

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/09/2014
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaint IN00147005.</p> <p>Complaint IN00147005 - Substantiated. Federal/State deficiencies related to the allegations are cited at F203 and F226.</p> <p>Survey dates: April 7 & 9, 2014</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 25 SNF/NF: 110 Total: 135</p> <p>Census Payor Type: Medicare: 25 Medicaid: 98 Other: 12 Total: 135</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>Please accept the Plan of Correction, official 2567, as credible allegation of compliance for Carmel Health & Living effective April 21, 2014. The facility is respectfully requesting a desk review for this survey.</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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	IAC 16.2. Quality review completed by Debora Barth, RN.				

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F000203 SS=E	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a) (6) of this section.</p> <p>Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a) (4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone</p>			

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	<p>number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on record review and interview, the facility failed to ensure resident rights were protected and ensure appropriate documentation prior to a transfer or discharge of a resident for 3 of 3 residents reviewed in a sample of 5. (Residents "A", "D" and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 04-07-14 at 9:00 a.m. Diagnoses included, but were not limited to, syncope, hypertension, pain, chronic obstructive pulmonary disease, recurrent urinary tract infections and depression with delusions. These diagnoses remained current at the time of the record review.</p>	F000203	<p>F203 Notice Requirements before Transfer/Discharge It is the practice of this provider to ensure each residents' rights are protected and State required paperwork accompanies the resident upon transfer or discharge. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents identified have returned to the facility without concern. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents being transferred or discharged have the potential to be affected. · An inservice was held immediately with all licensed staff discussing all paperwork required for resident transfer or discharge. · A file folder was added to each nurse's 	04/21/2014

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	<p>A review of the progress note by Licensed Nurse #12, dated 03-30-14 at 12:58 a.m., indicated the following: "2 aides went into resident room to help get ready for dinner [evening meal], resident began slapping one of the aide's and accusing him of feeling her up, nursing supervisor notified. [Name of local police department] came to discuss incident with patient, patient stated to police that the children were trying to set a fire. [Name of Nurse Practitioner] notified and order given to transfer patient to [name of hospital]. Family also notified. EMS [Emergency Medical System] called. Writer kept patient with her during her med. [medication] pass with no further incidents. EMS arrived at 8:30 p.m. for transport to [name of hospital]. Report called to [name of hospital] ER [Emergency Room] and Transitional's unit."</p> <p>Interview on 04-07-14 at 2:30 p.m. Licensed Nurse #10 indicated she had been at the medication cart when the Certified Nurses Aide #11 came out of the room and told her of the accusation. "She told me the resident was hitting [name of Certified Nurses Aide #5] and that [resident] accused him of feeling her up. I was working with Insulin's and told the Certified Nurses Aides to take [name of</p>		<p>station which contains the State required transfer form. Medical records designee will ensure it remains full. · Medical records will use an audit tool after each transfer/discharge to ensure all paperwork was sent. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Medical records or designee will perform an audit within 24 hours of transfer or discharge to ensure appropriate paperwork has been included. · The audit will be turned into the DON or designee. · Any items identified on the audit will be corrected immediately. · Staff not adhering to policy will be re-educated or disciplinary action up received to and including termination. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Any identified concerns from audits will be addressed immediately by the DON or designee. · Employees not adhering to policy will be re-educated up to and including termination. · Audits will be completed after every transfer / discharge, Monday through Friday, and will continue indefinitely.- the weekend supervisor/nurse manager will audit transfers occurring</p>				

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	<p>Resident "A" up to the nurses station. The nurse [Licensed Nurse #3] who was at the nurses station called the Supervisor [Licensed Nurse #4]. [Name of Licensed Nurse #4] called me and said I needed to send [resident] to [name of hospital]. The Nurse Practitioner gave me the order to send [resident] to the hospital. I know I put papers in an envelope for the ambulance staff to take with them." When interviewed what documents she put in the envelope, the Licensed Nurse indicated "It was the face sheet, physician orders and list of medications."</p> <p>When interviewed if the specific State Form titled "Notice of Transfer or Discharge," had been completed for the resident, the Licensed Nurse indicated "no."</p> <p>When interviewed if an order had been written in the resident's record the Licensed Nurse indicated "no."</p> <p>A review of the "Job Specific Orientation - Charge Nurse," on 04-09-14 at 9:00 a.m., indicated Licensed Nurse #10 received the training for Bed-hold policy & Procedures on 03-22-14.</p>		<p>on Saturday/Sunday and on holidays and will continue indefinitely. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Compliance date: April 21, 2014</p>				

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	<p>During an interview on 04-04-14 at 2:15 p.m. the local area hospital nurse indicated Resident "A" had been sent to the hospital without any pertinent information. The nurse indicated the licensed nurse on the hospital unit received a telephone call the day after the resident had been admitted questioning if the hospital had performed a "rape kit" on the resident "That is out of the scope of practice for our Nurse Practitioner so we called [name of local police department]. I used to work in Long Term Care and I know there are specific policies they have to follow."</p> <p>2. The record for Resident "D" was reviewed on 04-07-14 at 2:05 p.m. Diagnoses included, but were not limited to, congestive heart failure, history of urinary tract infection, hypertension, anxiety and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident began to experience respiratory distress on 04-04-14 at 4:05 a.m. and the resident was "sent out" to the hospital.</p> <p>Further review of the record lacked documentation "Notice of Transfer or</p>				

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	<p>Discharge."</p> <p>3. The record for Resident "E" was reviewed on 04-07-14 at 2:15 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, atrophy, confusion, adjustment disorder, hypertension and complicated urinary tract infection. These diagnoses remained current at the time of the record review.</p> <p>The record indicated on 03-10-14 at 8:29 a.m. "Res. [Resident] confused, hard to rouse, responds to verbal stimuli with moans/grunts, BP [blood pressure] low, C.O [complains of] hesitancy and abd. [abdominal] discomfort, unable to urinate. MD [Medical Doctor] notified, new order to send res. to ER [Emergency Room]."</p> <p>The record lacked documentation "Notice of Transfer or Discharge."</p> <p>4. A review of the facility policy on 04-07-14 at 9:30 a.m., titled "Resident Rights" indicated the following:</p> <p>"4. Notice before transfer: Before an interfacility transfer or discharge occurs, the facility just, on a form</p>						

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	<p>prescribed by the state department, do the following. (a) Notify the resident or the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. (b) Place a copy of the notice in the resident's clinical record and transmit a copy to the following: The resident, the resident family member if known, the resident legal representative if known, the local long-term care ombudsman program (for involuntary transfer/discharge only), the person or agency responsible for the resident's placement, maintenance, and care in the facility, the resident's physician when the transfer is for the resident welfare the resident no longer needs facility services, or the resident needs cannot be met by the facility. (c) Record the reasons in the resident's clinical record."</p> <p>A review of the facility policy on 04-07-14 at 2:00 p.m., titled "Reports to Run," indicated "Resident transfer - What to Send," included the following "Bed hold under documents, Physician orders, Transfer form, Face Sheet and Advance Directive, Call report to the hosp. [hospital] Send copy of change in Condition or FAX [facsimile] to ER [Emergency Room]."</p>			
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	<p>A review of the facility procedure on 04-09-14 at 9:00 a.m., titled "Transfer/Discharge Procedure," indicated "The following items are will need to completed, printed and sent with the resident: FORMS - Bed Hold Policy, Face sheet, Progress Notes and Orders, Vitals, Send a copy of most recent pertinent labs and Code Status." Documentation required in the resident's clinical record included the order to send to ER [Emergency Room], Change of condition Event, Transfer/Discharge Observation, Document the change and transfer in a progress note."</p> <p>5. The facility "ER/Hospital Discharge Education" indicated the following was needed for transfer: "Bed Hold policy, Notice of Transfer/Discharge, write an order to send to ER, face sheet, transfer form, any pert. [pertinent] labs that might be associated with why they are being sent out, copy of Code Status, Vital Signs, Copy of physician orders, Call report to ER and document, obtain Fax number for ER and fax over Change in condition Event, document per progress note how the resident was transferred to hospital, make a copy of all of this and put in the resident's cubby.</p>				

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	<p>During an interview on 04-07-14 at 2:15 p.m., the Administrator verified the Transfer/Discharge Procedure was not being followed by the nursing staff.</p> <p>This Federal tag relates to Complaint IN00147005.</p> <p>3.1-12(a)(3) 3.1-12(a)(4)(A) 3.1-12(a)(6)(A) 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii) 3.1-12(a)(6)(A)(iv) 3.1-12(a)(6)(A)(v)</p>						

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure they implemented their policy and procedure regarding the investigation of an abuse allegation, in that when a staff member was accused of an allegation of abuse, the facility staff failed to ensure the protection of other residents during the initial steps of the investigation and allowed the staff member continued interaction with other residents for 1 of 4 abuse allegations reviewed. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 04-07-14 at 9:00 a.m. Diagnoses included, but were not limited to, syncope, hypertension, pain, chronic obstructive pulmonary disease, recurrent urinary tract infections and depression with delusions. These diagnoses remained current at the time of the record review.</p>	F000226	<p>F226 Develop/Implement Abuse/Neglect policies It is the practice of this provider to protect all residents during an investigation regarding abuse and neglect. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 returned to facility after psych stay without concern and remains on the facility buddy system. Nursing staff involved received education/disciplinary action. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents involved in an abuse allegation have the potential to be affected. · An inservice was held immediately and on April 15th for all staff discussing procedures for suspending an employee involved in an allegation as first priority. · The entire abuse policy was also discussed. · An audit tool is included in every investigation to ensure procedures for suspension were followed. · Staff not adhering to following 	04/21/2014			

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	<p>A review of the progress note by Licensed Nurse #12, dated 03-30-14 at 12:58 a.m., indicated the following: "2 aides went into resident room to help get ready for dinner, resident began slapping one of the aide's and accusing him of feeling her up, nursing supervisor notified. [Name of local police department] came to discuss incident with patient, patient stated to police that the children were trying to set a fire. [Name of Nurse Practitioner] notified and order given to transfer patient to [name of hospital]. Family also notified. EMS [Emergency Medical System] called. Writer kept patient with her during her med. [medication] pass with no further incidents. EMS arrived at 8:30 p.m. for transport to [name of hospital]. Report called to [name of hospital] ER [Emergency Room] and Transitional's unit."</p> <p>During an interview on 04-07-14 at 12:00 p.m. Licensed Nurse #3 indicated she had completed her shift when Certified Nurses Aide #11 came to the Nurses Station and told her that she and Certified Nurses Aide #5 went into Resident "A" room to put [resident] in her wheelchair and get her ready for dinner. The Licensed Nurse indicated she was told what had happened and the</p>		<p>policy will receive education and/or disciplinary action up to and including termination. . What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · An audit tool will be completed by the administrator or designee for every reportable event to ensure policy was followed. -timeliness of the suspension will be documented by the administrator/designee on the audit tool. · Corporate consultants approve every incident reported. · Nurse consultant will randomly audit abuse investigations upon weekly visits. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · Any identified concerns from audits will be addressed immediately. · Employees not adhering to policy will be re-educated up to and including termination. · Audits will be completed after during every abuse allegation by the administrator/designee. -Timeliness of suspension will be documented on the audit tool with corporate review. · The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of</p>				

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	<p>accusation the resident made against Certified Nurses Aide #5. "That was around 4:45 or 5:00 p.m., and we kept [name of Resident "A"] at the nurses station. I clocked out around 5:40 p.m."</p> <p>Interview on 04-07-14 at 12:35 p.m. Licensed Nurse #4 indicated she was the Manager on Duty that day but had already left the building. The nurse indicated she received a call from Licensed Nurse #3 regarding the allegation against Certified Nurses Aide #5. "I notified the Administrator and the Director of Nurses. I told [name of Licensed Nurse #3] not to do anything until I got back to the building. It took about 15 minutes. I didn't tell anyone to send [name of Certified Nurses Aide #5] home. When I got back to the facility [name of Resident "A"] was at the nurses station in her wheelchair and [name of Certified Nurses Aide #5] was down the hall. I told Certified Nurses Aides #5 and #11 to write statements. After [name of Certified Nurses Aide #5] finished his written statement, I had him clock out and go home."</p> <p>A review of the typed statement on 04-07-14 at 10:00 a.m. by Licensed Nurse #4, dated 03-29-14, indicated</p>		<p>reviews will be adjusted as needed. Compliance Date: April 21, 2014</p>				

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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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	<p>the following: "Received a call from Station 7. [Name of Licensed Nurse #3] informing me that resident [name of Resident "A"] had accused a male employee of molesting her, she stated that [name of Certified Nurses Aide #5] and [name of Certified Nurses Aide #11] were attempting to get the resident out of bed and when [name of Certified Nurses Aide #5] attempted to put her leg brace on she started hitting out at him and [name of Certified Nurses Aide #11] saying your molesting me. I had her put [name of Certified Nurses Aide #5] on the phone and he explained that [name of Certified Nurses Aide #11] had asked him to help her get [name of Resident "A"] up because she was hitting out. That he put her left shoe on and when he went to put the brace on her right leg before her shoe she said to him to stop molesting her. I called and made [Director of Nurses] aware and she directed me to call [name of Administrator]. I called [name of Administrator] and explained to her the situation and she said that [name of Resident "A"] had to be questioned. I told her I would return to the facility and speak with her. [Name of Administrator] directed me to take [name of Certified Nurses Aide #11] to the room with me and</p>			
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	<p>talk with [name of Resident "A"]. When I got to the facility I went to the unit and told [name of Certified Nurses Aide #5] to write a statement and to then clock out and leave to which he did."</p> <p>Interview on 04-07-14 at 2:30 p.m. Licensed Nurse #10 indicated she had been at the medication cart when the Certified Nurses Aide #11 came out of the room and told her of the accusation. "She told me the resident was hitting [name of Certified Nurses Aide #5] and that [resident] accused him of feeling her up. I was working with Insulin's and told the Certified Nurses Aides to take [name of Resident "A"] up to the nurses station. The nurse [Licensed Nurse #3] who was at the nurses station called the Supervisor [Licensed Nurse #4]."</p> <p>During an interview on 04-07-14 at 3:15 p.m. Certified Nurses Aide #5 indicated that Certified Nurses Aide #11 asked him to help [name of Resident "A"]. "With that resident we do the buddy system, so no one can do anything alone with her. When I got to the room, [resident] was sitting on the side of the bed and we had to get her into her wheelchair. I knew she wore a brace, so I had to lift up</p>						

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	<p>the pant leg and apply the brace. That's when she said 'stop you're molesting me.' We went ahead and transferred her to the wheelchair. The nurse [#10] was passing medications. [Name of Certified Nurse #11] came down and told the Nurse [#3] and she called the others. I went on about my work and continued to get the other residents I think two other residents up for dinner."</p> <p>A review of the handwritten statement from Certified Nurses Aide #5 on 04-07-14 at 10:00 a.m., and dated 03-29-14 indicated the following; "[Name of Certified Nurses Aide #11] asked me to go with her to get [name of Resident "A"] up for dinner. When we got into the room she was trying to stand up. When <sic> told her we were going to take her down for dinner she said 'okay.' I grabbed her shoes <sic> I put the left shoe on fine. I went to put her right shoe on and she has a brace so I had to raise her pant leg a little and when I did that she smacked me. When I strapped the brace she said I was trying to molest her and I was feeling her up. [Name of Certified Nurse #11] reassured her that I was trying to help her only to put her brace on. [Name of Certified Nurses Aide #11]</p>			
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	<p>and I transferred her into her chair with no issue and we came and reported to the nurse."</p> <p>A review of Certified Nurses Aide #5 "Time Card" on 04-07-14 at 2:30 p.m., indicated the staff member "clocked out" at 5:40 p.m. on 03-29-14.</p> <p>During an interview on 04-09-14 at 9:50 a.m., the Social Service staff #8 indicated that regardless if a resident is on a 'buddy system' or not, the policy still needs to be followed.</p> <p>Interview on 04-09-14 at 10:00 a.m., Licensed Nurse #9 indicated she found out about the allegation on Sunday when she came to work to be the Manager on Duty. When interviewed if a resident is identified with the need of the 'Buddy System' the policy and procedure "needs to be followed and the person accused should be sent home immediately."</p> <p>A review of the facility policy on 04-07-14 at 9:15 a.m., titled "Abuse Prevention," indicated the following:</p> <p>"It is the policy of CarDon & Associates to provide each resident with an environment that is free from verbal, sexual, physical and mental</p>			
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	<p>abuse, corporal punishment, and involuntary seclusion. We have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity. The following guidelines outline the components of our Abuse Prevention Program: V. Abuse Investigations - Policy Statement - All reports of resident abuse, neglect and injuries of unknown source shall be immediately and thoroughly investigated by facility management.</p> <p>7. Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of the investigation have been reviewed by the administrator. VI. Protection of Resident During Abuse Investigations: Policy Statement - Our facility will protect resident from harm during investigations of abuse allegations. 1. During abuse investigations, resident will be protected from harm and removed from any potential abusive situation immediately prior to any other action set forth below: a. Employees accused of participating in the alleged abuse will be immediately suspended until the findings of the investigation have been reviewed by the administrator."</p>			
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	<p>A review of facility Inservice Education related to Abuse Prohibition Policy and Procedure on 04-09-14 at 10:30 a.m., indicated Licensed Nurses #3 and #4 attended education for abuse and neglect on 01-14-2014 and Licensed Nurse #10 received the education on 03-12-14 in regard to the immediate suspension of an employee accused of abuse or neglect.</p> <p>The Federal tag relates to Complaint IN00147005.</p> <p>3.1-28(a)</p>			
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