

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2016
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER	STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 18, 19, 20, 23 & 24, 2016</p> <p>Facility number: 000326 Provider number: 155430 AIM number: 100290770</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 3 Medicaid: 20 Other: 10 Total: 33</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on May 26, 2016.</p>	F 0000		
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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 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to honor a resident choices for bathing type. This deficient practice had the ability to affect 1 of 3 residents reviewed for choices. (Resident #1)</p> <p>Finding includes:</p> <p>A clinical record review was completed on 5/23/2016 at 9:30 A.M. Resident #1 was admitted on 10/22/2002. Her diagnoses included, but were not limited to: diabetes mellitus, osteoporosis, legal blindness, schizoaffective disorder, cardiac arrhythmia and neuropathy.</p> <p>The MDS (Minimum Data Set) assessment, dated 4/18/2016, indicated it</p>	F 0246	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 6/22/2016.</p> <p>F-246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES It is the policy of this facility to ensure that each resident has the right to reside and receives services in the facility with reasonable accommodations of</p>	06/22/2016

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	<p>was very important for Resident #1 to choose between a tub bath, shower, bed bath or a sponge bath.</p> <p>During an interview on 5/19/2016 at 10:28 A.M., Resident #1 indicated she would like to take a tub bath, however one had not been offered to her.</p> <p>During an interview on 5/23/2016 at 10:37 A.M., the DON (Director of Nursing) indicated she did not know if the bath tub was in working order. She indicated that upon admission to the facility, residents are asked what day they would like to take their showers. She indicated that Resident #1 had let staff know she wanted a tub bath previously.</p> <p>During an interview on 5/23/2016 at 10:56 A.M., the DON indicated Resident #1 had not received a therapy assessment to see if she was able to safely get into and out of the bath tub. She indicated she would ask the physical therapy department to assess her.</p> <p>On 5/24/2016 at 10:58 A.M., the DON indicated the facility did not have a policy related to bathing choices for residents.</p> <p>3.1-3(v)(1)</p>		<p>individualneeds and preferences, including each one's preference for bathing. What corrective action will be completed for residents affected? Resident #1 was interviewed for her bathing preference on 5/24/16. She was then assessed bytherapy on 5/24/16 to determine the safety of using a tub bath. Therapydetermined that the tub would not be safe for this resident. Resident waseducated on safety of using the tub, resident understands the safety issues andstated that she will be satisfied with the shower. The IDT membersand nursing staff will be in-serviced on each resident's right to choice andpreferences in their care on 6/13/16 . What other residents identified as having thepotential to be affected and corrective action taken? All residents havethe potential to be affected by this practice. Allother alert and oriented residents were interviewed as to their bathingpreferences and any changes from previous stated preferences were noted in theresidents' record, care plan, and on the c.n.a assignment sheets. Family ofthose residents not able to communicate their preference were contacted andwere interviewed as to their bathing preference. And any changes were noted inthe resident record, care planand on the resident assignment sheet.</p>		

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			<p>If a concern should be voiced in the future, the DON will meet with the resident and reschedule his/her bathtime in accordance with his/her preferences. This change will be reflected on the resident's care plan and on the CNA assignment sheet. What other measures will be put into place to make sure this practice does not recur? All new admissions will be questioned as to their bathing preference by using form HC-SS-22, and if unable to communicate, families will then be interviewed to determine preferences. All preferences/choices will be added to the c.n.a assignment sheets and care plans. Each resident will also have their preference for bathing reviewed at each scheduled care plan conference. If there are any changes, they will be noted in the care plan conference notes and will be updated on the CNA assignment sheet and the resident's care plan. The DON/designee will audit all admissions for completion of form HC-SS-22 for documentation of preferences, and then will check the bathing schedule, CNA assignment sheet, and care plan for accuracy. (See attachment "A") Any identified concerns will be addressed by the DON at the time of the audit. Once the situation has been addressed, the DON will re-train staff regarding the facility policy and practice of</p>	

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F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure 1 of 1 residents reviewed for incontinence was thoroughly assessed after	F 0315	honoring residents' preferences. How will corrective action be monitored to ensure deficient practice does not recur and what QA will be put in to place? The DON will bring the results of her audits to the monthly QA Committee meeting for 3 months. The MDS Coordinator will also bring a list of any resident bathing preferences that have been changed during scheduled care plan conferences. Once the 3 months have been completed, and if the facility has reached 100% compliance, the QA Committee may decide to stop the written audits at that time. The process itself, as outlined previously, will continue on an ongoing basis. Date of Compliance: June 22, 2016 F315 NO CATHETER, PREVENT UTI, RESTORE BLADDER It is the policy of this facility to ensure that a resident who is incontinent of bladder receives	06/22/2016	

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	<p>experiencing a significant decline in bladder continency. (Resident #35)</p> <p>Finding includes:</p> <p>The clinical record review for Resident #35 was completed on 5/23/2016 at 8:51 A.M. Resident #35 was admitted on 5/25/2014. Her diagnoses included but were not limited to: Alzheimer's disease, hypertension, osteoarthritis, chronic kidney disease, anxiety disorder, muscle weakness, major depressive disorder, dementia with behavioral disturbances, psychosis and a history of urinary tract infections.</p> <p>The annual MDS (Minimum Data Set) assessment, completed on 05/05/15, indicated the resident was occasionally incontinent of her bladder, was severely cognitively impaired and required extensive staff assistance for toileting needs.</p> <p>The Bladder Assessment Form, completed on 05/05/15 for Resident #35 indicated the resident was on a Restorative Toileting Program with staff toileting the resident to decrease incontinent episodes. The assessment indicated the resident was both continent and incontinent of her bladder.</p>		<p>appropriate treatment and services to restore as much normal bladderfunction as possible, including a thorough assessment after a significantdecline in bladder continence.</p> <p>What corrective action will be completed forresidents affected? Resident #35 had anew five-day voiding pattern completed. The care plan was reviewed and updatedto reflect the current bladder continence status. Nurses and MDSstaff will be re-educated on the policy and completion of Bladder assessmentsand five-day voiding sheets on 6/7/16. (See attachment "C")</p> <p>What other residents identified as having thepotential to be affected and corrective action taken? All otherresidents have the potential to be affected. All current Bladder assessmentswill be reviewed by 6/7/16 for accuracy and any discrepancies and or changes incontinence status noted will be addressed by initiating a new bladder assessmentalong with a five-day voiding diary. (Seeattachment "B") When completed, the toileting plan will be reflected in theresidents' care plan and CNA assignment sheet.</p> <p>What other measures will be put into place to make sure this practice</p>	

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	<p>The quarterly MDS assessment, completed on 10/22/15, indicated the resident had declined and was now always incontinent of her bladder.</p> <p>The most recent annual MDS assessment, completed on 04/11/16, indicated Resident #35 was severely cognitively impaired, was non ambulatory and required the extensive assistance of two staff for transfer and toilet use and was always incontinent of her bowels and bladder</p> <p>A Bladder Assessment Form, completed on 04/11/16, for Resident #35 indicated the resident was incontinent of her bladder. The History questions on the form, to be answered by the resident or the resident's family members, had a line drawn through them and "unable to answer accordingly" was handwritten across the section. Handwritten in the section for information if the resident was continent was the following: "Resident is dependent on staff for all ADL [Activities of Daily Living] to include toileting. Incontinent of bladder. Peri-care given upon incontinent episode." The section for documentation of a 5 day voiding pattern start time was left blank.</p> <p>During an interview on 5/23/2016 at 9:46</p>		<p>does not recur?</p> <p>Each week, the MDS Coordinator and/or DON will audit all bladder assessments and five-day voiding diaries of residents listed on the monthly MDS calendar. They will bring the results of the audits to the weekly Standards of Care meeting for review by the IDT. Any changes in bladder incontinence identified will be discussed and recommendations will be made for new assessments to be completed. Once those are completed, a revised toileting plan will be devised for each affected resident.</p> <p>How will corrective action be monitored to ensure deficient practice does not recur and what QA will be put into place?</p> <p>The DON and MDS Coordinator will bring the results of the audits to the monthly QA Committee meeting for 3 months. Once the 3 months have been completed, and if the facility has reached 100% compliance, the QA Committee may decide to stop the written audits at that time. The process itself, as outlined previously, will continue on an ongoing basis.</p> <p>Date of Compliance: June 22, 2016</p>	

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	<p>A.M., the MDS nurse indicated the resident was already incontinent in 2015, so a new 5 day voiding pattern would not have been completed because there had not been a change in her incontinence.</p> <p>After a discussion with the MDS nurse, on 05/23/2016 at 10:42 A.M., regarding the significant decline in Resident #35's bladder continence status, which was documented on the October 2015 quarterly MDS assessment, she indicated no assessment had been completed but the resident had been discontinued from the Restorative toileting plan due to cognitive issues. The MDS nurse also indicated the resident was having some knee pain and issues and had received some physical therapy and had started to utilize a stand up lift for transfers at the time.</p> <p>On 5/24/16 at 12:45 P.M., the Administrator provided the facility policy and procedure, titled "Bladder Incontinence Program," dated May 2006 and revised on 02/09, and indicated this was the policy and procedure the facility currently used. The policy and procedure indicated the following: "...the admitting nurse will fill out the "Bladder Assessment Form...3. Whether the resident is continent or incontinent, the nurse will fill out the history portion of</p>			

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F 0465 SS=E Bldg. 00	<p>the assessment form. If the resident is unable to give a history, the nurse will talk to accompanying family members, in an attempt to get as much information as possible...5. If the resident is incontinent, the nurse will skip #6 and initiate the 5-day bladder record...5. ...Reassessment will occur at least quarterly after that, as indicated by the resident's condition and the outcome of the bladder program...."</p> <p>3.1-41(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interviews the facility failed to ensure the hot water temperature was comfortable and warm for residents in 15 of 18 resident room handwashing sinks. (Room #'s 1, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and</p>	F 0465	F 465. - The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public, including appropriate temperatures at the handwashing sinks in the resident rooms. What	06/22/2016

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	<p>18.)</p> <p>Finding includes:</p> <p>During observation of resident rooms, conducted on 05/18/16 and 05/19/16, the hot water from the faucet at the handwashing sinks in the following rooms was noted to not get warm after running for a few minutes: Room #'s 1, 3, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 and 18.</p> <p>During an interview on 05/19/16 at 9:31 A.M., alert and oriented Resident #10 indicated she never had hot water in her room. She indicated she liked to wash her personal underclothes and she did not feel like she could wash them thoroughly in the cold water.</p> <p>During an interview on 05/19/16 at 12:45 P.M., alert and oriented Resident #26 indicated the lack of hot water had been an ongoing issue for a long time. She indicated it was especially frustrating to her because she liked to wash out her hose in the sink and she could only get cold water. She indicated she had notified the Maintenance Supervisor regarding the issue. While she was talking about the lack of hot water, she noted the Maintenance Supervisor, Employee #10 in the hallway. She called</p>		<p>corrective action will be done by the facility? The Yoke Mixer Valve was cleaned and reinstalled, some faucets were changed, and the main water line was replaced with larger lines increasing temperature and volume to each room. This was completed 6-3-16. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. Maintenance person has completed temperature room checks on every room and found that the temperatures now reach appropriate temperatures of at least 100°F within 30 seconds up to 2 minutes with continued rise in temperatures to 102°F -115°F. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? Maintenance or designee will monitor temperatures of at least 9 rooms 5 days per week for 2 weeks, then 4 rooms 5 days per week routinely, and ongoing, and will log the temperatures as they are taken. Members of the IDT will speak with their assigned residents at least 5 days a week as part of the "Angel" program to ensure the water temperature is no longer an issue. In addition to the temperature checks, Maintenance will monitor pipes for leakage and will ensure the</p>	

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	<p>him over and again complained about the hot water. Employee #10 indicated he realized there was an issue but indicated the city had installed a larger water pipe so the water pressure issues had been resolved. It was unclear how the lack of hot water was being addressed.</p> <p>During an environmental tour of the facility, completed on 05/23/16 between 1:00 P.M. to 1:40 P.M., with the Maintenance Supervisor and the Director of Nursing, there was a lack of hot water noted in three residents rooms, Room #2, 3, and 5. The hot water faucet was left running for over 5 minutes and the hot water temperature failed to reach 100 degrees Fahrenheit. The hot water temperature in 6 more rooms did reach over 100 degrees but it took close to five minutes for the warmer temperature to be obtained.</p> <p>During an interview with the Maintenance Supervisor, during the Environmental tour on 05/23/16 between 1:00 P.M. to 1:40 P.M., he indicated he was aware the hot water temperatures were supposed to be between 100 degrees - 120 degrees Fahrenheit. He indicated it took a long time for the hot water to circulate and get up to the 100 degree temperature especially when the kitchen was washing dishes.</p>		<p>cleanliness of the yoke valve every 6 months as part of the preventivemaintenance program. Any noted issues will be brought to the attention of theAdministrator at that time so that the problem can be fixed as quickly aspossible. How will the facility monitor its correctiveactions to ensure that the deficient practice will not recur? Maintenance willprovide the quality assurance committee, with the results of the evaluationsand checks at the monthly QA Committee meetings. This will continue for aperiod of no less than 6 months. Once the 6 month period has been completed andthe facility has met 100% compliance, the QA committee may elect to reduce ordiscontinue the written evaluation. (See attachment "F") However, the ongoingpreventive maintenance checks as outlined above, including the checking of thewater temperatures will continue and be documented on an ongoing basis. Date ofCompliance: June 22, 2016</p>	

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F 9999 Bldg. 00	<p>Review of water temperature log for May 2016 indicated there were 5 times a room hot water temperature was 98.1 to 99.7 and did not reach 100 degrees but the rest of the temperatures were within range</p> <p>On 05/24/16 at 11:30 A.M., the Administrator indicated the city had been working on the water lines recently to increase the pressure coming into the building. She also indicated the water temperatures were within range after the Environmental tour had been finished and were currently in range.</p> <p>3.1-19(f)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall</p>	F 9999	<p>F9999 3.1-14 PERSONNEL</p> <p>It is the policy of this facility to ensure that each employee has a first step Mantoux skintest read within 48 to 72 hours of administration.</p> <p>What corrective action will be completed for residents affected?</p>	06/22/2016

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	<p>include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. (1) At the time of employment, or within (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be documented negative tuberculin skin test testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 10 employees had a first step Mantoux skin test read within 48 to 72 hours of administration. (Employee #1)</p>		<p>No resident was directly affected by this deficient practice. Staff member # 1 received a repeat first step Mantoux on 5/18/16, and a 2nd step Mantoux on 6/1/16. Both were read within 48 to 72 hours of administration and documented accordingly.</p> <p>What other residents identified as having the potential to be affected and corrective action taken: No residents were identified as being affected. All newly hired staff have had Mantoux documentation audited for timeliness. Any discrepancies noted were resolved. No other staff member was found to be out of compliance with the Mantoux skin test”..</p> <p>What other measures will be put into place to make sure this practice does not recur? All new hires will be audited by the DON and the Business Office Manager for timely completion and documentation of Mantoux skin tests. (See attachment “D”) If any issues are identified, the Administrator and department manager will be notified at that time. The missing Mantoux skin test will be administered and documented as quickly as possible. The IDT will review the system in place for Mantoux compliance with all staff and will make recommendations for process improvement as necessary.</p> <p>How will corrective action be monitored to ensure deficient practice does not recur and what</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/24/2016	
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER				STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975			
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	<p>Finding includes:</p> <p>A review of personnel files was conducted on 5/24/2016 at 9:45 A.M., and indicated the following:</p> <p>Employee #1, a dietary employee, had a start date of 4/7/2016.</p> <p>A form titled "Mantoux Tracking Form," dated 4/5/2016, indicated Employee #1 was administered a 1st step Mantoux (a test to screen for Tuberculosis) on 4/5/2016. The form indicated "Repeat 1st." The form indicated that the next Mantoux test was administered on 5/18/2016.</p> <p>During an interview on 5/24/2016 at 12:25 P.M., the DON (Director of Nursing) indicated they had to start over on the Mantoux testing due to Employee #1 having more than three weeks since the 1st Mantoux test.</p> <p>On 5/24/2016 at 12:35 P.M., the DON indicated the facility did not have an available policy for a two step Mantoux testing.</p> <p>3.1-14(t)</p> <p>3.1-14 PERSONNEL</p>		<p>QA will be put into place?</p> <p>The DON or Business Office Manager will bring the results of the Mantoux audits to the monthly QA meetings for the next 3 months. Once the 3 month period is over and the facility has reached 100% compliance, the QA Committee may decide to stop the written audits; however, the Business Office Manager and DON will continue to check the files of all new employees for compliance with Mantoux skin tests on an ongoing basis.</p> <p>Date of Compliance: June 22, 2016</p> <p>F9999 3.1-14 PERSONNEL</p> <p>It is the policy of this facility to ensure that the required dementia training is completed for all employees, as required.</p> <p>What corrective action will be completed for residents affected?</p> <p>Dementia in-service was completed by staff # 2 on 5/24/16.</p> <p>What other residents identified as having the potential to be affected and corrective action taken:</p> <p>No residents were affected by this practice. All other staff member education files were reviewed for completion of Dementia education. Any noted discrepancies were resolved.</p> <p>What other measures will be put into place to make sure this practice does not recur?</p> <p>Beginning on the 25th of each month, the Business Office Manager will print off a list of all staff members who have not yet</p>				

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	<p>(u) In addition to the required inservice 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 of 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 the required dementia inservicing was completed for 1 employee in a sample of 10. (Employee #2)</p> <p>Finding includes:</p> <p>A review of personnel files was conducted on 5/24/2016 at 9:45 A.M., and indicated the following:</p> <p>Employee #2's file indicated she had completed her dementia training on 1/4/2015.</p>		<p>completed the required Dementiaeducation. Any staff member listed will have until the end of that same monthto complete the education as required. If it is not completed timely, thatstaff member will be removed from the schedule until such time that theeducation is completed. Auditing will be completed monthly. (See attachment"E")</p> <p>How will corrective action be monitored toensure deficient practice does not recur and what QA will be put into place?</p> <p>The BusinessOffice Manager will bring the results of the dementia training audits to themonthly QA meetings for the next 3 months. Once the 3 month period is over andthe facility has reached 100% compliance, the QA Committee may decide to stopthe written audits; however, the Business Office Manager will continue to checkthe files of all employees for compliance with dementia training on an ongoingbasis.</p> <p>Date ofCompliance: June 22, 2016</p>	

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	<p>A form titled "Individual Completed Education Report." dated 5/24/2016, indicated Employee #2 completed 60 minutes of dementia training on 5/24/2016.</p> <p>During an interview on 5/24/2016 at 12:25 P.M., the DON (Director of Nursing) indicated that Employee #2 had not completed her annual dementia training until 5/24/2016.</p> <p>3.1-14(u)</p>			