STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155480	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVILLE HEALTHCARE CENTER	11049 SR 101 BROOKVILLE, IN 47012

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F0000	This visit was for the Investigation of Complaint IN00113236. Complaint IN00113236- Substantiated, Federal/State deficiencies related the allegations are cited at F-157, F-323 & F-385. Survey dates: July 31, & August 1, 2012 Facility number: 000550 Provider number: 155480 AIM number: 100286110 Survey team: Angel Tomlinson, RN- TC Census bed type: SNF/NF: 77 Total: 77 Census payor type: Medicare: 11 Medicaid: 52 Other: 14 Total: 77 Sample: 7 These deficiencies reflect State findings cited	F0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	

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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	in accordance with 410 IAC 16.2. Quality review completed on August 6, 2012 by Bev Faulkner, RN			

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F0157 SS=D	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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify family members of a resident's change in condition in a timely manner for 1 of 3 residents sampled for notification in a total sample	F0157	F157 Requires the facility to notify family members of a resident's change in condition in a timely manner. 1. Resident A was not harmed. 2. All residents have the	08/06/2012

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	of 7 (Resident #A). Finding include: Review of the record of Resident #A on 8-1-12 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, grief reaction, anemia, Chronic Obstructive Pulmonary Disease (COPD), depression, Parkinson's disease, intertrochanteric left hip fracture and hypertension. The nurses note for Resident #A, dated 7-22-12 at 8:00 a.m., indicated the resident was lethargic and unable to take medication or eat breakfast. The resident's vital signs were within normal limits, oxygen saturation was 88% and oxygen applied. The resident's saturation went up to 97%. The nurses note for Resident #A, dated 7-22-12 at 11:30 a.m., indicated the resident's family was called. The nurses note for Resident #A, dated 7-22-12 at 1:00 p.m., indicated the Nurse Practitioner was called and an order was received to send the resident to the Emergency Room (ER). 911 was called and report called to the local hospital. The local Emergency Room (ER) report		potential to be affected. The nurse's notes were reviewed for the last month to ensure family members were notified timely. No concerns were noted. See below for corrective measures. 3. The physician and family notification policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. All nurse's note entries will be reviewed daily to ensure that the family was notified immediately of a resident's chance in condition. If a resident has a chance in condition nursing management will be contacted and the management staff will ensure that the staff has notified the family. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter to ensure prompt family notification. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before August 6, 2012.	

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	for Resident #A, dated 7-22-12, indicated the chief complaint was "altered level of awareness." The resident was brought for unresponsiveness. Apparently the resident had not been responding to voice commands since this morning. The resident upon arrival was speaking and alert and oriented. The resident had been given ammonia capsule before the physician had seen her. The final diagnoses was unresponsiveness, now resolved, possibly secondary to depression, cerumen impaction of the right ear canal and Urinary Tract Infection (UTI). Interview with Resident #A's family member on 7-31-12 at 3:50 p.m., indicated on 7-22-12 the resident was unresponsive. The family member indicated the facility left the resident for 5-6 hours unresponsive without calling an ambulance. The family member indicated they felt that the facility should have called them when the facility could not get the resident awake. The family member indicated when the family arrived at the facility the resident would not talk or wake up and had brown drool coming from her mouth. Interview with LPN #4 on 7-31-12 at 4:30 p.m., indicated he was the nurse taking care of Resident #A on 7-22-12 when the			

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	resident was sent to ER. LPN #4 indicated between 8:00 a.m. to 8:30 a.m., the CNA's came and reported to him the resident did not eat any breakfast or wake up. LPN #4 indicated it was normal for Resident #A to not wake up until later in the morning. LPN #4 indicated he assessed the resident and her vital signs were normal and oxygen saturation was around 88%. LPN #4 indicated oxygen was applied to the resident and her oxygen saturations went up in the 90's. LPN #4 indicated the resident would open her eyes, but would not say anything. LPN #4 indicated he called Physician #1 four times because the resident would not eat/drink or take any medication. LPN #4 indicated he did not receive a call back from Physician #1, so he called the on-call service for the on-call Physician. LPN #4 indicated the on call service would not page Physician #2 because the facility had his phone number. LPN #4 indicated he called Physician #2 three times and he did not get a response from Physician #2 either. LPN #4 indicated he called the DON and was told if he could not get a hold of a physician to call the Nurse Practitioner. LPN #4 indicated he had not called the resident's family at that point because he wanted to be able to tell the family what the Physician had said. The family notification policy provided			

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	by the Director Of Nursing (DON) on 8-1-12 at 3:45 p.m., indicated the facility was to notify the resident and responsible party of any change in condition that may or may not warrant a change in the treatment plan. "If there is a significant change in the resident's condition which warrants emergency medical intervention, notification will be made immediately, regardless of the hour of the day." This Federal tag relates to Complaint IN00113236. 3.1-5(a)(2)			

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F0323 SS=D	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 implement an assistive device of foot pedals for a resident who required foot pedals for wheelchair safety and positioning resulting in the resident falling out of the wheelchair while staff pushed the resident down the hall for 1 of 3 residents sampled for accidents in a total sample of 7 (Resident #A). Finding include: During observation on 7-31-12 at 1:00 p.m., Resident #A was sitting the hallway in wheelchair. The resident had bilateral foot pedals with side support. The resident had a built up tennis shoe on her left foot. Interview with Resident #A at this time indicated she always had her foot pedals on the wheelchair. The resident indicated the staff push her in the wheelchair. Review of the record of Resident #A on 8-1-12 at 9:50 a.m., indicated the resident's diagnoses included, but were	F0323	F323 Requires the facility to implement an assistive device of foot pedals for a resident who required foot pedals for wheelchair safety and positioning. 1. Resident A was not harmed. 2. All residents have the potential to be affected. An audit was completed to ensure all assistive devices were placed on the resident's wheelchair. All assistive devices were present and a list was made to ensure all departments are aware of what assistive devices need to be on the wheelchair prior to transporting the resident. See below for corrective measures. 3. The fall management policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the on the above procedure. 4. All resident's wheelchairs will be assessed daily to ensure that the wheelchairs have the assistive devices present to ensure safety and positioning. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly	08/06/2012

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	not limited to, grief reaction, anemia, Chronic Obstructive Pulmonary Disease (COPD), depression, Parkinson's disease, intertrochanteric left hip fracture and hypertension. The fall careplan for Resident #A, dated 3-2-12, indicated the resident had multiple risk for falls including, but not limited to, impaired balance, unsteady gait, anemia, Parkinson disease, history of hip fracture, depression, pain and low level of physical activity. The Occupational Therapy evaluation for Resident #A, dated 1-24-12 to 2-21-12, indicated the resident was referred for wheelchair positioning and mobility. The wheelchair positioning included, but not limited to, bilateral leg rests. The objective assessment indicated the resident was placed in a wheelchair with bilateral adjusted leg rest with right lateral support. The nursing note for Resident #A, dated 3-11-12 at 8:25 p.m., indicated the resident was being pushed down the hall and fell out of the wheelchair. The Medical Doctor (MD) was notified and the resident was sent to the Emergency Room. The incident/accident report and		thereafter to ensure assistive devices are on the wheelchair prior to transporting a resident. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before August 6, 2012.	

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	investigation for Resident #A, dated 3-11-12, indicated the resident was being pushed from the 100 hall and fell out of the wheelchair. The resident had an 3.5 centimeter by 3 centimeter hematoma on the left side of the head. The staff indicated the resident had removed the foot pedals off the wheelchair. The resident indicated the reason she removed foot pedals was because they bothered her and she did not need them. The interdisciplinary team determination of the cause of the fall was possibly due to there were no foot pedals on the wheelchair. The Emergency Department report for Resident #A, dated 3-11-12, indicated the resident had an head injury. The resident was going down a small ramp and apparently had her legs in front of her. The resident remembers attempting to slow down with her feet and then pitched forward. The resident fell forward and landed directly on her head. The final diagnosis was left frontal contusion status post fall. The discharge ER instructions for Resident #A, dated 3-11-12, indicated the resident's coumadin was to be held until further notice from Primary Care Physician.			

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	The Occupational Therapy evaluation for Resident #A, dated 3-14-12, indicated the circumstances leading to the referral was recent fall and decreased safe wheelchair positioning. The note indicated the resident's wheelchair positioning included, but not limited to, bilateral leg rests. The comment on progress indicated the resident was to have bilateral leg rest while up in wheelchair. The Minimum Data Set (MDS) assessment for Resident #A, dated 5-17-12, indicated the resident required extensive assistance of one person for locomotion on the unit. The resident's mobility devices were walker and wheelchair. The resident had one fall since admission that resulted in an injury (except major)- included, but were not limited to, hematoma. During interview with CNA #1 and CNA #2 on 7-31-12 at 1:05 p.m., indicated they knew which residents required foot pedals because it was on the ADL daily sheet. When queried to see the ADL daily sheet. CNA #2 indicated it was in a book kept at the nursing station. Interview with Resident #A's family member on 7-31-12 at 3:50 a.m., indicated the resident was being wheeled down the hall by the staff and did not			

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	have her foot pedals on her wheelchair when she fell on 3-11-12. The family member indicated the resident had a big knot on her head. The family member indicated the resident should have never fell out of the wheelchair. The family member indicated the staff who cared for the resident should have known the resident was supposed to have foot pedals on the wheelchair. The family member indicated she was told by the facility staff that the resident's foot/leg got caught under the wheelchair and the resident went to the floor face first. During interview with the Director Of Nursing (DON) on 8-1-12 at 11:10 a.m., indicated the residents who required foot pedals were not documented on the ADL daily sheet. The DON indicated the staff knew which residents required foot pedals for their wheelchair by the foot pedals being left in the wheelchair seat, this would let the person know that was getting the resident into the wheelchair that the resident required foot pedals. During interview with the Assistant Director Of Nursing (ADON) on 8-1-12 at 12:45 p.m., indicated the fall on 3-11-12 involving Resident #A was investigated by her. The ADON indicated she had talked with the staff immediately involved in the situation and found out			

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	that Resident #A had been routinely taking off the foot pedals of her wheelchair. The ADON indicated the resident had went to the restroom with assistance from staff on 3-11-12 at approximately around 6:45 p.m., the ADON indicated the staff that assisted the resident to the bathroom did not put the resident's foot pedals back on the wheelchair before wheeling the resident to an activity. The ADON indicated the Activity Assistant was wheeling the resident back from the activity the resident fell out of the wheelchair. During interview with the Activity Assistant on 8-1-12 at 1:40 p.m., indicated CNA #3 had brought Resident #A to an activity on 3-11-12. The Activity Assistant indicated CNA #3 did not tell her that Resident #A's foot pedals were not on the wheelchair. The Activity Assistant indicated she had not noticed the foot pedals were not on the resident's wheelchair. The Activity Assistant indicated she had seen Resident #A have foot pedals on in the past, but not on a consistent basis. The Activity Assistant indicated when she was wheeling Resident #A back to her room the resident had an extended shoe on and it got caught under the wheelchair's front wheel and the resident fell forward and hit her eye on the floor. The Activity Assistant indicated			

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	the resident had an "goose egg" above her eye and her eye was black. During interview with the DON on 8-1-12 at 3:45 p.m., indicated she was unable to find any documentation that Resident #A had been taking her foot pedals off the wheelchair prior to the fall on 3-11-12. The fall management procedure provided by the DON on 8-1-12 at 9:45 a.m., indicated the purpose was to assess all residents for risk factors that may contribute to falling. To provide planned interventions identified by the team, as appropriate, for resident use in maintaining or returning to the highest level of physical, social, and psychosocial functioning as possible. This Federal tag relates to Complaint IN00113236. 3.1-45(a)(2)			

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F0385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. Based on interview and record review, the facility failed to have a functioning system for a facility nurse to contact an physician during the weekend for a resident with a change in condition for 1 of 3 residents sampled for quality of care in a total sample of 7 (Resident #A). Finding include: Review of the record of Resident #A on 8-1-12 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, grief reaction, anemia, Chronic Obstructive Pulmonary Disease (COPD), depression, Parkinson's disease, intertrochanteric left hip fracture and hypertension. The nurses note for Resident #A, dated 7-22-12 at 8:00 a.m., indicated the resident was lethargic and unable to take	F0385	F385 Requires the facility to have a functioning system for a facility nurse to contact a physician during the weekend for a resident with a change in condition 1. Resident A was not harmed. 2. All residents have the potential to be affected. See below for corrective measures. 3. The Acute change in condition/emergency physician service policy and procedure was reviewed with no changes made. (See attachment D) The staff was inserviced on the on the above procedure. 4. The DON will be notified immediately if unable to reach the primary physician or medical director of a resident's change in condition. The DON will advise the staff to transfer the resident to the hospital when a resident's condition is warranted. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four	08/06/2012

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	medication or eat breakfast. The resident's vital signs were within normal limits, oxygen saturation was 88% and oxygen applied. The resident's saturation went up to 97%. The nurses note for Resident #A, dated 7-22-12 at 8:30 a.m., Physician #1 was paged two times. The nurses note for Resident #A, dated 7-22-12 at 9:30 a.m., the on call service was called. The nurses note for Resident #A dated, 7-22-12 at 10:30 a.m., Physician #2 was called two times. The nurses note for Resident #A, dated 7-22-12 at 11:30 a.m., the resident's family was called and did not agree for the resident to be sent to the hospital. The resident's family indicated they would come to the facility. The nurses note for Resident #A, dated 7-22-12 at 1:00 p.m., the Nurse Practitioner was called and an order was received to send the resident to the Emergency Room (ER). 911 was called and report called to the local hospital. The nurses note for Resident #A dated, 7-22-12 at 7:50 p.m., indicated report was		weeks, then every two weeks times two months, then quarterly thereafter to ensure the staff is following the procedure if unable to reach the physician and that the nurse's notes reflect the procedure. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before August 6, 2012.	

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	received from the local hospital ER and the resident had an Urinary Tract Infection (UTI). A new order was received for Bactrim (antibiotic). The resident received 1 milligram of Rocephen (antibiotic) at the hospital. The following late entry nursing notes were written on 7-22-12: The nursing note for Resident #A, dated 7-22-12 at 2:00 p.m. for 8:15 a.m. (late entry), indicated the resident showed no signs of distress. The nursing note for Resident #A, dated 7-22-12 for 8:45 a.m. (late entry), indicated vital signs within normal limits. The resident continues to sleep deeply. There was no change in level of consciousness or behaviors. The nursing note for Resident #A, dated 7-22-12 for 9:00 a.m. (late entry), indicated oxygen saturations were 98%. The resident showed no signs of pain or distress. The resident had no respiratory distress. The nursing note for Resident #A, dated 7-22-12 for 10:00 a.m. (late entry), indicated the resident was opening and closing her eyes. The resident was not in distress. The resident's vital signs were			

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	within normal limits. The nursing note for Resident #A, dated 7-22-12 for 11:00 a.m. (late entry), indicated the resident continues to open her eyes at times. The nursing note for Resident #A, dated 7-22-12 for 8:15 a.m. (late entry), indicated the resident's vital signs were within normal limits. The resident had no change in level of consciousness or behavior. The resident was not observed in distress. The local Emergency Room (ER) report for Resident #A, dated 7-22-12, indicated the chief complaint was "altered level of awareness." The resident was brought for unresponsiveness. Apparently the resident had not been responding to voice commands since this morning. The resident upon arrival was speaking and alert and oriented. The resident had been given ammonia capsule before the physician had seen her. The final diagnoses was unresponsiveness, now resolved, possibly secondary to depression, cerumen impaction of the right ear canal and Urinary Tract Infection (UTI). The ER discharge instructions for Resident #A, dated 7-22-12, indicated to			

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	contact the Medical Doctor for further problems and encourage fluids. Resident #A was admitted back to the facility on 7-22-12. Interview with Resident #A's family member on 7-31-12 at 3:50 p.m., indicated on 7-22-12 the resident was unresponsive. The family member indicated the facility left the resident for 5-6 hours unresponsive without calling an ambulance. The family member indicated the facility told her they were unable to get a hold of a physician to send her to the emergency room. The family member indicated they felt that the facility should have called them when the facility could not get the resident awake. The family member indicated the facility should have called an ambulance. The family member indicated when the family arrived at the facility the resident would not talk or wake up and had brown drool coming from her mouth. Interview with LPN #4 on 7-31-12 at 4:30 p.m., indicated he was the nurse taking care of Resident #A on 7-22-12 when the resident went to ER. LPN #4 indicated between 8:00 a.m. to 8:30 a.m., the CNA's came and reported to him the resident did not eat any breakfast or wake up. LPN #4 indicated it was normal for Resident #A to not wake up until later in			

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	the morning. LPN #4 indicated he assessed the resident and her vital signs were normal and oxygen saturation was around 88%. LPN #4 indicated oxygen was applied to the resident and her oxygen saturations went up in the 90's. LPN #4 indicated the resident would open her eyes, but would not say anything. LPN #4 indicated between himself, the CNA's and Respiratory Therapy, the resident was checked on approximately every 15 minutes. LPN #4 indicated he called Physician #1 four times because the resident would not eat/drink or take any medication. LPN #4 indicated he did not receive a call back from Physician #1, so he called the on-call service for the on-call Physician. LPN #4 indicated the on call service would not page Physician #2 because the facility had his phone number. LPN #4 indicated he called Physician #2 three times and he did not get a response from Physician #2 either. LPN #4 indicated he called the DON and was told if he could not get a hold of a physician to call the Nurse Practitioner. LPN #4 indicated he had not called the resident's family at this point because he wanted to be able to tell the family what the Physician had said. LPN #4 indicated he called the family and explained he had attempted to get a hold of a physician and was unable to. LPN #4 indicated the family did not want the resident sent to			

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	the hospital until they came to the facility and seen the resident. LPN #4 indicated when Resident #A's family arrived at the facility around 1:00 p.m., the family requested for the resident to be sent to the hospital. LPN #4 indicated he called the Nurse Practitioner and received an order to send the resident to the hospital. LPN #4 indicated he never did receive a call back from Physician #1 or Physician #2. Interview with the Director Of Nursing (DON) on 8-1-12 at 3:45 p.m., indicated on 7-22-12 Physician #1 did not call LPN #4 back related to Resident #A's change in condition because the physician was not on-call that weekend. The DON indicated the reason LPN #4 called Physician #1 was because the physician always answered her cell phone when the facility called. The DON indicated the answering service for the on-call physician gave LPN #4 the wrong number for Physician #2. The DON indicated LPN #4 called her and she instructed him to call the Medical Director or the Nurse Practitioner for an order to send the resident the emergency room. The DON indicated on 7-23-12 the facility received a phone call from a man stating he had received messages from the facility on his phone and that he was not Physician #2. The DON indicated there were two physician lists at the nursing station, one			

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	of the list had Physician #2's correct number on it and the second physician list did not have Physician #2's phone number on it. The DON indicated she added Physician #2's phone number to the list. This Federal tag relates to Complaint IN00113236. 3.1-22(b)(2)			