

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2015
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00180770 and IN00181131.</p> <p>Complaint IN00180770 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00181131 - Substantiated. Federal/State deficiencies related to the allegations are cited at F353 and F9999.</p> <p>Survey dates: August 31 and September 1, 2015</p> <p>Facility number: 000572 Provider number: 155535 AIM number: 100267710</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 5 Medicaid: 50 Other: 9 Total: 64</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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 0353 SS=E Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, record review and interview, the facility failed to ensure nursing staff in sufficient numbers to</p>	F 0353	The facility failed to ensure sufficient nursing staffing was maintained to provide services to the residents which included, but	09/10/2015

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	<p>answer call lights and provide assistance with activities of daily living (ADLs) for 6 of 6 residents reviewed (Residents F, G, H, J, K and M), 2 of 2 family interviews (Residents J and K) and 5 of 7 staff interviews (Staff # 1, 2, 3, 4, and 6).</p> <p>Findings include:</p> <p>On 8/26/2015 via e-mail, an ambulance service Paramedic indicated, "On 8/7/2015 at 9:28 a.m., [ambulance service] was to pick up resident from [facility] for a non-emergency run to [hospital]...Ambulance arrived at [facility] at 9:42 a.m. on 8/7/15. Ambulance staff did not note a nurse anywhere...."</p> <p>During an initial tour of the facility on 8/31/2015 at 10:01 a.m. and multiple subsequent random observations throughout the survey, multiple call lights were observed sounding consistently.</p> <p>During a confidential interview on 8/31/2015 at 1:40 p.m., Staff # 2 indicated there was consistently not</p>		<p>may not be limited to answering call lights and providing assistance with activities of daily living. This deficient practice affected 6 of 6 residents (Residents F, G, H, J, K and M) reviewed for staffing. F 353: Requires the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 1. It is the goal of the facility to provide services to its residents to allow the resident to attain or maintain their highest practicable physical and psychosocial well-being. The affected residents were not identified, thus, the following corrective actions will be taken. 2. In an effort to identify specific concerns/patterns/trends relative to staff availability/response, interviews shall be conducted inquiring of timely response to call lights, staff availability, etc. Any specific patterns/trends in times of day, caregivers, etc., shall be addressed. As all residents have the potential to be affected, the following corrective actions have been taken. 3. The facility has continued to hire staff in an effort to reduce the amount of overtime and possible staff burnout. Administration and nursing administration have met to review current acuity and staffing</p>		

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	<p>enough staff to meet resident needs on evening shift (2:00 p.m. to 10:00 p.m.), and every other weekend routinely has only four Certified Nursing Assistants (CNAs) scheduled. Staff # 2 indicated there were often only two CNAs scheduled at the start of evening shift, and day shift staff must stay over, "at least two to three days per week". Staff # 2 indicated management staff knew staffing would be short ahead of time and asked day shift staff to stay over, on the day, without notice. Staff # 2 indicated the Director of Nursing (DON) has indicated staff could bring their children in to the facility so they could work.</p> <p>During a confidential interview on 9/1/2015 at 9:25 a.m., Staff # 3 indicated the facility "goes through periods" where there is not enough staff scheduled to meet resident care needs.</p> <p>During a confidential interview on 9/1/2015 at 10:10 a.m., Staff # 6 indicated he/she was afraid to discuss staffing due to the DON pulling staff into her office for questioning after survey interviews and indicating, "Somebody's</p>		<p>patterns in an effort to ensure staff are best utilized in response to residents' plans of care. Nursing management has been re-educated on assessing the need for a sufficient amount of staff to care for the residents. Nursing staff shall be addressed in regard to ensuring the correct number of caregivers is secured for resident transfer as per plan of care, timely response to call lights, procedure in response to staff call-ins, and of the need to notify administration should unexpected staffing vacancies be such to prohibit the meeting of resident needs per plan of care.</p> <p>4. As a means of quality assurance, and in an effort to ensure a sufficient amount of staff is present, the administrator or designee will complete the staffing PPD daily for 4 weeks, then weekly for four weeks, monthly times two and then quarterly until 100% compliance with ensuring sufficient nursing staff is maintained. (See attachment A). Daily rounds on scheduled days of work will be conducted in an effort to assess sufficiency of staff as evidenced by ability to care for the residents according to their careplans and provide timely response to resident needs. (See attachment A). Results of the rounds, PPD reviews and any additional corrective action taken shall be reported to the Quality Assurance Committee during quarterly</p>	

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	<p>going to get fired." Staff # 6 indicated, "residents aren't getting changed [incontinent care] for shifts at a time" due to not having enough staff. Staff # 6 recalled a day the previous week when there were 2 nurses and 3 CNAs for the entire facility. Staff # 6 indicated, "I was almost in tears. Residents were reaching [to me] from the doorway to go to the bathroom. Family member's jaws were dropped". Staff # 6 indicated he/she must routinely come in an hour early and stay three hours over his/her assigned shift. Staff # 6 indicated he/she and other staff members have repeatedly relayed concerns over staffing numbers to management and that management routinely does not assist with resident care. Staff # 6 indicated when concerns regarding staffing are brought to management by staff, residents or family members, "We [CNAs/nursing staff] just get reprimanded for not being fast enough."</p> <p>On 9/1/2015 at 11:04 a.m., the Executive Director indicated he did receive complaints from residents and staff regarding "call lights taking too long."</p>		meetings and the plan revised (e.g., extended if concerns persist), if warranted. 5. The above corrective action will be completed on or before September 10, 2015.	

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	<p>During a confidential interview on 9/1/2015 at 11:48 a.m., Staff # 4 indicated the call lights are routinely not answered and residents must wait a long time for assistance on evening shift and weekend shifts. Staff # 4 indicated, "Half of them are on their phones or gossiping in the hallway." Staff # 4 indicated staff often congregate in the conference room on weekends and are not available to answer call lights and/or provide resident care.</p> <p>Resident E was interviewed on 9/1/2015 at 1:20 p.m. He/she indicated, "It's an everyday occurrence, we have to wait up to two hours [for call lights to be answered/for assistance]. I was told by an aide [CNA] at night, 'Go ahead and pee in the bed and I will change you.'" Resident E indicated, "One day last week, I pooped my pants [due to staff not answering call light in a timely manor]. I had to go in [motioned to bathroom]...I had to wash myself with my one good arm...it's degrading." Resident E indicated staff leave him/her and his/her roommate in the bathroom and do not</p>			

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	<p>return for long periods of time. Resident E indicated, "They put is in there [bathroom] and forget about us. They take too long...that potty chair hurts your butt." Resident E recalled a recent incident in which he/she dropped his/her utensils on the floor, pushed the call light for assistance, and was not assisted until two and one half hours later. He/she indicated, "I had to eat my turkey and dressing with my fingers. I can't even describe how that made me feel. I feel like, 'You're treating me like crap and I'm better than this.'" Resident E indicated he/she had voiced concerns regarding staffing to management, but nothing had been done to increase/improve staffing.</p> <p>A current "CNA Assignment Sheet", provided by the DON on 8/31/2015 at 2:19 p.m., indicated Resident E required assistance with activities of daily living (ADLs), required the assistance of one staff person for transfers, required a wheelchair for mobility, was a fall risk, and was continent of bowel and bladder.</p> <p>Resident F was interviewed on 9/1/2015 at 1:38 p.m. He/She indicated there are</p>			

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	<p>routinely "two people [CNAs] to cover both ends [entire facility] on evening and night shift. Resident E indicated he/she has had multiple incontinent episodes as a result of waiting for staff to answer his/her call light. Resident F indicated, "They shock me when they come within thirty minutes.... They say, 'Well we're short staffed. We can't always get there at your beck and call...do you know how many people we have to take care of?'" Resident F indicated, "[It makes me feel] like a piece of crap. It's embarrassing and humiliating."</p> <p>A current "CNA Assignment Sheet", provided by the DON on 8/31/2015 at 2:19 p.m., indicated Resident F required assistance with activities of daily living (ADLs), required the assistance of one staff person for transfers, required a wheelchair for mobility, was a fall risk, and was incontinent of bowel and bladder.</p> <p>On 9/1/2015 at 1:40 p.m., Resident K and two family members indicated the facility did not have enough staff on the weekends.</p>			

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	<p>On 9/1/2015 at 1:42 p.m., Resident M indicated, "I don't think we have enough staffing...It takes a while [for staff to answer call lights and/or address needs]. Nights more than other times."</p> <p>Resident H was interviewed on 9/1/2015 at 1:50 p.m. He/she indicated there was only one CNA on duty for the entire facility the night before and that there is frequently not enough help on evening, night and weekend shifts. The resident indicated, "It can take a couple hours [for staff to answer call lights]. Several times it's taken ninety minutes...There are times I end up wetting myself". Resident H indicated his/her medications were frequently administered late. Resident H indicated he/she has voiced concerns to management on multiple occasions, indicating, "There are no changes. They just say, 'We'll do better in the future.'" Resident H indicated toward the end of night shift, he/she overheard CNA # 5 indicate to Resident J, "Go ahead and crap the bed. Somebody'll [sic] clean it up in a little bit".</p>			

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	<p>A current "CNA Assignment Sheet", provided by the DON on 8/31/2015 at 2:19 p.m., indicated Resident H required assistance with activities of daily living (ADLs), required a Hoyer lift for transfers, required a wheelchair for mobility, was a fall risk, and was incontinent of bowel and bladder.</p> <p>Resident J's family member and Power of Attorney (POA) was interviewed on 9/1/2015 at 2:12 p.m. He/she indicated he/she visited the resident twice per day. Resident J's family member recalled an incident "about three or four weeks ago" when he/she arrived early in the morning. The family member indicated, "The bed was a mess [with feces]." Resident J's family member indicated, Resident J and a day shift staff member indicated to him/her, that Resident J had pushed his/her call light for toileting assistance and was instructed by a night shift CNA to "go ahead and go in the bed". Resident J's family member indicated, "There is absolutely not enough staff... [Resident J's] no dog. I don't want [Resident J] treated like a dog". Resident J's family member indicated he/she had</p>			

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	<p>discussed staffing concerns with management, stating, "Nothing changes [regarding staffing]" .</p> <p>A current "CNA Assignment Sheet", provided by the DON on 8/31/2015 at 2:19 p.m., indicated Resident J required assistance with activities of daily living (ADLs), required the assistance of one staff person for transfers, required a wheelchair for mobility, was a fall risk, and was incontinent of bowel and bladder.</p> <p>Resident J was observed on 9/1/2015 at 2:20 p.m. in his/her bed. A strong odor of urine was observed.</p> <p>During a confidential interview on 9/1/2015 at 2:31 p.m., Staff # 1 indicated there was not enough staffing to meet resident care needs most evenings and residents had to wait a long time for call lights to be answered, assistance with toileting, and/or with bathing. Staff # 1 indicated there were "literally three and four" CNAs most evening shifts.</p> <p>Resident G was interviewed on 9/1/2015</p>			

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	<p>at 2:25 p.m. He/she indicated staffing was "awful on second shift." The resident indicated staff were not able to assist him/her with toileting in a timely manner and that he/she had multiple incontinent episodes as a result of waiting for staff assistance. Resident G indicated evening and night staff had indicated to her, "Go ahead. Do what you gotta [sic] do. I say, 'But I don't like to do that.' They say, 'Well you have to do what you have to do if you can't hold it.'" Resident G indicated, "I feel awful. It's awful. The way you feel...you have to lay there in that."</p> <p>Daily Staffing Sheet for 8/31/2015, provided by the ED on 8/31/2015 at 12:40 p.m., indicated two nurses and two CNAs scheduled for the entire evening shift (2:00 p.m. to 10:00 p.m.). An additional CNA was scheduled to arrive at 3:30 p.m. and two additional CNAs were scheduled to arrive at 4:00 p.m. Night shift (10:00 p.m. to 6:00 a.m.) indicated 2 nurses and 1 CNA scheduled for the entire shift.</p> <p>On 9/1/2015 at 11:05 a.m., the DON</p>			

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	<p>indicated she and the ADON shared responsibility for staffing. She indicated, "I didn't think to look [regarding night shift 8/31/2015]. I didn't know about it until ten o'clock this morning." The DON indicated Resident H required "constant" one-on-one nursing assistance.</p> <p>The DON was interviewed on 9/1/2015 at 1:49 p.m. She indicated there was no facility policy and procedure for staffing and staffing numbers were based on resident census. The DON indicated, "It wouldn't matter if there were 15 of them [CNAs], it still wouldn't be enough." The DON indicated the "minimum staffing requirement" was four CNAs on day and evening shift (two CNAs for each hall), and four CNAs was "adequate." The DON indicated there were four CNAs scheduled and/or working "approximately four days per week."</p> <p>Blank Daily Staffing Sheets indicated the following: Day Shift: One nurse for each of the two halls/medication cart, three additional staff (CNAs) for each of the two halls, and one treatment nurse.</p>			

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	<p>Evening Shift: One nurse for each of the two halls/medication cart, three additional staff (CNAs) for each of the two halls, and two treatment nurses.</p> <p>Night Shift: One nurse for each of the two halls/medication cart and three additional staff (CNAs) for the whole facility.</p> <p>Review of staffing for August 1 through August 31, 2015 indicated the following: Day Shift: 6 days with 2 nurses, 4 CNAs and no treatment nurse. Evening Shift: 6 days with 2 nurses, 4 CNAs and no treatment nurse. Night Shift: 19 days with one to four CNAs arriving 2-4 hours after a day or evening shift started.</p> <p>The current Resident Census and Conditions of Residents document, provided by the DON on 9/1/2015 at 2:54 p.m., indicated, of 64 residents in the facility, 50 required assist of one or two staff for bathing and 14 were totally dependent on staff for bathing; 52 required assist of one or two staff for dressing and 12 were totally dependent on staff for dressing; 47 required the assist of one or two staff members for</p>			

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	<p>transferring and 17 were totally dependent on staff for transferring; 45 required assist of one or two staff for toilet use and 19 were totally dependent; 58 required the assist of one or two staff for eating and 6 were totally dependent; 14 residents required respiratory treatment; 1 resident required tracheostomy care; and 10 residents required ostomy care.</p> <p>A copy of the February, 2015 Resident Council Minutes was provided by the Activities Director on 9/1/2015 at 3:02 p.m. Discussion of New Business indicated, "Nursing: Issues [with] call lights not being answered or answered but requests not being followed through..."</p> <p>A copy of the July, 2015 Resident Council Minutes was provided by the Activities Director on 9/1/2015 at 3:02 p.m. Discussion of New Business indicated, "Nursing: 1. Call lights during meals and on 2nd shift [after] 4 pm. 2. 3rd shift [no symbol] answer lights [after] 4 am d/t [due to] get-ups. 3. Nurses not answering lights or giving care. 4. Staff</p>			

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F 9999 Bldg. 00	<p>'buddy up' in rooms [list 4 staff names]."</p> <p>A copy of the current Resident Rights Policy and Procedure was provided by the Executive Director (ED) on 9/1/2015 at 12:16 p.m. The policy indicated, but was not limited to, "Resident Rights: The resident has a right to a dignified existence...Quality of Life: a) Dignity: A facility must care for it's residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>This Federal tag relates to Complaint IN00181131.</p> <p>3.1-17(a)</p> <p>Based on interview and record review, the facility failed to report to the Indiana State Department of Health (the division)</p>	F 9999	F9999 Requires the facility to report to the Indiana State Board of Health if resident's fall which results in a fracture. 1. Resident B	09/10/2015

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	<p>one resident's fall, which resulted in a fracture (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 8/31/2015 at 12:36 p.m. Diagnoses included, but were not limited to, chronic bullous pemphicoid (autoimmune condition causing large, fluid-filled blisters on skin), severe aortic valve stenosis, and depression.</p> <p>Minimum Data Set (MDS) assessment, dated 6/4/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15; indicating the resident was cognitively intact. The resident required extensive, one person physical assist for transfers and toilet use. The resident was not steady, and only able to stabilize with staff assistance moving from a seated to standing position, moving on and off toilet, and surface to surface transfer (transfer between bed and chair or wheelchair). The resident normally used a wheelchair for mobility.</p> <p>Resident B's Nurse's Note, dated 8/7/2015 at 6:00 a.m. indicated, "Resident found on floor in bathroom of his room next to wheelchair. Skin tears noted [and] R [right] hip + leg hurted [sic]. NP [Nurse Practitioner] gave order</p>		<p>ambulated independently to the bathroom and fell which resulted in a right hip fracture. 2. All residents have the potential to be affected. The last 30 days of incident and accident reports as well as notice of concern reports were reviewed ensuring no incidents occurred that needed to be reported to Indiana State Board of Health. No further concerns were noted. See below for corrective measures. 3. The Unusual Occurrences policy and procedure was reviewed with no changes made. (See attachment B) The Administrator and Director of Nurses were inserviced on the above procedure. 4. All incident reports and notice of concerns will be reviewed by the Administrator daily to ensure that any incident needing to be reported to Indiana State Board Of Health is completed timely. The Administrator will also conducted the nurse consultant and review the reports as well. If the incident requires notification of the Indiana State Board of Health it will be done immediately. The Administrator or his designee will utilize the monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality</p>	

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	<p>to get x-ray...."</p> <p>A copy of Resident B's Accident & Incident Report and Investigation, dated 8/7/2015, was provided by the Director of Nursing (DON) on 8/31/2015 at 1:12 p.m. The document indicated, "Time [of incident]: 4 a [4:00 a.m.]...Thorough description of incident: CNA walked in to find resident sitting on floor in his bathroom next to wheelchair. Type of injury: None__ Skin Tear X Bruise__ Fracture__ Laceration___...Other (describe): [blank]...Internal or external rotation of any extremity noted? No...Any verbal or non-verbal signs of pain? Yes. If yes, explain: in arm [and] leg. PRN med given. Was it necessary to send the resident to the hospital for evaluation/treatment? No. Was it necessary to obtain any laboratory tests or x-rays as a result of the incident? R leg/hip...."</p> <p>Resident B's Hospital History and Physical, dated 8/7/2015, indicated, "Date of service: 08/07/2015. Reason for admission: Right intertrochanteric [proximal/upper part of femur/thigh bone] femur fracture. History of Present Illness: [Resident B] is an 87 year old nursing home resident who had fallen early this morning while going to the bathroom. The patient primarily</p>		<p>assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before September 10, 2015.</p>	

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	<p>ambulates in a wheelchair..."</p> <p>On 9/1/2015 at 11:04 a.m., the Executive Director (ED) indicated he did not report Resident B's fall with fracture to the division, indicating, "I probably should have."</p> <p>A copy of the current Unusual Occurrences Policy and Procedure was provided by the ED on 9/1/2015 at 1:15 p.m. The policy indicated, "This facility shall ensure the division is immediately informed...within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety or health of the resident or residents, including, but not limited to, any: ...major accidents...The facility shall utilize the guidelines provided by [division] (effective...; revised 1/15/13) to define 'Reportable Incidents Policy' (see attached)..."</p> <p>The attached division Reportable Incidents Policy indicated, "01/15/2013 (title change)...Reportable Incidents: ...(6) Significant Injuries: ...3) fractures sustained by a totally dependent resident (as defined on MDS)..."</p> <p>The current division Incident Reporting Policy, dated 7/15/2015 indicated, "Effective Date: 7/5/15. Cancels:</p>			

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	<p>Reportable Incident Policy and [division] Reportable Unusual Occurrence Policy...Purpose: To provide guidance on the type of incidents to be reported; the timeline for reporting...Policy: Incidents required to be reported by federal and/or state law will be submitted to [division]...C. Types of incidents reportable under State rules only. 5. Major accidents...Examples: ALL fractures...."</p> <p>This State tag relates to Complaint IN00181131.</p> <p>3.1-13(g)(1)</p>			