

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155299	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2015
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 13, 14, 15, 16, and 19, 2015.</p> <p>Facility number: 000196 Provider number: 155299 AIM number: 100267390</p> <p>Census bed type: SNF: 2 SNF/NF: 46 Total: 48</p> <p>Census payor type: Medicare: 7 Medicaid: 33 Other: 8 Total: 48</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on October 27, 2015.</p>	F 0000	<p>This Plan of Correction shall serve as this facility's credible allegation of compalince. Preparation , submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in the survey. Respectfully Submitted Beth Ingram Executive Director</p>	
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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 0242 SS=D Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview the facility failed to ensure each resident had a choice regarding when to get up in the morning for 1 of 3 residents reviewed for choices of the 5 residents who met the criteria for choices. (Resident #47)</p> <p>Finding includes:</p> <p>Interview with Resident #47 on 10/14/15 at 9:12 a.m., indicated she wakes up between 6:00 and 6:30 a.m. She further indicated she would like to get out of bed at that time, but she had to wait until 7:00 a.m., or after before staff come and get her dressed.</p> <p>On 10/16/15 at 5:39 a.m. and 6:25 a.m., the resident was observed in bed. The room lights were noted to be off in her room. Nursing staff were observed on the Pod (Nursing Unit) getting other residents up.</p> <p>On 10/16/15 at 7:15 a.m., the resident</p>	F 0242	<p>Step 1: Resident #47 was re-interviewed to verify her preferences. Her pocket guide was updated and staff was re-educated to her preferences.</p> <p>Step 2: All Residents or their Family members were re-interviewed to verify individual preferences. Pocket guides were updated as needed and staff were re-educated. Step 3: Residents or their Family members will be re-interviewed during the quarterly care plan meetings to verify preferences, or more frequently as needed. Pocket guides will be updated. All staff will be re-educated regarding honoring our Resident's individual preferences. Step 4: The Administrator or her designee will audit compliance with resident preferences as follows;Week one 10% of the population will be audited daily.Weeks two through four 10% will be audited three times weekly.Weeks five through nine 10% will be audited once weekly.For the next four months 10% will be audited monthly.</p>	11/16/2015

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	<p>was observed sitting on the side of the bed. At that time, the resident was dressed in her night gown. The resident stated, "I am getting a little disgusted because I have been up since 6:15 a.m. The Nurse came in to give me my medications and I cannot go back to sleep after that. They know I want to be up early, and I do not want to be the last one down to the dining room for breakfast."</p> <p>Interview with LPN #2 the midnight Nurse on 10/16/15 at 7:35 a.m., indicated she had administered medications to the resident that morning. She indicated the medications were scheduled for 6:00 a.m., and at that time, the resident received two Tylenol pills, Systane eye drops, and an oral mouth rinse.</p> <p>On 10/16/15 at 8:00 a.m., CNA #1 entered the resident's room to get her up out of bed and dressed.</p> <p>The record for Resident #47 was reviewed on 10/15/15 at 3:19 p.m.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/9/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was alert and oriented. The resident was an extensive assist with one person physical assist</p>		Results will be reported to the QAPI team. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continued auditing. Compliance assured 11/16/15				

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F 0312 SS=D Bldg. 00	<p>with bed mobility, dressing, toilet use, and transfers. The resident was totally dependent for locomotion on and off the unit.</p> <p>The ICF (Unit 100) Aid Assignment Sheet dated 10/9/15 indicated there was no information regarding the resident's preference to get up early.</p> <p>Interview with CNA #1 on 10/16/15 at 9:20 a.m., indicated she was unaware the resident wanted to get up early.</p> <p>Interview with the Director of Nursing on 10/16/15 at 10:00 a.m., indicated she would ask the resident if she wanted her medication times changed or if she would prefer to get up between 6:00 a.m. and 6:30 a.m.</p> <p>3.1-3(u)(1)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure a</p>	F 0312	F312 Step 1: Oral care was provided for Resident #32. Step 2: All Residents were checked	11/16/2015

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	<p>totally dependent resident received personal hygiene care related to oral care for 1 of 3 residents reviewed for Activities of Daily Living (ADLS) of the 26 residents who met the criteria for ADLS. (Resident #32)</p> <p>Finding includes:</p> <p>Interview with Resident #32's spouse on 10/13/15 at 1:55 p.m., indicated Nursing staff does not provide oral care for the resident. He indicated his wife does not have teeth, but they could use mouth swabs.</p> <p>On 10/16/15 at 6:53 a.m., CNA #1 and CNA #2 entered the resident's room to provide morning care and to get her out of bed. The CNAS provided peri care first because the resident did not want her face washed. After providing peri care they placed a clean incontinent brief on the resident and put on her pants. Both CNAS removed her nightgown and placed an undershirt on her and then placed her shirt on. CNA #1 put on a clean pair of socks and put on her slippers. CNA #2 left the room to get the Hoyer (a resident transferring device) lift to get the resident up and into her wheelchair. After the resident was placed in the wheelchair, CNA #1 put a right hand splint on her hand. Both CNAS</p>		<p>for proper oral hygiene, and interviewed for their preference for assistance desired. Step 3: Care Plans and CNA Pocket guides were updated to reflect each Resident's care needs. Staff will be re-educated to the importance of providing proper oral care.</p> <p>Step Four: The Administrator or designee will audit compliance with resident oral care as follows;</p> <p>Week one, 10% of the population will be audited daily.</p> <p>Weeks two through four, 10% will be audited three times weekly.</p> <p>Weeks five through nine, 10% will be audited once weekly.</p> <p>For the next four months, 10% will be audited monthly. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit.</p>				

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	<p>removed their gloves, washed their hands, and left the room, indicating they were done with morning care. Neither CNA provided oral care to the resident by swabbing her mouth with the oral swabs.</p> <p>On 10/15/15 at 9:13 a.m., the record for Resident #32 was reviewed. The resident's diagnoses included, but were not limited to, heart failure, blindness both eyes, stroke, high blood pressure, convulsions, glaucoma, and aphasia.</p> <p>The Annual Minimum Data Set (MDS) assessment dated 9/11/15 indicated the resident was severely impaired for decision making. The resident was totally dependent for transfers and bed mobility with two person physical assist. The resident was totally dependent with dressing and personal hygiene with one person physical assist.</p> <p>The current plan of care updated 9/18/15 indicated the resident required total assist with bathing, dressing, personal hygiene, and toileting related to vision impairment.</p> <p>The ICF (Unit 100) Aid assignment sheet dated 10/9/15 was reviewed. The CNA assignment sheet indicated under the section "Extras" Husband sets clothes out. There was no information regarding</p>		Compliance assured 11/16/15	

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	<p>oral care.</p> <p>The current 3/13/12 Morning Care policy provided by the Director of Nursing on 10/16/15 at 10:06 a.m., indicated the purpose of morning care was to cleanse and refresh the resident, while stimulating circulation and providing comfort and preparing the resident for the day. One of the procedures was to provide oral care by providing mouth care with a toothbrush and toothpaste or oral swab and mouthwash.</p> <p>Interview with CNA #1 on 10/16/15 at 9:20 a.m., indicated morning care was to be provided to all residents in the morning. She further indicated morning care consisted of doing peri care, washing the resident's face and under arms, putting deodorant on the resident if they wanted it, and providing oral care. The CNA indicated she did not provide oral care to Resident #32 and she should have. She indicated she did not even think about using the swabs in her mouth.</p> <p>Interview with LPN #1, day shift nurse on the ICF Pod on 10/16/15 at 9:25 a.m., indicated oral care was to be provided with morning care.</p> <p>3.1-38(a)(3)(C)</p>			

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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>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 observation, record review, and interview, the facility failed to ensure a Gradual Dose Reduction (GDR) was completed related to an Antidepressant medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #7)</p> <p>Finding includes:</p>	F 0329	<p>Adendum: All Residents with an order for Psychotropic medications will be reviewed to assure gradual dose reductions. Physicians will be contacted for any Residents requiring GDR and follow up assured. Step 1: A request was made for the physician to document his reason for declining a GDR for Resident #7. Step 2: The drug regimine for all residents with anti-depressant medication will be</p>	11/16/2015

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	<p>On 10/14/15 at 2:56 p.m., Resident #7 was observed sitting in her wheelchair next to her bed with her eyes closed. The resident was observed not to be displaying any behaviors.</p> <p>The record for Resident #7 was reviewed on 10/15/15 at 9:39 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder, anemia, high blood pressure, type two diabetes mellitus, and mood disorder due to known physiological condition.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/30/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 3, which indicated the resident was severely impaired for decision making. The resident was coded as having no hallucinations or delusions. The resident was also coded as having physical and verbal behaviors at least 4 to 6 days during the assessment period. The resident received and an antipsychotic and an antidepressant for 7 days.</p> <p>The plan of care updated 10/5/15 indicated the resident had the potential for signs and symptoms of depression related to the loss of independence and can no longer to go back to assisted</p>		<p>reviewed for need of Gradual Dose Reduction and proper physician documentation when a GDR is declined. Step 3: Social Services or Designee will review Pharmacy recommendations monthly for GDR and assure Physician review along with proper documentation. Social Services will be re-educated to the requirements for GDR. Step Four: The Social Services or designee will audit compliance with un-necessary Drugs and Physician documentation as follows; Pharmacisit recommendations will be reviewed for GDR following the monthly visit for six months. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit. Compliance assured 11/16/15</p>		

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	<p>living.</p> <p>Physician Orders dated 7/22/14 and on the current 10/2015 recap indicated Sertraline (Zoloft: an antidepressant) 50 milligrams (mg) at night time.</p> <p>Social Service Progress Note dated 9/15/15 at 10:27 a.m., indicated the resident was seen by Psych Services on 9/14/15. The recommendations would be forwarded to the primary care Physician for review.</p> <p>Behavioral care solutions visit by the Nurse Practitioner dated 6/11/15 indicated the staff report no behaviors and the resident was doing well. The resident was always pleasant and cooperative. No signs of sedation and to continue all meds.</p> <p>Another visit by Behavioral care solutions dated 7/28/15 indicated the staff report no behaviors and the resident was pleasant and cooperative. She had no complaints but the resident admitted to being abusive to the staff.</p> <p>A Behavioral care solutions visit dated 9/14/15 indicated it was highly recommended for GDR for the Zoloft medication. The recommendation was to reduce Zoloft 50 mg every night times 6</p>			

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	<p>weeks with Sundays off.</p> <p>A Pharmacy recommendation dated 1/1-1/18/15 indicated the resident was on Ativan (Anti-anxiety medication) 0.5 mg every 12 hours as needed, Haldol (an antipsychotic medication) 1 mg twice a day, Zoloft 50 mg every night, and Depakote (a mood stabilizer medication) 250 mg twice a day. The Pharmacist indicated all of the above medications were due for re-evaluation of their dosage. The Pharmacist recommended for the Zoloft or Depakote to be reduced. The Physician only signed his name for the recommendation on 3/4/15 to not do the GDR. There was no further documentation as to why a GDR could not be considered.</p> <p>Interview with the Social Service Director (SSD) on 10/15/15 10:45 a.m., indicated the family would absolutely not give consent to reduce Haldol. She further indicated the resident's Physician had not documented any reasons why the resident could not have had a GDR for the Zoloft.</p> <p>3.1-48(b)(2)</p>			

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F 0387 SS=D Bldg. 00	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure the resident's Physician visited the resident at least one time every 60 days for 1 of 1 residents reviewed for Physician visits. (Resident #7)</p> <p>Finding includes:</p> <p>The record for Resident #7 was reviewed on 10/15/15 at 9:39 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder, anemia, high blood pressure, type two diabetes mellitus, and mood disorder due to known physiological condition.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/30/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 3, which indicated the resident was severely impaired for decision making.</p>	F 0387	<p>F 0387 Step 1: Resident #7 was attended by her physician on 11/4/15. Step 2: All Residents records were reviewed for timeliness of Physician visits and the physician notified if not timely. Step 3: A letter was sent to all attending physicians re-educating them to the federal requirements. Medical Records will audit physician's visits monthly for timeliness and inform the Administrator when a physician is not current. The Administrator and the Medical Director will contact physicians who are not compliant. The Medical Director will attend the Resident if the Physician is unable or unwilling to attend. Step Four: The Administrator or designee will audit compliance with Physician visits as follows; All physician's visits will be monitored monthly for compliance. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit. Compliance assured</p>	11/16/2015			

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F 0463 SS=D Bldg. 00	<p>Physician Progress notes were reviewed. The Physician had visited the resident on 9/11/14, 2/18/15, 4/23/15 and 8/21/15. There were no other visits documented in the resident's medical record.</p> <p>Interview with the Administrator on 10/15/15 at 11:00 a.m., indicated the Physician had not made the required visit to the resident at least one time every 60 days.</p> <p>3.1-22(d)(1)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents were provided functioning call system devices at their bedsides, for 1 resident in a sample of 38. (Room #102-1)</p> <p>Finding includes:</p> <p>On 10/14/2015 at 9:33 a.m., an observation was made in Room 102-1. The bedside call light was pressed, the light did not illuminate on the bedside</p>	F 0463	<p>11/16/15</p> <p>F463 Step 1: The identified call light was replaced immediately. The Resident residing in the room was not adversely affected. Step 2: All call lights were tested the same day and none were identified. Step 3: All staff were re-educated to the process for reporting a call light that does not function properly. Maintenance was re-educated to respond promptly to a report of a malfunctioning call light. Step Four: The Administrator or designee will audit compliance</p>	11/16/2015

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 5909 LUTE RD PORTAGE, IN 46368
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F 0465 SS=B Bldg. 00	<p>panel on the wall, it also did not illuminate outside the resident's room.</p> <p>Interview with the Director of Nursing on 10/14/2015 at 9:42 a.m., indicated the bedside call light was not functioning properly and was replaced by her at that time.</p> <p>Interview with the Maintenance Director on 10/16/15 at 8:15 a.m., indicated he was made aware on 10/14/2015 of the bedside call light in Room 102-1 not functioning properly and he did check all the residents' call lights in the facility that day.</p> <p>3.1-19(u)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a functional and sanitary environment was maintained related to broken and marred wood moldings, urine odors, discolored wood fillings on residents' room doors, and stained carpets on 2 of 3 units throughout the facility. (Unit 100 and 200)</p>	F 0465	<p>with resident call lights as follows; 16 call lights will be audited weekly on a rotating basis so that all light is checked monthly. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit. Compliance assured 11/16/15</p> <p>Step 1: All issues identified were corrected. Step 2: An audit of all Resident areas were completed. Issues identified will be corrected. Step 3: Maintenance was re-educated to the requirements to maintain a clean and safe environment. Step Four: The Administrator</p>	11/16/2015

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	<p>Finding includes:</p> <p>During the Environmental tour on 10/16/15 at 8:10 a.m., with the Maintenance Director, the following was observed:</p> <ol style="list-style-type: none"> 1. Unit 100 <ol style="list-style-type: none"> a. Room 102, there was broken wood molding along the bottom of the window. Two residents resided in this room. b. Room 104, there was a strong odor of urine. Two residents resided in this this room. c. Room 106, the bedroom door frame was marred and there was discolored wood filling in the gouges. Two residents resided in this room. d. Room 109, the carpet in front of bed two was stained. The bedroom door was marred and there was discolored wood filling in the gouges. Two residents resided in this room. e. Room 110, the bedroom door was marred and there was discolored wood filling in the gouges. Two residents 		<p>or designee will audit environment sanitation and repair as follows;</p> <p>Week one, 10% of the rooms will be audited daily.</p> <p>Weeks two through four, 10% will be audited three times weekly.</p> <p>Weeks five through nine, 10% will be audited once weekly.</p> <p>For the next four months, 10% will be audited monthly. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit.</p> <p>Compliance assured 11/16/15</p>	

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F 9999 Bldg. 00	<p>resided in this room.</p> <p>f. Room 111, the bedroom door was marred and there was discolored wood filling in the gouges. One resident resided in this room.</p> <p>2. Unit 200</p> <p>a. Room 202, the wood molding on the wall behind the head of the bed was marred. Two residents resided in this room.</p> <p>b. Room 203, the bedroom door was marred and there was discolored wood filling in the gouges. Two residents resided in this room.</p> <p>Interview with the Maintenance Director on 10/16/15 at 8:20 a.m., indicated all the above was in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>			
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	<p>3.1-14 PERSONNEL</p> <p>(u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure six hours of dementia-specific training was completed within six months of initial employment for 3 of the 6 employees who had been hired since February 2014. (Dietary Aide #1, CNA #3, and CNA #4)</p> <p>Finding includes:</p> <p>a. The employee file for Dietary Aide #1 was reviewed on 10/19/15 at 11:00 a.m. The dietary aide was hired on 9/1/14. The dietary aide had not completed her</p>	F 9999	<p>Step 1: The identified staff received the required education. Step 2: Completion of Dementia Training was identified as an issue prior to the survey. All staff education was audited and all staff were provided Dementia education. A plan was put in place to assure ongoing complinace. Step 3: A new hire education check list is initiated to assure all new employees complete the required training, including Dementia training in a timely manner. All Department heads will be educated to the requirement for their staff to complete training in a timely basis. Step Four: The Inservice Director or designee will audit compliance with new hire and annual dementia training as follows; All new hires will be tracked monthly for compliance and removed from the schedule if not completed in time. 2015 Annual training is nearly completed by 11/30/15. Results will be reported to the QAPI team monthly. The QAPI team will monitor compliance and recommend changes to the audit, including the need for continuing audit. Compliance assured 11/16/15</p>	11/16/2015	

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	<p>dementia-specific training.</p> <p>b. The employee file for CNA #3 was reviewed on 10/19/15 at 11:05 a.m. The CNA was hired on 10/16/14. The CNA had only completed 1 hour of dementia-specific training.</p> <p>c. The employee file for CNA #4 was reviewed on 10/19/15 at 11:10 a.m. The CNA was hired on 7/1/14. The CNA had only completed 2 hours of dementia-specific training.</p> <p>Interview with the In-service Director on 10/19/15 at 2:45 p.m., indicated the above employees had not completed 6 hours of dementia-specific training within 6 months of hire.</p> <p>3.1-14(u)</p>			