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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165523	A. BUILDING _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF ESTHERVILLE	2001 FIRST AVENUE NORTH ESTHERVILLE, IA 51334

(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 Correction date: 12/24/2024 The following deficiencies resulted from the facility's annual recertification survey and investigation of facility reported incidents #124758-I, and #125255-I, conducted December 9, 2024 to December 12, 20204. Facility reported incident #124758-I was not substantiated. Facility reported incident #125255-I was not substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jenny Acclemm — TITLE: administrator — (X6) DATE: 12/27/24

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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(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State

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Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and policy review the facility failed to notify the Long

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Term Care (LTC) Ombudsman of a transfer to a hospital for 1 of 2 residents (Resident #190) reviewed. The facility reported a census of 36 residents.

Findings include:

Review of Resident #190's Clinical Census in the Electronic Health Record (EHR) revealed Resident #190 had a hospital unpaid leave from 10/30/24 to 11/6/24.

Review of the facility document, Notice of Transfer Form to Long Term Care Ombudsman, for the month of 10/24 revealed there was no notification for the Resident 190's hospitalization beginning on 10/30/24.

During an interview on 12/11/24 at 1:42 PM the Administrator acknowledged Resident #190 was neither on the Discharge Report nor the Notice of Transfer to Long Term Care Ombudsman Report. The Administrator stated the resident had been missed on his transfer to the hospital. The Administrator indicated she completed the Ombudsman notifications.

On 12/12/24 at 8:00 AM the Administrator stated the expectation was for residents transferred to acute hospitals to be on the Ombudsman Report.

The facility policy titled Transfer and/or Discharge, Including Against Medical Advice last revised 10/22 revealed a copy of the transfer or discharge notice should be sent to the Long Term Care Ombudsman and noted in the record.

The facility provided document, The Iowa Health Care Association Protocols for Use and Issuance

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F 623	Continued From page 4 of Nursing Facility Transfer Notices dated 9/19, revealed copies of notices for emergency transfers must be sent to the Ombudsman, but may be included on a monthly summary.	F 623		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		

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regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, staff interviews, and policy review, the facility failed to complete comprehensive assessments within required time frames for 7 of 7 residents (Residents #4, #7, #8, #15, #18, #189, and #190). The facility reported a census of 36.

Findings include:

On 12/10/24 at 9:31 AM, multiple record reviews revealed seven (7) past-due Comprehensive

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Assessments (Minimum Data Sets - MDS) and were documented as follows:
1) Resident #4's MDS included an Assessment Reference Date (ARD - last day of observation period) of 11/04/24 with an in-progress status. It indicated 22 days past due.
2) Resident #7's MDS included an ARD of 10/07/24 with an in-progress status. It indicated 50 days past due.
3) Resident #8's MDS included an ARD of 11/05/24 with an in-progress status. It indicated 22 days past due.
4) Resident #15's MDS included an ARD of 10/14/24 with an in-progress status. It indicated 41 days past due.
5) Resident #18's MDS included an ARD of 10/03/24 with an in-progress status. It indicated 54 days past due.
6) Resident #189's MDS included an ARD of 10/29/24 with an in-progress status. It indicated 28 days past due.
7) Resident #190's MDS included an ARD of 10/03/24 with an in-progress status. It indicated 54 days past due. It also included five (5) other past-due, in-progress MDS assessments with ARDs of 11/06/24, 11/11/24, 11/18/24, and 11/24/24.

The Resident Assessment Instrument (RAI) indicated a resident's MDS assessments must be completed within 14 days from the ARD.

A policy titled "Comprehensive Assessment" revised 08/22 indicated the Assessment Coordinator is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule:
a) Within fourteen (14) days of the resident's

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F 636	Continued From page 7 admission to the facility; b) When there has been a significant change in the resident's condition; c) At least quarterly; and d) Once every twelve (12) months. On 12/12/24 at 8:01 AM, the Administrator stated she expected Comprehensive Assessments to be completed in a timely fashion.	F 636		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:	F 851		

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F 851	Continued From page 8 (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (July 1 - September 30) review, facility staffing reports review, employee time cards review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ	F 851		

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F 851	Continued From page 9 Staffing Data Report. The facility reported a census of 36 residents. Findings include: The PBJ Staffing Data Report with run date 12/4/24 triggered for failing to have licensed nursing coverage 24 hours/day - 4 or more days within the quarter with <24 hours/day licensed nursing coverage with specific infraction dates. The report reflected 7 dates with failure to provide 24 hour/day nursing coverage during August and September. Review of the Nurse Schedule for the infraction dates revealed nursing shifts covered by the Director of Nursing (DON), Staff C, Licensed Practical Nurse (LPN), Staff D, LPN, Staff E, Registered Nurse (RN), Staff F, RN, and Staff G, RN for 7/7 dates. Review of time cards for the infraction dates revealed nursing services were provided for 24 hours/day. On 12/11/24 at 2:19 PM the Business Office Manager (BOM) stated she submitted the missed punches to Weblock, then uploaded them into a folder in Teams and then the Corporation would handle it from there. On 12/12/24 at 8:55 AM the Administrator stated during this quarter July 1 - September 30 their previous Corporation took care of submitting hours to PBJ. The Administrator acknowledged that during this period their own staff hours were not being transferred correctly to be submitted to PBJ and the Corporation was aware of this and looking into it.	F 851		
F 880 SS=D	Infection Prevention & Control	F 880		

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F 880	Continued From page 10 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 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 §483.71 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	F 880		

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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 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 observations, clinical record review, staff interviews, and policy reviews the facility failed to implement appropriate hand hygiene and infection control practices to mitigate the spread of pathogens during mealtimes, catheter management, and laundry delivery. The facility reported a census of 36.

1) On 12/09/24 at 12:11 PM, Staff A, Certified Nurse Aide (CNA) put on a pair of gloves, picked

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a fork off the floor with her right hand, and placed it on the table. She walked behind a resident (Resident #34) seated in a tilt-chair, repositioned the resident to face the right side of the table, sat down to the right of the resident, and began feeding the resident. She wiped the resident's mouth with a napkin in her right gloved hand, picked up the resident's milk cup from the top with her gloves, and gave the resident some milk. She did not perform hand hygiene or change gloves throughout the process.

A policy titled "Handwashing/Hand Hygiene" revised 10/22 indicated employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under conditions which included before and after assisting a resident with meals.

On 12/12/24 at 8:30 AM, the Director of Nursing (DON) stated staff should not pick utensils off the floor then assist a resident to eat.

2) The Minimum Data Set (MDS) quarterly assessment with completed date 7/9/24, documented Resident #10 had a Brief Interview for Mental Status score of 10/15 indicating moderate cognitive impairment. The MDS documented diagnoses that included hemiplegia for unspecified cerebrovascular disease affecting the right dominant side, diabetes, and a Stage 3 Pressure Ulcer. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #10 required substantial/extensive assistance with activities of daily living (ADLs), mobility, and transfers. The resident had an indwelling catheter.

Resident #10's Care Plan revealed approaches

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for staff to follow including the resident having a catheter, following Enhanced Barrier Precautions, taking care of catheter equipment, and monitoring of signs/symptoms for urinary tract infections.

Observation on 12/10/24 at 12:36 PM revealed Resident #10 self propelling her wheelchair with the catheter bag and tubing dragging on the floor.

The facility provided document, Indwelling Urinary Catheters, revealed the catheter tubing and drainage bag were to be kept off the floor.

On 12/12/24 at 8:25 AM the Infection Preventionist (IP)/Director of Nursing (DON) stated the expectation would be for catheter bags/tubing to be kept in dignity bags and not on the floor.

The Administrator on 12/12/24 at 8:00 AM stated the expectation would be for catheter tubing and drainage bags to be kept off the floor.

3) Observations on the following dates and times of laundry carts being moved by Staff B, Laundry Aide:
On 12/9/24 at 1:46 PM observed Staff B delivering resident laundry in an uncovered cart.
On 12/10/24 at 11:35 AM observed Staff B transporting uncovered dirty clothes from the West Hallway across the serving area and outer dining area to the North Hallway.
On 12/10/24 at 11:40 AM observed Staff B transporting an empty laundry cart from the North Hallway to the East Hallway. The staff picked up dirty clothes and moved the uncovered laundry cart from the East Hallway to the North Hallway.
On 12/10/24 at 1:41 PM observed Staff B transport uncovered clean linens and slings from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165523	A. BUILDING _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRE OF ESTHERVILLE	2001 FIRST AVENUE NORTH ESTHERVILLE, IA 51334

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the North Hallway to the West and East Hallways.

On 12/10/24 at 1:55 PM Staff B stated she should cover the laundry cart when delivering laundry. The staff stated they had forgotten to cover the laundry as there was too much going on, and that she typically covers it. Staff B further stated she was unaware that dirty laundry needed to be covered prior to transporting through the facility.

The facility provided document, Handling of Clean Linen and Linen Distribution, revealed that clean laundry should be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. The document further revealed the cart should be covered once it is filled and distributed to the units.

On 12/12/24 at 8:15 AM the IP/DON stated laundry should be covered at all times when transported in the facility.

On 12/12/24 at 8:00 AM the Administrator stated it was the expectation that laundry be covered during transportation whether clean or dirty.

Aspire of Estherville
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F623

The Facility strives to ensure it establishes and maintains notification of the resident or resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

Corrective action taken for resident having potential to be affected by deficient practice

- Resident #190 was resubmitted to the Ombudsman for correction.
- The administrator was reeducated on submitting census for accurate reporting of monthly discharges.

How the center will identify other residents having the potential to be affected by the same deficient practice.

Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not reoccur,

- The monthly discharge report will be audited monthly by the administrator or designee for four months prior to the submission to the Long-Term Care Ombudsman.
- All bed holds and discharges will be reviewed monthly for 4 months by the administrator or designee to ensure they match the discharge summary report prior to submitting monthly discharges to the Long-Term Care Ombudsman.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

- Identified concerns shall be reviewed by the facilities QAA Committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

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F636
The Facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

Corrective action taken for resident having potential to be affected by deficient practice

- An interim MDS Coordinator took over MDS on 12/9/24 to ensure MDS's are being done and submitted timely.
- Department Heads were educated on 12/16/24 on their responsible sections and when they need completed.
- Interim MDS Coordinator communicates 2-3 days a week via email on when MDS's are completed, and the expectation is to be completed no later than the submission date.

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not reoccur.

- An interim MDS Coordinator took over MDS on 12/09/24 and communicated via email on 12/16/24 to all department heads on their responsible sections and completion dates for timely submissions. All past due MDS will be submitted no later than 12/31/24. Interim MDS Coordinator and Administrator or designee will audit MDS completion dates weekly for 8 weeks, weekly for 4 weeks until new MDS Coordinator is fully trained.
- A new full-time MDS has been hired for 02/03/24 and is currently working PRN until her status changes to full time. She was educated on timely submissions by the Administrator and Interim MDS Coordinator on 12/16/24.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

- Identified concerns shall be reviewed by the facilities QAA Committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

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F851
The facility strives to ensure it establishes and maintains mandatory submission of staffing information based on payroll data in a uniform format.

Corrective action taken for resident having potential to be affected by deficient practice

- Staff C, Staff D, Staff E, Staff F, Staff G will be audited each payroll to ensure staff are registered on the PBJ to reflect 24 hour a day nursing staff coverage.
- The administrator or designee will audit all staffing hours bi-weekly to ensure accuracy of staff reporting on the PBJ for 6 weeks and then monthly after that.

How the center will identify other residents having the potential to be affected by the same deficient practice.
All staff and residents in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not reoccur.

- The Administrator or designee will continue to verify staff accuracy through payroll bi-weekly in preparation for the PBJ quarter 4 submission.
- The Administrator or designee will update all warnings at each payroll bi-weekly x6 weeks that triggers missing hours and submit corrections timely.
- The Administrator has been educated on the new PBJ process with new management and will report all PBJ moving forward.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

- Identified concerns shall be reviewed by the facilities QAA Committee quarterly.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.

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F880
The facility strives to ensure it establishes and maintains an infection prevention and control program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

Corrective action taken for resident having potential to be affected by deficient practice

- All staff are performing proper hand hygiene.
- Privacy bags are on every catheter bag.
- Laundry is covering all clean linen when delivering clothes to resident rooms

How the center will identify other residents having the potential to be affected by the same deficient practice.
Residents residing in the facility have the potential to be affected.

What changes will be put into place to ensure that the problem will be corrected and will not reoccur.

- All staff have been educated on hand hygiene and random audits will be performed for hand hygiene with staff for 4 weeks and quarterly x2 and at monthly in-services on 1/2/25.
- All staff have been educated on the use of privacy bags and random audits will be performed for privacy bag usage on each catheter for 4 weeks and quarterly x2.
- All staff have been educated on the delivery of clean lines and random audits will be performed on clean linen delivery to rooms for 4 weeks and quarterly x2.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

- Identified concerns shall be reviewed by the facilities QAA Committee.
- Recommendations for further corrective action will be discussed and implemented to sustain compliance.