

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2014
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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F000000	<p>This visit was for the Investigation of Complaints #IN00141818, #IN00142005, #IN00142565, & #IN00143493.</p> <p>Complaint #IN00141818-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F323, & F514.</p> <p>Complaint #IN00142005-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F323, & F514.</p> <p>Complaint #IN00142565-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 & F514.</p> <p>Complaint #IN00143493-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: February 6, 7, & 10, 2014</p> <p>Facility number: 000051 Provider number: 155121 AIM number: 100275490</p>	F000000	We respectfully request an IDR for F323 to reduce the severity	

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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	<p>Survey team: Michelle Carter, RN- TC Sandra Nolder, RN</p> <p>Census bed type: SNF- 15 SNF/NF- 114 Total= 129</p> <p>Census payor type: Medicare- 21 Medicaid- 88 Other- 20 Total= 129</p> <p>Sample= 9</p> <p>These deficiencies reflect findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley on February 17, 2014.</p>						

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified in regards to physician's orders for re-evaluation for 1 of 9 residents</p>	F000157	1) Resident J no longer resides at this facility. Nurse who noted order has been educated to notify MD when MD order states re-evaluation. 2) Any resident with an MD order for re-evaluation has	03/12/2014	

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	<p>reviewed for following physician orders, in a sample of 9. (Resident J)</p> <p>Findings include:</p> <p>The clinical record for Resident J was reviewed on 2/7/14 at 11:10 A.M.</p> <p>Diagnoses for Resident J included, but were not limited to, idiopathic peripheral neuropathy, chronic kidney disease- stage 3, anemia, glaucoma, pathologic fracture to humerus, cardiomyopathy, type 2 diabetes mellitus, peripheral vascular disease, congestive heart failure, depressive disorder, and intracranial hemorrhage.</p> <p>A physician's order, dated 10/2/13, indicated, "Lasix 20 milligrams (mg.) 1 pill, orally, daily for 2 weeks, then re-evaluate."</p> <p>The October 2013 MAR indicated Resident J finished the Lasix on 10/17/13.</p> <p>Physician telephone orders, dated 10/31/13, at 7:00 P.M., indicated, "D/C [discontinue] Lasix order-clarification."</p>		<p>the potential to be affected. MD will be notified with any order received for re-evaluation by nursing staff. DNS/Designee conducted audit of MD orders stating re-evaluation to ensure MD was notified. 3) DNS/Designee will complete inservice for staff that any MD order stating re-evaluate requires MD notification when the re-evaluation needs to occur. MAR/TAR will also reflect the need to notify MD when re-evaluation is to occur by 3/12/14. Nursing management will review new MD orders daily and any MD orders with re-evaluation will be checked to ensure they are on the MAR/TAR. 4.To ensure compliance, the DNS/Designee will complete the MD order MAR/TAR Documentation Flow Sheet/Continuous Quality Improvement tool weekly x 4, then monthly x 6, then quarterly thereafter and report to CQI committee overseen by the executive director monthly x 6 months. Compliance will be 100% or action plan will be developed.</p>		

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F000282 SS=D	<p>Nurses notes, dated 10/31/13, at 10:22 P.M., indicated, "New order received and noted to dc [discontinue] Lasix order noted"</p> <p>Clinical documentation did not indicate the notification of the physician related to the Lasix completion and order for re-evaluation. On 2/7/14, at 2:00 P.M., during an interview with the DoN, she indicated the facility did not have documentation related to the physician notification of the completion of the Lasix order for Resident J.</p> <p>This federal tag relates to Complaint #IN00142565.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure physician orders were</p>	F000282	1) Resident B discharged home. Resident C discharged home. Resident D continues to reside in the facility. Resident D's	03/12/2014			

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	<p>followed for 1 of 9 residents reviewed for following physician orders, in a sample of 9, (Resident B) and plans of care were followed to ensure fall interventions were followed to prevent the likelihood of falls for residents who were deemed at risk for falls for 2 of 4 residents reviewed for falls, in a sample of 9 (Resident C and D). Resident D fell on 12/13/13 that resulted with a fracture to her left thumb and wrist, laceration to her forehead and right cheek, with 6 sutures, a nasal fracture and purple bruising to her entire face and neck area.</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 2/6/14 at 11:50 A.M.</p> <p>Diagnoses for Resident B included, but were not limited to, status post left below the knee amputation, pyrogenic arthritis, chronic viral hepatitis C, thrombocytopenia, liver cirrhosis secondary to alcoholism, type 2 diabetes mellitus, osteoarthritis, chronic congestive splenomegaly, and bipolar disorder.</p> <p>A physician's order, dated 1/13/14, indicated, "Cleanse left knee area</p>		<p>care plan has been reviewed and updated to accurately reflect current plan of care. DNS/Designee to complete inservice for staff regarding fall interventions and documentation of fall interventions including but not limited to neuro checks, 15/30 minute checks, and low bed in low position and following MD orders for dressing changes by 3/12/14.2) All residents at risk for falls have the potential to be affected. Resident care plans reviewed by DNS/Designee to ensure fall interventions are followed and MD orders for dressing changes are followed. Staff inserviced regarding fall interventions and documentation of fall interventions but not limited to neuro checks, 15/30 minute checks, and bed to be in low position and following MD orders for dressing changes. 3) IDT review of all new admissions to ensure fall prevention interventions are in place. IDT review after each fall to ensure root cause is identified and new intervention is in place. DNS/Designee will reivev falls to ensure that interventions are implemented and documented. 4) Nurse managers to complete MAR/TAR Documentation Flow sheet//Continuous Quality Improvement tool to be utilized 3x/weekly for 6 months and report findings to CQI committee overseen by the</p>		

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	<p>with antibiotic soap and water, rinse with normal saline, apply silvermed gel with q-tip, cover with gauze, and secure with paper tape. Change daily."</p> <p>The January 2014 medication administration record (MAR) indicated the dressing was not changed on 1/17, 22, & 23, 2014.</p> <p>During an interview, on 2/6/14, at 4:50 P.M., with the Director of Nursing (DoN), she indicated the January 2014 MAR and the January 2014 nursing notes did not indicate the dressing change was performed on 1/17, 22, & 23, 2014.</p> <p>2. Resident D's record was reviewed on 02/07/14 at 10:25 A.M.</p> <p>Diagnoses for Resident D, included, but were not limited to, epilepsy, sleep apnea, acute embolism deep vessel lower extremity, congestive heart failure, chronic airway obstruction, and a history of intracrainial hemorrhage.</p> <p>The December 2013 medication administration record (MAR), physician's orders included, but were not limited to: 12/11/13- Bed pad and wheelchair</p>		<p>executive director. Compliance will be 100% or action plan will be developed.</p>		

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	<p>pad alarms to alert staff of unassisted transfers. Check placement and function every shift. 12/13/13- Low bed</p> <p>Resident D had a care plan, dated 7/8/13, that addressed the problem at risk for falls related to "readmission, diagnosis osteoporosis, restless leg syndrome, anxiety, history of falls, antihypertensive, psychotropic, diuretic, narcotic and antiseizure use, impaired vision, impaired gait or balance, and use of assistive device."</p> <p>Interventions included, but were not limited to, "bed against the wall, low bed, winged mattress, bed and chair alarms, encourage and remind the resident to use the call light, non-skid footwear when up, and wheelchair for mobility."</p> <p>Resident D had a care plan that addressed the problem of "required assistance with activities of daily living" related to "impaired mobility, impaired gait and balance, and use of assistive device", dated 7/8/13.</p> <p>Interventions included, but were not limited to, "1/4 side rails times one to the right side rail, assist times two to</p>			

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	<p>the wheelchair, and use bedside commode."</p> <p>A document titled, "Resident Profile", which the CNA's used to provide care for the resident, indicated that as of 12/11/13 she was an assist of two for transfers to the wheelchair, was to have bed and chair alarms in place, was to have a winged mattress and 1/4 side rail times one to the right side of her low bed and her bed was to have been against the wall.</p> <p>Nursing notes, dated 12/11/13, at 7:38 P.M., indicated the nurse was called to the room by Resident D's roommate. Resident D was found in the bathroom on her bilateral knees, in front of the toilet, facing the wheelchair with her body, arms, and her head laid in the wheelchair. The resident was assisted to the standing position and transferred into her wheelchair with extensive assist of four person physical assist. Resident D's call light was on at the time of the fall. Staff "counseled" the resident to use her call light and wait for assistance before she transferred herself. Nursing notes indicated the resident had, recently, been experiencing increased weakness. The new fall prevention interventions</p>			

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	<p>were bed and wheelchair alarms to alert the staff to unassisted transfers. The staff were to check the function and placement of the alarms, every shift.</p> <p>Nursing notes, dated 12/13/13, at 8:45 A.M., indicated the nurse heard a loud crash and went into the Resident D's room. She found the Resident D lying on her stomach next to the bed with a profuse amount of blood surrounding her head. The left side of her face was resting on the floor and her right arm was next to her body, her left arm was under her body and her bilateral legs were outstretched. Lacerations were noted to her face and right arm. She had a bloody nose. The resident stated she "just fell over." The immediate intervention was to send Resident D to the emergency room for evaluation and treatment.</p> <p>Documentation did not indicate the bed alarm was sounding when the resident fell on 12/13/13.</p> <p>A document titled "Neurological Assessment" was used to document the resident's neurochecks, status post falls on 12/11/13 and 12/13/13. The document dated 12/11/13 and/or the nurses notes did not</p>				

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	<p>indicate the neurocheck documentation for the following dates and times: 12/13/13 - 6:00 A.M. - 2:00 P.M. 12/14/14 - 2:00 P.M. - 10:00 P.M. 12/15/14 - 6:00 A.M. - 2:00 P.M. 12/16/14 - 2:00 P.M. - 10:00 P.M.</p> <p>A document titled "Safety Check List-15 Minutes" was used to document the resident's 15 minute safety checks for the fall prevention intervention. Documentation was not evidenced for the following dates and times: 12/11/13 - 7:33 P.M. to 10:00 P.M. 12/12/13 - 6:30 A.M. to 7:45 A.M. 12/15/13 - 6:30 A.M. to 6:45 A.M. 12/17/13 - 2:30 P.M. 12/18/13 - 6:15 A.M. to 6:45 A.M. 12/20/13 - 10:00 P.M. to 11:45 P.M. 12/21/13 - 12:00 A.M. to 5:45 A.M.; and 2:15 P.M. to 9:45 P.M. 12/22/13 - 6:15 A.M. to 12/26/13 at 6:45 A.M. (4 days) 12/27/13 - 6:15 A.M. to 6:45 A.M. 12/28/13 - 6:15 A.M. to 6:45 A.M.; and 10:00 P.M. to 11:45 P.M. 12/29/13 - 12:00 A.M. to 6:45 A.M. 12/31/13 - 6:15 A.M. to 1:45 P.M.; and 10:15 P.M. to 11:45 P.M. 01/01/14 - 12:00 A.M. to 11:45 P.M. 01/02/14 - 12:00 A.M. to 1:45 A.M. 01/08/14 - 6:15 A.M. to 6:45 A.M. 01/09/14 - 6:15 A.M. to 6:45 A.M.</p>			

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	<p>01/12/14 - 6:15 A.M. to 6:45 A.M.</p> <p>A document titled "Safety Check List-30 Minutes" was used to document the resident's 30 minute safety checks for the fall prevention intervention. Documentation was not evidenced for the following dates and times: 01/15/14 - 7:00 A.M. to 10:00 A.M.; and 7:00 P.M. to 9:30 P.M. 01/19/14 - 6:30 A.M. 01/20/14 - 10:30 P.M. to 11:59 P.M. 01/21/14 - 12:00 A.M. to 6:30 A.M. 01/26/14 - 3:30 P.M. to 9:30 P.M.</p> <p>During an observation, on 02/07/14 at 5:50 A.M., Resident D was observed to be sleeping in her bed. The bed was not in the lowest position to the floor. The bed height was at standard height, 36 inches, at the surveyors pelvic area.</p> <p>During an interview on 02/10/14 at 10:30 A.M., the DoN indicated a resident that was at risk for falls, could be left alone in the bathroom, if that resident was alert and oriented. She indicated she expected the staff to instruct and remind the resident to use the call light, when finished on the toilet. She indicated, she expected, if the resident was a fall risk, not alert and</p>						

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	<p>oriented, the staff stay with the resident. She indicated a low bed should be lower than a standard bed. The DoN stated, in regard to what an area that was left unmarked on the neuro and 15 minute checks indicated, "I think we all know what that means. The checks weren't done."</p> <p>3. Resident C's record was reviewed on 02/06/14 at 12:15 P.M.</p> <p>Diagnoses for Resident C, included, but were not limited to, seizure disorder, cerebral degeneration, bipolar, history of personal falls, anxiety, and rhabdomyolosis.</p> <p>The January 2014 MAR included, but were not limited to, the following physician orders: 12/23/13- Personal alarm to bed at all times 01/02/14- Wheelchair pad alarm to chair when up 01/04/14- Alarming mats to side of bed-Check function and position every shift.</p> <p>Resident C had a care plan, dated 12/24/13, that addressed the problem at risk for falls related to "new admit, history of falls, impaired mobility, impaired gait and balance,</p>				

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	<p>use of assistive device, incontinence, diagnosis rhabdomyolosis, chronic obstructive pulmonary disease, history of seizures, hypoglycemic use, antihypertensive use, antiseizure use, benzodiazepine use and antihistamine use".</p> <p>Interventions included, but were not limited to "alarming floor mats to both sides of bed, wheelchair pad alarm, bed pad alarm, call light in reach, and non skid footwear."</p> <p>Resident C had a care plan that addressed the problem "requires assistance with activities of daily living" related to "impaired mobility, impaired gait and balance, use of assistive device, incontinence, and diagnosis rhabdomyolosis," dated 12/24/13.</p> <p>Interventions included, but were not limited to "assistance times two to wheelchair."</p> <p>Nursing notes indicated Resident C had two falls while in the facility. The first fall was on 12/24/13 at 4:20 P.M. The fall was unwitnessed and the resident indicated he had his call light on while in bed. He got up to get his urinal when he slid and fell.</p>			

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	<p>He was found lying supine next to the air conditioner with his knees bent and his head at the foot of the bed. The interventions put into place to prevent another fall were 15 minute safety checks and neurochecks.</p> <p>Nursing notes indicated the second fall was on 01/02/14 at 2:55 P.M. The fall was witnessed. Resident C went to the bathroom, unassisted, and a staff member tried to assist him. He fell before the staff member assisted him. The resident indicated he held onto the bar in the bathroom, but was unable to get his legs to move towards the toilet. The immediate intervention was to educate the resident to use the call light and wait for help.</p> <p>A Brief Interview for Mental Status (BIMS), dated 01/04/14, indicated Resident C was not cognitively intact. Therefore, not a candidate for re-education.</p> <p>A document titled, "Neurological Assessment" was used to document Resident C's neurochecks, after his fall on 12/24/13. Documentation for the following shift dates and times were not evidenced as completed: 12/24/13 - 2:00 P.M. - 10:00 P.M.</p>						

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	<p>12/25/13 - 6:00 A.M. - 2:00 P.M. 12/26/13 - 6:00 A.M. - 2:00 P.M., 2:00 P.M. - 10:00 P.M. 12/27/13 - 6:00 A.M. - 2:00 P.M.</p> <p>During a confidential interview on 02/07/14 at 1:45 P.M., Resident C's family member indicated the facility was aware he was a fall risk when he fell the first time. The family member indicated when Resident C fell, the first time, on 12/24/13, he was trying to go to the bathroom and his call light was on.</p> <p>This federal tag relates to Complaints #IN00141818 and #IN001412005.</p> <p>3.1-35(g)(2)</p>			

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place to prevent the likelihood of falls for residents who were deemed at risk for falls for 2 of 4 residents reviewed for falls (Resident C and D). Resident D fell on 12/13/13 that resulted with a fracture to her left thumb and wrist, laceration to her forehead and right cheek, with 6 sutures, a nasal fracture and purple bruising to her entire face and neck area.</p> <p>Findings include:</p> <p>1. Resident D's record was reviewed on 02/07/14 at 10:25 A.M.</p> <p>Diagnoses for Resident D, included, but were not limited to, epilepsy, sleep apnea, acute embolism deep vessel lower extremity, congestive heart failure, chronic airway obstruction, and a history of intracranial hemorrhage.</p>	F000323	<p>Requesting IDR to reduce severity 1) Resident C discharged home. Resident D continues to reside in the facility. Resident D's care plan update to reflect current plan of care. DNS/Designee will complete staff inservice regarding fall interventions and documentation of fall interventions including but not limited to neuro checks, 15/30 minute checks, and low bed in low position as well as licensed nurses will be inserviced on documenting the fall and the events surrounding the fall as well as effectiveness of interventions by 3/12/14. 2) All residents at risk for falls have the potential to be affected. DNS/Designee will complete staff inservice regarding fall interventions and documentation of fall interventions including but not limited to neuro checks, 15/30 minute checks, and low bed in low position as well as licensed nurses will be inserviced on documenting the fall and the events surrounding the fall as well as effectiveness of interventions by 3/12/14. Resident care plans reviewed by DNS/Designee to ensure fall interventions are</p>	03/12/2014			

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	<p>February 2014 physician's order recapitulation (recap) included, but were not limited to the following orders:</p> <p>09/04/13- Levetiracetam (anti-seizure medication) 250 milligram (mg.) take 1 tablet by mouth twice daily.</p> <p>12/11/13- Bed pad and wheelchair alarms to alert staff of unassisted transfers. Check placement and function every shift.</p> <p>12/13/13- Low bed.</p> <p>12/19/13- May utilize 2 1/4 side rails as enablers for bed mobility.</p> <p>A significant change Minimum Data Set (MDS) Assessment dated 11/21/13 indicated Resident D's Brief Interview for Mental Status (BIMS) was cognitively intact. The resident's functional status for Activities of Daily Living Assistance indicated the resident required limited assistance with one person physical assistance for bed mobility, extensive assistance with one person physical assistance for transfers, extensive assistance with one person physical assistance for dressing, supervision with one person physical assistance with eating, extensive assistance with one person physical assistance for</p>		<p>followed. 3) IDT review of all new admissions to ensure fall prevention interventions are in place. IDT review after each fall to ensure root cause is identified and new interventions in place. DNS/Designee will conduct rounds each shift daily on a random sample of 10 residents on each hall to ensure fall interventions are in place until 100% compliance achieved and then weekly. 4) Nurse management to complete Fall Management/Continuous Quality Improvement tool to be utilized to audit new admissions and falls 3x/weekly for 6 months and report to CQI committee overseen by the executive director. Compliance will be 100% or action plan will be developed.</p>		

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	<p>toileting and extensive assistance with one person assist with personal hygiene.</p> <p>Resident D's Balance during Transitions and Walking, dated 11/21/13, indicated when she moved from a seated to a standing position, walked with an assistive device, turned around and faced the opposite direction while walking, moved on and off the toilet, or transferred between the bed and chair or to the wheelchair, she was not steady and was only able to stabilize with staff's assistance.</p> <p>Resident D had a care plan, dated 7/8/13, that addressed the problem at risk for falls related to "readmission, diagnosis osteoporosis, restless leg syndrome, anxiety, history of falls, antihypertensive, psychotropic, diuretic, narcotic and antiseizure use, impaired vision, impaired gait or balance, and use of assistive device."</p> <p>Interventions included, but were not limited to, "bed against the wall, low bed, winged mattress, bed and chair alarms, encourage and remind the resident to use the call light, non-skid footwear when up, and</p>			

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	<p>wheelchair for mobility."</p> <p>Resident had a care plan that addressed the problem "required assistance with activities of daily living" related to "impaired mobility, impaired gait and balance, and use of assistive device," dated 7/8/13.</p> <p>Interventions included, but were not limited to, "1/4 side rails times one to the right side rail, assist times two to the wheelchair, and use bedside commode."</p> <p>A document titled, "Resident Profile", which the CNA's used to provide care for the resident, indicated that as of 12/11/13 she was an assist of two for transfers to the wheelchair, was to have bed and chair alarms in place, was to have a winged mattress and 1/4 side rail times one to the right side of her low bed and her bed was to have been against the wall.</p> <p>The "Resident Progress Notes" indicated Resident D had progressively been getting weaker before she had two falls on 12/11/13 and 12/13/13.</p> <p>Nursing notes, dated 12/09/13 at 1:00 A.M., indicated "the resident</p>			

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	<p>sat on the side of the bed with her feet on the floor and her hands on the arms of the wheelchair and yelled "Help me". A nurse came into the room and the resident indicated she needed to go to the bathroom. The resident was placed into her wheelchair with an extensive assist of two persons and taken to the bathroom. The nurse and CNA were unable to toilet the resident due to when she stood during the transfer to the toilet, she yelled "I am going down" and pulled on the nurse and about knocked her over. They attempted to use the stand up lift, but was unable to due to the resident was unable to stand and assist with the lift. The nurse and CNA placed her back in the wheelchair without toileting her and transferred her to bed with extensive assist of two persons. The resident was toileted on the bedpan."</p> <p>Nursing notes, on 12/09/13, at 11:58 A.M., indicated "the resident was very weak and unable to walk or transfer. She nearly fell while trying to transfer herself from the wheelchair to the toilet."</p> <p>On 12/09/13, at 9:20 P.M., nursing notes indicated, "the resident was weak and unable to stand during the</p>			

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	<p>evening and had to use the bedpan during the evening shift."</p> <p>Nursing notes, dated 12/10/12, at 2:56 A.M., indicated "the resident continued to be weak and was unable to stand. She used her call light to ask for assistance with transfers."</p> <p>On 12/10/13, at 10:33 P.M., nursing notes indicated, "the resident had generalized weakness and required two persons to transfer her."</p> <p>On 12/11/13, at 9:46 A.M., nursing notes indicated, "the resident had generalized weakness and all transfers were completed with two person physical assist."</p> <p>Nursing notes, dated 12/11/13 at 7:33 P.M., indicated, "the nurse was called to the room by the resident's roommate. The resident was found in the bathroom on her bilateral knees in front of the toilet, facing the wheelchair with her body, arms, and head laid in the wheelchair. The resident was assisted to the standing position and transferred into her wheelchair with extensive assist of four person physical assist. The resident's call light was on at the time of the fall. Staff "counseled"</p>			

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	<p>the resident to use her call light and wait for assistance before she transferred herself. Nursing notes indicated the resident had been experiencing increased weakness recently. The new interventions for the fall was bed and wheelchair alarms to alert the staff to unassisted transfers. The staff were to check the function and placement of the alarms every shift.</p> <p>12/12/13 at 12:10 P.M., "the resident continues to be very weak and was unable to transfer herself."</p> <p>12/13/13 at 3:36 A.M., "the resident's weakness continued and she transferred poorly. She required a maximum assist of two with lifting and cueing."</p> <p>12/13/13 at 8:45 A.M., "the nurse heard a loud crash and went into the resident's room. She found the resident lying on her stomach next to the bed with a profuse amount of blood surrounding her head. The left side of her face was resting on the floor and her right arm was next to her body, her left arm was under her body and her bilateral legs were outstretched. There were lacerations noted to her face and right arm. She had a bloody nose.</p>			

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	<p>The resident stated she "just fell over." The immediate intervention was to send the resident to the Emergency Room for evaluation and treatment."</p> <p>Documentation did not indicate the bed alarm was sounding when the resident fell on 12/13/13.</p> <p>Nursing notes, dated 12/14/13, at 11:07 P.M., indicated, "the resident was very confused and lethargic at times. She had dark bruising to her entire face, sutures to her right cheekbone and the left wrist had a temporary cast in place. She had discolorations to her bilateral legs and arms. The resident's bilateral lung sounds had wheezes and crackles to the upper and lower lobes. She had a foley catheter in place."</p> <p>Nursing notes, dated 12/15/13, at 9:35 A.M., continued to indicate, "the resident had edema to her face and she continued to be very weak. She had purple bruising to her face and neck areas."</p> <p>A document titled "Neurological Assessment" was used to document the resident's neurochecks, status post falls on 12/11/13 and 12/13/13.</p>						

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	<p>The document dated 12/11/13 and/or the nurses notes did not indicate the neurocheck documentation for the following dates and times:</p> <p>12/13/13 - 6:00 A.M. - 2:00 P.M. 12/14/14 - 2:00 P.M. - 10:00 P.M. 12/15/14 - 6:00 A.M. - 2:00 P.M. 12/16/14 - 2:00 P.M. - 10:00 P.M.</p> <p>A document titled "Safety Check List-15 Minutes" was used to document the resident's 15 minute safety checks for the fall prevention intervention. Documentation was not evidenced for the following dates and times:</p> <p>12/11/13 - 7:33 P.M. to 10:00 P.M. 12/12/13 - 6:30 A.M. to 7:45 A.M. 12/15/13 - 6:30 A.M. to 6:45 A.M. 12/17/13 - 2:30 P.M. 12/18/13 - 6:15 A.M. to 6:45 A.M. 12/20/13 - 10:00 P.M. to 11:45 P.M. 12/21/13 - 12:00 A.M. to 5:45 A.M.; and 2:15 P.M. to 9:45 P.M. 12/22/13 - 6:15 A.M. to 12/26/13 at 6:45 A.M. (4 days) 12/27/13 - 6:15 A.M. to 6:45 A.M. 12/28/13 - 6:15 A.M. to 6:45 A.M.; and 10:00 P.M. to 11:45 P.M. 12/29/13 - 12:00 A.M. to 6:45 A.M. 12/31/13 - 6:15 A.M. to 1:45 P.M.; and 10:15 P.M. to 11:45 P.M. 01/01/14 - 12:00 A.M. to 11:45 P.M. 01/02/14 - 12:00 A.M. to 1:45 A.M.</p>			

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	<p>01/08/14 - 6:15 A.M. to 6:45 A.M. 01/09/14 - 6:15 A.M. to 6:45 A.M. 01/12/14 - 6:15 A.M. to 6:45 A.M.</p> <p>A document titled "Safety Check List-30 Minutes" was used to document the resident's 30 minute safety checks for the fall prevention intervention. Documentation was not evidenced for the following dates and times: 01/15/14 - 7:00 A.M. to 10:00 A.M.; and 7:00 P.M. to 9:30 P.M. 01/19/14 - 6:30 A.M. 01/20/14 - 10:30 P.M. to 11:59 P.M. 01/21/14 - 12:00 A.M. to 6:30 A.M. 01/26/14 - 3:30 P.M. to 9:30 P.M.</p> <p>On 02/06/14 at 4:30 P.M., the resident's face was observed to have purple bruising under her bilateral eyes, purple, yellow and green bruising to her right side and middle of her forehead and a small (pea sized) hard scab on the middle of her forehead.</p> <p>During an observation, on 02/07/14 at 5:50 A.M., Resident D was observed to be sleeping in her bed. The bed was not in the lowest position to the floor. The bed height was at standard height, 36 inches, at the surveyors pelvic area.</p>						

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	<p>During an interview on 02/10/14 at 10:30 A.M., the DoN indicated a resident that was at risk for falls, could be left alone in the bathroom, if that resident was alert and oriented. She indicated she expected the staff to instruct and remind the resident to use the call light, when finished on the toilet. She indicated, she expected, if the resident was a fall risk, not alert and oriented, the staff stay with the resident. She indicated a low bed should be lower than a standard bed. The DoN stated, in regard to what an area that was left unmarked on the neuro and 15 minute checks indicated, "I think we all know what that means. The checks weren't done."</p> <p>During a confidential interview with a family member on 02/06/14 at 3:00 P.M., the family member indicated when the resident fell on 12/13/13, the staff had left her at the side of the bed and they knew she was weak. The family member indicated she had spells where she would get weak and the staff knew this and they should not have left her sitting on the side of the bed by herself.</p> <p>During an interview on 02/06/14 at 4:30 P.M., Resident D indicated she</p>						

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	<p>fell on 12/13/13, after a CNA left her on the side of the bed, after assisting her to the bathroom. During this interview, Resident D indicated there were several times when she called for assistance, using her call light, and help did not arrive for extended periods of time. She indicated on the following dates:</p> <p>Date unknown, evening shift- A CNA placed her on the bedside commode. There was "some kind of commotion outside with the weather" and the CNA left Resident D to check on the "commotion". The CNA did not return to take her off the commode. Resident D indicated her family member came into her room and found her on the commode. After an hour, she got someone to take her off the commode.</p> <p>2/5/14, during the night- She waited, at least, an hour for someone to answer her call light.</p> <p>2/6/14, during the night- She waited 35 minutes for someone to answer her call light. She needed to go to the bathroom.</p> <p>She indicated she had been incontinent, two to three times, in the past, while she waited for someone to answer her call light. She indicated staff left her on the toilet</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904		
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	<p>and told her to pull the emergency cord when she was done, but, sometimes, it took awhile for staff to get there.</p> <p>An untitled document, called the call light log, dated 02/07/14, indicated Resident D had turned on her call light at these dates and times, and the light was reset in following amount of time: 02/05/14 at 2:47 A.M., alarm reset in 29.8 minutes 02/05/14 at 5:52 A.M., alarm reset in 19.5 minutes 02/05/14 at 6:43 A.M., alarm reset in 40.3 minutes 02/05/14 at 9:05 P.M., alarm reset in 67.4 minutes 02/06/14 at 12:09 A.M., alarm reset in 42.3 minutes 02/06/14 at 3:17 A.M., alarm reset in 33.8 minutes</p> <p>During an interview on 02/07/14 at 5:58 A.M., RN #1 indicated when a resident pressed a call light, if it was not answered within two minutes, the other two hallways on the first floor would be activated to signal that the other hallway needed help.</p> <p>During an interview on 02/07/14 at 6:30 A.M., the Administer indicated, "the call light system, after so many</p>				

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	<p>minutes, was, also, signaled upstairs, to the computer on the second floor, to let staff know assistance was needed."</p> <p>During an interview on 02/07/14 at 9:45 A.M., the Administer indicated she did not have a certain amount of minutes expected for the staff to answer call lights. She indicated 44 minutes was too long for residents to wait for a call light to be answered. She indicated because the call light log indicated it took awhile to reset the call light, it did not always mean that the light was not answered in a timely manner, or for that amount of time, because, sometimes, the staff may have forgotten to shut off call lights, after they answered them.</p> <p>During an interview on 02/07/14 at 11:30 A.M., the Director of Nursing (DoN) indicated Resident D had her breakfast tray at her bedside table, on 12/13/13, when she fell. She indicated she ate breakfast sitting on the side of the bed, frequently. She indicated the resident told her the bedside table rolled and she fell forward onto the floor.</p> <p>During an interview on 02/07/14 at 4:15 P.M., the DoN indicated when she went into the resident's room,</p>						

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	<p>after she fell, on 12/13/13, the bed alarm was off, but there were two CNA's in the room who could have shut the bed alarm off before she got in there. She indicated the documentation for whether the alarm was sounding or not should be documented on the fall event report. She indicated she had been having a difficult time getting the nurses to document whether the bed and wheelchair alarms were sounding when a resident fell. She indicated this had been a problem and "We are working on trying to fix it, but I can't tell you right now, if the bed alarm was sounding or where you can find it in the chart."</p> <p>During an interview on 02/07/14 at 10:35 A.M., CNA #2 indicated the resident was very independent before she had her two falls in December. She indicated Resident D would press her call light and the staff would assist her to the bathroom, but after the fall on 12/13/13 the resident was bedridden with a Foley catheter for a couple days. CNA #2 indicated the resident would eat at the side of the bed, sometimes. She indicated she was back to an one person physical assist, now.</p>						

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	<p>2. Resident C's record was reviewed on 02/06/14 at 12:15 P.M.</p> <p>Diagnoses for Resident C, included, but were not limited to, seizure disorder, cerebral degeneration, bipolar, history of personal falls, anxiety, and rhabdomyolosis.</p> <p>The January 2014 MAR included, but was not limited to the following physician orders: 12/23/13- Personal alarm to bed at all times 01/02/14- Wheelchair pad alarm to chair when up 01/04/14- Alarming mats to side of bed-Check function and position every shift.</p> <p>A 14 day Minimum Data Set (MDS) Assessment, dated 01/04/14, indicated the resident was not cognitively intact. The resident required extensive assist with one person physical assist for transfers, toileting, dressing, personal hygiene, and ambulation in the room and the corridor. He required supervision and one person physical assist for eating and extensive assist and two person physical assist for bed mobility. Balance during Transitions and Walking, indicated Resident C was not steady and was only able to</p>				

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	<p>stabilize with staff's assistance, when he moved from a seated to standing position, walked with an assistive device, turned around and faced the opposite direction, while walking, moved on and off the toilet, and transferred between the bed and chair or the wheelchair.</p> <p>Resident C had a care plan, dated 12/24/13, that addressed the problem risk for falls related to "new admit, history of falls, impaired mobility, impaired gait and balance, use of assistive device, incontinence, diagnosis rhabdomyolosis, chronic obstructive pulmonary disease, history of seizures, hypoglycemic use, antihypertensive use, antiseizure use, benzodiazepine use and antihistamine use"</p> <p>Interventions included, but were not limited to "alarming floor mats to both sides of bed, wheelchair pad alarm, bed pad alarm, call light in reach, and non skid footwear."</p> <p>Resident C had a care plan that addressed the problem "requires assistance with activities of daily living" related to "impaired mobility, impaired gait and balance, use of assistive device, incontinence, and</p>						

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	<p>diagnosis rhabdomyolosis", dated 12/24/13.</p> <p>Interventions included, but were not limited to "assistance times two to wheelchair."</p> <p>A document titled, Hospitalist History and Physical, dated 12/15/13, indicated Resident C presented to the hospital with frequent falls, for the past two months, but worsening over the last two days. The report indicated he had slept on the floor the night before he was admitted to the hospital because his wife was unable to get him up and he had fallen three times the day he was admitted to the hospital. A review of systems indicated he was positive for right leg weakness.</p> <p>An undated document, titled, Resident Assessment, indicated the resident had gait disturbance problems, frequent falls for two months and he fell three times on the day of his admission to the hospital.</p> <p>Nursing notes indicated Resident C had two falls while in the facility. The first fall was on 12/24/13 at 4:20 P.M. The fall was unwitnessed and the resident indicated he had his call</p>				

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	<p>light on while in bed. He got up to get his urinal when he slid and fell. He was found lying supine next to the air conditioner with his knees bent and his head at the foot of the bed. The interventions put into place to prevent another fall were 15 minute safety checks and neurochecks.</p> <p>Nursing notes indicated the second fall was on 01/02/14 at 2:55 P.M. The fall was witnessed. The resident went to the bathroom, unassisted, and a staff member tried to assist him. He fell before the staff member assisted him. The resident indicated he held onto the bar in the bathroom, but was unable to get his legs to move towards the toilet. The immediate intervention was to educate the resident to use the call light and wait for help.</p> <p>A document titled, "Neurological Assessment" was used to document Resident C's neurochecks, after his fall on 12/24/13. Documentation for the following shift dates and times were not evidenced as completed: 12/24/13 - 2:00 P.M. - 10:00 P.M. 12/25/13 - 6:00 A.M. - 2:00 P.M. 12/26/13 - 6:00 A.M. - 2:00 P.M.; and 2:00 P.M. - 10:00 P.M. 12/27/13 - 6:00 A.M. - 2:00 P.M.</p>			

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	<p>During a confidential interview on 02/07/14 at 1:45 P.M., Resident C's family member indicated the facility was aware he was a fall risk when he fell the first time. The family member indicated when Resident C fell, the first time, on 12/24/13, he was trying to go to the bathroom and his call light was on.</p> <p>A current policy titled, "Fall Management Program" dated 09/2013, provided on 02/10/14, by the Administrator, indicated "Policy: It is the policy of (Name of Company) to ensure residents resident within the facility will maintain physical functioning through the establishment of physical, environment, and psychosocial guidelines to prevent injury related to falls...2. All new admissions will be considered a fall risk based upon his/her new living arrangements, and his/her reasons for being admitted in to the nursing facility...."</p> <p>This federal tag relates to Complaints #IN00141818 and #IN001412005.</p> <p>3.1-45(a)(2)</p>			

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F000514 SS=D	<p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure documentation was accurate and complete for the administration of 16 medications, and for post fall safety checks, for 3 of 9 residents reviewed for complete and accurate documentation, in a sample of 9. (Resident B, C & D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 2/6/14 at 11:50 A.M.</p> <p>Diagnoses for Resident B included, but were not limited to, status post left below the knee amputation, pyrogenic arthritis, chronic viral hepatitis C, thrombocytopenia, liver</p>	F000514	<p>1) Residents B & C discharged home. Resident D continues to reside in the facility. Resident D's care plan has been reviewed and updated to accurately reflect plan of care. Nurses who failed to document medication administration educated re: policy for medication administration and documentation on Resident B.2) All residents have the potential to be affected. DNS/Designee to complete inservice for nursing staff on Medication administration and documentation policy and Inservice nursing staff regarding fall interventions and documentation of fall interventions including but not limited to neuro checks and 15/30 minute safety checks. Inservice licensed nurses to review MARS/TARS with shift to shift report to help ensure documentation has been</p>	03/12/2014	

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	<p>cirrhosis secondary to alcoholism, type 2 diabetes mellitus, osteoarthritis, chronic congestive splenomegaly, and bipolar disorder.</p> <p>The January 2014 medication administration record (MAR) for Resident B indicated the following medications, dated 12/13/13:</p> <ol style="list-style-type: none"> 1. Lithium 300 milligrams (mg.) 1 capsule by mouth twice daily. 2. Omeprazole 40 mg. 1 capsule by mouth, once daily. 3. Propanol 80 mg. 1 tablet by mouth twice daily. 4. Risperidone 0.5 mg. 1 tablet by mouth daily at bedtime. 5. Vitamin B-100 100 mg. 2 tablets by mouth once daily. 6. Zinc Sulfate 220 mg. 1 capsule by mouth once daily. 7. Clonazepam 2 mg. 1 tablet by mouth twice daily. 8. Spironolactone 25 mg. 1 tablet by mouth once daily, upon rising. 9. Aspirin 81 mg. 1 tablet by mouth 		<p>completed. DNS/Designee reviewed MARS/TARS for month of February to ensure documentation completed. 3) Nurse will utilize MARS/TARS with shift to shift report to help ensure documentation has been completed. IDT review after each fall to ensure root cause is identified and new interventions in place. 4)CQI tool for follow up after falls to ensure interventions in place and documentation completed will be completed Mon-Fri by nurse managers and report to CQI committee overseen by executive dircetor. Compliance will be 100% or action plan will be developed. Nurse management to complete MAR/TAR Documentation Flow Sheet/Continuous quality improvemet tool to audit MAR/TAR doumentation 3x/weekly for 6 months and report to CQI committee. Compliance will be 100% or action plan will be developed.</p>				

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	<p>once daily, upon rising.</p> <p>10. Daily Vite Tab 1 tablet by mouth once daily, upon rising.</p> <p>11. Docusate Sodium 100 mg. 1 capsule by mouth twice daily.</p> <p>12. Ferrous Sulfate 325 mg 1 tablet by mouth twice daily.</p> <p>13. Florastor 250 mg. 1 capsule by mouth twice daily.</p> <p>14. Gabapentin 600 mg. 1 tablet by mouth twice daily.</p> <p>15. Furosemide 40 mg. 1 tablet by mouth once daily.</p> <p>16. Levothyroxine 25 micrograms (mcg) 1/2 tablet (12.5 mcg) by mouth once daily.</p> <p>The January 2014 MAR was not documented on January 5, 2014, for the aforementioned medications, regarding if the medications were or were not administered.</p> <p>Nursing notes, did not evidence the administration or lack of administration of the ordered medications for Resident B, on January 5, 2014.</p>			

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	<p>During an interview, on 2/6/14, at 4:50 P.M., the DoN indicated she did not know and did not have a reason, related to the lack of documentation on the MAR on January 5, 2014. She indicated nursing notes did not provide a reason, either. It was unknown if the medications were administered to or refused by Resident B.</p> <p>2. Resident C's record was reviewed on 02/06/14 at 12:15 P.M.</p> <p>Diagnoses for Resident C included, but were not limited to, seizure disorder, cerebral degeneration, bipolar, history of personal falls, anxiety, and rhabdomyolosis.</p> <p>A document titled, "Neurological Assessment" was used to document Resident C's neurochecks, after his fall on 12/24/13. Documentation for the following shift dates and times were not evidenced as completed:</p> <p>12/24/13-- 2:00 P.M. - 10:00 P.M. shift 12/25/13-- 6:00 A.M. - 2:00 P.M. shift 12/26/13-- 6:00 A.M. - 2:00 P.M., 2:00 P.M. - 10:00 P.M. shifts 12/27/13-- 6:00 A.M. - 2:00 P.M.</p>			
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	<p>shift.</p> <p>3. Resident D's record was reviewed on 02/07/14 at 10:25 A.M.</p> <p>Diagnoses for Resident D, included, but were not limited to, epilepsy, sleep apnea, acute embolism deep vessel lower extremity, congestive heart failure, chronic airway obstruction, and a history of intracranial hemorrhage.</p> <p>A document titled "Safety Check List-30 Minutes" was used to document the resident's 30 minute safety checks for the fall prevention intervention, status post falls. Documentation was not evidenced for the following dates and times:</p> <p>01/15/14 - 7:00 A.M. to 10:00 A.M. and 7:00 P.M. to 9:30 P.M. 01/19/14 - 6:30 A.M. 01/20/14 - 10:30 P.M. to 11:59 P.M. 01/21/14 - 12:00 A.M. to 6:30 A.M. 01/26/14 - 3:30 P.M. to 9:30 P.M.</p> <p>During an interview on 02/10/14 at 10:30 A.M., the DoN stated, in regard to what an area that was left unmarked on the neuro and 15 minute checks indicated, "I think we all know what that means. The checks weren't done."</p>				

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	<p>This federal tag relates to Complaint's #IN00142565, #IN00142005, & #IN00141818.</p> <p>3.1-50(a)(1)</p>			