

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155353	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/13/2015
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00175642.</p> <p>Complaint IN00175642 - Substantiated. Federal/State deficiencies related to the allegations are cited at F159 and F224.</p> <p>Survey dates: July 7, 8, 9, 10, and 13, 2015</p> <p>Facility number: 000244 Provider number: 155353 AIM number: 100288790</p> <p>Census bed type: SNF/NF: 34 Total: 34</p> <p>Census payor type: Medicaid: 28 Other: 6 Total: 34</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	See Cover Letter This Plan of Correction constitutes the written allegations of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exist or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Greensburg desires this Plan of Correction to be considered the Facility's Allegation of Compliance. Compliance effective on August 12, 2015.	

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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F 0159 SS=D Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>				

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to maintain resident funds in interest-bearing accounts and provide quarterly account statements for 3 of 13 residents reviewed of the 29 residents with accounts residing in the facility through December 2014. (Residents #B, C and D)</p> <p>Findings include:</p> <p>An interview was conducted on 07/09/2015 at 2:24 P.M. with the Administrator and Business Office Consultant (BOC) #1. The Administrator and BOC #1 indicated the bank had changed the residents' account to a noninterest-bearing account and it was not brought to their attention until the audit was completed on January 13, 2015.</p> <p>An interview was conducted on 07/10/2015 at 1:47 P.M. with the Administrator. She indicated no quarterly statements had been distributed to the residents or their legal</p>	F 0159	<p>F159 It is the policy of this facility that all resident funds located in Resident Trust accounts will be in interest bearing accounts.</p> <p>1. <u>What corrective action will be done by the facility?</u> An audit was conducted by the Business Office consultants, beginning 12/31/14 as a result of concerns from the Administrator regarding documentation of residents' financial records. The Administrator immediately contacted the Director of Operations to report her concerns, and the decision was made to conduct a full audit. After the audit was conducted, the Business Office Consultant determined that no interest had been applied to these accounts. The local Main Source Bank had changed the account from an interest bearing account to a non-interest bearing account without notifying the facility. Once the facility realized that on January 20, 2015, each resident's account had interest applied back to May of 2013, which was the first month that interest stopped being applied to these accounts. The Business Office Manager</p>	08/12/2015

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	<p>representatives for the 09/01/2014 through 12/31/2014 quarter. She further indicated no residents or resident's representatives complained of missing funds or missing statements. No resident went without services or property as a result of the missing funds, nor were any concerns voiced at Resident Council meetings.</p> <p>Record Review of the Resident Trust Fund Statements for the quarter dating between 09/01/2014 and 12/31/2014 for Residents #B, C and D, were provided by the BOM (Business Office Manager) on 07/10/2015 at 10:39 A.M. No interest was noted on any of the three accounts for the timeframe indicated.</p> <p>The Policy and Procedure, dated 10/2014, that was in place at the time of the occurrence for "Resident Trust", was provided by the Administrator on 07/10/2015 at 9:25 A.M. The policy indicated Personal Funds are to be maintained in an interest-bearing account. The procedure states, "... 6. According to Federal Regulations, the Facility must provide a Statement to the resident or responsible party quarterly, showing all activity in that residents' trust account."</p> <p>This Federal tag relates to Complaint</p>		<p>who was newly hired this year, has been instructed on the need to send out quarterly statements to all residents with trust accounts at the end of each quarter. Quarterly statements have already been sent out in March 2015 and June 2015 to all residents with trust accounts.</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with money in Resident Trust accounts were affected. The Business Office Consultants conducted an audit of all Resident Trust accounts and any accounts found without evidence that interest had been added to their accounts did receive an additional amount of money in each account for any interest owed, going back to May 2013, payable by the company. If in the future, the Administrator or Business Office Consultant finds that there has been no interest added to any Resident Trust account, an audit will be conducted and any money that is owed to the residents will be paid in full by the company, as indicated by the audit results. Once the resident's trust account has been corrected, the Administrator will review the facility policy regarding the management of the Resident Trust accounts with the Business Office Manager, with follow up written progressive counseling for</p>	

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	IN00175642.  3.1-6(c) 3.1-6(g)		noncompliance with the established policy. In addition, each resident (or legal representative) with a trust account is receiving quarterly statements for his/her own account. If it is found that a quarterly statement has not been sent as per policy, the Administrator will make sure that one is done as quickly as possible. Once it has been sent, the Administrator will review the facility policy with the Business Office Manager and will give written progressive counseling for continued noncompliance. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> The bank has been notified by the Administrator that no one has the authorization to change the interest bearing account to any other type of account. The Administrator will check to see that interest is entered into the resident trust reconciliation worksheet and the bank statement monthly. She will also check the individual statements of each resident to ensure that interest has been entered into the Hickory Creek Trust system. The Administrator will sign the reconciliation worksheet and the bank statements to indicate that she has reviewed each one. The Business Office Consultant will check the bank statements and the resident trust reconciliation worksheet at least quarterly. Any	

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F 0224 SS=E Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROP RIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  Based on interview and record review, the facility failed to follow the Policy and Procedure in regard to counting the cash box weekly and completion of quarterly audits. This deficient practice affected 29 residents who had personal funds	F 0224	identified issues in either area noted in this section will be addressed as indicated in question #2. 4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator will report the results of her monitoring the bank statements and resident trust reconciliation, as well as the results of the Business Office Consultant's quarterly monitoring of those items with the QAA committee for review and further recommendations, if any. The Administrator will continue with these monitoring activities on an ongoing basis, even when the QAA committee no longer requires regular reporting. See attachment QA Audit Sheet #1 Date of Compliance: August 12, 2015  F224 It is the policy of this facility to implement written policies and procedures that prohibit abuse and neglect, including misappropriation of resident's property. The facility would like to state that the Administrator	08/12/2015	

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	<p>accounts with the facility.</p> <p>Findings include:</p> <p>An interview was conducted on 07/09/2015 at 2:00 P.M. with the Administrator and BOC (Business Office Consultant) #1. The Administrator indicated she and BOC #1 oversee the BOM (Business Office Manager). The Administrator further indicated she was not counting the cash box because the reconciliation's completed by the BOM were "working out". BOC #1 indicated she was in the facility once a month and reviewed reconciliation documents provided quarterly by the BOM. BOC #1 further indicated she did not perform periodical audits prior to the discovery of missing funds.</p> <p>During an interview on 07/10/2015 at 11:00 A.M., the Administrator indicated a total of \$9,751.70 was discovered missing from the Resident accounts following an audit by BOC #1 and BOC #2 that was completed on 01/13/2015.</p> <p>Record review of the Manual Check Request dated 01/13/2015, provided by the Administrator on 07/10/2015 at 1:45 P.M., itemized the missing funds totaling \$9751.70. This document indicated the following:</p>		<p>notified her Director of Operations when she noted some suspicious signatures on the distribution log. A full audit of the Resident Trust accounts was done; in addition, the Indiana Department of Health and the local police department were notified of the incident and the results of the audit, which indicated questionable entries, documentation, and signatures. The employee responsible for this was placed on suspension, and all money that was found to be misappropriated was paid back by the company to each resident affected. The residents and/or legal representatives were notified of the occurrence, and the responsible employee was subsequently terminated from employment. Examination of existing processes regarding the resident trust accounts was done when the results of the audit were known. Improvement in the facility practices regarding those processes was initiated shortly after the audit in January 2015 and has continued since that time. 1. <u>What corrective action will be done by the facility?</u> The facility has repaid every residents' trust accounts for any monies that were found to have been taken without permission from their account, as a result of the audit done by the Business Office Consultants. The Business Office Manager who was newly hired this year, has been instructed on the need to</p>	

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	<p>Checks made out to residents; were signed, but resident could not sign: \$ 4690.00</p> <p>Cash withdrawn, but signatures are questionable: \$ 3220.67</p> <p>Deposits listed on ledger cards (have been removed to balance account), but did not show up on any deposit slip: \$ 300.00</p> <p>Cash short in box: \$ 1541.03</p> <p>The Policy and Procedure, dated 10/2014, that was in place at the time of the occurrence for "Resident Trust ", was provided by the Administrator on 07/10/2015 at 9:25 A.M. The Procedure states, "...The cash box MUST be counted weekly by the Business Office Manager and Administrator to make sure the box balances to the distribution Log. After checking the balance put your initials and date next to the amount in Box Balance. The trust money box must be counted by both the Business Office Manager &amp; Administrator before the Business Office Manager is scheduled to be off work for more than a couple of days. The count must be initialed &amp; dated by both parties. Upon the return of the Business Office Manager to work, the money box must be counted for accuracy. This count must be initialed &amp; dated by</p>		<p>send out quarterly statements to all residents with trust accounts at the end of each quarter. Quarterly statements have already been sent out in March 2015 and June 2015 to all residents with trust accounts. 2. <u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u> All residents with trust accounts have the potential to be affected by this practice. Since the time of the audit and repayment of the trust accounts, the facility has maintained each account as required by facility policy, which is detailed in question #3. Each resident (or legal representative)with a trust account is receiving quarterly statements for his/her own account.If it is found that a quarterly statement has not been sent as per policy, the Administrator will make sure that one is done as quickly as possible. Once it has been sent, the Administrator will review the facility policy with the Business Office Manager and will give written progressive counseling as indicated for continued noncompliance. In the future, if the Administrator or Business Office Consultant finds that the accounting of the resident trust accounts has not been done as required, the Director of Operations and Administrator(if not already involved) will be</p>	

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	<p>both parties. The Business Office Consultant will periodically audit this. ... 8. The Business Office Consultant will regularly audit Trust ledgers and Distribution Logs for accuracy."</p> <p>This Federal tag relates to Complaint IN00175642.</p> <p>3.1-28(a)</p>		<p>immediately notified. A full audit will be performed, and any missing money will be repaid to the residents affected. Once the residents' accounts are verified and accurate, the Administrator or Director of Operations will follow through with re-training, along with progressive disciplinary action, up to and including termination of employment, as indicated by the identified issue. 3. <u>What measures will be put into place to ensure this practice does not recur?</u> All residents with trust accounts will enter their transactions on the resident trust logs. The Business Office Manager and the Administrator will count the cash boxes on Friday, placing their signatures next to the date and the amount. If the Administrator is not present, the Director of Nursing will perform the count with the Business Office manager. The Business Office Consultant will review and initial the cash box logs during her regular visits. This has been practice and policy since the discovery of the misappropriation of funds in January 2015. The Business Office Manager sends the quarterly statements of the Resident Trust accounts to the resident to sign, if he/she is able to do so. A copy is also sent to the legal representatives, as well. A copy of each statement is kept in the Business Office for that</p>	

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			<p>quarter, and the Administrator signs the file quarterly to indicate that all statements have been sent to the legal representative or signed by the resident. The Business Office Consultant will check to see that the quarterly files are in place during her routine visits. All monthly bank statements are being checked for authentic signatures, along with checking the ending balance of the statement, and comparing that ending balance with the ending balance in the checkbook. This is being signed by the Administrator, as well, to indicate her review. These processes have also been in place and operational since January 2015.</p> <p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> The Administrator or Business Office Manager will bring the results of the trust account and cash box monitoring activities to the monthly QAA Committee meeting for review and further recommendations for the next 3 months. At the end of that time, the committee members may decide that regular reporting of the resident trust processes is no longer needed, but the monitoring activities will continue on an ongoing basis, regardless of whether or not they are reviewed with the QAA committee. Date of Compliance: August 12, 2015</p>	

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan related to urinary incontinence for 1 of 2 residents reviewed for urinary incontinence. (Resident #13)</p> <p>Findings include:</p> <p>The clinical record for Resident #13 was reviewed on 07/09/2015 at 10:23 A.M. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes, history of stroke, dementia, anxiety, and psychotic</p>	F 0279	<p>F279 It is the policy of this facility to develop care plans for all residents' needs, including bladder incontinence. <b><u>#1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u></b> The care plan for Resident #13 has been developed to reflect her occasional incontinence of bladder. Licensed nurses have been inserviced on the need for consistent charting, including for those residents who have partial incontinence, and the IDT (interdisciplinary team) has been</p>	08/12/2015	

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	<p>disorder. Review of the physician's orders indicated the resident was on a diuretic for hypertension. The Prospective Payment System (PPS) assessment, dated 03/30/2015, indicated Resident #13 was occasionally incontinent of urine. The quarterly Minimum Data Set (MDS) assessment, dated 04/01/2015, indicated Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, signifying the resident was alert and oriented. The MDS Bladder assessment indicated the resident was occasionally incontinent of urine.</p> <p>The "ADL (Activities of Daily Living) Flow Records", provided by the MDS coordinator on 07/09/2015 at 1:57 P.M., indicated Resident #13 had documented episodes of incontinence on May 29, 30 and 31, 2015 and on June 28 and 29, 2015.</p> <p>The Care Plans for Resident #13 were reviewed on 07/09/2015 at 10:32 A.M. and were dated as reviewed by the facility on 06/25/2015. There was no urinary incontinence care plan provided by the facility for Resident #13.</p> <p>During an interview on 07/09/2015 at 11:28 A.M., the Director of Nursing (DON) indicated there was no care plan</p>		<p>inserviced on the need for thorough review of all care plans to make sure that each is reflective of the residents' current status. <b>#2 How will the facility identify other resident having the potential to be affected by the same deficient practice?</b></p> <p>All residents who have incontinence have the potential to be affected by this practice. The DON has reviewed all residents' incontinence status. Any identified concerns with care plans being reflective of incontinence issues have been corrected. In the future, if the DON or any member of the IDT identifies that a resident's care plan is not reflective of his/her current status as it relates to incontinence, the DON will be notified and the care plan updated as quickly as possible. Once that is done, the Administrator or the DON will review the facility policy with the involved staff and written counseling will be done as indicated by continued noncompliance. <b>#3 What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?</b> The MDSC or DON will audit all completed MDS assessments and related care plans each month x 3 months. See Attachment Audit sheet #2. At the end of that time period, the DON or MDSC will continue to audit at least 8 residents' MDS</p>	

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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT GREENSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N LINCOLN ST GREENSBURG, IN 47240
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F 0431 SS=D Bldg. 00	<p>created for urinary incontinence related to Resident #13.</p> <p>During an interview on 07/09/2015 at 1:51 P.M., Registered Nurse (RN) #3 indicated Resident #13 was occasionally incontinent of bladder and had difficulties holding her urine to reach the bathroom.</p> <p>During an interview on 07/09/2015 at 1:56 P.M., the MDS Coordinator indicated Resident #13 was occasionally incontinent of urine, which was documented on the "ADL Flow Records".</p> <p>3.1-35(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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</p>		<p>assessments and corresponding care plans quarterly for the next 2 quarters. Any identified concerns will be addressed as indicated in question #2. <b><u>#4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u></b> MDS/DON will present the results of their audits to the QAA Committee at the monthly meetings for review and recommendations. At the end of the 3rd quarter of audits, the QAA committee may decide to stop the documented audits; however, the IDT, including the MDSC and DON, will continue the process of checking MDS assessments and care plans on an ongoing basis.</p> <p><b>Completion date: 08/12/15</b></p>	

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	<p>date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to follow current, acceptable practice for the disposal of expired medications for 1 of 3 medication storage areas observed. (Medication refrigerator)</p> <p>Findings include:</p> <p>An observation of the medication refrigerator was conducted on 07/08/2015 at 10:18 A.M. with the Director of Nursing (DON). A medication labeled Tuberculin Purified Protein Derivative (PPD) injection solution, had an opened date of 04/21/2015. Two single dose vials of pneumonia vaccines had expiration dates of 03/08/3015. All three of the expired medications were located</p>	F 0431	<p>F431 It is the policy of this facility to follow current acceptable practice for disposal of expired medications. <b>#1 How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</b> Nurses will be inserviced by the DON on the facility policy for checking and discarding any medications that are expired. <b>#2 How will the facility identify other resident having the potential to be affected by the same deficient practice?</b> No residents were affected by this practice; however, in the future, if the DON or any licensed nurse finds an expired medication, it will be disposed of according to the facility policy. If it is found by a</p>	08/12/2015

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	<p>in a clear plastic bin on the middle shelf of the refrigerator.</p> <p>During an interview on 07/08/2015 at 10:27 A.M., the DON indicated she failed to check for the PPD that had been ordered a week ago to replace the expired medication. The DON further indicated, the facility normally did not stock pneumonia vaccine and was unsure as to why the expired pneumonia vaccine was in the refrigerator.</p> <p>The current policy and procedure for "Medication Storage in the Facility", dated 6/2011, was provided by the DON on 07/08/2015 at 10:15 A.M. The policy indicated, "...Any outdated...drugs...must be removed from stock and destroyed according to the drug destruction policy." Package insert for the PPD injection solution indicated, a vial of PPD which has been "... entered and in use for 30 days should be discarded."</p> <p>3.1-25(o)</p>		<p>charge nurse, he/she will notify the DON, so that the involved staff can be re-trained on the facility policy. Written counseling will occur for those staff members involved in continuing noncompliance. <b><u>#3 What measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur?</u></b> The DON will check for expired medications weekly in all medication storage areas, including the medication room refrigerator, and will report to the IDT members of the Standards of Care committee regarding her findings for the next 6 months. The pharmacy will complete an audit of medications for expiration dates monthly, will remove them as needed, and will report the findings of that visit, including any expired medications, to the DON and/or Administrator. Nurses will check for expired meds monthly when defrosting and cleaning refrigerator. See Attachment Audit Sheet #3. Any identified instances of noncompliance will be addressed as indicated in question #2. <b><u>#4 How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u></b> Results of weekly audits will be brought to the weekly Standard of Care meeting by the DON or Administrator for 6 months. Results of weekly audits, audits by pharmacy and</p>	

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			licensed nurses will be brought to QA meeting monthly for review and recommendation for 6 months. At the end of that time, if 100% compliance is reached, the committee may decide to stop the documented audits; however, the weekly checking by the DON and the monthly checking by the pharmacy and nurses will continue on an ongoing basis. Date of Compliance: 8/12/15		