STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 08/13/2019

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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
F 000	INITIAL COMMENTS An unannounced complaint and extended survey was conducted at this facility from July 8, 2019 through August 13, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records, facility policy and procedures, hospital records and other facility documentation as indicated. The facility census the first day of the survey was 166. The survey sample size was 3. Abbreviations/definitions used in this report are as follows: ad hoc - when necessary or needed; ALS (Amyotropic Lateral Sclerosis) - A progressive neurological disorder which results in weakened muscles and deformity; Apnea - cessation of breathing for short periods of time; AVAPS (Average Volume Assured Pressure Support) - a portable non-invasive ventilator; Bed mobility - how a resident moves to and from lying position, turns side to side and positions body while in bed; BIMS (Brief interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best; BiPAP - machine that helps the patient breathe; Bipolar Disorder - mood disorder; Blood Pressure - the measure of the force of blood against the walls of a blood vessel; Bolus - pouring a formula into the gastrostomy tube via a syringe; BVM (Bag Valve and Mask) - an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs	F 000		

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

Electronically Signed | 08/23/2019

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 000	Continued From page 1 mechanically by squeezing a reservoir of oxygen or air; Carbon Dioxide (CO2) - gas formed during breathing; CHF - Congestive Heart Failure; heart unable to pump enough blood to meet the body needs; Cognitively intact - able to make own decisions; cm - centimeter; COPD (Chronic Obstructive Pulmonary Disease) - A group of progressive lung disorders characterized by increasing breathlessness; CPAP - machine for breathing assistance during sleep; CPR - Cardiopulmonary resuscitation, an emergency procedure that is done when someone's breathing or heartbeat has stopped in hopes of providing time for first responders to arrive; 45 degree angle - halfway between a flat slope and a vertical slope; Diaphoresis - profuse sweating; DNR - A Do not Resuscitate order is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating; DON - Director of Nursing; e.g-for example; EHS _ Environmental Health Specialist; Facility Assessment - the facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies; Hemoptysis - coughing out blood from the respiratory tract; HS (hs) - at bedtime; HOB - head of the bed; H20-water;	F 000		

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F 000	Continued From page 2	F 000		

Hospice - service that provides care to residents that are terminally ill;
Humidifier - an electrical appliance that increases humidity in a single room or an entire building;
Hypoxia/Hypoxic - deficiency in the amount of oxygen reaching the body tissues;
Lactic acidosis - refers to lactic acid build up in the bloodstream. Lactic acid is produced when oxygen levels become low in cells within the areas of the body where metabolism takes place;
Lethargy - lack of energy and enthusiasm;
MD - Medical Doctor;
Minimum Data Set (MDS) - standardized assessment forms used in nursing home;
Nasal pillows - a type of CPAP mask consisting of plastic inserts that look like headphone earbuds that slip directly into the nostrils. The prescribed pressure used to keep the airway open is delivered through this mask;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
02 - oxygen;
Panic disorder - sudden strong feeling of fear;
PEG tube - Percutaneous endoscopic gastrostomy (PEG) a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate;
POA (Power of Attorney) - represent or act on another's behalf in private affairs, business, or some other legal matter;
PRN (prn)- as needed;
Pulse oximetry (POX) - measures blood oxygen saturation levels with a desired range of 94% to 100%;
Respiratory acidosis - usually caused when the body is unable to remove enough carbon dioxide (CO2) through breathing, a failure of ventilation;.
Respiratory Failure - inability of the lungs to

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F 000	Continued From page 3 perform the basic task of gas exchange; lack of oxygen and/or excess carbon dioxide; RRT - Registered Respiratory Therapist; Tachycardia/Tachycardic - an abnormally fast heart rate; TAP Alarm - clip attached to the resident's foot that alarms and alerts staff when resident taps it to seek assistance; Total assistance - full staff performance of an activity; TAR (Treatment Administration Record) - list of daily/weekly/monthly treatments to be performed; Tracheostomy (trach) - a tube placed through a tracheostomy (opening) to provide an airway and to remove secretions from the lungs; Tracheitis - inflammation of the trachea; Trilogy 100 - Clinical Manual used as a guide for resident's AVAPS portable ventilator; UTI - urinary tract infection; Ventilator - machine designed to move breathable air into and out of the lungs for a patient who is physically unable to breathe; VBG (Venous Blood Gas) - a laboratory blood test commonly used for estimating the acid-base status, oxygenation and carbon dioxide concentration of unwell patients; VPAP - a variable positive airway pressure machine is an auto-adjusting, bilevel breathing device similar to a BIPAP machine, which provides two levels of pressure to match your natural inhalation and exhalation rhythm. AVPAP machine may be used to treat sleep apnea and other sleep disorders; x - times.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		8/23/19

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F 657	Continued From page 4 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, review of facility policy and procedure, and review of the Trilogy 100 Clinical Manual, it was determined that for one (R3) out of 3 sampled residents, the facility failed to ensure that R3's comprehensive care plan was reviewed and revised to include R3's needs and the use of the Trilogy 100 AVAPS ventilator in accordance with the facility's policy and the manufacturer's recommendations. Findings include:	F 657	A. R3's respiratory care plan was updated upon discovery, to include specific equipment being utilized (AVAPS), prescribed AVAPS setting, prescribed AVAPS duration of usage, type of delivery (nasal pillows/face masks), pulse oxygen saturation measuring, the need for continuous nursing monitoring, and visual monitoring during an alarm silence period. B. All residents with respiratory care plans	

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F 657	Continued From page 5 Cross refer to F695 Review of R3's clinical record revealed: 2/14/17 - A care plan was initiated and entitled, "The resident has altered respiratory status/Difficulty Breathing related to ALS, Utilizes AVAP 23 hours/day." The interventions included: - "Assist resident/family/caregiver in learning signs of respiratory compromise. - BiPAP/CPAP/VPAP settings:...are- Titrated pressure: (X) cm H2O via (nasal pillow, nose mask or full-face mask) (frequency). - Elevate HOB. Please ensure HOB is 30-45 degrees when care not being provided (safety precautions). If resident needs HOB greater than 45 degrees for comfort/improve respiratory status - must be supervised. - Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. - Monitor for signs and symptoms of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain (type of chest pain): Accessory muscle usage; Skin color changes to blue/grey. - Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. - Position resident with proper body alignment for optimal breathing pattern; - Provide relaxation training as appropriate to help normalize breathing patterns (e.g. biofeedback, imagery, progressive muscle relaxation).	F 657	were reviewed and revised as needed. C. Root cause of non-comprehensive respiratory care plan determined to be lack of education. The DON/designee will re-educate the nurses on compliance of care plan documentation on all residents with respiratory compromise, to ensure the care plan is resident specific to address the respiratory needs and care being provided are included. D. The DON/designee will complete an audit on the respiratory care plans weekly for three weeks and then monthly for three months until 100% compliance is achieved. Result of the audit will be brought to the QAPI steering committee for further evaluation or recommendation.	

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F 657	Continued From page 6 - Use pain management as appropriate. Monitor/document side effects and effectiveness." According to the facility's policy and procedure entitled "BiPAP/CPAP/AVAPS", updated July 2018, stated, "The majority of patients will bring their BiPAP/CPAP machine from home. Manufacturer's recommendations should be followed." The facility's "Trilogy 100 Clinical Manual (for AVAPS)", dated 6/15/17, under "Warnings and Cautions", stated the following manufacturer's recommendations: "...Ventilator dependent patients should be continuously monitored by qualified personnel...do not rely on any single alarm to detect a circuit disconnect condition...Respond immediately to any alarm. It may indicate a potentially life-threatening condition...Visually monitor the patient and ventilator at all times during an Alarm Silence period. Allowing alarms to continue without intervention may result in harm to the patient...Make sure the alarm volume is set loud enough to be heard by the caregiver. Consider the use of a remote alarm...". Review of R3's care plan revealed that the facility failed to review and revise the comprehensive care plan to reflect R3's needs and use of the Trilogy 100 AVAPS ventilator in accordance with the facility's policy and the manufacturer's recommendations. The facility failed to include the interventions of the need for continuous monitoring by qualified personnel and visual monitoring during an alarm silence period. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 7/18/19 at	F 657		

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F 657	Continued From page 7 approximately 11:45 AM.	F 657		
F 695 SS=J	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: Cross Refer to F726 and F919 Based on observation, staff and resident interviews, review of residents' clinical records, facility policy and procedures, hospital records, facility documentation and the facility's "Trilogy 100 Clinical Manual" for AVAPS (Average Volume Assured Pressure Support), as indicated, it was determined that a resident who needs respiratory care failed to be provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (R3) out of 3 sampled residents. For R3, who needed respiratory care with a Trilogy 100 AVAPS (non-invasive ventilator/life saving respiratory device), with a built in alarm system, failed to be provided such care. The facility failed to have a system in place for continuous monitoring of R3 and the ventilator for signs of respiratory compromise in order to ensure R3's safety. On 5/31/19 at 10:45 PM, after E3 (3-11 shift LPN) had R3's mask adjusted and both (oxygen)	F 695	A. R3's call bell was not visible from the nurse's station. On May 31, 2019, there was approximately 30 minutes of time before the staff saw the call bell panel at the nurse's station activated for R3's room and responded to the call bell. B. A secondary remote alarming device has been installed at the nursing station to allow for both visual and audible continuous monitoring of the AVAPS functionality on 8/8/2019. The secondary remote alarm will both visually and audible alert the staff that the AVAP has entered an alarm condition, which would require nursing staff intervention. The DON/designee has educated all nursing staff on the functionality and response to the secondary alarm. A whole house call bell system audit was also completed on 8/15/2019 and education was provided to nursing staff on how to both visually and audibly check for call bells, as well as	8/23/19

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F 695	Continued From page 8 tubings were secured tightly E3 left the room. The facility failed to ensure that R3 was continuously monitored while the incoming 11-7 AM staff were receiving reports during the change of shift and while the outgoing 3-11 PM nursing staff were still on the unit. During that period of time, R3's ventilator tubing became disconnected from the mask on the Trilogy 100 AVAPS ventilator, designed to move breathable air into and out of R3's lungs. R3 became severely hypoxic at a level of 50% oxygen saturation (normal range 92-100%) and experienced a respiratory arrest (stopped breathing). Upon being found by facility staff, rescue breathing was initiated with a BVM. R3 was then transferred to the hospital ER per physician's order and family request for treatment and evaluation. The facility's lack of a system for continuous monitoring resulted in harm to R3 and the facility's lack of intervention presented the continued likelihood of repeated harm. An immediate jeopardy was identified on 8/8/19 at 3:20 PM and was abated on 8/8/19 at 7:30 PM. Findings include: Review of R3's clinical records, facility policy and procedures, hospital records, facility documentation and the facility's Trilogy 100 AVAPS Clinical Manual revealed the following: The facility's policy and procedures entitled "BiPAP/CPAP/AVAPS" updated 7/18 stated, "PURPOSE: To provide non invasive support for patients who are diagnosed with obstructive sleep apnea, COPD, CHF, neuromuscular disease and other diseases per medical practitioner order...Manufacturer's recommendations should be followed." The facility's "Trilogy 100 Clinical Manual (for	F 695	prioritization of call bells for residents who experience respiratory compromise. C. The secondary remote alarm will be checked every shift to ensure functionality by nursing staff and documented in the medical record. Whole house monthly call bell audits were also completed to ensure proper functioning, and will continue monthly by the Maintenance director/designee. D. Secondary remote alarm audits will be completed by the DON/designee to ensure proper secondary remote alarm functionality daily until 100% compliance is met x 3 weeks. Then will be monitored for compliance 3 x week for 3 weeks. Then monitored once a month for 100% compliance x three months. Results of the audits will be reviewed and any issues identified immediately corrected. Results of the audit will be brought to the facility QAPI meeting for further evaluation and recommendations.	

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F 695	Continued From page 9 AVAPS)," dated 6/15/17, stated under "Warning and Caution" to follow manufacturer's recommendations: "...Ventilator dependent patients should be continuously monitored by qualified personnel...For ventilator dependent patients, do not rely on any single alarm to detect a circuit disconnect condition...Trilogy 100 is a restricted medical device designed for use by Respiratory Therapists or other trained and qualified caregivers under the supervision of a physician...Respond immediately to any alarm. It may indicate a potentially life-threatening condition...Visually monitor the patient and ventilator at all times during an Alarm Silence Period (such as during meals, personal care and maintenance of the ventilator). Allowing alarms to continue without intervention may result in harm to the patient...Make sure the alarm volume is set loud enough to be heard by the care giver. Consider the use of a remote alarm...". R3 was admitted to the facility on 2/6/17 with diagnoses that included ALS (Amyotropic Lateral Sclerosis)and Panic Disorder. R3 required use of a life saving respiratory device/ventilator the Trilogy 100 AVAPS with humidifier and connecting alarm system device to detect a circuit disconnect condition. R3's treatment orders included the following: 2/7/17 - "AVAPS Use Nasal Pillows during the day - No O2 (oxygen), no humidifier. Switch to AVAPS face mask at HS and turn humidifier on. Do not undo side straps. You may tighten and loosen by using forehead knob for comfort...Check placement of tap call pad (tap-to-click function allows you to tap your touchpad as a click,	F 695		

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F 695	Continued From page 10 instead of pressing the button). Resident prefers pad to be clipped to the pillow by his feet." 2/8/17 - "AVAPS on at all times...May remove for eating. Nasal pillows During Day without Humidity and Mask at night with Humidity - Remember to turn on Humidifier Machine." 2/9/17 - "Please ensure HOB less than 45 degrees when care not being provided (safety precautions)...". 2/14/17 -A Care plan entitled, "The resident has altered respiratory status/Difficulty Breathing related to ALS, Utilizes AVAPS 23 hours/day" was initiated. Interventions included: Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger; Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. 5/7/19 - The quarterly MDS assessment revealed that R3 had a BIMS ((Brief interview for Mental Status) score of 15 (cognition, mental status was intact). R3 was totally dependent and required the total assistance of 2 person/staff for all of his/her activities of daily living, such as bed mobility, transfers from one surface to another, hygiene/bathing, toileting, and others. 5/26/17 - A care plan entitled, "Impaired verbal communication related to aphasia secondary to ALS. He/she can mouth word" was revised. The care plan included the intervention, Eyegaze technology via resident's laptop for	F 695		

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F 695	Continued From page 11	F 695		

communication (must be out of bed to recliner to utilize laptop); 8/10/17 an additional intervention was added to the care plan that stated, "Unable to response (sic) to knock on the door, continue to knock first then enter room."

An undated written statement by E3 (LPN) stated, "On 5/31/19, I was the nurse on the 3-11 shift...R3 went to bed at around 10:15 pm. I was called to his/her room to put in (sic) Mask on (sic) at around 10:30 (PM). I put his/her mask on adjusted it as he/she instructed me to...I pushed on both tubings (ends connected to the ventilator and to the mask) to make sure they were secured tightly. I left R3's room at around 10:45 pm. After 10:45, I was still on the unit. I did not see or hear R3's light."

5/31/19 11:15 PM - A Nursing Progress Note stated, "nurse (E4, LPN) entered room at 23:15 (11:15 PM) to answer call light and found resident not breathing. Supervisors were notified and immediately initiated rescue breathing."

5/31/19-11:17 PM - A Nursing Progress note stated, "This writer was alerted to come to R3's room immediately...Resident's color is pale. Resident has a pulse but no measurable respirations. Rescue breathing initiated with BVM. Pulse Ox went from 50% - 97 %...".

Per a doctor's order and the POA's permission, R3 was transferred to the hospital ER for evaluation and treatment.

6/1/19 - The hospital ER physician's record stated, "Respiratory arrest stabilized enroute with bag valve mask. BiPAP initiation on arrival for comfort only...Resident's VBG/Venous Blood Gas

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F 695	Continued From page 12	F 695		

laboratory report was consistent with respiratory acidosis and lactic acidosis, unclear if due to hypoxia or underlying infection...improvement in mental status with BiPAP, patient opening eyes...".

6/4/19 - A written statement by E4 (LPN) revealed, "On 5/31/19, I was the nurse on (Name of unit) for 11-7 shift. I entered the building at 2300 (11:00 pm). I received report and counted narcs (narcotic drugs) with two nurses. After receiving report, I sat down at the nurses station. I seen (sic) the call bell for (R3's room number) ringing at the nurses station, answered the bell and found resident not responding. Prior to report, I did not see the resident's call bell ringing. Upon discovering resident had no respirations, supervisors were alerted, rescue breathing initiated and 911 activated."

7/9/19 at approximately 3:30 PM - Interview with R3 revealed the following sequence of events: R3 stated that
"approximately after 10:30 PM that night and I believed before 11:00 PM, the end of the hose (tube) fell off from the mask and fell against the blanket. As soon as the hose slipped off, I kicked the call button, (tapped with foot) and turned the call light on before the alarm sounded. Alarm went off 2 times and stopped. My last memory was trying to kick the blanket off to cause the hose to fall on the floor. I hoped that would get the alarm going. It took forever service (sic) to respond. I passed out before they (staff) came." According to R3, the pressure of air on the tube against the blanket is similar to breathing and caused the alarm to stop.

7/15/19 at approximately 1:00 PM, Surveyor 1

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F 695	Continued From page 13 and E11 (RRT) tested the alarm system of the Trilogy 100 AVAPS ventilator, for volume sounds at it's highest setting with R3's door closed. It was determined that the ventilator alarm sound could be heard when standing near R3's entry door. The ventilator alarm could not be heard at all when standing in the hallway further away from the resident's door. The facility failed to ensure that R3's Trilogy 100 AVAPS ventilator alarm was able to be heard by staff members up and down the unit's hallway. Additionally, R3 stated to the surveyor and E11, that he/she wanted the door closed at all times for 2 reasons: to confine the humidifier mist to the room, and to prevent wandering residents from entering his/her room. 7/16/19 to 7/17/19 - Four (4) CNAs (E5, E6, E7, E8) and 3 LPNs (E4, E9, E10) who worked in the unit where R3 resides were interviewed. It was revealed that the Trilogy 100 AVAPS alarm could be heard when standing next to R3's door, but it was not loud enough to be heard when further away from the door or down the hallway. In addition, the call light above R3's door could not be seen from the other areas of the unit or from the nursing station. The call light sounds could be heard from the nursing station via a call light panel that identified the room number where the call was coming from. However, the staff had to be inside the nursing station to see it. 7/17/19 at approximately 11:30 AM - Surveyor 1 (RN) and Surveyor 2 (EHS) observed the call light on R3's room. The call light above R3's door was not visible on the other areas of the unit. The door frame above the door leading to the hallway blocked R3's call bell overhead light from being seen from the nurse's station. The call light sounds could be heard from the nursing station	F 695		

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F 695	Continued From page 14 via a call light panel that showed the room number where the call was coming from. However, the light above R3's room could not be seen outside of the nursing station and from other areas of the unit. Review of facility provided training sign in sheets for licensed nursing staff revealed that there was no training completed for use of the Trilogy 100 AVAPS, nor any competencies completed in 2017 or 2018. In 2019, training records revealed that a total of seven (7) nurses received training on the Trilogy 100 AVAPS, however, there had not been any competencies completed. The facility failed to ensure for R3, who required the non-invasive Trilogy 100 AVAPS, as a life saving respiratory device, that care was provided consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. The facility failed to ensure a system of continuous monitoring was in place for R3 and the Trilogy 100 AVAPS ventilator for signs of respiratory compromise to ensure R3's safety. 8/8/19 3:20 PM - A meeting was held with E1 (NHA) and E2 (DON) and the survey team. The survey team informed the facility that an Immediate Jeopardy was identified involving R3 and the facility's failure to ensure continuous monitoring of R3 and the Trilogy 100 AVAPS ventilator. 8/8/19 6:00 PM - The facility submitted an abatement plan to the survey team. A remote alarm was installed at the nurse's station on R3's unit. The remote alarm was connected to the Trilogy 100 AVAPS ventilator and when triggered	F 695		

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F 695	Continued From page 15 could be heard throughout the unit. Additionally, the remote alarm flashed with a red light at the nurse's station. The facility also inserviced nursing staff and other auxiliary staff on the remote alarm from the 7-3 PM and 3-11 PM shift from that day. The evening supervisor was to train the night supervisor and then both would train the night shift staff. Training would be ongoing until 100% was achieved. The Immediate Jeopardy was abated on 8/8/19 at 7:30 PM. 8/13/19 3:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 695		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712		8/23/19

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F 712	Continued From page 16 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that alternating required personal visits (at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter) were made by the physician for two (R1 and R3) out of three (3) sampled residents. Findings include: 1. R3 was admitted to the facility on 2/7/17. Review of R3's clinical record revealed that provider visits (MD or NP) were completed as follows: 2/21/19 - A 60 day review visit was completed by E13 (MD). 2/26/19 - A visit for an insect bite/rash was completed by E14 (NP). 3/14/19 - A visit for recurrent UTI symptoms was completed by E14 (NP). 4/25/19 and 5/30/19 - A follow up for recurrent UTI symptoms and a review of chronic conditions was completed by E14 (NP). 7/17/19 - A visit for a left upper extremity rash was completed by E15 (NP). Review of physician notes revealed that as of 8/13/19, the physician's last personal visit with R3 was on 2/21/19. The next required 60 day visit was completed by E14 (NP) on 4/25/19. The next required 60 day visit should have been completed by E13 (MD) near the end of 6/19. The facility failed to ensure that alternating required visits were completed by the physician.	F 712	A. The deficient practice was not able to be corrected upon discovery due to past time of occurrence. B. A whole house audit of Physician visits was completed to ensure that the alternating NP to MD visit schedule was correct moving forward. C. The DON/designee provided education to the Physicians and NPs to ensure compliance with the alternating NP to MD visit schedule. D. The DON/designee will complete a random audit on 10 residents' monthly for six months until 100% compliance is achieved. Result of the audit will be brought to the QAPI steering committee for further evaluation or recommendation.	

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F 712	Continued From page 17 8/12/19 approximately 5:00 PM - Findings were reviewed with E2 (DON). 8/13/19 3:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON), at which time there was no additional information provided to the surveyors. 2. Review of R1's clinical record revealed the following: 8/2/18 - R1 was admitted to the facility for long term care. 8/3/18 - R1 was seen for a history and physical by E11 (MD). 8/21/18 - On the first 30 day required visit after admission to the facility, R1 was seen for a follow-up of tracheitis and a review of chronic conditions by E12 (NP). 10/1/18 - On the second 30 day required visit after admission to the facility, R1 was seen for odorous trach secretions and a review of chronic conditions by E12 (NP). Despite R1 being seen by E12 (NP), the facility failed to ensure that R1 was seen by E11 (MD) on the second 30 day required visit as per the Federal Regulation §483.30(c)(1) . 11/8/18 - On the third 30 day required visit after admission to the facility, R1 was seen for a dislodged trach and a review of chronic conditions by E12 (NP). 8/12/19 at approx. 4:44 PM - Finding was reviewed with E2 (DON). The facility failed to	F 712		

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F 712	Continued From page 18 ensure that R1 was seen by E12 (MD) on the second 30 day required visit after admission to the facility. 8/13/19 at 3:30 PM - Finding was reviewed during the Exit Conference with E1 (NHA) and E2 (DON).	F 712		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		8/23/19

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F 726	Continued From page 19 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of facility training records, competency testing, and staff interviews, it was determined that the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for one (R3) out of three (3) residents sampled. The facility failed to ensure that initial training and subsequent annual training was conducted with licensed nursing staff on the use of R3's Trilogy 100 AVAPS (Average Volume Assured Pressure Support), a non-invasive portable ventilator. Findings include: Cross refer F695 The Facility Assessment, last reviewed 10/19/18, identified one resident in the facility with an AVAP ventilator. The Facility Assessment stated, "...Ongoing audits and data analysis are an essential part of our Quality Assurance Performance Improvement Program and may lead to ad hoc competencies and in servicing:...Specialized care - ...ventilator care...". 1/6/17 - An agreement for Respiratory Services was entered into by the facility and a private contractor. One of the services listed was	F 726	A. The deficient practice was not able to be corrected upon discovery due to past time of occurrence. B. No other areas of training affected. C. The Respiratory Therapist/designee provided all nurses with education and competency was assessed for the use of the AVAP. All newly hired nursing staff will be educated/competency assessed for the use of the AVAP. AVAP education and competency testing will be conducted on an annual basis. D. The DON/designee will complete a bi-weekly audit x three months until 100% compliance is achieved. Result of the audit will be brought to the QAPI steering committee for further evaluation or recommendation.	

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F 726	Continued From page 20 respiratory in-servicing of staff for an additional fee. 2/7/17 - R3 was admitted to the facility with diagnoses that included ALS. R3 required use of a Trilogy 100 AVAPS ventilator. 2/7/17 through 12/31/17 - Review of training records provided by the facility lacked evidence of any training or check of competencies with the licensed nursing staff on the Trilogy 100 AVAPS ventilator. 1/1/18 through 12/31/18 - Review of training records provided by the facility lacked evidence of any training or check of competencies with the licensed nursing staff on the Trilogy 100 AVAPS ventilator. 5/15/19 - Review of training records provided by the facility revealed that an inservice was completed with licensed nursing staff on BiPAP, CPAP, nebulizers (portable machine used to convert medication into an aerosol mist), and breath sounds. Additionally, an in-service post test was completed by each nurse to test for competency. There was no evidence that any training or competency checks were completed for the Trilogy 100 AVAPS ventilator. 5/30/19 - Two (2) in-service attendance sign in sheets for the same training session were provided to two (2) different surveyors. Signatures of the attendees were the same on both sign in sheets. However, one of the sheets stated under inservice overview, "O2, Pulse Oximetry, CPT, Advanced devices." The second sign in sheet stated the same, plus had "...Trilogy..." added in a different handwriting. Review revealed that	F 726		

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F 726	Continued From page 21 although there was a post test completed on the other portions of the training, there was no post test or competency check for the Trilogy 100 AVAPS. 6/18/19 - An agreement renewal for Respiratory Services was entered into by the facility and a private contractor. The respiratory services included in-service/competency testing for an additional fee. 8/13/19 approximately 12:26 PM - During an interview, E2 (DON) stated that he/she spoke with the respiratory services Director and was told that there had not been any training completed by them in the facility in 2017. E2 confirmed that there was no training or competency completed on the Trilogy 100 AVAPS in 2018 or on 5/15/19. E2 also confirmed that on the 5/30/19 2:30 PM and 3:30 PM training sign in sheets, "Trilogy" was entered on one sheet but not the other and there were no competencies completed for the Trilogy 100 AVAPS. E2 stated that according to the Respiratory Services Director, they had "just started" doing competencies for the Trilogy 100 AVAPS. 8/13/19 approximately 3:00 PM - Interview with E1 (NHA) revealed that although the facility had a contract with the respiratory services provider, the services were an "as needed" basis in 2017 and 2018. E1 stated that in 2019, a regular schedule was established. The facility failed to ensure that initial training and subsequent annual training was conducted with licensed nursing staff on the use of R3's Trilogy 100 AVAPS (Average Volume Assured Pressure Support), a non-invasive portable ventilator.	F 726		

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F 726	Continued From page 22 8/13/19 approximately 3:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON).	F 726		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) process failed to identify an issue and failed to implement corrective action after the 5/31/19 incident with R3's Trilogy 100 AVAPS, a non-invasive ventilator. The issue was identified and brought to the facility's attention by a surveyor on 7/18/19. Findings include: Cross refer to F695 Review of R3's clinical record revealed: 2/6/17 - R3 was admitted to the facility with a diagnosis of ALS and required a non-invasive ventilator, the Trilogy 100 AVAPS for breathing assistance. The Trilogy 100 AVAPS device had a built in alarm system to alert staff when disconnections occur. The built in alarm was audible from the device only and could be heard within a limited area as R3 preferred to keep the door closed.	F 867	A. Deficient practice was unable to be corrected due to having past the time of occurrence. B. Any hospitalization or occurrence of incidents will be reviewed daily with the interdisciplinary team meeting to determine if QA review is appropriate. C. The NHA provided the interdisciplinary team education on the process of QAPI/QAA improvement activities. D. The NHA/designee will complete a monthly audit of the daily interdisciplinary meetings x three months to ensure 100% compliance is achieved. Result of the audit will be brought to the QAPI steering committee for further evaluation or recommendation.	8/23/19

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F 867	Continued From page 23 5/31/19 at 11:15 PM - A nurse's note stated, "nurse (E4, LPN) entered room at 23:15 (11:15 PM) to answer call light and found resident not breathing (respiratory arrest). Supervisors were notified and immediately initiated rescue breathing." 5/31/19 - R3 was emergently transferred to the hospital for respiratory arrest. 7/9/19 at approx. 3:30 PM - During an interview, R3 stated, "Approximately after 10:30 PM that night (5/31/19) and I believed before 11:00 PM, the end of the hose (tube) fell off the mask and fell against the blanket. As soon as the hose slipped off, I kicked the call button (tapped with foot), and turned the call light on before the alarm sounded. Alarm went off 2 times and stopped...". 8/13/19 at approx. 3 PM - During a combined interview, E1 (NHA) and E2 (DON) were asked if the facility's QAPI program identified and corrected any quality deficiencies after the 5/31/19 incident with R3's Trilogy 100 AVAPS device. E1 stated that the facility's QAPI Committee reviewed R3's 5/31/19 incident as an acute hospitalization for respiratory distress and no issues were identified. 8/13/19 at 3:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). The facility's QAPI process failed to identify an issue and implement corrective action after the 5/31/19 incident with R3's Trilogy 100 AVAPS mask/tube disconnection when there was an absence of an audible continuous monitoring system in place so that nursing staff were immediately alerted when the disconnection occurred. The issue was identified and brought to the facility's attention by a	F 867		

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F 867	Continued From page 24 surveyor on 7/18/19.	F 867		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility failed to ensure that the facility was adequately equipped to ensure one (R3) resident with disabilities, out of 3 sampled residents to call for assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. While the facility had a call bell system in place for R3 and an audible alarm could be heard if staff were at the nursing station control box, the system failed in that R3's light was unable to be seen by staff from the nursing station and other areas of the unit. Findings include: Cross refer to F695 Review of R3's clinical record revealed: R3 was admitted to the facility on 2/6/17 with diagnoses that included ALS (Amyotropic Lateral Sclerosis) and Panic Disorder. R3 used a life saving respiratory device/ventilator, the Trilogy 100 AVAPS with a humidifier and a connecting	F 919	A. R3's call bell was not visible from the nurse's station. Staff had to be at the nurses' station to see that R3's call bell was activated on the call bell panel. B. A secondary remote alarming device has been installed at the nursing station to allow for both visual and audible continuous monitoring of the AVAPS functionality on 8/8/2019. The secondary remote alarm will both visually and audible alert the staff that the AVAP has entered an alarm condition, which would require nursing staff intervention. The DON/designee has educated all nursing staff on the functionality and response to the secondary alarm. A whole house call bell system audit was also completed on 8/15/2019 and education was provided to nursing staff on how to both visually and audibly check for call bells, as well as prioritization of call bells for residents who experience respiratory compromise.	8/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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
F 919	Continued From page 25 alarm system to detect a circuit disconnect condition. According to the 5/7/19 Quarterly MDS assessment, R3's cognition/mental status was intact, however, R3 was totally dependent/total assistance of 2 person/staff for activities of daily living, such as bathing. R3 was non-verbal due to ALS. Additionally, R3 had virtually no movements from the neck down and had a tap call pad clipped to the pillow by his/her feet that he/she used to activate the call light for assistance. 5/26/17 - R3 used "Eyegaze" technology via the resident's laptop for communication (must be out of bed to recliner to utilize the laptop). 6/3/19 - E1 (NHA), E2 (DON) and R3's parents had a meeting that included the family's concern that R3's "visual call alert system is compromised from the nurse's station". The facility's implemented action was that an additional call bell system test was conducted after the meeting and " both visual and audible functionality were within normal functional limits. Staff to be in-serviced on call bell response prioritization for residents with respiratory concerns". However, the facility had no action in place for how R3's call bell light would be immediately visible to staff members or to a centralized staff work area and immediately relay the call, without having to go inside the unit's nursing station. 6/4/19 - A written statement by E4 (LPN) revealed, "On 5/31/19, I was the nurse on (Name of unit) for 11-7 shift. I entered the building at 2300 (11:00 PM). I received report and counted	F 919	C. The secondary remote alarm will be checked every shift to ensure functionality by nursing staff and documented in the medical record. Whole house monthly call bell audits were also completed to ensure proper functioning, and will continue monthly by the Maintenance director/designee D. Secondary remote alarm audits will be completed by the DON/designee to ensure proper secondary remote alarm functionality daily until 100% compliance is met x 3 weeks. Then will be monitored for compliance 3 x week for 3 weeks. Then monitored once a month for 100% compliance x three months. Results of the audits will be reviewed and any issues identified immediately corrected. Results of the audit will be brought to the facility QAPI meeting for further evaluation and recommendations. Whole house call bell audits will be completed by the Maintenance Director/designee to ensure proper functionality monthly until 100% compliance is met and will continue on a monthly basis as preventative maintenance. Results of the audits will be reviewed and any issues identified immediately corrected. Results of the audit will be brought to the facility QAPI meeting for further evaluation and recommendations.	

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F 919	Continued From page 26 narcs (narcotic drugs) with two nurses. After receiving report, I sat down at the nurses station. I seen (sic) the call bell for (R3's room number) ringing at the nurses station, answered the bell and found resident not responding. Prior to report, I did not see the resident's call bell ringing. Upon discovering resident had no respirations, supervisors were alerted, rescue breathing initiated and 911 activated." 7/16/19-7/17/19 - 4 CNAS (E5, E6, E7, E8) and 3 LPNs (E4, E9, E10) who worked and were familiar with the unit where R3 resided were interviewed. The interviews confirmed the following: -The call light above R3's door could not be seen from the other areas of the unit, and from the nursing station. The wall beam above the entrance to R3's hallway door blocked the view of the call light. -The call light sounds could be heard from the nursing station via a call light panel that identified the room number of the triggered call light, but only if a staff member was at the nursing station to see it. Surveyor observations revealed the following: -The call light above R3's door was not directly visible to staff and could not be seen from the other sections of the unit, including the area by the nurses station when triggered. A wall/ceiling beam blocked the view of R3's lit call light. -The call light sounds could be heard from the nursing station via a call light panel that identified R3's room number, but, only if a staff member was at the nursing station to see it. -Additionally, R3's Trilogy 100 AVAPS ventilator	F 919		

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F 919	Continued From page 27 alarm system sounds could only be heard when standing outside of R3's bedroom door (kept closed all the time per R3's request); the alarm was not loud enough to be heard when away from R3's door and in all of the other areas of the unit. While the facility had a call bell system in place for R3 and an audible alarm could be heard if staff were at the nursing station control box, the system failed in that R3's light was unable to be seen by staff from the nursing station and other areas of the unit. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 7/18/19 at approximately 11:45 AM.	F 919		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights Healthcare & Rehab. Center DATE SURVEY COMPLETED: August 13, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint and extended survey was conducted at this facility from July 8, 2019 through August 13, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 166. The survey sample totaled 3 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed August 13,**	Cross Refer to the CMS 2567-L survey completed August 13, 2019, F657 F695 F712 F726 F867 F919	8/23/19

Provider's Signature _____ Title NHA Date 8/23/19

NAME OF FACILITY: Regal Heights Healthcare & Rehab. Center DATE SURVEY COMPLETED: August 13, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	2019, F657, F695, F712, F726,F867, and F919.		
3201.9.	**Reportable Incidents**		
3201.9.8	**Significant Injuries**		
3201.9.8.4.6	**Any serious unusual and/or life-threatening injury.**		
	Based on record review and interview, the facility failed to immediately and/or report an incident that was serious unusual life-threatening injury for one (R3) out of 3 sampled residents within 8 hours of the occurrence of the incident to the Division of Health Care Quality, office of the Division of Long Term Care Residents Protection. Findings include:		
	Review of R3's clinical record and facility documents revealed: R3 was admitted to the facility on 2/6/17 with diagnoses that included ALS and required the use of a life saving device AVAPS with humidifier and connecting alarm system device to detect a circuit disconnect. R3's cognition/mental status was intact. R3 was also totally dependent and needed assistance of 2 person/staff for all of activities of daily living. R3 had impaired verbal communication and used an "Eyegaze" technology via resident's laptop. R3 had virtually no movements from neck down, and had a tap call pad clipped to the pillow by this resident's foot and used to activate the call light for assistance.		

Provider's Signature _____ Title NHA Date 8/23/19

NAME OF FACILITY: Regal Heights Healthcare & Rehab. Center DATE SURVEY COMPLETED: August 13, 2019

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	On 5/31/19 a nursing progress note stated that E4 (LPN) at 23:15 PM (time) entered R3's room to answer call light and found resident not breathing (respiratory arrest). Supervisors were notified and immediately initiated rescue breathing. R3's pulse Ox went from 50% oxygen saturation to 97 %. R3's heart rate remained tachycardic until 911 arrived. R3 was administered Morphine drip for comfort and used of BiPAP to improve mental status. Interview with R3 on 7/9/19 at 3:30 PM revealed that at approximately 10:30 PM and "I believed before 11:00 PM", the end of the hose (oxygen tube) from his/her mask fell off and fell against the blanket. As soon as the "hose" slipped off, R3 kicked the call button to turn the call light on before the alarm sounded. (Alarm sounded 2 x and stopped). Before R3 passed out, his/her last memory was trying to kick the blanket off (per R3, pressure of air against the blanket is similar to breathing) to cause the hose to fall on the floor and hope that would get the alarm going. Interview with E2 (DON) on 7/10/19 at 12:08 PM revealed that investigation of the incident was initiated. However, review of the investigation documentation lacked documented evidence that R3 was interviewed related to the incident		

Provider's Signature _____ Title NHA Date 8/23/19

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	occurrences. Additionally, the facility failed to recognized and identified that R3's incident was serious and life threatening with significant injury and therefore, was reportable. The facility failed to report R3's incident dated 5/31/19 that was serious, unusual and life-threatening with significant injury, to the State Agency, the office of the Division of Long Term Care Residents Protection. Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference on 7/18/19 at 11:45 AM.	A. Deficient practice was unable to be corrected due to having past the time of occurence. B. No other incidents were affected. C. The nursing Supervisors were educated on the criteria for reporting incidents to the Division of long term care. D. The DON/designee will complete a weekly audit of all incidents X Three weeks then monthly X3 months to ensure 100% compliance is achieved. Result of the audit will be known to QAPI steering committee for further evaluation or recommendation.	8/23/19

Provider's Signature _____ Title NHA Date 8/23/19