STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155693		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 Bldg. 00	This visit was for the Investigation of Complaint IN00169553. Complaint IN00169553 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F441, and F514. Survey dates: March 26, 27, 30, and 31, 2015 Facility number: 002955 Provider number: 155693 AIM number: 200346570 Survey team: Jennifer Carr, RN - TC Census bed type: SNF: 45 SNF/NF: 25 Residential: 39 Total: 109 Census payor type: Medicare: 35 Medicaid: 19 Other: 16 Total: 70 Sample: 4	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1			
F 309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review and interview, the facility failed to ensure 1 of 4 sampled residents (Resident B) received timely treatment for infections as ordered by the physician, resulting in the resident being admitted to the hospital with sepsis and the facility failed to administer insulin according to physician's orders for 1 of 8 residents (Resident D) observed for medication administration, which had the potential to result in life-threatening increase or decrease in blood glucose levels. Findings include: 1a. Resident B's closed record was reviewed on 3/26/2015 at 12:31 p.m. Diagnoses included, but were not limited	F 309	Licensed nursing staff who did not administer the antibiotic to resident B were immediately re-educated on Med Pass Procedures and Error Prevention and disclipined. RN#1 who did not administer the correct amount of sliding scale insulin to resident D was immediately in-serviced on Guidelines for Accuchecks and Specific Medication Administration Procedures, and Insulin Review related to sliding scale. LPN responsible for not transcribing the diagnosis for resident B was immediately in-serviced on Guidelines for Medication Orders. All residents have the potential to be affected. Licensed nursing staff will be in-serviced on Med Pass Procedures and Error Prevention, Guidelines for Accuchecks, Insulin Review, Specific	04/30/2015

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	to, cerebral vascular accident (stroke), history of pneumonia, and history of Clostridium difficile (bacterial infection of the intestines). Admission Minimum Data Set (MDS) assessment, dated 1/2/2015, indicated a Brief Interview for Mental Status (BIMS) score of 11; indicating the resident was cognitively intact. Physician's Orders, dated 3/5/2015 at 4:34 p.m., indicated, "Vincomycin [sic] [Vancomycin: antibiotic] 250 mg [milligrams] (5 ml [milliliters]) po [by mouth] QID [four times daily] x 14 days. Indication-DX [diagnosis]: C-diff [Clostridium difficile]." Resident B's March, 2015 Medication Administration Record (MAR) indicated, "Vancomycin 250mg (5ml) p.o. qid x 14 days. 3/5/2015 [to indicate the order date]. Scheduled dose times indicated, "12 AM, 6 AM, 12 N, 6 PM." The MAR documentation indicated Resident B did not receive any doses on 3/5/2015. The documentation for the 3/6/2015 scheduled doses at 12:00 a.m., 6:00 a.m., and 12:00 p.m. indicated circled initials, to indicate the medication was not administered. The MAR indicated Resident B received the first dose of Vancomycin on 3/6/2015 at 6:00 p.m.		Medication Administration Procedures, and Guidelines for Medication Orders. PCA Pharmacy will conduct random medication administration audit. DHS or designee will complete medication transcription and administration audits of all new medication orders 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly x4 weeks, then montly for 6 months. Results will be forwarded to QA monthly until substantial compliance is achieved. DHS or designee will complete random Medication Pass Observation related to insulin administration of sliding scale. Audits will be conducted 3x/week for 4 weeks then 2x/week for 4 weeks then weekly for 4 weeks, then monthly for 6 months. The results of audits/observations will be reported, reviewed and trended for compliance thru the QA committee for a minimum of 6 months, then randomly thereafter for further recommendations. Corrective action completion date: 4/30/2015	

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	Nurse's Notes, dated 2/19/2015 at 4:00 p.m., indicated physician's orders for routine medication and laboratory work in one month. The following Nurse's Notes, dated 3/4/2015 at 9:00 a.m., indicated, "Res [resident] c/o [complained of] diarrhea [with] foul odor. MD notified. N.O. [new order] 1) Stool spec [specimen] for C.diff. Dx [diagnosis] diarrhea." The following Nurse's Notes, dated 3/5/2015 at 4:00 p.m., indicated, "C-diff results reviewed and Vancomycin 250 mg (5 ml) po QID x 14 days ordered...." The following Nurse's Notes, dated 3/6/2015 at 9:00 a.m., indicated, "N.O. 1) C-Diff [sic] precautions." The following Nurse's Notes, dated 3/7/2015 at 10:00 a.m., indicated, "Pt [patient] c/o [complained of] not feeling well. B/P [blood pressure] 80/40, P [pulse] 57, Resp [respiratory rate per minute] 24...O2 [oxygen saturation] 80%." The following Nurse's Notes, dated 3/7/2015 at 10:55 a.m., indicated, "B/P 70/40, P 100, Resp 22, Pt on 6 L [liters] of oxygen unable to get O2 stat [sic].			

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	Send to ER [Emergency Room] for eval [evaluation]." The following Nurse's Notes, dated 3/7/2015 at 11:00 a.m., indicated, "Ambulance here to transport pt to [hospital name] via stretcher." Infection Assessment and Review, dated 3/5/2015, indicated, "Type of Infection: C-diff. Symptoms: diarrhea [with] foul odor. Treatment required: Yes. MD Orders: Vancomycin. Vital Signs: Pulse: 96. B/P [blood pressure]: 101/68. Respirations: 18. Temperature: 97.0 [degrees Fahrenheit].... Follow Up [on reverse]: Date: 3/6/15. Time: 2 [a.m.] - 10 [p.m.]. Assessment completed [check mark]. VS [vital signs] [check mark] 97.6 [to indicate temperature in degrees Fahrenheit]. Symptoms continue [check mark]. Isolation continues [check mark]. ABT/Tx [antibiotic/treatment] continues [check mark].... Date: 3/7/15. Time: 10 [p.m.] - 6 [a.m.]. Assessment completed [check mark]. VS [check mark] 98.4. Symptoms continue [check mark]. ABT/Tx [check mark].... Date: 3/7/15. Time: 6 [a.m.] - 2 [p.m.]. Transfer to hospital." Hospital History and Physical, dated 3/7/2015, indicated, "DATE OF SERVICE: 3/7/2015 at 16:57 p.m.			

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	HISTORY OF PRESENT ILLNESS: "...has been brought to the ER for evaluation for hypotension [low blood pressure], hypoxemia [low oxygenation of blood] and altered mental status.... ASSESSMENT AND PLAN: 1. Recurrent severe Clostridium difficile colitis... This is the likely source of patient's severe sepsis [life-threatening blood infection] and septic shock [severe drop in blood pressure which can lead to organ and respiratory failure and death]...." A copy of Resident B's Certificate of Death, dated 3/10/2015, indicated, "...3. Time of Death: 8:21 PM. 4. Date of Death: 3/8/2015.... Cause of Death: A. Cardiac Arrest. B. Septic Shock. C. Clostridium Difficile Colitis...." The Director of Health Services (DHS) was interviewed on 3/26/15 at 2:58 p.m. She indicated Resident B began having loose stools on 3/4/2015 and was diagnosed with C. diff 3/5/2015. She indicated she discovered Resident B did not receive the first four doses of the ordered antibiotic between 3/5/2015 and 3/6/2015 after Resident B's death. The DHS indicated the medication was available in the EDK [Emergency Drug Kit] at the time it was ordered and stated, "So that was a med error."			

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	The current Medication Pass Procedures and Error Prevention Policy and Procedure was provided by the Assistant Director of Health Services (ADHS) on 3/27/2015 at 1:28 p.m. The procedure included, but was not limited to, "...Check emergency boxes first.... Responsibilities for administering medications ordered - withholding medications due to medication not being available is not acceptable - first check the EDK [Emergency Drug Kit] box...." Licensed Practical Nurse (LPN) #3 was interviewed on 3/27/2015 at 2:20 p.m. She indicated she worked day shift on 3/6/2015 and was assigned to Resident B's hall. LPN #3 indicated the third shift nurse giving her report that morning indicated Resident B had an order for Vancomycin, but she did not administer the medication because it had not been delivered from pharmacy. LPN #3 indicated, "Most of the time, we go to the EDK. I was wrong in assuming we didn't have any [Vancomycin]." Registered Nurse (RN) #4, who was on duty 3/6/2015 during evening shift, was interviewed on 3/30/2015 at 1:45 p.m. RN #4 indicated a CNA [Certified Nurse Aide] on duty indicated to her, "[RN #4], this man [Resident B] isn't acting right."			

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	RN #3, who was on duty 3/6/2015 during evening shift, was interviewed on 3/30/2015 at 1:55 p.m. RN #3 indicated, "You could just tell he [Resident B] didn't feel well." CNA #2, who was on duty 3/7/2015 during day shift, was interviewed on 3/30/2015 at 2:14 p.m. CNA #2 indicated she recalled assisting Resident B with breakfast the morning of 3/7/2015 and the resident "would not eat." CNA #2 indicated she told nursing staff, "Something's not right [with Resident B]." b. Resident B's Physician's Orders, dated 1/5/2015, indicated, "Rocephin [antibiotic] 1 GM [gram] IM [intramuscular injection] dly [daily] x 5 days." The order did not include an indication (diagnosis) for the medication. January, 2015 Medication Administration Record (MAR) indicated Resident B received the first dose on 1/7/2015. The DHS was interviewed on 3/30/2015 at 2:08 p.m. She indicated, "I don't know why [Rocephin] wasn't started." The DHS indicated the medication was available in the Emergency Drug Kit (EDK) at the time it was ordered and that			

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	antibiotics should be started "immediately or the next day when pharmacy brings it." On 3/31/2015 at 1:50 p.m., the DHS indicated she could not find a documented physician's indication or diagnosis for the Rocephin ordered 1/5/2015 for Resident B, and indicated it was ordered to treat "pneumonia." A copy of the current Guidelines for Medication Orders Policy and Procedure was provided by the Director of Health Services (DHS) on 3/31/2015 at 9:55 a.m. The procedure included, but was not limited to, "...When recording medication orders specify: 1. The type, route, dosage, frequency, strength of the medication and reason for order (i.e. Dilantin 100mg po, TID for seizure disorder)...." 2. Resident D's clinical record was reviewed on 3/30/2015 at 2:00 p.m. Diagnoses included, but were not limited to, insulin-dependent diabetes. March, 2015 Physican's Orders indicated, "Humalog 100 units/ml [milliliter] vial. Accu-CK [blood glucose testing] QID [6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m.] w/ [with] SSI [sliding scale insulin]: 70 - 140 = 0 units. 141 - 180 = 4 units. 181 - 220 = 6 units...."			

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	Registered Nurse (RN) #1 was observed during a routine medication pass beginning on 3/30/2015 at 11:07 a.m. RN #1 performed a scheduled blood glucose test on Resident D and indicated the result was "184 [mg/dl (milligrams per deciliter)]." RN #1 was then observed drawing up 4 units of Humalog (100 units/ml) insulin and administering it to Resident D. Resident D's March, 2015 MAR was reviewed on 3/30/2015 at 3:58 p.m. On 3/16/2015 at 11:00 a.m., blood glucose result indicated, "134 [mg/dl]. Amount of Humalog insulin given per sliding scale indicated, "4 [units]." On 3/22/2015 at 11:00 a.m., Resident D's blood glucose result indicated, "142 [mg/dl]. Amount of Humalog insulin given per sliding scale indicated, "2 [units]." On 3/28/2015 at 11:00 a.m., Resident D's blood glucose result indicated, "144 [mg/dl]. Amount of Humalog insulin given per sliding scale indicated, "0 [units]." On 3/30/2015 at 11:00 a.m., Resident D's blood glucose result indicated, "184 [mg/dl]. Amount of Humalog insulin			

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	given per sliding scale indicated, "4 [units]." On 3/31/2015 at 11:16 a.m., the ADHS indicated, "[Resident D] should have gotten six units [during observed medication pass on 3/30/2015]." This Federal tag relates to the Investigation of Complaint IN00169553. 3.1-37(a)			
F 441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program			

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	determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure proper hand hygiene during medication administration for 5 of 10 residents observed for medication administration (Residents D, F, H, J, and K), wound care for 1 of 1 resident observed for wound care (Resident D), and 1 of 1 resident observed for colostomy care (Resident M). Findings include: 1. Registered Nurse (RN) #1 was observed during a routine medication pass beginning on 3/30/2015 at 11:05 a.m. RN #1 did not perform hand washing or use hand sanitizer before or after dispensing medications to Resident	F 441	F441 RN #1 was immediately re-educated on Guidelines for Handwashing/Hand Hygiene related to medication administration, colostomy care, and wound care. RN#2 was immediately re-educated on Handwashing/Hand Hygiene related to medication administration. All residents have the potential to be affected Licensed nursing staff will be in-serviced on Guidelines for Handwashing/Hand Hygiene. DHS or designee will complete random handwashing audits 3x/week for 4 weeks then 2x/week for 4 weeks then weekly x4 weeks, then monthly for 6 months. The results of audits/observations will be reported, reviewed and trended for compliance thru the QA committee for a minimum of 6 months, then randomly thereafter	04/30/2015

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	D at 11:07 a.m., Resident F at 11:15 a.m., or Resident H at 11:22 a.m. 2. During the same medication pass observation, on 3/30/2015 at 11:25 a.m., RN #1 was called into Resident M's room to replace a colostomy bag. RN #1 entered Resident M's bathroom, where the resident was observed sitting on the toilet. RN #1 donned clean gloves, applied a new colostomy bag, discarded the gloves, and performed hand washing for nine seconds. 3. On 3/30/2015 at 1:14 p.m., RN #1 and Certified Nurse Aide (CNA) #1 were observed performing incontinence care and wound care on Resident D. RN #1 and CNA #1 entered the room, donned clean gloves, and performed incontinence care and wound care to two pressure ulcer sites on Resident D. Following wound care, RN #1 discarded the soiled gloves and performed hand washing for six seconds. RN #1 left the room and began preparing medications for Resident L. 4. RN #2 was observed during a routine		for further recommendations. Corrective action completion date: 4/30/2015	

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	medication pass beginning on 3/30/2015 at 3:45 p.m. RN #2 did not perform hand washing or use hand sanitizer before dispensing medications for Resident J. RN #2 was observed dispensing one Coumadin 2 mg [milligram] tablet into his bare hand and placing it into a medication cup. RN #2 transported the medication cup in his left hand with his bare index finger over the rim and inside the medication cup. RN #2 entered Resident J's room, administered the resident's oral medications, donned clean gloves, administered Timolol 0.25% eye drops into each eye, discarded the gloves, left the room, and began preparing medications for Resident K. RN #2 did not perform hand washing or use hand sanitizer prior to, or following the administration of Resident K's medications. A copy of the current Specific Medication Administration Procedures Policy and Procedure was provided by the Assistant Director of Health Services (ADHS) on 3/26/2015 at 3:27 p.m. The procedure included, but was not limited to, "...J. Cleanse hands using			

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	antimicrobial soap and water or facility-approved hand sanitizer before beginning a med pass, before handling medication, and before contact with a resident.... S. When finished with each resident, wash hands with antimicrobial soap and water or use facility-approved hand sanitizer. These guidelines refer to all medications, in addition to specific procedures for each route of administration." A copy of the current Medication Pass Procedures and Error Prevention Policy and Procedure was provided by the ADHS on 3/27/2015 at 1:28 p.m. The procedure included, but was not limited to, "...3. INFECTION CONTROL: ...Wash hands with soap and water at the start of your med pass and: After direct resident contact.... After removing gloves.... Use hand sanitizer between every resident if no direct patient contact.... Do not touch pills directly.... 5. OPTHALMIC SOLUTIONS AND OINTMENTS: ...Wash hands and wear gloves.... Remove gloves, wash hands...." A copy of the current General Wound			

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	155693		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	and Skin Care Guidelines Policy and Procedure was provided by the ADHS on 3/30/2015 at 12:22 p.m. The procedure included, but was not limited to, "1. Wash hands before and after resident contact...." A copy of the current Guideline for Handwashing/Hand Hygiene Policy and Procedure was provided by the Director of Health Services (DHS) on 3/30/2015 at 2:40 p.m. The procedure included, but was not limited to, "...3. Healthcare workers shall wash their hands at times such as: ...c. Before/after having direct physical contact with residents. d. After removing gloves.... 8. Wash well for 20 seconds...." A copy of the current Guidelines for Colostomy Ileostomy Policy and Procedure was provided by the DHS on 3/31/2015 at 1:32 p.m. The DHS indicated the procedure should be utilized for changing colostomy bags. The procedure included, but was not limited to, "...3. To perform the procedure: ...b. Wash and dry hands thoroughly.... e. Put on gloves.... 4. Upon completion of the			

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	procedure: ...g. Remove and discard gloves.... Wash and dry hands thoroughly...." This Federal tag relates to the Investigation of Complaint IN00169553. 3.1-18(l)			
F 514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to accurately document the indication (diagnosis) for ordered medications and the administration of intraveneous fluids for 1 of 4 residents reviewed for quality of care (Resident B). Findings include:	F 514	F514 LPN responsible for not transcribing the diagnosis for resident B Rocephin was immediately in-serviced on Guidelines for Medication Orders. LPN responsible for not transcribing the diagnosis for IV fluids was immediately in-serviced on Infusion Therapy Medication Administration Policy and Procedure and Administering IV Solutions. All residents	04/30/2015

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	1. Resident B's closed record was reviewed on 3/26/2015 at 12:31 p.m. Diagnoses included, but were not limited to, cerebral vascular accident (stroke), history of pneumonia, and history of Clostridium difficile (bacterial infection of the intestines). Resident B's Physician's Orders, dated 1/5/2015, indicated, "Rocephin [antibiotic] 1 GM [gram] IM [intramuscular injection] dly [daily] x 5 days." The order did not include an indication (diagnosis) for the medication. On 3/31/2015 at 1:50 p.m., the Director of Health Services (DHS) indicated she could not find a documented physician's indication or diagnosis for the Rocephin ordered 1/5/2015 for Resident B, and indicated it was ordered to treat "pneumonia." A copy of the current Guidelines for Medication Orders Policy and Procedure was provided by the DHS on 3/31/2015 at 9:55 a.m. The procedure included, but was not limited to, "...When recording medication orders specify: 1. The type, route, dosage, frequency, strength of the medication and reason for order (i.e. Dilantin 100mg po, TID for seizure		receiving IV therapy have the potential to be affected. Licensed staff will be in-serviced on Guidelines for Medication Orders, Infusion Therapy Medication Administration Policy and Procedure, and Administering IV solutions. DHS or designee will complete medication transcription and documentation of all new IV medications and IV fluid orders 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly x4 weeks, then montly for 6 months. The results of audits/observations will be reported, reviewed and trended for compliance thru the QA committee for a minimum of 6 months, then randomly thereafter for further recommendations. Corrective action completion date:4/30/2015	

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	disorder)...." 2. Resident B's Physician's Orders, dated 1/8/2015 at 12:50 p.m., indicated, "...2. IV [intravenous] fluids [arrow] L.R. [lactated ringers] @ [at] 60 ml/hr [milliliters per hour] x 1000 ml...." The order did not include an indication (diagnosis) for the medication. Resident B's Nurse's Notes, dated 1/8/2015 at 1:00 p.m., indicated, "...NP [Nurse Practitioner] in to see [with] N.O. [new order]: ...2. IV [intravenous] fluids [arrow] L.R. [lactated ringers] at 60 ml/hr [milliliters per hour] x 1000 ml...." Nurse's Notes did not include an indication (diagnosis) for the medication. Resident B's January, 2015 MAR indicated, "Medication: IV fluids L.R. @ 60 ml/hr x 1000 ml. Hour: 1/8/15 [to indicate order date] FYI [for your information]." There was no evidence on the MAR or Resident B's clinical record to indicate the resident had IV access or received the medication. On 3/30/2015 at 4:01 p.m., the DHS and Assistant Director of Health Services (ADHS) provided three documents as evidence that Resident B received the IV			

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	fluids as ordered. The first document indicated, [name] Pharmacy. Date: 1/8/2015.... Hydration: Lactated Ringers. Rate: 60 ml/hr...." The second document indicated, "24 Hour Nursing Report 1/8/2015. Resident Info: [ResidentB]. Day Shift: Started IV.... Evening Shift: IV started patent L) [left] ant [antecubital vein]." The third document indicated, "24 Hour Nursing Report 1/9/2015. Resident Info: [ResidentB]. Night Shift: IV 60/hr....." On 3/30/2015 at 4:20 p.m., the ADHS indicated the IV access and administration of the medication should have been documented in Resident B's clinical record. A copy of the current Infusion Therapy Medication Administration Policy and Procedure was provided by the DHS on 3/31/2015 at 9:55 a.m. The procedure included, but was not limited to, "...K. Document in Nursing Progress Notes: 1) Type of solution and medication. 2) Duration of medication infusion....." A copy of the current Administering IV			

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	Solutions Policy and Procedure was provided by the DHS on 3/31/2015 at 9:55 a.m. The procedure included, but was not limited to, "...L. Document the procedure." This Federal tag relates to the Investigation of Complaint IN00169553. 3.1-50(a)(1)(2)			