled shift. 3. Education to be added to new employee orientation for licensed staff on ensuring the medical record is complete and accurate. Audits will be conducted by the DON/Designee of the treatment administration record to ensure documentation of wound care completion 5x per week for 2 weeks, weekly X 4 weeks and monthly X 3 months. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate	

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F 842	Continued From page 21 During a follow-up interview with the WN on 6/23/22 at 1:40 PM, she revealed she was not working full-time at the facility from 3/22/22 through 6/1/22. An interview was conducted on 6/23/22 at 8:04 AM with Nurse #3, who was the weekend floor nurse assigned to Resident #78 on 4/23/22 and 4/24/22. She revealed if the WN was not in the building on Saturday, then the nurse on duty would perform wound care. Nurse #3 stated she could not recall if Resident #78 went to dialysis on 4/23/22, but if she did not perform her wound care on day shift then she would have passed it on to the night shift nurse. She indicated she did complete Resident #78's wound care on 4/24/22. Nurse #3 stated that she sometimes documented in the TAR, but if she was too busy and could not remember then she would not be able to document. During an interview on 6/23/22 at 8:50 AM with the Director of Nursing (DON), who was also the floor nurse for Resident #78 on 5/1/22, revealed the floor nurses performed wound care if the WN was not in the building. The DON stated she had to help the nurse aide with incontinence care for Resident #78, and the wound cleanse and dressing change was performed on 5/1/22 but not documented due to data entry error. She indicated that she should have signed off on it when she completed the treatment, but she forgot. The DON stated her expectation with documentation was that all treatments, medications, and care be documented as soon as they were performed. An interview was conducted with the	F 842	the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 842	Continued From page 22	F 842		

Administrator on 6/23/22 at 3:09 PM. She revealed her expectation was that documentation should be accurate and timely.

2. Resident #260 was admitted to the facility on 3/30/22 and discharged to the hospital on 4/10/22 with diagnoses that included dementia and arthritis.

A physician order dated 4/5/22 - 4/8/22 to apply betadine solution to left buttock every shift (three times daily) for wound care then apply zinc oxide.

Record review of the Treatment Administrator Record (TAR) for the month of April 2022 revealed daily wound care treatment was left blank for the following dates: 4/6 day shift, 4/6 evening shift, 4/7 day shift, and 4/8 evening shift.

An interview was conducted with the Wound Nurse (WN) on 6/22/22 at 4:43 PM. She revealed that she covered all wound care from 8:30 AM - 5:00 PM Monday - Friday and sometimes on Saturdays. The WN indicated which ever staff member performed wound treatment would have signed the TAR. The WN indicated she usually signed the TAR at the end of the day or in between treatments. When she was not in the facility, she stated the floor nurse, or another other nurse would be assigned to wound care.

During a follow-up interview with the WN on 6/23/22 at 1:18 PM, she revealed the betadine and zinc were to be applied by both her and the floor nurse. The WN stated she could not recall Resident #260 or the details of her wound. During the month of April 2022, she indicated she had worked intermittently.

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	345049	A. BUILDING _____ B. WING _____	C 06/23/2022

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F 842	Continued From page 23 An interview was conducted on 6/23/22 at 2:42 PM with Nurse #4, who was the evening floor nurse assigned to Resident #260 on 4/6/22. She revealed she was quite certain that she applied the betadine with zinc during her shift. Nurse #4 indicated even when Resident #260 was combative and physically abusive with staff, the wound treatment was completed. She stated the documentation was not completed in the TAR because she forgot to sign. An interview was attempted with Nurse #7, who was the evening nurse for Resident #260 on 4/8/22; however, he was unable to be reached during the investigation. During an interview on 6/23/22 at 8:50 AM with the Director of Nursing (DON), she revealed her expectation with documentation was that all treatments, medications, and care be documented as soon as they were performed. An interview was conducted with the Administrator on 6/23/22 at 3:09 PM. She revealed her expectation was that documentation should be accurate and timely.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		7/22/22

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 25 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, 1) the facility failed to ensure staff donned Personal Protective Equipment (PPE) according to the Center of Disease Control and Prevention (CDC) to include a gown, gloves, eyewear, and a N-95 mask when Nurse #3 entered a resident's room who was under transmission-based precautions (TBP) labeled Quarantine Enhanced Barrier Precautions for 1 of 4 residents reviewed for infection control (Resident #219). 2) The facility failed to implement the facility's wound care policy during wound care when staff failed to change gloves and sanitize hands between resident's wounds when cleaning and applying new dressings for 1 of 3 resident observed for wound care. (Resident #63) Findings included: 1. The Centers for Disease Control and	F 880	1. The facility failed to ensure staff donned Personal Protective Equipment (PPE) according to the Center of Disease Control and Prevention (CDC) to include a gown, gloves, eyewear, and an N-95 mask when Nurse #3 entered a resident #219s room who was under transmission-based precautions (TBP) labeled Quarantine Enhanced Barrier Precautions. The center employed the “5 Whys Method of Root Cause Analysis” and determined the following to be the root cause. The center failed to follow the process outlined in the facility policy Personal Protective Equipment (PPE). Interview with Nurse #3 revealed that the agency staff member was knowledgeable of the policy and has completed education and competencies related to proper use of PPE for COVID-19 Enhanced Droplet precautions in the centers’ Observation	

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Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following statement under Section 2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

Resident #219 was readmitted to the facility on 6/16/22.

Review of the 5-day Minimum Data Set (MDS) assessment dated 5/24/22 revealed Resident #219 had moderately impaired cognitive skills for daily decision making with memory problems.

Review of the admission Minimum Data Set (MDS) assessment dated 6/6/22 revealed Resident #219's cognition was not assessed.

An observation on 6/20/22 at 2:55 PM revealed Nurse #3 knocked on Resident #219's door and spoke to the resident from the doorway. The signage on the door indicated Resident #219 was under the transmission-based precautions: "Quarantine Enhanced Barrier Precautions" which indicated a gown, gloves, eyewear, and a N-95 mask were to be worn when entering the room. NA #3 entered the room wearing only a N-95 mask and eyewear. Resident #219 was on Intake Unit (OIU). Nurse #3 relates that she doesn't feel the PPE should be required as she knows the resident did not have COVID-19. Nurse #3 felt and verbalized her feelings that non-compliance was her choice, just did not choose to be compliant with the centers' PPE guidance. The SDC provided provided re-education with Nurse #3 to ensure a gown, gloves, eyewear, and an N-95 mask is donned prior to entering a room that is labeled transmission based precautions on 6/20/22.

The facility failed to implement the facility's wound care policy during wound care when staff failed to change gloves and sanitize hands between resident's wounds when cleaning and applying new dressings for resident #219 observed with wound care. In review of the F880 deficiency related to proper use of Personal Protective Equipment (PPE). The center employed the "5 Whys Method of Root Cause Analysis" and determined the following to be the root cause. The center failed to follow the process outlined in the facility policy SHCRC20001.07 titled "Clean Dressing Change." Multiple interviews with Treatment Nurse revealed that the staff member was knowledgeable of the policy and has completed education and dressing change competencies throughout her tenure in the center. The Treatment Nurse relates that she was nervous during the observation of the dressing change. The Treatment Nurse had prepared the correct number of

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F 880	Continued From page 27 precaution due to readmission from the hospital 4 days prior. During an interview with Nurse #3 on 6/20/22 at 3:07 PM, she revealed she did not wear a gown or gloves when she entered Resident #219's quarantine room only a few minutes earlier because she knew the resident did not have COVID. Nurse #3 stated the PPE was necessary for Resident #219's room, but she did not put it on because she knew she was not positive for COVID. An interview on 6/23/22 at 9:02 AM with the Director of Nursing (DON) revealed her expectation was that all PPE guidelines be followed as posted. During an interview with the Infection Preventionist (IP) on 6/23/22 at 12:05 PM, she revealed there should never be a time when staff crossed the threshold of a room on TBP precautions when PPE should not be worn. She stated she performed daily rounds to ensure enough PPE was available for staff. An interview on 6/23/22 at 3:09 PM with the Administrator revealed her expectation was that all staff follow the requirements of PPE for TBP rooms. 2) Resident #63 was admitted to the facility on 3/9/21 with diagnoses that included quadraplegia and diabetes. Review of Resident #63's care plan dated 5/10/22 revealed he was at risk for pressure ulcer injury and had identified pressure injuries.	F 880	gloves for the dressing change, but left some of them on the top of her treatment cart. The nurse failed to realize at the time of the observation that she had skipped one of the required hand hygiene steps. The DON provided re-education on changing gloves between a resident's wounds when cleaning and applying new dressings and completed dressing change competency with the treatment nurse on 6/23/22. 2. On 6/30/22 the SDC/designee to provide re-education with all staff on proper use of Personal Protective Equipment related to precautions and with licensed staff on changing gloves between a residents' wounds when cleaning and applying new dressings to be completed. The DON/designee to complete competencies on "Clean Dressing Change" to be completed with licensed staff. Quality, Safety, and Education Portal (QSEP) training entitled CMS Targeted COVID 19 Training for Frontline Nursing Home Staff and CMS Targeted COVID 19 Training for Nursing Home Management to be completed by staff. Staff who have not been educated or had competencies completed by the end of the day 7/22/22 will be in-serviced before their next scheduled shift. 3. Education to be added to orientation for new employees on proper use of Personal Protective Equipment related to precautions and added to orientation with licensed staff on changing gloves between a residents' wounds when cleaning and	

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F 880	Continued From page 28 Review of Resident #63's most recent Minimum Data Set dated 5/16/22 revealed that he was cognitively intact and had three stage four pressure ulcers. On 6/22/22 at 11:00 AM wound care was observed for Resident #63. The facility treatment nurse cleaned Resident #63's left ischium wound, sacral wound and right ischium without removing gloves and performing handwashing. The treatment nurse failed to remove gloves and perform handwashing between applying clean dressings to Resident #63's left ischium wound, sacral wound and right ischium. An interview was conducted with the treatment nurse on 6/22/22 @3:13 PM. The treatment nurse stated that she had left the additional gloves on the treatment cart and did not realize that she had not completed hand hygiene between wounds. An interview with the Director of Nursing on 6/22/22 at 3:50 PM revealed that she felt that since Resident #63's wounds were all in the same location and the treatment nurse did not touch the resident's skin there was no cross contamination.	F 880	applying new dressings. The DON/designee to complete competencies on “Clean Dressing Change” during orientation with licensed staff. Quality, Safety, and Education Portal (QSEP) training entitled CMS Targeted COVID 19 Training for Frontline Nursing Home Staff and CMS Targeted COVID 19 Training for Nursing Home Management to be completed during orientation. Audits will be conducted by the DON/Designee to validate that staff following the proper use of Personal Protective Equipment and will choose 3 nurses to audit on clean dressing change technique, hand-hygiene with glove changes weekly X 4 weeks and monthly X 3 months. These audits will be conducted weekly for 4 weeks, then monthly for 3 months. If employees are noted to be non-compliant with use of appropriate PPE corrective action will be taken. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to. QAPI by the Administrator monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	