

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2011
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN46219
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R0000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00098248.</p> <p>Complaint IN00098248-Substantiated, State Residential Findings related to the allegations are cited at R 0241 and R 0187.</p> <p>Survey dates: October 11, 12, 13, 2011</p> <p>Facility number: 005729 Provider number: 005729 AIM number: N/A</p> <p>Survey team: Connie Landman, RN-TC Diana Zgonc, RN Christi Davidson, RN</p> <p>Census bed type: Residential: 50 Total: 50</p> <p>Census payor type: Other: 50 Total: 50</p> <p>Sample: 8</p> <p>These State Residential findings are cited in accordance with 410 IAC 16.2.</p>	R0000	Submission of this plan of correction shall not constitute or be construed as an admission by CrownPointe of Indianapolis that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of CrownPointe of Indianapolis. The following plan of correction serves as the facility's allegation of compliance.	

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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R0187	<p>Quality review completed on October 17, 2011 by Bev Faulkner, RN</p> <p>(k) Hot water temperature for all bathing and hand washing facilities shall be controlled by an automatic control valve. Water temperature at point of use must be maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.</p> <p>Based on observation and interview, the facility failed to maintain safe water temperatures for 3 of 3 rooms checked for water temperatures (Room # 101, 112 & 122).</p> <p>Findings include:</p> <p>During an environmental tour on 10/11/11 at 3:30 P.M., water temperatures were checked and found to be high in the following rooms: #101 133.2 degrees #112 132.3 degrees #122 132.8 degrees</p> <p>During an interview with the Administrator on 10/11/11 at 4:00 P.M., she indicated the water heater had been replaced and the temperature had been high (128 degrees) on 10/5/11. At that time, the Administrator instructed the Maintenance Director to recheck the water temperatures on 10/6/11. The</p>	R0187	<p>I and II All residents of the facility could be affected by water temperature at point of use not maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit. The adjustment to the new water heater had been made with water temperatures re-checked and were within parameters on 10/12/2011. III As a means to ensure ongoing compliance, the Maintenance Director will check all bathing and hand washing facilities in the facility weekly for the first month; bi-weekly for the second month; and monthly thereafter. IV As a means of quality assurance, the Administrator/Executive Director shall go with the Maintenance Director on periodic / ongoing checks of bathing and hand washing facilities to ensure water temperature at point of use is being maintained between one hundred (100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit.</p>	10/28/2011

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R0241	<p>Administrator indicated the Maintenance Director did not recheck the water temperatures and was terminated on 10/10/11.</p> <p>The water temperatures were rechecked on 10/13/11 and were within parameters.</p> <p>This state finding relates to Complaint IN00098248.</p> <p>(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were administered by licensed nursing personnel or Qualified Medication Aides as evidenced by Certified Nursing Assistants (CNAs) retrieving medications from locked boxes in resident rooms and handing docu-dose [a single dose pre packed] medication to three of three residents which had the potential to effect 50 of 50 residents in the</p>	R0241	I and II The licensed nurse (Resident Health and Services Director) will put a key in each resident's apartment to access their medication box. Because all residents of the facility could be affected by the deficient practice, the licensed nurse (Resident Health and Services Director) will meet with each resident of the facility for evaluations as to whether or not they can self administer their medications. The residents who are determined	11/28/2011			

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	<p>facility which were all assessed to be self-administer with medications. (#46, #15, #27)</p> <p>Findings include:</p> <p>1. The record for resident #46 was reviewed on 10/12/11 at 9:30 a.m.</p> <p>Diagnoses included, but were not limited to osteoarthritis, hypertension, dementia and macular degeneration.</p> <p>An Evaluation of Needs/Services Plan of Resident #46, dated 09/15/1,1 indicated, "...Memory impaired-requires assist or supervision with decisions...Resident needs meds reminders from doc-u-dose-packets..."</p> <p>A Medication Self Administration Assessment form for Resident #46, dated 09/15/11, indicated, "...Cognitive ability...Limited...Dementia...Resident responsible for self administration after receiving pre-dispensed medication using the Docu-Dose system...[box marked Yes]...Resident receives staff reminders to self administer medications either from weekly dispenser or via Docu-Dose system...[box marked Yes]...List method of storage that will be utilized in an effort to safeguard other residents from risk of hazard: lockbox...Physician order in</p>		<p>from the evaluations not be able to self administer their medications independently will then be divided into three categories; first category, residents who are alert and oriented with physical limitations; second category, residents who are memory impaired with physical limitations; and the last category, residents who are memory impaired but do not have physical limitations. Those residents with physical limitations will be further evaluated for assistive devices to make self administer of medications a more independent process. The licensed nurse (Resident Health and Services Director) will educate all CNAs on the difference between a medication pass and a medication reminder. The licensed nurse (Resident Health and Services Director) will also educate the CNAs on how to properly conduct a medication reminder. As well, all residents will be educated on the difference between a medication pass and a medication reminder. Part of the education for the CNAs will be as follows; they are only to queue a resident not retrieve the pre-packaged medication pack and hand the pack to the resident as CNA #3 was observed doing for resident #46. The CNAs will also be educated to the fact that if a resident has a question and/or concern regarding their medications, they need to contact</p>				

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	<p>place for those medications to be self-administered...[box marked Yes]...."</p> <p>A set of physician's orders for Resident #46, dated 08/31/11, indicated, "...may self medicate with or without reminders...nurse may medicate if needed...."</p> <p>A nurses note, dated 03/23/11 at 3:30 p.m., indicated, "...holding coumadin x [times] 5 days, holding lasix x 2 days...plan set in clinic...."</p> <p>During the initial facility tour on 10/11/11 at 9:30 a.m., the Resident Care Supervisor [RCS] indicated that there was no medication pass in the facility, and that the residents received medication reminders.</p> <p>During a residential interview on 10/11/11 at 12:55 p.m., Resident #46 indicated the CNAs got medicine out and "line it up when it is time to take it." Resident #46 was alert and oriented and in the main dining room eating lunch during the interview.</p> <p>During a staff interview on 10/12/11 at 10:30 a.m., CNA #2 indicated, another CNA was assigned "med pass" for 10/12/11. CNA #2 indicated, the CNA started "med pass" at 11:30 a.m., because</p>		<p>the licensed nurse (Resident Health and Services Director) so she may address their question and/or concern. The facility will schedule an additional CNA to work on first shift and an additional CNA to work on second shift. By adding more staff, this should allow the CNAs adequate time to queue the resident through their medication reminder. With R 241 plan of correction being two fold, the completion date for the above will be 11/11/2011. III The systemic change the facility will make to ensure that the deficient practice does not recur is to immediately run an employment ad, interview and hire Qualified Medication Aides (QMAs). What this means for the facility is simply put, the only employees of the facility to conduct medication reminders will either be the licensed nurse (Resident Health and Services Director) or a Qualified Medication Aide. IV As a means of quality assurance, the Administrator/Executive Director will assist the licensed nurse (Resident Health and Services Director) by placing the employment ad as well as assisting her with the hiring process. As a means of quality assurance the licensed nurse (Resident Health Services Director) will conduct spot audits on CNAs while giving medication reminders.</p>				

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	<p>the CNA had to do blood pressures and blood sugars.</p> <p>During a staff interview on 10/12/11 at 10:45 a.m., CNA #3 indicated, "I do med reminders." When asked to describe a "med reminder," CNA #3 indicated the medication was retrieved from the resident's lock box and handed to the resident. CNA #3 indicated the resident was then observed taking the medication. CNA #3 indicated she had a master set of keys to the lock boxes. CNA #3 indicated not all resident boxes have keys on the box accessible to the resident. CNA #3 indicated medication packs come color coded for morning, noon, evening and bedtime. CNA #3 indicated all residents received medication reminders. CNA #3 indicated there is no documentation of the medications ordered for each resident provided to the CNAs.</p> <p>During an observation and interview on 10/12/11 at 11:00 a.m., CNA #3 knocked on Resident #46's door and announced it was time to take medications. CNA #3 opened Resident #46's lock box with a key on a master key chain. The lock box did not have a key on it. CNA #3 retrieved a pre-packaged medication pack that contained two pills. The pack was marked with "NOON." CNA #3 handed the pack to the resident and remained in</p>						

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	<p>the resident's room until the resident had swallowed the two pills. Resident #46 asked CNA #3, "Is this one my pain pill? This one is calcium." CNA #3 indicated she did not know.</p> <p>Resident #46 indicated a key to the lock box was not provided, "They take care of that for me."</p> <p>CNA #3 indicated if the resident did not take the medication it was reported to the RCS. CNA #3 indicated the RCS would be notified if the resident requested a pain pill.</p> <p>During an interview on 10/12/11 at 1:30 p.m., regarding the hold orders for Resident #46's Coumadin and Lasix, the RCS indicated she took those doses out so they would be held.</p> <p>2. The record for Resident #15 was reviewed on 10/11/11 at 1:40 p.m.</p> <p>Diagnoses included, but were not limited to Insulin Dependent Diabetes Mellitus, arthritis, and anxiety.</p> <p>A physician's order set, dated 09/13/11, indicated, "...may self medicate with or without reminders...nurse may medicate if needed...."</p> <p>During an interview on 10/11/11 at 10:30</p>				

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	<p>a.m., Resident #15 indicated her medications were kept in her room in a lock box. Resident #15 indicated the CNAs gave her medications.</p> <p>3. The record for Resident #27 was reviewed on 10/12/11 at 12:00 p.m.</p> <p>Diagnoses included, but were not limited to dementia, depression, hypertension, hypothyroidism and hyperlipidemia.</p> <p>During an interview on 10/12/11 at 9:50 a.m., Resident #27 indicated her medications were kept in her room in a lock box. Resident #27 indicated, the CNAs unlock the box and give the medication due for that time.</p> <p>On 10/11/11 at 12:35 p.m., a self-administration assessment policy and a medication administration policy was requested from the Administrator.</p> <p>During the end of day conference on 10/11/11 at 3:30 p.m., a job description for CNAs was requested from the Administrator.</p> <p>During an interview on 10/13/11 at 12:55 p.m., the RCS was made aware of the observation of CNA #3 opening the lock box, retrieving noon medication and handing pre-packaged medications to</p>						

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	<p>Resident #46. The RCS indicated, "Ya, that's how med reminders are done." She indicated, "We keep keys on a master."</p> <p>On 10/11/11 at 12:55 p.m., a policy provided by the Administrator, titled, "Medication Administration," indicated, "Policy: Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions. Those residents capable may self-administer medication independently without reminders. However, those residents incapable of self-administering medications may use a weekly pill dispenser with specific days of the week denoted on the lid. This pill dispenser will be used to assist in proper medication administration on a daily basis. It will be the responsibility of the responsible family member, licensed nurse or qualified medication aide to dispense medications, however, may be requested to verbally remind the resident of the need to open the pill dispenser and take the previously dispensed medications. If incapable to self-administer medications with or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician...If indicated, the staff will be responsible to remind the individual resident of the need to administer his/her medication on a daily</p>						

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	<p>basis...Should the responsible family member be unable to dispense medications on a weekly basis, a licensed practical nurse (LPN), registered nurse (RN) or qualified medication aide (QMA) will be requested to do so. ...Should the resident be incapable to self-administer medications with or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician and document the same...."</p> <p>On 10/13/11 at 9:00 a.m., job description provided by the Administrator titled, "Certified Nursing Assistant (CNA) dated 11/09, indicated, "Purpose: The Certified Nursing Assistant is a member of the health care team who works under the supervision of a licensed nurse to perform basic nursing care tasks as assigned...Provide applicable residents with medication reminders in the morning, at noon, in the afternoon, and at bedtime...Other Job Functions: 1. Functions within the limits of own experience and knowledge and practices safely and competently within job description...."</p> <p>This state finding relates to Complaint IN00098248.</p>						

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R0244	<p>(4) Preparation of doses for more than one (1) scheduled administration is not permitted.</p> <p>Based on observation, interview and record review, the facility failed to ensure that no more than one dose of medication would be prepared as evidenced by several pre-filled insulin syringes observed in 1 of 1 resident room observed for pre-filled insulin in a total sample of 8. (#18)</p> <p>Findings include:</p> <p>The record for resident #18 was reviewed</p>	R0244	<p>I The licensed nurse (Resident Health and Services Director) of the facility shall not prepare more than one (1) dose of scheduled administration. Resident # 18 now uses a SoloSTAR as opposed to pre-filled insulin syringes.</p> <p>II As the practice of pre-filling insulin syringes not being labeled and dated could affect all residents on scheduled insulin or sliding scale insulin, all insulin dependant residents of the facility have been switched to either a</p>	10/31/2011

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	<p>on 10/11/11 at 10:20 a.m.</p> <p>Diagnoses included, but were not limited to diabetes, hypertension, dementia and Stage III Alzheimer's.</p> <p>An Evaluation of Needs/Services Plan, dated 09/15/11, for Resident #18 indicated, "...Memory impaired-requires assist or supervision with decisions...Resident needs meds reminders from doc-u-dose packets...."</p> <p>A Medication Self Administration Assessment, dated 09/15/11, for Resident #18 indicated, "...Cognitive ability: Limited...Resident responsible for self administration after receiving pre-dispensed medication using the Docu-Dose system [box marked Yes]...Resident receives staff reminders to self administer medications either from weekly dispenser or via Docu-Dose system. [box marked Yes]...Physician order in place for those medications to be self-administered. [box marked yes]...."</p> <p>A physician's order set, dated 08/31/11, for Resident #18 indicated, "...may self medicate with or without reminders...nurse may medicate if needed...."</p> <p>A physician's order set, dated 08/31/11,</p>		<p>SoloSTAR pen or FlexPen. All insulin dependant residents of the facility have been in-serviced on the proper use of the SoloSTAR or FlexPen. Upon the initial use of either the SoloSTAR or FlexPen, they shall be labeled with the resident's name, Physician's name and the expiration date.</p> <p>III In an effort to ensure ongoing compliance, the licensed nurse (Resident Health and Services Director) will in-service all new residents who are insulin dependant on the proper use of the SoloSTAR or FlexPen.</p> <p>The expiration date of the SoloSTAR or FlexPen will be monitored with weekly audits by the Licensed Nurse (Resident Health and Services Director) each and every Monday.</p> <p>IV As a means of quality assurance, the Executive Director/Administrator shall meet with the licensed nurse (Resident Health and Services Director) weekly to address her observations in an effort to confirm continued compliance.</p>				

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	<p>for Resident #18 indicated, "...insulin sliding scale Novolog: 200-250 2units (sic) 251-300 4 units 301-350 6 units 351-400 8 units call if over 400 blood sugar bid...."</p> <p>During an interview on 10/11/11 at 10:20 a.m., the Resident Care Supervisor (RCS) indicated Resident #18's insulin is pre set. RCS indicated, "I'll show you, it will make more sense."</p> <p>During an observation on 10/11/11 at 10:55 a.m., the RCS knocked on Resident #18's door and announced it was time for a blood sugar check. Resident #18 checked his blood sugar using a personal glucometer, and it read 244. According to the resident's sliding scale, he required 2 units Novolog insulin. The RCS opened Resident #18's personal refrigerator and along the inside of the refrigerator door were 4 Styrofoam cups. The first cup was marked 200 - 250, the second cup was marked 251-300, the third cup was marked 301-350 and the fourth cup was marked 351-400. Each cup contained at least four syringes. The syringes were not labeled or dated. The RCS retrieved a syringe out of the cup marked 200-250 and handed the syringe to Resident #18</p>						

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R0273	<p>for self administration.</p> <p>During an interview on 10/11/11 at 11:00 a.m., the RCS indicated she pre fills insulin syringes each week for Resident #18 and places the syringes in the appropriate cup. She indicated the insulin vial was kept in her office. The RCS indicated the unused syringes were disposed of every 10 days. The RCS indicated the syringes were not labeled or dated when filled. The RCS indicated she does not have a specific amount of syringes that she filled every week. The RCS indicated the refrigerator did not need to be locked unless the resident had a history of behaviors or a suicide attempt.</p> <p>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and record review, the facility failed to ensure dietary staff washed their hands for the appropriate length of time during food preparation and serving for 2 of 2 kitchen observations (Cook #1). This practice had the potential to affect 50 of 50 residents.</p>	R0273	I and II All dietary staff shall receive in-service training in regard to correct hand washing procedures and cross contamination during meal preparation. Hand washing training will be the responsibility of the licensed nurse (Resident Health and Services Director).	11/04/2011			

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	<p>Findings include:</p> <p>During an observation in the kitchen on 10/11/11 at 9:10 A.M., Cook #1 was observed making salmon patties and placing them on a large flat sheet pan. She was wearing gloves and removed them prior to taking the sheet pan, covered, holding the salmon patties, to the refrigerator and leaving them there. She returned to the prep area with a large box of frozen bacon slices. Without washing her hands or putting gloves on, Cook #1 placed parchment paper on a flat sheet pan, removed a frozen layer of bacon slices, with her bare hands, and placed the layer on the parchment paper. She then repeated this procedure five more times. Cook #1 indicated the bacon was for the breakfast service the next morning. After covering and dating the bacon slices in the pans, Cook #1 took them to the refrigerator to thaw. Cook #1 then washed her hands for 5 seconds, touching the lid of the trash can with her clean hands to throw away the used paper towel. Cook #1 then went to the prep area to make other lunch preparations.</p> <p>During an observation of the lunch service on 10/11/11 at 12:30 P.M., Cook #1 was serving food with gloved hands. During a short lull in the service, Cook #1 left the serving area to go to the back of</p>		<p>Cross contamination training will be the responsibility of the Registered Dietician and Food Services Director.</p> <p>III As a means to ensure on going compliance, each employee shall be required to perform return demonstration of correct hand washing procedures. Additionally, the Food Services Director shall monitor for correct hand washing procedures and cross contamination concerns daily during scheduled days of work. Should concerns be noted, staff will be re-educated accordingly.</p> <p>IV As a means of quality assurance, the Executive Director/Administrator shall meet with the Food Services Director at least monthly and address observations in an effort to confirm continued compliance with correct hand washing and meal preparation procedures of the dietary staff.</p>				

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R0300	<p>the kitchen. On return to the serving area, Cook #1 removed the gloves, washed her hands for 5 seconds, and put on clean gloves. At that time Cook #1 returned to the steam table and stirred the foods while waiting for the next order from the dining room.</p> <p>A current facility policy, dated 10/03 and last reviewed 4/09, titled "Handwashing/Hand Hygiene", provided by the Administrator on 10/13/11 at 9:00 A.M., indicated:</p> <p>"... Handwashing Procedure: ... 5. Lather all areas of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, and around your fingernails. Continue this scrubbing action for at least 15 seconds....Please note, food service employees shall perform this scrubbing action for at least 20 seconds...."</p> <p>(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date. Based on observation, record review and interview, the facility failed to ensure Novolog Insulin were disposed of after</p>	R0300	I and II Continued use of a vial of Novolog Insulin after the expiration date could affect all	10/28/2011

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	<p>the expiration date for 2 of 8 observations of expired medications (Resident #18 & # 42).</p> <p>Findings include:</p> <p>During observation of the medication storage in the Resident Care Supervisors office refrigerator on 10/12/11 at 2:30 P.M., the following insulins were found to be expired: Resident # 18 Novolog Insulin opened 9/12/11 Resident # 42 Novolog Insulin opened 9/13/11</p> <p>During an interview with the RCS at the same time, she indicated she thought insulins were good for 30 days.</p> <p>During an interview with the Administrator on 10/13/11 at 9:45 A.M., she indicated the facility did not have a policy for insulin storage. "We get the information from the pharmacy."</p> <p>During an interview with the RCS on 10/13/11 at 10:00 A.M., she indicated the pharmacy instructed her to refer to the manufacturer's inserts that come with the vials of insulin for the expiration dates. The manufacturer's insert titled "Novolog" and provided by the RCS on 10/13/11 at 10:00 A.M., indicated the opened vial of Novolog, refrigerated/room temperature,</p>		<p>insulin dependant residents of the facility. The facility has switched from the use of insulin in vials to either the SoloSTAR or FlexPen. While both the SoloSTAR and FlexPens have an expiration date, the Licensed Nurse (Resident Health and Services Director) has been in-serviced regarding the importance of the expiration date, the importance of disposing all medications not used by the expiration date, and reading the manufacturer's insert to educate one's self on the expiration date.</p> <p>III In an effort to insure ongoing compliance, the licensed nurse (Resident Health and Services Director) shall label the SoloSTAR or FlexPen with the resident's name, Physician's name and the date opened. The expiration date of the SoloSTAR or FlexPen will be monitored with weekly audits by the Licensed Nurse (Resident Health and Services Director) each and every Monday.</p> <p>1V As a means of quality assurance, the Executive Director/Administrator shall meet with the Licensed Nurse (Resident Health and Services Director) weekly to address observations in an effort to confirm continued compliance.</p>				

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

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FORM APPROVED

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	could be used for 28 days.				