DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	s0196	A. BUILDING: _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE	100 VILLAGE VIEW CIRCLE WILLIAMSBURG, IA 52361

(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) COMPLETE DATE
A 000	Initial Comments Assisted living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 44 Number of tenants with cognitive disorder: 1 TOTAL census of Assisted Living Program: 45 The investigation of Incident #102538-I and the recertification visit conducted to determine compliance with certification for an Assisted Living Program were completed. The following regulatory insufficiencies were cited:	A 000	POC attached ok 4-22-22	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure regarding narcotic medication. This pertained to 1 of 1 tenant reviewed with missing medication (Tenant #1). Findings follow: 1. Record review on 3-21-22 of an Resident Occurrence Report indicated on 1-19-22 at 7:35 a.m. it was determined Tenant #1 had four tablets of Tramadol missing. Continued record review revealed the Program's Investigation Form indicated at 7:35 a.m. on 1-19-22 the Clinical Administrator was informed Tenant #1's bubblepack was missing four tablets of Tramadol. An internal investigation was	A 150		

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A 150	Continued From page 1 initiated and interviews were completed with staff that provided services to Tenant #1 on 1-18-22 and 1-19-22. Tenant #1 was also interviewed and law enforcement was notified. The Program's investigation did not reveal an alleged perpetrator and Tenant #1 did not sustain any injury. The correction action indicated as of 1-20-22 a nurse would set up one Tramadol tablet in a sealed envelope, with one envelope for each day of the week. The bubblepack was kept double locked in the medication cart in the nurses office. Staff that administered would only have access to the weekly envelopes and not the bubblepack. A Controlled Medication Record for PRN or Scheduled Narcotics document would be in each medication administration record (MAR) to sign out narcotics. The staff administering the medications would call the second staff on duty to verify the count and to cosign the sheet for the accurate count. If staff was working alone, staff would call the on-call nurse and provide the current count, how many were given and how many remained. The nurse would cosign when she was back in the building. 2. When interviewed on 3-22-22 at 3:49 p.m. and 3-23-22 at 10:55 a.m. the Clinical Administrator said on 1-20-22 it was decided to limit access in the medication cabinet Tenant #1's apartment. Nurse #1 set up one Tramadol tablet in a small, sealed envelope (for each day of the week). When staff administered the medication they called a second staff to verify and they cosigned the sheet. When there was not a second staff on duty, staff called the on-call nurse, gave a verbal count over the phone and the nurse cosigned the count when she came into the building. Staff did not count shift to shift. The lead aide (medication passer) had a key to the medication cabinets in the apartments and the bath aide (second staff)	A 150		

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A 150	Continued From page 2	A 150		

had a key to the medication cabinets. The Clinical Administrator and Nurse #1 also had a key to the medication cabinets. When the bath aide's keys were not being used they were stored in the office behind a locked door.

When interviewed on 3-23-22 at 10:15 a.m. Nurse #1 confirmed after the missing Tramadol, Tenant #1's Tramadol was set up from the bubblepack into envelopes every seven days. When the medication was administered staff called another staff to sign it out. If there was not another staff they called the nurse and the nurse would sign on Monday.

3. Record review on 3-21-22 of Tenant #1's file revealed the January, February and March MARs reflected an order for Tramadol 50 milligram (mg), take one tablet, orally, daily. It also reflected the use of a Controlled Medication Record PRN or Scheduled Narcotics document for Tenant #1, which was started on 1-20-22. The document reflected the medication was Tramadol 50 mg, one tablet, orally daily. It provided date, time, current count prior to administration, the amount administered and the amount that remained. It also provided spaces for two signatures, the first and second signatures.

4. Record review revealed the Program's Medication Management Diversion Prevention Policy indicated the unlicensed staff count procedure for controlled substances (schedule II) indicated medication keys that allowed access to controlled substances would be kept secured. Medication counts would be verified with two staff members. If there was only one staff on duty, the count would be completed at the next shift change with two staff. After the supply was counted and reconciled, staff would record initials

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A 150	Continued From page 3 on the MAR. 5. In summary, Tenant #1 had four missing Tramadol tablets noted on 1-19-22. At that time her medications were administered from a bubblepack and stored in her locked medication cupboard. After the discovery of missing Tramadol tablets, the Program provided corrective action, which included Tenant #1's Tramadol would be place in individual sealed enveloped (one tablet for one day; weekly). Staff completed a narcotic sign out sheet when it was administered and another staff cosigned the record. If a second staff was not scheduled staff called the on-call nurse, a verbal count was completed and the nurse cosigned upon her return to the building. The Program did not follow the policy and procedure related to their medication diversion prevention policy. Based on interview and record review the Program failed to follow its policy and procedure related to medication administration. This pertained to 2 of 2 tenants reviewed that received staff assistance with medication administration (Tenants #1 and #3). Findings follow: 1. Record review on 3-21-22 of Tenant #1's file revealed an order was received to change Tenant #1's Tramadol as needed at night to Tramadol scheduled daily at bedtime dated 9-7-21. The document indicated Tenant #1 was taking her as needed Tramadol every night and she reported it helped her sleep throughout the night. Continued record review revealed January, February and March 2022 MARs reflected Tramadol 50 mg, take one tablet, orally once per day. Staff initiated the administration of the medications at 8:00 a.m. The order as indicated	A 150		

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A 150	Continued From page 4 above for Tramadol reflected Tramadol 50 mg, take one tablet at bedtime. 2. Record review on 3-22-22 of Tenant #3's file reviewed a New Prescription Summary document indicated a new order for Tramadol HCl 100 mg, take one tablet, three times daily as needed for pain dated 8-17-21. A Physician Order Form from the pharmacy reflected current orders dated 1-26-22. The orders did not reflect an order for Tramadol HCl 100 mg, take one tablet, three times daily as needed for pain. Review of Tenant #3's file did not reflect a discontinue order for the medication. The February and March 2022 MARs did not reflect an order for the Tramadol three times daily as needed. 3. Record review of the Program's Iowa Medication Management Policy indicated physician orders would be obtained for all medications to be administered. Physician orders would be received upon admission, with a change in orders, with a change in condition and annually. 4. When interviewed on 3-22-22 at approximately 1:50 p.m. and 3-23-22 at approximately 3:23 p.m. the Clinical Administrator confirmed an order was not found related to the time change of Tenant #1's Tramadol from bedtime to morning. She said a discontinue order was not found for Tenant #3's as needed Tramadol.	A 150		
A 290	481-69.25(1)i Tenant Documents	A 290		

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A 290	Continued From page 5 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 2 of 4 tenants reviewed (Tenants #1 and #3). Findings follow: 1. Record review on 3-21-22 of Tenant #1's file revealed Tenant #1's service plan dated 8-3-21 reflected it was updated on 11-18-21 to reflect Tenant #1's medications were set up in a bubblepack by a pharmacy. Tenant #1 had previously had medications set up in a planner. Medications sent in bottles would set up in a seven day planner by a nurse until the stock of the bottles was gone. On 1-20-22 another update was made to the service plan that reflected Tenant #1's Tramadol would be set up in small envelope, one tablet for each day. The bubblepack would be stored (double locked) in the office medication cart. A controlled count sheet was to be signed off with two staff signatures with each administration. Continued record review revealed nurse's notes did not reflect entries related to the 11-18-21 and 1-20-22 changes to the service plan. Nurse's notes were not documented by exception, including a change of pharmacy and medication	A 290		

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A 290	Continued From page 6 set up (11-18-21) and with a change in storage and documentation of Tenant #1's Tramadol medication (1-20-22). 2. Record review on 3-22-22 of Tenant #3's file revealed cellulitis (resolved on the legs) and morbid (severe) obesity. -A New Prescription Summary document dated 8-2-21 indicated a new order was received for Combine ABD 5"x 9" pad and to use for the dressing daily. -A New Prescription Summary document dated 8-2-21 indicated a new order was received for Silver Sulfadiazine 1% external cream, apply to the affected areas one or two times daily. -A New Prescription Summary document dated 8-17-21 indicated a new order was received for Tramadol HCl 100 mg, take three times daily as needed for pain. Continued record review revealed After Visit Summary document indicated Tenant #3 was seen on 9-3-21 for a venous stasis ulcer of the right calf and left calf (limited to breakdown of the skin) and yeast dermatitis. Orders were received related to the yeast in the abdominal folds, axilla and under breast to cleanse folds two to three times daily with mild soap and water, dry and apply Nystatin powder. Interdry could be be used with the powder. Orders were also received to wash her legs well with soap and water daily, wear compression socks and wraps to legs when she was out of bed, moisturize legs twice daily and as needed and apply Mepilex AG to the open areas to the legs until healed. Further record review revealed the Resident	A 290		

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A 290	Continued From page 7 Notes indicated the following: -On 7-6-21 it was not the primary care provider (PCP) was notified of Tenant #3's bilateral lower extremities that were red and warm to the touch. There were blisters forming over the lower legs. Some of the blisters were scratched open and other blisters remained intact. Tenant #3 had just completed antibiotics for cellulitis on 6-7-21. The PCP did not want to start another round of antibiotics but did want her sent to a wound clinic. -On 7-27-21 it was noted Tenant #3's bilateral lower extremities (BLE) were "mildly reddened, dry crusted serous fluid covers blisters that had been weeping." The skin was cleansed with normal saline and padded dry. Telfa pads were placed over the open areas and were secured with gauze. A second fax was sent to the PCP regarding a different treatment to the open blisters and scheduling at a local wound clinic. -On 9-24-21 it was noted a 90 day assessment was completed. Tenant #3 had been treated at a wound clinic on Fridays for cellulitis and ulceration on her BLE. Tenant #3 had 1-2+ edema in her BLE and wore tubigrips. Her legs had improved with the wound care treatment. Tenant #3 had yeast infections in her abdominal folds, thighs and under her armpits and topical medications were ordered. Continued record review revealed nurse's notes were not documented by exception for Tenant #3 with new medication and treatment orders, with updated status of Tenant #3's skin and ulcerations and with the initiation of a wound clinic visit and when wound clinic visits were discontinued.	A 290		

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A 290	Continued From page 8 3. When interviewed on 3-23-22 at approximately 3:23 p.m. the Clinical Administrator confirmed all nurse's notes were provided for the tenants listed above.	A 290		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the identified needs of the tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3 and #4). Findings follow: 1. Record review on 3-21-22 of Tenant #1's file revealed MD Orders document noted on 8-31-21 reflected Tenant #1 used a continuous positive airway pressure (CPAP) machine. The service plan dated 8-3-21 failed to include his use of a CPAP and assistance needed related to the treatment. 2. Record review on 3-21-22 of Tenant #2's file revealed Resident Notes indicated the following: -On 1-20-22 it was noted Tenant #2 fell in his apartment, getting out of his chair. Three maintenance staff assisted Tenant #2 back into this chair.	A 395		

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A 395	Continued From page 9 -On 2-17-22 (late entry for 2-15-22) it was noted Tenant #2 fell in bedroom and his spouse called for maintenance staff to assist him in getting up from the floor. -On 2-21-22 it was noted Tenant #2 slid off the chair onto the floor. Staff was instructed to call 911 to assist in getting Tenant #2 up. -On 2-22-22 it was noted Tenant #2 and his spouse reported a fall to staff that had occurred during the night. They had not called anyone to get him up. They worked at it for a long time and were able to get him back to the chair. -On 2-28-22 (late entry for 2-26-22) it was noted Tenant #2 fell after getting up from the toilet. He reported being dizzy when he got up. -On 3-3-22 it was noted a meeting was held with administrative staff and Tenant #2's family regarding him remaining at the Program. He had five falls in February. Tenant #2 could stand only for a brief time and his legs gave out. It was noted he needed a higher level of care. The note indicated his spouse helped him get dressed and pushed him in his wheelchair. It was noted "Unsure if he is showering, or how often she helps him to the bathroom and with transfers." -On 3-14-22 it was noted Tenant #2 was found on the floor with his back against the recliner. Three staff assisted Tenant #2 up off the floor. Continued record review revealed the Commons Functional Assessment dated 9-2-21 (updated 1-14-22) revealed his spouse assisted with incontinence when needed. Further record review revealed the service plan	A 395		

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A 395	Continued From page 10 reflected Tenant #2's history of falls and used a four wheeled walker. The service plan indicated staff escorted Tenant #2 to and from meals. The service plan did not reflect the use of the wheelchair, except for evacuation purposes. The service plan also did not include Tenant #2's weakness and the interventions related to his falls. The service plan failed to reflect his spouse assisted with personal cares. 3. Record review on 3-22-22 of Tenant #3's file revealed cellulitis (resolved on the legs) and morbid (severe) obesity. A 30 Day and Quarterly Nurse Review document dated 12-22-21 indicated Tenant #3 was able to self toilet but would not flush the toilet. It also indicated Tenant #3 lacked motivation to move and that Tenant #3 had compression hose but did not like to wear them. An MD Orders document noted on 7-16-21 reflected an order for Calmoseptine, apply ointment to the abdominal folds and coccyx area twice daily with an order date of 1-25-21. The document indicated Tenant #3 was independent getting dressed in the morning but required assistance at bedtime. Tenant #3 lacked motivation to complete her activities of daily living on her own. When staff assisted her with bathing she "makes no effort to wash any of her body parts she is able to reach." Tenant #3 ate her meals in her apartment daily. Tenant #3 had a yeast infection under her abdominal folds, between her thighs and in her arm pits and topical medications were ordered. Continued record review revealed Resident Notes indicated the following:	A 395		

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A 395	Continued From page 11 -On 7-6-21 it was not the primary care provider (PCP) was notified of Tenant #3's bilateral lower extremities that were red and warm to the touch There were blisters forming over the lower legs. Some of the blisters were scratched open and other blisters remained intact. Tenant #3 had just completed antibiotics for cellulitis on 6-7-21. The PCP did not want to start another round of antibiotics but did want her sent to a wound clinic. -On 7-27-21 it was noted Tenant #3's bilateral lower extremities (BLE) were "mildly reddened, dry crusted serous fluid covers blisters that had been weeping." The skin was cleansed with normal saline and padded dry. Telfa pads were placed over the open areas and were secured with gauze. A second fax was sent to the PCP regarding treatment to the open blisters and scheduling at a local wound clinic. -On 9-24-21 it was noted a 90 day assessment was completed. The entry indicated Tenant #3 was not motivated to move from her recliner and had all meals in her apartment. She ambulated one to two times per day to the bathroom. Staff provided showers twice weekly but Tenant #3 did not assist with washing areas she could reach. She required assistance of both upper and lower body dressing and putting her protective undergarment and products on over her feet. Tenant #3 slept in her recliner and asked the staff to assist in minor chores for her. Tenant #3 had been treated at a wound clinic on Fridays for cellulitis and ulceration on her BLE. Tenant #3 had 1-2+ edema in her BLE and wore tubigrips. Her legs had improved with the wound care treatment. Tenant #3 had yeast infections in her abdominal folds, thighs and under her armpits and topical medications were ordered.	A 395		

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A 395	Continued From page 12 Further record review revealed After Visit Summary document indicated Tenant #3 was seen on 9-3-21 for a venous stasis ulcer of the right calf and left calf (limited to breakdown of the skin) and yeast dermatitis. Orders were received related to the yeast in the abdominal folds, axilla and under breast to cleanse folds two to three times daily with mild soap and water, dry and apply Nystatin powder. Interdry could be be used with the powder. Orders were also received to wash her legs well with soap and water daily, wear compression socks and wraps to legs when she was out of bed, moisturize legs twice daily and as needed and apply Mepilex AG to the open areas to the legs until healed. Continued record review revealed the February and March 2022 medication administration records (MARs) reflected orders for Calmoseptine, apply ointment to abdominal folds and coccyx area twice daily, Eucerin, apply a thin layer to both legs each a.m. and p.m. twice daily, Nystatin topical powder, apply a thin layer of powder, cleanse folds two times daily with soap and water, dry and apply Nystatin powder twice daily. The February and March MARs reflected at times Tenant #3 refused the topical medications and treatments. Service Charting Form from from 2-13-22 to 3-19-22 reflected daily weights were to be completed. The service charting logs reflected Tenant #3 routinely refused the task. The last weight obtained provided by the Program was dated 12-22-21. Further record review revealed the service plan dated 6-28-21 reflected staff assisted Tenant #3 with showers and encouraged her to wash her face and other body parts. The service plan	A 395		

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HIGHLAND RIDGE	100 VILLAGE VIEW CIRCLE WILLIAMSBURG, IA 52361

(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) COMPLETE DATE
A 395	Continued From page 13 regarding grooming was left blank. The grooming category also included dressing, which was also not completed. The service plan indicated she ate her meals in the dining room and received room trays. It also documented she was independent with putting on her own incontinent products. The service plan reflected staff administered creams and ointments and Tenant 3's BLE were edematous, had discolored skin and blisters. The service plan failed to be updated to reflect these needs. 4. Record review on 3-22-22 of Tenant #4's file revealed diagnoses included moderate major depression and generalized anxiety disorder. Resident Notes indicated the following: -On 12-16-21 it was noted Tenant #4 had fallen. -On 12-20-21 it was noted Tenant #4 had fallen and sustained a skin tear. -On 2-21-22 (late entry for 2-19-22) it was noted Tenant #4 called for staff assistance via the pendant and staff observed her sitting in the chair with blood running down her leg into her shoe. She went to the hospital via ambulance and returned with stitches in the left knee. She reported she fell in the laundry room and walked to her apartment before calling staff. She did not have her walker with her and was reminded to use her walker at all times due to her history of falls. Continued record review revealed a MD Visit document dated 10-19-21 reflected orders including: Zoloft 50 mg, offer all activities, orders to have mental heath counseling. A Psychotherapy Intake Notes dated 11-29-21	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	s0196	A. BUILDING: _____ B. WING _____	C 03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE	100 VILLAGE VIEW CIRCLE WILLIAMSBURG, IA 52361

(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) COMPLETE DATE
A 395	Continued From page 14 indicated Tenant #4 moved into the program in August 2021, had been tearful, withdrawn and depressed since she arrived and indicated auditory hallucinations. The Psychotherapy Treatment plan revealed the prescribed frequency of treatment was weekly. A Psychotherapy Treatment Plan document dated 1-28-22 and 2-10-22 indicated the prescribed frequency of treatment was every two weeks. The service plan dated 9-24-21 failed to be updated to include Tenant #4's use of a walker and history of falls. The service plan failed to include her psychotherapy visits to treat her depression and anxiety. 5. When interviewed on 3-23-22 at approximately 3:23 p.m. the Clinical Administrator confirmed all current service plans were provided for the listed above.	A 395		

PLAN OF CORRECTION

This plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary.

In continuing compliance with 481- 67.2(3) Programs Policies and Procedures, Highland Ridge corrected the deficiency as follows:

Date of Compliance 4/22/2022

1. Tenant #1, chart was reviewed. A clarification order for Tramadol was received 4/22/22. On Tenant #3, orders were reviewed and an order received on 4/22/22 to discontinue Tramadol, as Tenant was not using.
2. A review of department policies were reviewed and re-education provided with all staff, including Medication Management Diversion Prevention Policy and Iowa Medication Management policy. A chore was added to staff's Daily Assignment Sheet for count verification to be completed daily. Access to narcotic keys was reviewed, and an adjustment made to the campus routine to limit access to narcotic keys including Clinical Administrator, ALP Nurse and Lead RA who completes medication administration.
3. As part of Highland Ridge's ongoing commitment to quality assurance, the Clinical Administrator will complete audits of medical records monthly to ensure compliance. Audits will also be conducted to assure compliance of daily narcotic count verification. Audits will be conducted for one quarter to ensure ongoing compliance.

In continuing compliance with 481- 69.25(1)i Tenant Documents, Highland Ridge corrected the deficiency as follows:

Date of Compliance 4/22/2022

1. Tenant #1, chart review completed and a note made 4/21/22 regarding medication administration process and Service plan updates. Tenant #3 chart review completed and Nursing Note made on 4/21/22 for clarification of current orders for chronic skin conditions. Program Nurse will continue to conduct a nurse review every 30 days following admission, 90 days, annually and with any change in health status such as requiring PT/OT, increased pain, comments of self-harm or significant change in medication.
2. A review of department policies was done, including Assisted Living Service Plan Policy and IA AL Assessment and Focused Review Policy, was completed by ALP Nurses with Regional Director of Clinical Services(RDC) and re-education on 4/20/2022. An emphasis was made on documenting in the medical record any changes made to the Service Plan based on tenant assessment.
3. As part of Highland Ridge's ongoing commitment to quality assurance, the AL Program Nurse will complete audits of medical records monthly to ensure compliance. Audits will be conducted for one quarter.

In continuing compliance with 481- 69.26(4), Service Plans, Highland Ridge corrected the deficiency as follows:

Date of Compliance 4/22/2022

1. Tenant #1 Service Plan reviewed and updated 4/21/22 to include tenant's independence with her CPAP machine. Tenant #2 discharged from the program 4/1/22. Tenant #3 Service Plan was reviewed on 4/21/22 and updated to include interventions addressing refusals of care, skin treatments, and assistance with bathing and grooming

needs. Tenant #4 Service Plan reviewed 4/21/22 and updated with her needs for mental health services.
2. A review of department policy, Assisted Living Service Plan Policy, was completed by ALP Nurses with RDC on 4/20/2022.
3. As part of Highland Ridge's ongoing commitment to quality assurance, the Program Nurse will complete audits of medical records monthly to ensure compliance. Audits will be conducted for one quarter.