

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for the investigation of complaint #IN00103890.</p> <p>Complaint #IN00103890-Substantiated, Federal/state deficiency related to the allegation(s) is cited at W149.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of survey: 3/12, 3/13, 3/14 and 3/26/12</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Survey Team: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, Public Health Nurse Surveyor-RN (3/13 and 3/14/12)</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 4/2/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (G), the facility failed to implement its policy and procedures to prevent staff to client abuse with client A, and failed to prevent neglect of client E in regard to a fracture.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 3/13/12 at 10 AM. The facility's 2/8/12 reportable incident report indicated "Allegation of abuse: A nurse reported that [client A] was in the hallway early this morning. The nurse reports that she began to have a seizure and went down to the floor. A CNA (certified nurse aide) and another nurse went directly to [client A]. Allegedly [client A] swung out at the nurse [RN #2] and [RN #2] told [client A] 'Don't hit me' then she allegedly placed her foot on top of [client A's] hand and said 'I will step on you.' [RN #2] then began to take vital signs for [client A]. The reporting nurse immediately went to the phone and called the DNS (Director of Nursing Services) and the Executive</p>	W0149	<p>W149</p> <p>I Client A and G have mental anguish assessments completed. Staff was retrained on abuse after the incident of 2-8-12 occurred. Staff has been retrained on appropriate interaction with residents. The nurse involved in the incident of 2-8-12 was terminated. References for the nurse involved in the 2-8-12 incident's references will be obtained. Client G has a nursing care plan for her fracture which includes her risk and how to decrease risk of future fracture. A consult has been obtained for the Podiatry visit by client G. The Client Advocate completing the investigation for client G has been retrained that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event.</p> <p>III An audit has been completed of current employee files to Assure references were obtained. Residents with a fracture have been assured to have a care plan which addresses risk of fracture and how to decrease risk of future fractures.</p>	04/25/2012			

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	<p>Director. [RN #2] was suspended pending investigation. [Client A] continued to have seizure activity and was sent to the ER (emergency room) at [name of hospital]...[Client A] was assessed before going to the ER. There was (sic) no injuries noted at that time. An x-ray of left hand has been ordered but has not been done yet...." The 2/8/12 reportable incident report indicated the allegation was reported to the police department.</p> <p>Review of the facility's 2/1/12 to 2/13/12 witness statements indicated 1 nursing staff and 2 CNAs were present in the hallway when RN #2 interacted inappropriately with client A. The facility's 2/1/12- 2/13/12 witness statements indicated staff #8 was standing near RN #2 when RN #2 made the statements and physical gestures of abuse toward client A. The 2/1/12 to 2/13/12 witness statements indicated two of the three people who were present substantiated the allegation. The witness statements indicated staff #8, who was near RN #2, indicated RN #2 did not do anything to client A. The facility's 2/13/12 witness statement with the reporting nurse indicated "...I (reporting nurse) think the CNA (staff #8) is afraid of [RN #2]...."</p>		<p>Staff and Nursing have been re-trained that when a client has an outside physician visit a consult must be returned with the resident. Client Advocates and Director of Human Rights have been retrained that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event.</p> <p>IV Director of Clinical Education and Assistant Director of Clinical Education have been re-trained to obtain references of potential employees prior to completion of orientation. DCE monitors pre employment and employment activity which assures obtaining references for those candidates who are employed by Golden Living North Willow. Nursing has been re-trained to complete a care plan for any fracture that includes risk and how to prevent future fracture. Program Director and Director of Nursing assures a care plan is in place when a fracture occurs that addresses risk and prevention of fractures. Nurses and QMRPs have been trained to follow up on outside physician visits for residents and assure that a consult has been obtained in each case (will the nurses forward a copy of the consult to the QMRP so they can confirm that the appt occurred). The</p>				

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	<p>The facility's undated Allegation investigation indicated "...The staff members who were present and witnessed the interaction were interviewed separately. They were also interviewed on more than one occasion and the accounts of what occurred collaborate...Conclusion: The investigation indicated that [RN #2] had inappropriate physical interaction with the client [client A]. [RN #2] is terminated for failure to follow policy...."</p> <p>RN #2's personnel record was reviewed on 3/13/12 at 3:00 PM. RN #2's personnel record indicated the facility did not obtain and/or check RN #2's personal and/or work references prior to hiring RN #2 for employment. RN #2's record indicated the nurse had received 4 Employee Memorandum (corrective actions) within a 12 month period. Two of the four corrective actions (2/8/12 and 12/13/11) involved client care/allegations.</p> <p>Interview with administrative staff #2, #3 and #4 on 3/14/12 at 11:40 AM indicated client A was found to have a bruise on her lower arm. Administrative staff #2 and #4 indicated staff #8 indicated she did not see RN #2 say and/or do anything to client A. Administrative staff #2 indicated the other 2 staff, who witnessed the incident, heard and saw RN #2</p>		<p>abuse/neglect policy has been amended to include that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event. Human Rights Director to assure unknown injuries including a fracture of unknown origin is investigated 72 beginning 72 hours prior to the event. To be complete by 4-25-12.</p>				

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	<p>interact/abuse client A. Administrative staff #2 indicated RN #2 was terminated due to the incident.</p> <p>Interview with administrative staff #1 and #6 on 3/13/12 at 5:55 PM indicated they were not able to locate any references for RN #2. Administrative staff #1 and #6 indicated the facility should have checked/obtained at least 2 references for RN #2.</p> <p>Interview with administrative staff #1 on 3/14/12 at 1:36 PM indicated all facility staff were retrained on abuse and neglect on 2/9/12 and she (administrative staff #1 retrained staff #8) on abuse/neglect and reporting on the night shift on 2/9/12.</p> <p>The facility's policy and procedures were reviewed on 3/12/12 at 3:22 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish...Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are</p>						

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	<p>not limited to: threats of harm...Physical abuse includes hitting, slapping, pinching and kicking...."</p> <p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 3/13/12 at 10 AM. The facility's 2/27/12 reportable incident report indicated "[Client G] was having behaviors the morning of the 27th. She was sliding down the wall putting herself on the floor. When the staff went to wake her up for lunch from her nap she got up and went to the bathroom. The staff reported that they noted a shakeyness (sic) and wasn't sure about the gait. After she came out of the bathroom she walked out into the hall where the nurse pointed to her right foot. The staff assisted her into a w/c (wheelchair) and took her to the nurse. The nurse assessed and there (sic) removed her sock and shoe from her right foot. There was no sign of injury noted. There was no redness, no swelling, no bruising. The nurse thought it had to be behavioral sense (sic) her assessment did not reveal any symptoms. [Client G] then refused to walk and bear weight on the right foot. The doctor was called and an x-ray was ordered. Results were received stating-----'there is a fracture involving first metatarsal base. There is associated soft tissue swelling. No foreign body is</p>						

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	<p>seen. Osteoporosis is present. Acute first metatarsal base avulsion fracture without displacement. Avulsion fracture is defined as TEARING OF A PIECE OF BONE AWAY FROM THE MAIN BONE BY THE FORCE OF MUSCULAR CONTRACTION. This fracture could have been caused by seizure activity. An investigation is in progress."</p> <p>The facility's undated Fracture investigation indicated "On 2-21-12 [client G] was presenting with a change in condition. During the day shift she had pointed to her right foot. She had acted like she did not want to walk on her right foot. The nurse assessed her foot and ankle and no signs of injury or abnormalities was (sic) noted. On the evening shift she refused to come to the dining room for dinner. She did accept and eat food in her room. She was assessed and it was noted she had a low grade fever. The evening shift nurse did not see [client G] ever point to her foot or act is (sic) if she could not walk. He assessed her chief complaints to be weakness, incontinence, and low grade fever. The Doctor was notified and [client G] was sent to the ER (emergency room) for eval (evaluation) and treatment..." The undated investigation indicated client G was admitted to the</p>				

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	<p>hospital for blood in urine, dehydration and possible lung infiltrate. The undated investigation indicated client G returned to the facility on 2/26/12 when the client started having behaviors on 2/27/12 of sitting herself on the floor, and pointing to her right foot again. The undated investigation indicated client G walked to breakfast but refused to walk after eating. The undated investigation indicated when staff went to get the nurse, edema was noted to the client's right foot and bruising was present on the bottom of the client's right foot.</p> <p>The undated fracture investigation indicated "...None of the staff that were interviewed have ever seen anyone be mean to or try to hurt [client G]. None of them have seen [client G] have any behaviors that would contribute to a fracture...." The report indicated clients were also interviewed and they had not seen staff "...be mean or try to harm [client G]. None of them have ever seen [client G] fall and the staff was not there (sic). Conclusion: [Client G] has a diagnosis of Osteoporosis. She is on Calcium. We are consulting with [name of doctor] regarding the nature of this type of fracture and any recommendation he may have after he receives the result of the BMD (bone mineral density). At this time it is not know what happened to</p>						

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	<p>[client G's] right foot. Due to the bruising only being noted on the bottom of the foot, with no signs of injury on top of the right foot it is likely that she stepped on something that caused a break to her weakened bones...."</p> <p>An attached 3/2/12 letter to the undated investigation indicated the facility was seeking clarification/assistance in regard to how the fracture could have occurred. The 3/2/12 letter was addressed to client G's Podiatrist. The letter indicated the facility's investigator wanted to know if a "...muscle contraction" could have caused this type of fracture as the client had a seizure diagnosis. The letter indicated the facility had not witnessed any recent seizure activity with the client. The letter indicated "...I realize that there is no way that you could diagnose with any certainty the cause of this fracture. However your professional opinion on what type of trauma could cause a fracture of this nature would be helpful. Also the bruising was noted to only be on the bottom of her foot. Is this indicative of the force coming up from the bottom?"</p> <p>Review of the facility's 3/2/12 witness statements indicated the facility interviewed 2 CNA (certified nurse aides) and 2 nurses. The facility's 3/2/12 witness statements and/or undated</p>				

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	<p>fracture investigation did not indicate the facility interviewed any additional staff who worked with the client and/or did not indicate any documentation of client interviews.</p> <p>Client G's record was reviewed on 3/14/12 at 9:15 AM. Client G's 2/28/12 physician's order indicated "May schedule podiatry consult."</p> <p>Client G's 2/29/12 podiatry prescription order indicated "Dx (diagnosis) Foot Fracture (sic) Must wear air boot all weight bearing."</p> <p>Client G's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-2/27/12 at 9:00 AM, "Client unable to bear weight. Pointing at Rt (right) foot. Rt foot swollen. Discoloration noted to sole of foot, ankle swollen. Client expresses S/S (signs/symptoms) of pain during assessing Rt foot...[name of doctor] notified. New orders rec'd (received) to xray Rt foot and ankle...."</p> <p>-2/27/12 at 1:35 PM, "Xray results obtained. Fx (fracture) involving first metatarsal base of rt foot. Soft tissue swelling noted. Osteoporosis present. [Name of doctor] notified."</p>			

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	<p>-2/28/12 at 10:08 AM, "Xray results reviewed by [name of doctor]. New orders rec'd for Podiatry Consult."</p> <p>-2/29/12 at 2:01 PM, "...client went LOA (leave of absence) to Podiatry Appt (appointment) this A.M. Returned with new orders to use air boot with all weight bearing. RTC (return appointment) 3/29/12 @ (at) 0830. New orders rec'd to add Calcium 500mg (milligrams)/vit (vitamin) D BID (two times a day), check Vit D-25 Hydroxy level, schedule BMD per [name of doctor]."</p> <p>-2/26/12 at 12:30 PM, "Client returned from hospital at this time...Client alert and orient. No S/S of pain or discomfort noted. Skin assessment completed, discoloration noted to anticubital areas of bil (bilateral) arm from I.V. (intravenous) sites...client kept pulling I.V. lines out during stay at hospital...."</p> <p>-2/26/12 at 8:34 AM, "...Client still continues to have difficulty independently ambulating. Client has been using wheel chair for transfer. Client has +2 edema in right leg. Pedal pulses present and capillary refill is 3 sec. (seconds)...."</p> <p>-2/22/12 7:06 AM, "...Client sent to [name of hospital] @10:50p.m. for eval. had episode of being incont. (incontinent)</p>						

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	<p>x 3 on eve (evening) shift. Also shaky, T. (temperature) 99.8 and reportedly would not go to dining room for dinner. Client fed per staff in room...."</p> <p>-2/21/12 10:14 PM, "Client is sick. client (sic) was refusing to get out of bed during this shift and would not eat without food being brought to her...."</p> <p>Client G's record indicated the last Podiatry note in the record was dated 12/2/11. Other than the 2/29/12 physician's order the on prescription pad, there was no other documentation in client G's record of the 2/29/12 Podiatry visit.</p> <p>Client G's 1/11/12 quarterly Head to Toe Nursing Assessment indicated client G last had a seizure on 11/22/11.</p> <p>Client G's 2/18 and 2/19/12 Behavior Incident Reports indicated the client had placed herself on the floor on 2/18/12 and 2/19/12 and refused to get up.</p> <p>Client G's 2/29/12 IDT (interdisciplinary Team) note indicated the client's IDT met to review and discuss the client's hospitalization. The note indicated "...She (client G) returned on 2/26/12 with right leg edema and was refusing to walk. Upon return an x-ray was ordered which</p>			

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	<p>discovered a fracture of her first metatarsal toe. She was diagnosed with osteoporosis which was present on the x-ray. She was referred to [name of podiatrist] a foot specialist. He ordered an air cast for her to wear during waking hours....He also suggested ice as needed to keep the swelling down over the next three days as needed. He said the cast will let her ambulate independently and that a wheelchair would not be needed...."</p> <p>Client G's 1/19/12 Individual Support Plan (ISP) and/or 2/29/12 nursing Risk Plans indicated the facility did not develop/put a risk/nursing care plan in place for client G's Avulsion fracture.</p> <p>Interview with LPN #3 on 3/14/12 at 10:05 AM, by phone, indicated LPN #3 had called the nurse at the hospital ER and told them client G was having trouble with ambulation. LPN #3 indicated client G was having several medical/health issues which the ER nurse was informed about. LPN #3 indicated client G returned to the facility on a weekend day. LPN #3 stated "They (hospital medical staff) never looked at foot." LPN #3 stated the facility nursing staff called to check on the client while she was in the hospital and the hospital nursing staff indicated client G was "Taking 2 to 3 hospital staff to take her (client G) to the</p>				

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	<p>bathroom."</p> <p>LPN #3 indicated the bruising to client G's foot was noticed after the client returned from the hospital on 2/26/12. LPN #3 indicated she was the nurse on duty when client G returned from the podiatry appointment on 2/29/12. LPN #3 indicated upon client G's return from the podiatrist, she only remembered staff giving her a prescription order which indicated the client had a fracture. LPN #3 indicated there should be a consult note from the podiatrist in the record. LPN #3 indicated she was not sure if client G's risk plan had been updated in regard to client G's fracture.</p> <p>Interview with administrative staff #2, #3 and #4 on 3/14/12 at 11:40 AM indicated client G started complaining of her (client G's) leg/foot prior to being admitted to the hospital on 2/21/12. Administrative staff #2 indicated client G's leg was to be checked while the client was sent out to be evaluated and treated at the hospital. Administrative staff #2 indicated client G was admitted to the hospital and the hospital did not check the client's leg while she was there. Administrative staff #2 indicated while client G was in the hospital, administrative staff #5 went to see the client at the hospital and reminded the hospital staff of the complaints with client G's leg and not wanting to</p>				

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	<p>ambulate. Administrative staff #2 indicated once client G returned to the facility, client G was still not able to ambulate and the client's doctor ordered an x-ray and had the client treated by a Podiatrist versus sending the client back to the hospital. Administrative staff #2 indicated the facility did not how client G received an Avulsion fracture. Administrative staff #2 stated she had sent a note to the Podiatrist to "give his insight" on how the fracture may have occurred. Administrative staff #2 indicated the Podiatrist's office sent a note back stating they would have him respond to the facility's request when he returned as the Podiatrist was on vacation from March 9th through March 18th, 2012. When asked why the facility only interviewed 2 nursing staff and 2 CNAs, administrative staff #2 stated "I narrowed time line down. No one noticed difference about gait as something had to have occurred within a few hours of her not wanting to ambulate." Administrative staff #2 indicated she interviewed the staff who worked in that time frame. Administrative staff #2, #3 and #4 indicated they did not know how client G's IDT obtained the information on the 2/29/12 IDT note. Administrative staff #2 indicated there should be a Podiatry note and/or consult form in client G's record.</p>						

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	<p>Interview with the Director of Nursing (DON) on 3/14/12 at 1:05 PM indicated they were in the process of trying to find the Podiatrist documentation/note. The DON indicated a note may not have been sent back at the time of the 2/29/12 visit as the Podiatrist may have dictated a note.</p> <p>The facility's policy and procedures were reviewed on 3/12/12 at 3:22 PM. The facility's May 2001 policy entitled Reporting Alleged Violations indicated "...Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness...."</p> <p>This federal tag relates to complaint #IN00103890.</p> <p>3.1-28(a) 3.1-28 (d) 3.1-28 (e)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 1 of 34 allegations of abuse, neglect, injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation in regard to client G's fracture of unknown origin.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 3/13/12 at 10 AM. The facility's 2/27/12 reportable incident report indicated "[Client G] was having behaviors the morning of the 27th. She was sliding down the wall putting herself on the floor. When the staff went to wake her up for lunch from her nap she got up and went to the bathroom. The staff reported that they noted a shakeyness (sic) and wasn't sure about the gait. After she came out of the bathroom she walked out into the hall where the nurse pointed to her right foot. The staff assisted her into a w/c (wheelchair) and took her to the nurse. The nurse assessed and there (sic) removed her sock and shoe from her right foot. There was no sign of injury noted. There was no redness, no swelling, no</p>	W0154	<p>W154 I Client G has a mental anguish report completed. The Client Advocate completing the investigation for client G has been retrained that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event. III Client Advocates and Director of Human Rights have been retrained that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event. IV The abuse/neglect policy has been amended to include that an injury of unknown origin including a fracture of unknown origin must be investigated beginning 72 hours prior to the event. Human Rights Director to assure unknown injuries including a fracture of unknown origin is investigated 72 beginning 72 hours prior to the event. To be complete by 4-25-12.</p>	04/25/2012			

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	<p>bruising. The nurse thought it had to be behavioral sense (sic) her assessment did not reveal any symptoms. [Client G] then refused to walk and bear weight on the right foot. The doctor was called and an x-ray was ordered. Results were received stating-----'there is a fracture involving first metatarsal base. There is associated soft tissue swelling. No foreign body is seen. Osteoporosis is present. Acute first metatarsal base avulsion fracture without displacement. Avulsion fracture is defined as TEARING OF A PIECE OF BONE AWAY FROM THE MAIN BONE BY THE FORCE OF MUSCULAR CONTRACTION. This fracture could have been caused by seizure activity. An investigation is in progress."</p> <p>The facility's undated Fracture investigation indicated "On 2-21-12 [client G] was presenting with a change in condition. During the day shift she had pointed to her right foot. She had acted like she did not want to walk on her right foot. The nurse assessed her foot and ankle and no signs of injury or abnormalities was (sic) noted. On the evening shift she refused to come to the dining room for dinner. She did accept and eat food in her room. She was assessed and it was noted she had a low grade fever. The evening shift nurse did</p>				

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	<p>not see [client G] ever point to her foot or act is (sic) if she could not walk. He assessed her chief complaints to be weakness, incontinence, and low grade fever. The Doctor was notified and [client G] was sent to the ER (emergency room) for eval (evaluation) and treatment..." The undated investigation indicated client G was admitted to the hospital for blood in urine, dehydration and possible lung infiltrate. The undated investigation indicated client G returned to the facility on 2/26/12 when the client started having behaviors on 2/27/12 of sitting herself on the floor, and pointing to her right foot again. The undated investigation indicated client G walked to breakfast but refused to walk after eating. The undated investigation indicated when staff went to get the nurse, edema was noted to the client's right foot and bruising was present on the bottom of the client's right foot.</p> <p>The undated fracture investigation indicated "...None of the staff that were interviewed have ever seen anyone be mean to or try to hurt [client G]. None of them have seen [client G] have any behaviors that would contribute to a fracture..." The report indicated clients were also interviewed and they had not seen staff "...be mean or try to harm [client G]. None of them have ever seen</p>			

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	<p>[client G] fall and the staff was not there (sic). Conclusion: [Client G] has a diagnosis of Osteoporosis. She is on Calcium. We are consulting with [name of doctor] regarding the nature of this type of fracture and any recommendation he may have after he receives the result of the BMD (bone mineral density). At this time it is not know what happened to [client G's] right foot. Due to the bruising only being noted on the bottom of the foot, with no signs of injury on top of the right foot it is likely that she stepped on something that caused a break to her weakened bones...."</p> <p>An attached 3/2/12 letter to the undated investigation indicated the facility was seeking clarification/assistance in regard to how the fracture could have occurred. The 3/2/12 letter was addressed to client G's Podiatrist. The letter indicated the facility's investigator wanted to know if a "...muscle contraction" could have caused this type of fracture as the client had a seizure diagnosis. The letter indicated the facility had not witnessed any recent seizure activity with the client. The letter indicated "...I realize that there is no way that you could diagnose with any certainty the cause of this fracture. However your professional opinion on what type of trauma could cause a fracture of this nature would be helpful. Also the</p>			

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	<p>bruising was noted to only be on the bottom of her foot. Is this indicative of the force coming up from the bottom?"</p> <p>Review of the facility's 3/2/12 witness statements indicated the facility interviewed 2 CNA (certified nurse aides) and 2 nurses. The facility's 3/2/12 witness statements and/or undated fracture investigation did not indicate the facility interviewed any additional staff who worked with the client and/or did not indicate any documentation of client interviews.</p> <p>Interview with administrative staff #2, #3 and #4 on 3/14/12 at 11:40 AM indicated client G started complaining of her (client G's) leg/foot prior to being admitted to the hospital on 2/21/12. When asked why the facility only interviewed 2 nursing staff and 2 CNAs, administrative staff #2 stated "I narrowed time line down. No one noticed difference about gait as something had to have occurred within a few hours of her not wanting to ambulate." Administrative staff #2 indicated she only interviewed staff who worked in that time frame.</p> <p>3.1-28(d)</p>						

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure nursing services monitored health conditions, notified the physician promptly for changes in health status and/or sought clarification in regard to a healing fracture for 3 additional clients E, F and G.</p> <p>Findings include:</p> <p>1. Client E's record was reviewed on 03/13/2012 at 3:00 p.m. Diagnoses included, but were not limited to chronic constipation, history of intestinal obstruction, embolism (obstruction of an artery), and thrombosis (blood clot) of other specified veins.</p> <p>The February 2012 Medication Administration Record indicated the client's medications included, but were not limited to, Coumadin (blood thinner) 4.5 mg (milligrams) daily, Lasix (used to reduce swelling and fluid retention), and Klor-Con (potassium supplement) 10 mEq (millequivalents) daily.</p> <p>Weight records, dated 02/2011 through 02/2012, indicated client E's weight</p>	W0331	<p>W331 I Client G has a mental anguish report completed. Education has been completed with staff to include areas/issues cited in the 3-26-12 W331 tag including; Lack of assessment of a client return from an inpatient stay at the hospital, change of conditions were not reported to the physician, incomplete documentation, issues regarding change in urine and bowel output, dehydration, concern of Drug Interaction with an antibiotic, colon screening for cancer, and follow up when an Xray report is unclear.</p> <p>III Staff and Nursing have been re-trained that when a client has an outside physician visit a consult must be returned with the resident. Nurses have been trained to complete the Return from an Inpatient Hospital Form when a client returns from being inpatient at the hospital, reporting changes of condition to the physician per Clinical Health Status Change of Condition Guidelines, accurate and timely documentation, Drug Interaction Policy is located in the MAR, notifying the physician after 2 consecutive diarrhea stools, that North Willow will follow the</p>	04/25/2012			

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	<p>decreased from 149 pounds in 02/2011 to 126 pounds on 02/06/2012.</p> <p>Client E's dietary notes from 03/2011 through 02/2012 included entries for March, April, May, June, July, August, September, and October 2011. There was an additional entry on 12/18/2011. There were no entries for 2012.</p> <p>A dietary note, dated 03/01/2011, indicated client E's weight was 149.2 pounds. The record indicated a 4.9% weight loss during the previous 90 days and 6.75% reduction in weight during the previous 180 days. The record did not indicate the physician had been notified of the weight loss.</p> <p>A dietary note, dated 04/18/2011, indicated, "...Start weekly weights to monitor further weight trending..." The record did not indicate the physician had been notified of the weight loss.</p> <p>A dietary note, dated 06/13/2011, indicated client E weighed 132 pounds and had a "significant weight loss" of 8.97% during the past 90 days and 13.04% weight loss for the previous 180 days. The dietary note indicated, "...Recommend to increase portions to double to stabilize weight...." The record did not indicate the physician had been</p>		<p>American Cancer Society recommendations for colon cancer screening, and when a progress report or other report is unclear, the physician will be contacted for clarification. Staff will be re-educated on reporting change of condition including urine and bowel will be reported to the nurse and hydration.</p> <p>IV Nurses and QMRPs have been trained to follow up on outside physician visits for residents and assure that a consult has been obtained in each case. Follow up report for a resident hospitalized will include assuring these issues as appropriate; Return from an Inpatient Hospital Form when a client returns from being inpatient at the hospital, reporting changes of condition to the physician per Clinical Health Status Change of Condition Guidelines accurate and timely documentation, Drug Interaction Policy is located in the MAR, notifying the physician after 2 diarrhea stools, North Willow will follow the American Cancer Society recommendations for colon cancer screening, and when a progress report or other report is unclear, the physician will be contacted for clarification. Staff will be re-educated on reporting change of condition including urine and bowel will be reported to the nurse and hydration. . Auditing by DCE,</p>				

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	<p>notified of the weight loss.</p> <p>A dietary note, dated 07/18/2011, indicated, a 15.29% weight loss during the previous 180 days. The record did not indicate the physician had been notified of the weight loss.</p> <p>A dietary note dated 12/18/2011, indicated, "...Client's current weight is 130.00#...Will continue to monitor as needed..." The record did not indicate the physician had been notified of the weight loss.</p> <p>A Nursing Progress Note, dated 02/01/2012 at 10:50 p.m., indicated, "...client refused to eat dinner, warm to touch and refused to be checked for vs (vital signs)..."</p> <p>The next Nursing Progress Note recorded in client E's record was dated 02/03/2012 at 12:38 p.m. The progress note indicated, "...client refused her breakfast. During lunch staff noticed that her vision was compromised. client (sic) only responded to verbal instructions compare to visual coordination (sic), also client had a weight loss...client refused vs...md (sic) (Medical doctor) notified. don (sic) (Director of Nursing) notified. client (sic) sent to [hospital] for tx (treatment) and eval. (evaluation)...."</p>		ADCE, Client Advocates and Director of Human Rights will check for these items including follow up with Nurse or party assigned. This auditing completed for each resident with inpatient hospitalization on or after 4-12-12. To be complete by 4-25-12.		

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	<p>A Nursing Progress Note, dated 02/03/2012 at 10:23 p.m., indicated, "...client (client E) admitted to [hospital] for dx (diagnosis) dehydration...."</p> <p>A hospital discharge note, dated 02/06/2012, indicated client E was hospitalized for treatment of UTI (urinary tract infection) and dehydration.</p> <p>The record did not include documentation to indicate fluid intake and output were monitored after client E was discharged from the hospital on 02/06/2012 following treatment for UTI and dehydration.</p> <p>An undated "Warfarin (Coumadin) Overview indicated, "...Patients that are anticoagulated (hindering process of blood clotting) from warfarin have an extraordinarily high risk for drug interactions...Common drug interactions include:...Antibiotics...Warfarin therapy requires continual, intensive monitoring to ensure patient safety...changes in overall health will affect the balance of anticoagulation...."</p> <p>A Nursing Progress Note, dated 02/06/2012 at 1:11 p.m., indicated, "...client returned back from hospital @ (at) 1:00 p.m. today...client was admitted</p>			

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	<p>with dx of UTI (Urinary Tract Infection) and dehydration...resume current meds (medications) and a new order for keflex (antibiotic) 250 mg (milligrams) tid (three times a day) x (times) 5 days...last bm (bowel movement) was this morning large loose stool...." The record did not indicate the physician was notified of the loose stool.</p> <p>A Nursing Progress Note, dated 02/07/2012 at 6:09 a.m., indicated, "...CNA (Certified Nurse Aide) reports she (client E) had a very large amount of BM...."</p> <p>A Nursing Progress Note, dated 02/07/2012 at 12:00 p.m., indicated, "large BM reported. client (sic) remains on atb (antibiotic)...."</p> <p>A Nursing Progress Note, dated 02/10/2012 at 12:02 a.m., indicated xxxlg (extra, extra, extra large) bm (bowel movement) which was liquid...." The record did not indicate the physician was notified of the large liquid bowel movement.</p> <p>A Nursing Progress Note, dated 02/10/2012 at 9:23 p.m., indicated, "...noted client went to sleep several times in w/c (wheel chair) in classroom and at dinner...." The record did not indicate the</p>			

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	<p>physician was notified of client E's lethargy (drowsiness).</p> <p>A Nursing Progress Note dated 02/11/2012 at 7:31 a.m., indicated, "...Continue on ABT/Keflex (antibiotic/Keflex) for UTI. Client had loose bm x2 large amount, extra po (oral) fluids given...." The record did not indicate the physician had been notified of the loose bowel movements.</p> <p>A Nursing Progress Note, dated 02/11/2012 at 12:45 p.m., indicated, "...client received her last dose of antibiotics...had an episode of very loose stool. MD notified about loose stool...."</p> <p>A Nursing Progress note, dated 02/12/2012 at 7:32 a.m., indicated, "...RESIDENT WITH CHANGE OF MENTAL STATUS AND THREE LARGE WATERY STOOLS...RESIDENT DID NOT RESPOND TO VERBAL STIMULI...SENT TO...ER FOR EVAL AND TREATMENT...."</p> <p>A hospital laboratory report, dated 02/12/2012, indicated critical lab values of Potassium 2.5 (normal is 3.6-5.4), Calcium 5.4 (normal 8.5-10.2), Sodium 157 (normal is 136-146), PTT(partial thromboplastin time-how long it takes the</p>						

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	<p>blood to clot) 132.4 (normal is 9.5-11.9), and INR (indicates there is a high chance of bleeding) 13.05 (acceptable range is 2.0-3.0).</p> <p>A Hospital History and Physical, dated 02/12/2012 indicated, "...OVERALL IMPRESSION: 1. UTI, 2. Hypotensive (low blood pressure) with systemic inflammatory response syndrome, septic type picture (serious condition that occurs when an infection leads to life-threatening low blood pressure. Symptoms can affect any part of the body including the kidneys), 3...dehydrated, 4. Coagulopathy (bleeding disorder) secondary to Coumadin toxicity (overdose of drug or drug interaction), 5. Acute renal failure (kidney failure)...The patient will also receive FFP (Fresh Frozen Plasma - used to treat bleeding) and vitamin K (used to stop bleeding through clot formation)."</p> <p>A Hospice Inpatient Admission note, dated 02/15/2012, indicated, "...admitted to [hospital] on 02/12/2012 with severe dehydration, UTI...Noted to have severe MS (mental status) changes, agitation. Was found to be in renal failure...She was also found to have a small bowel obstruction, unclear etiology (cause)...Admitted to [in patient hospice] to manage pain, agitation in settling of renal failure & SBO (small bowel</p>				

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	<p>obstruction). Family wants comfort measures only...."</p> <p>A Hospice Progress Note, dated 02/16/2012 at 2:10 p.m., indicated "...renal failure, bowel obstruction, stridor (breath sound with high pitched wheezing)...prognosis-days...."</p> <p>A facility Nursing Progress Note, dated 02/18/2012 at 1:00 p.m., indicated, "...client passes away in hosp (hospital). sister (sic) called and gave report...."</p> <p>During an interview on 03/14/2012 at 12:00 p.m., the Director of Nursing (D.O.N.) indicated the facility did not have a protocol for increasing frequency of monitoring PT/INR for clients receiving antibiotic therapy or when a client had changes in overall health, including diarrhea. The D.O.N. provided a "Common Dangerous Drug Interactions in Long-Term Care" which listed drug interactions, including antibiotics, with Warfarin (Coumadin) on 03/14/2012 at 12:55 p.m.</p> <p>During an interview on 03/14/2012 at 12:55 p.m., the D.O.N. indicated client E's record was complete and included all facility documents. She indicated the record of fluid intake and output would have been in client E's record if they had</p>						

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	<p>been monitored following hospitalization for UTI and dehydration. The D.O.N. indicated the dietitian monitored client E's nutritional status. She stated, "It was difficult to maintain a weight since [client E] was on a pureed diet and honey thickened liquids." She indicated she was not aware of any diagnostic tests to determine a cause of weight loss during the past year. She stated, "Guidelines for colonoscopies have changed for this population." She indicated a screening colonoscopy was not recommended. The D. O. N. indicated the physician was not notified of loose bowel movements until 2/11/2012.</p> <p>2. During the 3/12/12 observation period between 3:40 PM and 5:31 PM, at the facility, client F refused to walk to the dining room with her roller walker. Client F got to the intersection of the hallway and stopped. Client F was telling administrative staff #5 she could not walk any further.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 3/13/12 at 10 AM. The facility's 3/11/12 reportable incident report indicated "[Client F] fell off the toilet onto her knees. Her knees were both reddened. [Client F] continue to c/o (complain of)</p>						

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	<p>pain and stated that she could no longer walk by 8:00AM (sic). x-rays (sic) were obtained of both legs and ankles. Old healed fracture was results (sic)...."</p> <p>Client F's record was reviewed on 3/14/12 at 9:15 AM. Client F's 3/11/12 Radiology Report indicated client F had no "fracture or dislocation of the left right ankle." The 3/11/12 Radiology Report indicated for client F's left ankle "...Results: There is a fracture involving distal tibia and fibula with no displacement. The joint alignment is maintained. There is associated soft tissue swelling. Conclusion: Old fixated healing ankle fracture as described above...." Client F's 3/11/12 x-ray reports of the client's legs did not indicate any additional fractures and/or dislocations.</p> <p>Client F's March 2012 Nursing Progress Notes did not indicate/include any additional nursing notes, clarification and/or documentation in client F's record regarding client F's healing fracture.</p> <p>Interview with LPN #1 on 3/14/12 at 10:09 AM indicated she was not aware of client F's healing fracture. LPN #1 indicated client F was found on the floor and in the bathroom and complained of her knees. LPN #1 indicated an x-ray was obtained. LPN #1 stated "I was told she</p>						

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	<p>did not have a fracture." LPN #1 indicated the information was told to her in a change of shift report meeting. When LPN #1 was shown the radiology report, which was in client F's record, LPN #1 reviewed the 3/11/12 report and stated "That's not negative for a fracture. Looks like a fracture that's healing." LPN #1 nursing staff should have contacted/faxed client F's doctor for clarification of the 3/11/12 radiology report to determine if client F actually had a healing fracture and/or old fracture which was noted in the x-ray. LPN #1 then took the 3/11/12 report on 3/14/12 and faxed to the doctor for clarification.</p> <p>Interview with administrative staff #5 on 3/14/12 at 11:12 AM indicated client F was refusing to walk to the dining room on 3/12/12. When asked why, administrative staff #5 stated "She wants a wheelchair so badly. Status symbol on west hall. Constant battle." Administrative staff #5 indicated client F had a fall over the weekend and the client had x-rays taken. Administrative staff #5 indicated the x-rays did not show the client had a fracture. Administrative staff #5 stated an x-ray showed client F had "previous breaks, calcification and brittle bones." Administrative staff #5 indicated client F's x-ray indicated the client had a healing fracture.</p>						

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	<p>Administrative staff #5 stated "The fracture could have been there since she was a kid." Administrative staff #5 indicated the radiologist had to document old fractures in that manner.</p> <p>Administrative staff #5 indicated client F had been ambulating without difficulty/problems.</p> <p>Interview with administrative staff #2, #3 and #4 on 3/14/12 at 11:40 AM indicated the facility was in the process of investigating the 3/11/12 incident. Administrative staff #2 indicated client F did not have a current fracture. When asked what the 3/11/12 radiology report meant, administrative staff #2, #3 and #4 indicated client F had a healing fracture which could have been there from years ago. Administrative staff #2, #3 and #4 indicated the facility's nursing staff should have obtained clarification in regard to the 3/11/12 x-ray.</p> <p>3. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 3/13/12 at 10 AM. The facility's 2/27/12 reportable incident report indicated "[Client G] was having behaviors the morning of the 27th. She was sliding down the wall putting herself on the floor. When the staff went to wake her up for lunch from her nap she got up and went to</p>						

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	<p>the bathroom. The staff reported that they noted a shakeyness (sic) and wasn't sure about the gait. After she came out of the bathroom she walked out into the hall where the nurse pointed to her right foot. The staff assisted her into a w/c (wheelchair) and took her to the nurse. The nurse assessed and there (sic) removed her sock and shoe from her right foot. There was no sign of injury noted. There was no redness, no swelling, no bruising. The nurse thought it had to be behavioral sense (sic) her assessment did not reveal any symptoms. [Client G] then refused to walk and bear weight on the right foot. The doctor was called and an x-ray was ordered. Results were received stating-----'there is a fracture involving first metatarsal base. There is associated soft tissue swelling. No foreign body is seen. Osteoporosis is present. Acute first metatarsal base avulsion fracture without displacement. Avulsion fracture is defined as TEARING OF A PIECE OF BONE AWAY FROM THE MAIN BONE BY THE FORCE OF MUSCULAR CONTRACTION...."</p> <p>The facility's undated Fracture investigation indicated "On 2-21-12 [client G] was presenting with a change in condition. During the day shift she had pointed to her right foot. She had acted like she did not want to walk on her right</p>						

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	<p>foot. The nurse assessed her foot and ankle and no signs of injury or abnormalities was noted. On the evening shift she refused to come to the dining room for dinner. She did accept and eat food in her room. She was assessed and it was noted she had a low grade fever. The evening shift nurse did not see [client G] ever point to her foot or act is (sic) if she could not walk. He assessed her chief complaints to be weakness, incontinence, and low grade fever. The Doctor was notified and [client G] was sent to the ER (emergency room) for eval (evaluation) and treatment..." The undated investigation indicated client G was admitted to the hospital for blood in urine, dehydration and possible lung infiltrate. The undated investigation indicated client E returned to the facility on 2/26/12 when the client started having behaviors on 2/27/12 of sitting herself on the floor, and pointing to her right foot again. The undated investigation indicated client G walked to breakfast but refused to walk after eating. The undated investigation indicated when staff went to get the nurse, edema was noted to the client's right foot and bruising was present on the bottom of the client's right foot.</p> <p>Client G's record was reviewed on 3/14/12 at 9:15 AM. Client G's 2/28/12 physician's order indicated "May schedule</p>			

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	<p>podiatry consult."</p> <p>Client G's 2/29/12 podiatry prescription order indicated "Dx (diagnosis) Foot Fracture (sic) Must wear air boot all weight bearing."</p> <p>Client G's Nursing Progress Notes indicated the following (not all inclusive):</p> <p>-2/27/12 at 9:00 AM, "Client unable to bear weight. Pointing at Rt (right) foot. Rt foot swollen. Discoloration noted to sole of foot, ankle swollen. Client expresses S/S (signs/symptoms) of pain during assessing Rt foot...[name of doctor] notified. New orders rec'd (received) to xray Rt foot and ankle...."</p> <p>-2/27/12 at 1:35 PM, "Xray results obtained. Fx (fracture) involving first metatarsal base of rt foot. Soft tissue swelling noted. Osteoporosis present. [Name of doctor] notified."</p> <p>-2/28/12 at 10:08 AM, "Xray results reviewed by [name of doctor]. New orders rec'd for Podiatry Consult."</p> <p>-2/29/12 at 2:01 PM, "...client went LOA (leave of absence) to Podiatry Appt (appointment) this A.M. Returned new orders to use air boot with all weight bearing. RTC (return appointment)</p>			

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	<p>3/29/12 @ (at) 0830. New orders rec'd to add Calcium 500mg (milligrams)/vit (vitamin) D BID (two times a day), check Vit D-25 Hydroxy level, schedule BMD per [name of doctor]."</p> <p>Client G's record indicated the last Podiatry note in the record was dated 12/2/11. Other than the 2/29/12 physician order on prescription pad, there was no other documentation in client G's record of the 2/29/12 Podiatry visit.</p> <p>Client G's 2/29/12 IDT (interdisciplinary Team) note indicated indicated the client's IDT met to review and discuss the client's hospitalization. The note indicated "...She (client G) returned on 2/26/12 with right leg edema and was refusing to walk. Upon return an x-ray was ordered which discovered a fracture of her first metatarsal toe. She was diagnosed with osteoporosis which was present on the x-ray. She was referred to [name of podiatrist] a foot specialist. He ordered an air cast for her to wear during waking hours...He also suggested ice as needed to keep the swelling down over the next three days as needed. He said the cast will let her ambulate independently and that a wheelchair would not be needed...."</p> <p>Client G's 1/19/12 Individual Support plan (ISP) and/or 2/29/12 nursing Risk</p>						

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	<p>Plans indicated the facility did not develop/put a risk/nursing care plan in place for client G's Avulsion fracture.</p> <p>Interview with LPN #3 on 3/14/12 at 10:05 PM, by phone, indicated LPN #3 was the nurse on duty when client G returned from the podiatry appointment on 2/29/12. LPN #3 indicated upon client G's return from the podiatrist, she only remembered staff giving her a prescription order which indicated the client had a fracture. LPN #3 indicated there should be a consult note from the podiatrist in the record. LPN #3 indicated she was not sure if client G's risk plan had been updated in regard to client G's fracture.</p> <p>Interview with administrative staff #2, #3 and #4 on 3/14/12 at 11:40 AM indicated there should be an Podiatry note and/or consult form in client G's record.</p> <p>Interview with the Director of Nursing (DON) on 3/14/12 at 1:05 PM indicated they were in the process of trying to find the Podiatrist documentation/note. The DON indicated a note may not have been sent back at the time of the 2/29/12 visit as the Podiatrist may have dictated a note.</p> <p>3.1-17(a)</p>						

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