STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLAIRE REHAB & NURSING	**115 DUTCH LANE ROAD FREEHOLD, NJ 07728**

(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 Complaints#: NJ146816, NJ146569, NJ146504, NJ146015, NJ145950, NJ144651, NJ143729, NJ141607, and NJ141575 Census: 121 Sample Size: 14 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		9/8/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/06/2021

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 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ146504 and NJ146015 Based on observations, interviews, and facility policy review, it was determined that the facility failed to keep a resident's room and care equipment clean for 1 (Resident [redacted]) of 3 rooms observed for cleanliness and failed to keep 1 of 1 treatment carts clean. Findings included: 1. During the initial tour of Resident [redacted]'s room on 08/03/2021 at 10:00 AM, the following observations were made: - Multiple gloves were strewn all over the resident's floor. - Crumpled paper towels on the resident's floor. - On the wall above the electrical switch was a brown substance covering approximately a 6-inch x 4-inch area. - There was a hole in the wall below the light	F 584	• All residents are at risk to be affected by the deficient practice. • Resident #4s room was cleaned in its entirety and extra TV was removed. • All resident [redacted] devices and poles inspected and cleaned. • Nursing & Housekeeping staff re-educated on best practice to keep resident rooms and common areas clean as well as process for cleaning [redacted] devices and poles. • Room and common area audit tool created to ensure compliance. ADON will audit 4 random rooms and common areas per week X4 weeks then 2 rooms/common areas X4 weeks. • Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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switch approximately 6 inches x 5 inches.
- Below the switch were dried splashes of a brown substance.
- The fan in the room had brown spots on the outside from the top to the bottom.
- The [redacted] and pole were covered with a dried white and brown substance.
- The bowl of the toilet was discolored and scratched and appeared black.
- The trashcan in the room had no liner.
- There were 2 functional televisions in the room with 1 of them on the floor facing the wall.
- Two clocks were in the room - one had the correct time, and one did not.
- The resident's bedside table drawer and the roommate's bedside table drawer were open.
- The resident's wheelchair had torn fabric and a dried white substance on the footboard and dirt collected in multiple places on the wheelchair.

During an observation on 08/03/2021 at 1:36 PM, a puddle of brown liquid was seen in the hall in front of Room [redacted]. There was no wet floor sign. Staff were seen walking by the area without stopping. The dirty linen cart was in the hall with linens hanging over the edge to the outside of the cart.

An interview was conducted with a family member (FM #14) on 08/03/2021 at 2:00 PM. FM #14 stated a few weeks ago on arrival, FM #14 saw [redacted] on the floor in the hallway. When FM #14 left 1½ hours later, the [redacted] was still on the floor. FM #14 added that while they had not reported the observation to anyone, they were sure staff had to have seen the [redacted] since it was obvious, and one had to step around it when walking in the hallway.

During an interview with Licensed Practical Nurse

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(LPN) #2 on 08/03/2021 at 2:30 PM, she stated she had not noticed the TV on Resident [redacted]'s floor until that morning and was unsure how long it had been there. She added the lid to the dirty laundry should be secured in a down position. She stated the cart was emptied every 2 hours, but staff could not predict how much dirty linen was stuffed in the cart.

Unit Manager (UM) #4 was interviewed on 08/03/2021 at 2:53 PM. She stated a family member (FM #4) for Resident [redacted] had reported seeing potato chips in the resident's dresser drawers and questioned why they were there since the resident was [redacted] fed. She stated FM #4 had also questioned the overall cleanliness of the building, but she had not written the concerns as a grievance. The UM stated she had reported the concerns to the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The day after the concern was received, housekeeping cleaned the resident's dresser drawers. The UM stated the television had been sitting on the floor in Resident [redacted]s room for at least a month. The TV belonged to the resident. She added the family member had been in the facility but had not offered to remove the TV. She added the family member questioned if the TV worked and why the resident had two TVs in the room. The UM stated housekeeping was responsible for cleaning [redacted] poles and [redacted], and staff were expected to pick up trash from the floors when it was seen.

On 08/03/2021 at 2:39 PM, the NHA was interviewed. He stated he found out about the family member's concern with cleanliness of the facility and Resident [redacted]'s room from an email he had received a few weeks ago. He added he did not necessarily consider a concern about

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cleanliness a grievance unless the lack of cleanliness was a continued problem. He added if any staff member saw [redacted] on the floor, that person should remove the [redacted] and clean the floor.

The Assistant Director of Nursing (ADON) was interviewed on 08/04/2021 at 9:33 AM. She stated topics covered in in-services for the housekeeping included clean linen carts being open, personal items left on medication carts, cleanliness of residents' rooms, tables, and floors. Gloves and paper towels should be picked up if dropped. She stated staff were instructed to clean up after themselves. She added if general clutter was found in a resident's room, housekeeping cleaned the room immediately. After 5:00 PM, the Certified Nursing Assistants (CNAs) or nurses should take care of cleanliness issues.

The DON stated on 08/04/2021 at 10:26 AM that she was not aware of FM #4's concern about the cleanliness of the resident's room. She was also not aware of a TV sitting on the floor in the resident's room, but thought it was probably due to trying to keep the resident's property together while moving room to room during the renovations of the building.

On 08/04/2021 at 11:30 AM, the Responsible Party (RP #4) for Resident [redacted] was interviewed via phone. She had no idea how long the TV had been sitting on the floor, but it had been there since visitation had restarted. She added since COVID-19 and specifically since visitation had resumed, the cleanliness of the building had declined. RP #4 stated on a recent visit, date unknown, potato chips were found in the resident's bottom drawer, and that Resident [redacted] s

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wheelchair was always dirty, the [redacted] and pole were dirty, and the floor surrounding the [redacted] had dried [redacted] on it. RP #4 added both (gender) and FM #4 had addressed the cleanliness of the resident's room and the facility with the NHA several times.

During an observation on 08/04/2021 at 3:48 PM, brown and white dried material was seen on the [redacted] and pole in Resident [redacted]s room. An area of dried yellow/tan substance was seen on the floor directly under the [redacted]

An observation of Resident [redacted]'s room on 08/05/2021 at 8:13 AM revealed a dried yellow/tan substance remained on the [redacted], the resident's wheelchair remained dirty, and the dried brown substance remained on the wall below the electrical switch.

Housekeeping Aide (HA) #2 was interviewed on 08/05/2021 at 8:16 AM. HA #2 stated she was assigned to clean the entire [redacted] floor with approximately 20 rooms. The HA added some of the rooms included two to four residents. The HA stated she was aware she was supposed to wipe down walls and clean the [redacted], but in her 8-hour shift, there was not enough time to do everything she knew she should. The HA observed Resident [redacted]'s [redacted], confirmed it was dirty, and confirmed she had been unable to clean the [redacted] that week. The HA looked at the wall by the room exit and stated she was responsible for cleaning it but sometimes just did not have time. At this time, she wiped the wall with a damp cloth and the brown stains were removed from the wall. The housekeeper stated she was unaware of any staff in-service that included nursing and housekeeping regarding housekeeping and nursing cleaning up when they

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dropped items or spilled items. The HA added both nurses and nursing assistants would drop gloves, paper towels, spil[redacted] solutions and other fluids, and it was left for housekeeping to clean up because the nurses and nursing assistants would not pick up after themselves. The HA stated she did clean dresser drawers as needed after nursing had removed the items from the drawers. When asked what she would do if she noticed potato chip crumbs in a drawer, she stated she would clean the crumbs out. The HA was unaware there had been an issue with crumbs in Resident [redacted]'s dresser drawer.

Licensed Practical Nurse (LPN) #2 was interviewed on 08/05/2021 at 8:26 AM. She stated nursing was responsible for cleaning the [redacted] when in use. If the nurses observed the treatment cart dirty, it should have been cleaned. She acknowledged Resident [redacted]s feeding pump was dirty. The nurse stated she had seen the gloves and paper towels on the floor on Tuesday, 08/03/2021. She acknowledged that neither of the residents who lived in that room could drop gloves and paper towels on the floor or leave drawers open. She stated that it had to have been staff that dropped the items and left the drawers open. The nurse stated she had cleaned the room up and then reported what she had seen to the ADON.

The Housekeeping Supervisor (HS) was interviewed on 08/05/2021 at 8:58 AM. He stated the housekeeping department was responsible for cleaning dried substances off the walls. He added he preferred housekeeping be responsible for cleaning the [redacted] and nursing be responsible for the electrical [redacted]. The HS confirmed HA #2 was responsible for cleaning the entire [redacted] floor, which was 22 rooms. He

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added that some were single rooms, some were double rooms, and some were quad rooms (4 residents per room). The HS agreed with the housekeeper that she did not have time to do everything required to clean each room. Previously, due to lack of housekeeping staff, HA #2 had worked 10-12 days in a row. The HS added it was not possible to get all the needed daily cleaning done due to the lack of staff.

The NHA and DON were interviewed on 08/05/2021 at 9:32 AM. He stated his expectation was for nursing to pick up paper towels, and if something was spilled, he expected a quick clean-up to prevent falls and then call housekeeping to further clean if the spill was in a hazardous area. The NHA acknowledged that neither Resident [redacted] or the resident's roommate was able to independently throw the gloves or paper towels on the floor. The residents were unable to leave dresser drawers open. The NHA stated on 08/03/2021 that when the condition of Resident [redacted]s room had been reported, he had investigated the condition of the resident's room and had spoken to the CNA assigned to Resident [redacted] He stated the CNA acknowledged she had removed the trash and did not put a new bag in the trash can. The NHA added his expectation was for nursing to clean up small, simple spills on [redacted] and poles if the [redacted] was not in use. [redacted] and poles should be checked for cleanliness by the nurse when the [redacted] was hung or taken down. Walls in residents' rooms should be cleaned as needed. The NHA added residents' rooms were deep-cleaned monthly. The NHA stated he thought one housekeeper for the [redacted] floor was sufficient to get the basics done. Basics included cleaning the floors, bathrooms, and immediate spills. Basic cleaning also included

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cleaning the [redacted] if the [redacted] was not in use. The DON stated the resident's [redacted] was off during the day shift.

The DON accompanied the surveyor to the [redacted] floor. The UM and/or nurse had cleaned the feeding pump but acknowledged the [redacted] had been dirty. The DON looked at the wheelchair for Resident [redacted] and acknowledged the dried white fluids on the footrest of the chair and the accumulation of dirt and grime in the crevices of the wheelchair. The DON stated the facility was in the process of developing a schedule for cleaning of wheelchairs. The DON acknowledged the condition of Resident [redacted]'s wheelchair was unacceptable. The DON looked at the wall by the door and acknowledged it was a dried brown substance on the wall that should have been removed.

2. On 08/02/2021 at 1:00 PM, the treatment cart was observed in the hall of the unit with brown matter on the side and a thick layer of dust and dirt along the bottom edge.

An observation was made on 08/05/2021 at 8:09 AM. The treatment cart was in the hall and the sides were covered with a brown/black dried substance with dust collected and standing on the bottom edge. The Unit Manager (UM) observed the treatment cart at this time and was interviewed. The UM stated housekeeping oversaw cleaning treatment carts. After observing the treatment cart, the UM stated the cart needed to be cleaned.

Licensed Practical Nurse (LPN) #2 was interviewed on 08/05/2021 at 8:26 AM. She stated she recently participated in an in-service that directed nurses to clean up after themselves

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F 584	Continued From page 9 and to wipe up spills. The LPN added treatment cart cleaning was the responsibility of nurses to clean the inside and the top, and housekeeping kept the outside clean. The Housekeeping Supervisor (HS) was interviewed on 08/05/2021 at 8:58 AM. The HS stated nursing was to inform housekeeping when the treatment cart needed to be cleaned, then housekeeping would clean the cart. The NHA was interviewed on 08/05/2021 at 9:32 AM. He stated treatment carts were cleaned as needed by nursing and housekeeping. The DON interjected she had a weekly audit for the treatment cart that addressed cleanliness, and night shift had an audit to address cleanliness. If the treatment cart or med cart required cleaning, the DON stated it was on the audit for the night staff to clean at that time. The DON accompanied the surveyor to the [redacted] floor. The UM and nurse stated they had cleaned the treatment cart but acknowledged to the DON it was obvious the 11:00 PM - 7:00 AM shift had not cleaned or checked the cart per expectations. The facility policy, titled, Cleaning Schedules, undated, indicated that cleaning schedules are developed and implemented to assure that each area of the facility is maintained in a safe, clean, and comfortable manner. The Resident Room Routine Daily Cleaning Steps, undated, noted that the housekeeper should inspect to see if everything had been completed before moving on to the next task.	F 584		
F 585	New Jersey Administrative Code § 8:39-31.4(a) Grievances	F 585		9/8/21

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F 585 SS=D	Continued From page 10 CFR(s): 483.10(j)(1)-(4)	F 585		

§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right

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to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in

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F 585	Continued From page 12 accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaint Intakes: NJ146015, NJ146504, and NJ146569 Based on interviews, record reviews, and facility policy reviews, it was determined that the facility failed to: 1. Log all grievances onto the grievance log; and 2. Develop and implement a grievance policy to ensure prompt resolution of grievances, that included steps to investigate, provide a summary of the grievance with corrective action to assure the long-term resolution, and include the name and contact information for the grievance official. This affected 1 (Resident [redacted]) of 1 resident reviewed for grievances. Findings included: 1. Resident [redacted] was admitted on [redacted] with diagnoses that included [redacted]. The most recent quarterly Minimum Data Set, dated [redacted], indicated the resident had severely [redacted] skills for daily decision making and was totally dependent on staff for all activities of daily living (ADLs). A review of the facility's Resident Concern Log for	F 585	• All residents are at risk to be affected by the deficient practice. • Resident [redacted]s RP grievance was re-written on a proper form that meets compliance with State regulation and added to the Grievance log. • Grievance policy and Grievance form updated to meet the State regulations. • Director of Social Services as well as all facility staff educated on revised Grievance policy and forms. • Admin/ DON will review grievances and Grievance Log weekly to ensure compliance and timely responses X4 weeks, then monthly x3 months. • Findings will be submitted to the monthly QAPI committee for 3 months who will determine further interventions as needed.	

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	315387	A. BUILDING _____ B. WING _____	C 08/05/2021

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June and July 2021 indicated one concern submitted by a member of Resident [redacted]'s family. On [redacted], the grievance indicated a concern about a [redacted]" on the resident's [redacted] and a missing remote control. There was no date of resolution or investigative details on the concern form. There was no documentation that indicated when the complainant had been notified of the resolution details.

The Nursing Home Administrator (NHA) was interviewed on 08/03/2021 at 2:39 PM. The NHA stated that family members were asked during the quarterly care plan meeting if there were any specific concerns that need to be addressed. He added that a resident or family member's concern regarding cleanliness of the building would not necessarily be considered a grievance unless the lack of cleanliness was a continuous problem. The NHA stated Resident [redacted]'s family member had emailed him about two weekends ago concerning the cleanliness of the dayroom and the resident's room. He stated since the family member's visit had been after lunch, and he had several younger residents that would throw items on the floor, he had not noted Resident [redacted]'s family member's housekeeping concerns on a grievance form but spoke to the family member on the phone and answered their concern through email.

Unit Manager (UM) #1 was interviewed on 08/03/2021 at 2:53 PM about any concerns Resident [redacted]s family had. She stated that one family member had complained of potato chips in a dresser drawer, adding that the family did not understand how that could happen since the resident did [redacted]. Other concerns reported by the family member included the overall cleanliness of the facility. She added

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the family member also had concerns about a large television (TV) sitting on the floor in the resident's room. The UM stated the TV had been there for about a month. The family member stated they did not think the TV worked. The family member wondered why the resident had a small TV that was functional and a large TV sitting on the floor. The UM stated she had not written the family member's concerns on a grievance form but reported the concerns to the Director of Nursing (DON) and the NHA.

On 08/04/2021 at 8:50 AM, the NHA brought in two grievance forms for concerns submitted by Resident [redacted]s family member. He stated that after speaking with the surveyors on the previous day, he decided to note the grievances on a Resident Concern form and note what he had done with the concerns. The NHA stated he had started a Quality Assurance Performance Improvement (QAPI) to address the facility's grievance process. The NHA added the QAPI was prompted by the conversations with surveyors on 08/03/2021 that lead the facility to believe they were not taking credit for actions taken.

The first Resident Concern Report, dated [redacted], from Resident [redacted]s family member was reviewed. Details included the receptionist not wearing a mask, potato chips in the resident's drawer, the resident being in bed at the time of the visit, and a [redacted] on the resident's [redacted]. Action taken included reeducation of the receptionist, the resident's room was cleaned, and nursing staff educated. The report did not have a date of resolution, did not include a date the complainant had been notified, and did not indicate whether the complainant agreed with the resolution actions. The report did not have any documentation to support an investigation had

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been conducted including interviews and did not identify specific people who were reeducated.

The second Resident Concern Report was dated 07/26/2021. Details of the concern included the resident was in bed at the time of the visit, there were flies in the room, refuse was on the floor of the dayroom, and the resident's room looked cleaner than the last visit. All actions were taken at the time of the grievance, but there was no date of resolution, no investigation details, and no actions to assure sustained compliance to prevent the incidents from occurring again.

The Social Worker (SW) was interviewed on 08/04/2021 at 9:12 AM. The SW stated [redacted] was the first time she had heard about the [redacted] on Resident [redacted]. This issue, along with a missing remote control, was brought to her attention when she received an email from Resident [redacted]s responsible party (RP). The SW stated she presented the concern during the morning meeting on [redacted]. She added the email also addressed a television sitting on the resident's floor but was unsure why she had not added that to the concern.

A telephone interview was held with Resident [redacted]'s responsible party (RP) on 08/04/2021 at 11:30 AM. The RP stated they had no idea how long the TV had been sitting on the floor, but it was there during each visit, and they had told staff about it multiple times. The RP added since COVID-19 and visitation had resumed, the cleanliness of the building had declined. They stated on one of the recent visits, date unknown, potato chips were found in the resident's bottom drawer, the wheelchair was always dirty, the [redacted] and pole were dirty, and there was dried [redacted] on the floor surrounding the [redacted] The

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RP added other family members had also addressed these issues with the NHA several times.

The NHA was interviewed on 08/05/2021 at 9:32 AM. The NHA stated Resident [redacted]'s family member acknowledged the potato chips had been removed from the dresser drawer. The NHA stated since there was no real timeline for the chips to be placed in the drawer, he was unable to investigate. The NHA acknowledged the facility grievance policy had no defined timeframe for grievance resolution and added the resolution timeframe depended on the quality of the grievance. The complainant only received a written response to grievance resolution if the complainant requested it. The NHA stated he either called or emailed results of a complaint resolution, but did not document times of calls, emails, or the complainant's response to the facility's resolution. He acknowledged he had no investigative notes for the missing remote, how the chips got into the drawer, or the general uncleanliness of the facility as expressed. The NHA acknowledged the facility's grievance policy needed to be revised to meet the required standards listed in the regulations.

The facility's Patient Concern/Grievance Policy, revised 08/2021, indicated under Purpose that challenges may arise which would require an investigation to a concern reported and if necessary, a plan of correction to be implemented. Under Procedure, Paragraph 2, the policy indicated each concern would be given a number for reference and logged for investigation and follow-up. Paragraph 5 indicated that at the end of the investigation, Social Services would enter the resolution into the concern log, and there would be follow up with the resident and

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