

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2016
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NAME OF PROVIDER OR SUPPLIER FAIRWAY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 19, 20, 21, 22, & 25, 2016.</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 6 Medicaid 35 Other: 5 Total: 46</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on May 02, 2016.</p>	F 0000	We respectfully request paper compliance with our 2016 Recertification and State Licensure Survey. Thank you in advance.	
F 0156 SS=D Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and</p>			

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	<p>procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure a Notice of</p>	F 0156	<p><u>FairwayVillage Plan of Correction</u> F-156</p>	05/10/2016

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	<p>Medicare Non-Coverage was provided to 3 of 3 residents at least 48 hours before the coverage ended. (Residents #12, #58, #19).</p> <p>Findings include:</p> <p>1. The clinical record review for Resident #12 was completed on 4/25/16 at 10:00 a.m. Diagnoses included, but were not limited to, weakness.</p> <p>A review of a Notice of Medicare Non-Coverage, indicated "The Effective Date Coverage of Your Current Comprehensive Outpatient Rehabilitation Services Will End: 3/10/16."</p> <p>A review of Resident #12's signature on the Notice of Medicare Non-Coverage form, lacked a date indicating the notice was received 48 hours prior to Medicare non-coverage of services.</p> <p>2. A clinical record review for Resident #58 was completed on 4/25/16 at 10:30 a.m. Diagnoses included, but were not limited to, muscle weakness.</p> <p>A review of a Notice of Medicare Non-Coverage, indicated "The Effective Date Coverage of Your Current Comprehensive Outpatient Rehabilitation Services Will End: 2/26/16."</p>		<p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; Five residents receiving Medicare have the potential to be affected How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken; Three of three residents were provided Notice of Medicare Non-Coverage by Social Services Director. The Social Service Director will issue Notice of Medicare Non-coverage (NOMNC) letters to beneficiaries 48hrs before the proposed end of services date. A complete audit was conducted for remaining resident receiving coverage under Medicare.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Services or designee will complete all Notice of Medicare Non-coverage (NOMNC) process and notification; ensuring residents are provided notice 48 hours in advance prior to proposed end of services. The ED/Designee will review all involuntary transfer discharges documentation to ensure the transfer discharge policies and procedures are followed. The Social Service Consultant provided in-service to the social service staff on 4-29-16</p>	

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	<p>A review of the acknowledgment signature on the Notice of Medicare Non-Coverage form, indicated Resident #58's Representative signed the form on 2/27/16.</p> <p>3. A clinical record review for Resident #19 was completed on 4/25/16 at 11:15 a.m. Diagnoses included, but were not limited to, flaccid hemiplegia affecting left dominant side.</p> <p>A review of a Notice of Medicare Non-Coverage, indicated "The Effective Date Coverage of Your Current Comprehensive Outpatient Rehabilitation Services Will End: 1/29/16."</p> <p>A review of the acknowledgment signature on the Notice of Medicare Non-Coverage form, indicated Resident #19's Representative signed the form on 4/6/16.</p> <p>4/25/16 11:46 a.m., the Social Services Director (SSD) indicated no documentation was found in Resident #12, #58, or #19's clinical records indicating the Residents or Representatives were notified 48 hours or more prior to their Medicare coverage ending.</p>		<p>regarding Notice of Medicare Non-coverage (NOMNC letter) How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place and Social Services Director is responsible for completing the Notice of Medicare Non-coverage (NOMNC) Continuously Quality Improvement tool weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed. By what date the systemic changes will be completed. May 10, 2016</p>	

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	<p>On 4/25/16 at 3:12 p.m., the SSD provided an undated instructional guide, titled, Notice of Medicare Non-Coverage (NOMNC) Quick Guide, and indicated it was the current instructional guide used by the facility. The instructional guide indicated, "...NOMNC form must be issued no later than two days (48 hours) before the proposed end of services...At the signature line, the resident or authorized representative must sign. The resident or authorized representative must fill in the date that he/she signs the document. (This is critical to demonstrating the 2-day notice requirement.)..."</p> <p>The Department of Health and Human Services Advance Beneficiary Notice of Noncoverage (ABN) Second Edition dated April 2011, indicated " ...The provider/supplier must issue an ABN to the beneficiary prior to providing care that may not be covered by Medicare because it is not medically reasonable and necessary in this particular case. ... A Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNFs), ... not later than 2 days before the termination of services."</p> <p>3.1-4(f)(3)</p>			

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F 0158 SS=E Bldg. 00	<p>483.10(c)(1) RIGHT TO MANAGE OWN FINANCIAL AFFAIRS The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility. Based on interview and record review, the facility failed to insure residents had ongoing access to their personal fund accounts in the evenings and on weekends.</p> <p>Findings include:</p> <p>During an interview on 4/20/16 at 2:40 P.M. with Resident #35, he indicated he could withdraw money from his personal fund account Monday through Friday during the day, but not in the evenings or on weekends.</p> <p>During an interview on 4/19/16 at 2:22 P.M. with resident #21, he indicated he could withdraw money from his personal fund account Monday through Friday during the day, but not in the evenings or on weekends.</p> <p>In an interview on 4/25/2016 at 3:30 p.m. with the Business Office Manager (BOM) it was indicated she was usually</p>	F 0158	<p>F-158 Whatcorrective action (s) will be accomplished for those residents found to havebeen affected by the deficient practice; All residents have the potential to be affected How other residents have the potential tobe affected by the same deficient practice will be identified and whatcorrective action (s) will be taken; Allresidents have the potential to be affected. Business Office Manager willensure residents have ongoing access to their personal funds account on eveningand weekends. Business Office Manager has listed weekend banking hours incommon area and letter stating new banking hours given to all residents. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; BusinessOffice Manger or designee will complete audit tool to ensure evening and weekendbanking hours are provided to facility residents.</p>	05/10/2016

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F 0244 SS=E Bldg. 00	<p>at the facility until 5:00 p.m., Monday through Friday, and if residents wanted to withdraw from their accounts then they should do so before 5:00 p.m. She indicated she was closed on the weekends, and if residents were going to need money from their personal fund accounts for the weekend then they would need to withdraw it on Friday before she leaves the facility.</p> <p>3.1-6(f)(1)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p>		<p>The ED/Designee will review all residents personal funds account audit tool documentation to ensure there is ongoing access provided per policies and procedures.</p> <p>The Business Office Consultant provided in-service to the social service staff on 5-5-16 regarding access to resident personal funds account during evening and weekend hours.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and</p> <p>Business Office Manager is responsible for completing the Personal Funds Account Continuously Quality Improvement tool weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.</p> <p>By what date the systemic changes will be completed.</p> <p>May 10, 2016</p>	

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	<p>Based on interview and record review, the facility failed to follow up on resident concerns and preferences during residents' monthly meeting.</p> <p>Findings include:</p> <p>On 4/25/2016 at 3:13 p.m., The Executive Director provided "Resident Preference Meeting Minutes" dated 12/17/15, Review of the minutes indicated Residents discussed activities, food preferences, and resident's rights. Residents suggestions of activities are as followed: Residents state they would like to make cards for families for the holidays. Resident's would like to have Bingo twice a week and for prizes they would like to add Pepsi instead of coke for one of the soda choices. Residents stated they would like ham instead of turkey for the family holiday meal. Resident #6 suggests dietary should have both for variety. MCD spoke with residents about upcoming activities and about facility possibly getting a bus. Residents were excited. Residents state it would be nice to start getting out when the weather warms up. Residents rights and Ombudsman information discussed. Two options on bottom of form to be checked, option one indicated: Grievance forms generated for concerns of one resident. Option two indicated:</p>	F 0244	<p>F-244 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; All residents have the potential to be affected How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken; All residents have the potential to be affected. Memory Care Director will ensure Resident Preference Meeting concerns are written on Grievances forms and concerns are followed-up by appropriate department. Memory Care Director conducted an additional Resident Preference Meeting and generated Grievances for resident#21, #36, #35 concerns. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Memory Care Director or designee will complete audit tool to ensure Residents Preference Meetings concerns are written on Grievance forms and followed by appropriate department. The ED/Designee will review all Resident Preference Meeting audit tool documentation to ensure concerns are generated on grievance forms and concerns are addressed per policies and procedures. The Memory Care Consultant provided in-service to the Memory Care Director on</p>	05/10/2016

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	<p>Resident Preference Meeting Follow up form generated for concerns of more than one resident. No check marks noted on either option.</p> <p>"Resident Preference Meeting Minutes" dated 2/29/16, indicated Resident #21 would like to go out more and there should be more entertainment. Resident #36 stated he would like more fried eggs, soups, salads and sausage. Resident #6 suggested the food should have more variety including ribs, wing night and more Italian sausages. Two options on bottom of form to be checked, option one indicated: Grievance forms generated for concerns of one resident. Option two indicated: Resident Preference Meeting Follow up form generated for concerns of more than one resident. No check marks noted on either option.</p> <p>"Resident Preference Meeting Minutes" dated 3/25/2016, indicated Residents state they would love to go on an outing to a ball game or to the zoo. Resident #35 indicated that he would love to go out on the patio more. Two options on bottom of form to be checked, option one indicated: Grievance forms generated for concerns of one resident. Option two indicated: Resident Preference Meeting Follow up form generated for concerns of more than one resident. No check marks</p>		<p>5-5-16 regarding Resident Preferences Meeting and Grievances How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place and The Memory Care Director is responsible for completing the Resident Preference Meeting Continuously Quality Improvement tool weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed. By what date the systemic changes will be completed. May10, 2016</p>	

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F 0278 SS=D Bldg. 00	<p>noted on either option.</p> <p>On 04/25/2016 at 2:06 p.m., Interview with Memory Care Director (MCD), indicated residents concerns during Resident Preference Meeting are addressed immediately and follow up is not documented.</p> <p>On 04/25/2016 at 2:10 p.m., Interview with Dietary manager, indicated Residents concerns during Resident Preference Meeting are addressed immediately at the time of the Resident Preference Meeting. So documentation is not done.</p> <p>3.1-3(l)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the</p>				

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	<p>resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Minimum Data Set assessments accurately reflected a resident's range of motion/contracture status, for 1 of 3 residents who met the criteria for review of range of motion and contractures. (Resident #30)</p>	F 0278	<p>F278</p> <p>What corrective action (s) will be accomplished for those resident(s) found to have been affected by the deficient practice;</p> <p>All MDS assessments for Resident # 30 have been corrected and re-transmitted to CMS.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective</p>	05/10/2016

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	<p>Findings include:</p> <p>The clinical record of Resident #30 was reviewed on 4/21/16 at 3:51 p.m. Diagnoses for the resident included, but were not limited to, congenital deformities of his feet.</p> <p>On 4/19/16 at 1:56 p.m., Licensed Practical Nurse #3 indicated Resident #30 had limited range of motion due to, "foot drop" on the right side. Foot drop is a weakness or paralysis of the muscles of the foot.</p> <p>An observation of the resident on 4/22/16 at 11:45 a.m., with the Therapy Manager, indicated the resident's right foot was turned inward and downward. He was not able to bend his foot upward at the ankle and the foot was very stiff when the Therapy Manager attempted to bend the foot/ankle upward manually. Observation of the resident walking at that time indicated he needed a walker, support boots on both feet, 2 assisting staff members, his gait was unsteady, and his right foot dragged on the floor and kept hitting his left foot while ambulating.</p> <p>A care plan created 12/11/14 and current through 6/17/16, indicated Resident #30 was at risk for falling due to, "...congenital deformity of foot."</p>		<p>action (s) will be taken;</p> <p>All residents with limitations to range of motion have been identified ashaving potential to be affected.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that thedeficient practice does not recur;</p> <p>All residents in the facility will be reassessedto identify limitations in range of motion. MDS assessmentswill be reviewed to insure that they accurately reflect the functional range ofmotion status for each of the residents identified. This review will bedocumented on an MDS audit tool. Any MDS assessments found to beinaccurate will be modified and retransmitted to accurately reflect theresident's functional status.</p> <p>How thecorrective action (s) will be monitored to ensure the deficient practice willnot recur, i.e, what quality assurance program will be put into place and</p> <p>. The MDS Coordinator is responsible for completing the MDS Continuously QualityImprovement audit tool weekly times 4 weeks and monthly times 6 months and thenquarterly thereafter. The results of these audits will be reviewed by the CQIcommittee overseen by the</p>	

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NAME OF PROVIDER OR SUPPLIER FAIRWAY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F 0329 SS=D Bldg. 00	<p>Quarterly Minimum Data Set (MDS) assessments dated 12/7/15 and 3/9/16, indicated Resident #30 had no functional limitation in his range of motion in his lower extremities. The assessments were electronically signed by the Director of Nursing Services, indicating they were accurate.</p> <p>3.1-31(i)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>		<p>ED. If threshold of 95% is not achieved an actionplan will be developed.</p> <p>By what date will systemicchanges be completed?</p> <p>May 10, 2016</p>	

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure AIMS (abnormal involuntary movement scale) testing was performed within 72 hours of an antipsychotic medication having been started, as indicated by facility policy, for 1 of 5 residents reviewed for unnecessary medication use. (Resident #20)</p> <p>Findings include:</p> <p>The clinical record of Resident #20 was reviewed on 4/22/16 at 3:45 p.m. Diagnoses for the resident included, but were not limited to, delusional disorders, depression, and dementia.</p> <p>Recapitulated physician orders for April, 2016, indicated on 11/23/15 (start date) Resident #20 was prescribed Risperdal, 2.5 milligrams, to be taken twice a day. Risperdal is an antipsychotic medication</p>	F 0329	<p>F329</p> <p>What corrective action will be completed for those residents found to have been affected by the deficient practice: An AIMS assessment was completed on resident #20 by MDS.</p> <p>How other resident have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who receive antipsychotic medication have the potential to be affected by the same deficient practice. All other residents receiving an antipsychotic medication were evaluated to</p>	05/10/2016

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	<p>used to treat schizophrenia and bipolar disorder. Possible adverse effects of Risperdal include abnormal involuntary movements (AIMS). An AIMS assessment was performed 12/23/15. (one month after the start date)</p> <p>On 4/25/16 at 10:47 a.m., the Director of Nursing (DON) indicated an AIMS assessment is supposed to be done at the time a resident begins taking an antipsychotic and the AIMS assessment for Resident #20 should have been done when the resident was started on the antipsychotic on 11/23/15.</p> <p>On 4/25/16 at 8:51 a.m., the DON provided a policy dated January 2016, titled, Psychotropic Management Policy, and indicated it was currently used by the facility. The policy indicated, "...5. An AIMS [Abnormal Involuntary Movements] assessment is required for residents who are taking antipsychotic medication. The assessment should be completed within 72 hours of a new order to initiate an antipsychotic and then every six months...."</p> <p>3.1-48(a)(3)</p>		<p>ensure all had a current AIMS assessment completed and that care plans were being followed.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>Any time a resident has a new order or a change in order for antipsychotics, it will be reported in morning clinical meeting. DNS/designee will follow up to ensure an AIMS assessment was completed. DNS/designee will conduct an in-service with nursing staff by May 9, 2016 on ensuring AIMS assessments are completed per policy.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place:</p> <p>DNS/designee will complete the continuous</p>	

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			quality improvement tool on antipsychotic medications weekly timesfour weeks and monthly times six. The results of the audit will be reviewed bythe CQI committee overseen by the ED. If a threshold of 95% is not achieved anaction plan will be developed.		