

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/27/2013
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN 46792
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F000000	<p>This visit was for the Investigation of Complaint IN00124497.</p> <p>Complaint IN00124497 - Substantiated. Federal/State deficiencies related to the allegation are cited at F157, F282, and F323.</p> <p>Survey dates: February 26, 27, 2013</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Survey team: Julie Call RN TC Virginia Terveer RN</p> <p>Census bed type: SNF/NF: 125 Total: 125</p> <p>Census payor type: Medicare: 7 Medicaid: 69 Other: 49 Total: 125</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Enclosed please find the plan of correction for the United Methodist Memorial Home, DBA Heritage Pointe. Submission of this plan of correction shall not constitute or be construed as an admission by Heritage Pointe that the allegations in the survey report are accurate or reflect accurately the provision of nursing care and service to the residents at Heritage Pointe.</p> <p>In view of the fact that the deficiencies cited all fall at level D with no quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidence of correction to confirm our substantial compliance in lieu of an on-site revisit.</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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	Quality review 3/05/13 by Suzanne Williams, RN			

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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 interview and record review, the facility failed ensure the resident's physician and the resident's POA (Power of Attorney) were notified of a resident's fall, for 1 of 3</p>	F000157	Please note that the DON told the surveyor she was made aware of Resident C being lowered to the floor on the evening of 2/14/13 by the ADON and continued pursuing	03/15/2013

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	<p>residents reviewed for physician notification in a sample of 4. (Resident C)</p> <p>Findings include:</p> <p>The clinical record of Resident C was reviewed on 2-26-13 at 2:30 p.m. The facility's Incident Details of the fall investigation indicated Resident C had fallen in his room during a transfer from his wheelchair to his recliner with assist of one CNA on 2-8-13. The incident was not investigated until 2-15-13. The Fall Incident report indicated there was no notification of the Physician or POA of Resident C's fall on 2/8/13.</p> <p>There was no documentation regarding the fall or of notification in nurse's progress notes dated 2/8/13.</p> <p>In an interview with the DON (Director of Nursing) on 2/27/13 at 4:20 p.m., she indicated she was not aware the resident had fallen until the morning of 2-15-13. The DON indicated the 2nd shift ADON (Assistant Director of Nursing) was notified on 2/14/13 by the local hospital that the resident was transferred to a different hospital due to flail chest and fractured ribs. The ADON began investigation that evening on 2/14/13. The DON</p>		<p>the investigation on the morning of 2/15/13.</p> <p>All residents were identified as having the potential to be affected by a lack of notification in a timely manner. 15% of the healthcare charts were audited to identify other possible notifications that had not been done in a timely manner. All nursing staff has been in-serviced regarding State and Federal Regulations for criteria on Notification of Changes. In-services also included the definition of what constitutes a fall.</p> <p>Q.A. chart reviews will be done weekly for 4 weeks then monthly for 3 months to ensure those residents' legal representatives or family members are notified of changes in a timely manner. The Q.A. Committee will review findings and make recommendations as needed.</p>		

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	<p>indicated during staff interviews for the investigation, CNA # 1 indicated Resident C was lowered to floor on 2/8/13. The staff nurse did not report Resident C's fall to the supervisor and did not complete an incident report.</p> <p>Review of the facility's Resident's Rights, dated June 1997, indicated, "...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 that results in injury and has the potential for requiring physician intervention...."</p> <p>The facility's Accident/Incident Policy dated 2012, indicated, "...The nurse in charge shall immediately notify the physician, the house supervisor, and the resident's responsible party of incidents...."</p> <p>This Federal tag is related to Complaint IN00124497.</p> <p>3.1-5(a)(1)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders for transfers and ambulation were followed for 1 of 3 residents reviewed for physician orders in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 1-26-2013 at 11:00 a.m. Physician orders for transfers and ambulation dated 1-18-2013 indicated the following: "Per PT (Physical Therapy) recommendation: D/C (discontinue) Hoyer lift. Resident to transfer and ambulate with 1 assist, walker and gait belt."</p> <p>A review of "Incident Details," dated 1-26-2013 at 12:15 a.m., indicated Resident B "fell face first onto floor," was unable to move bilateral legs and knees, had confusion and had a bruise noted to the left eye. Resident B was transferred to the hospital.</p> <p>The "Fall Scene Investigation Report"</p>	F000282	<p>Please note that the DON told the surveyors that information from the Transfer Summary was generated from the MDS and Nursing Assessments not from the CNA assignments. In addition, the surveyors never asked the DON any questions regarding how the 3 rd shift CNAs were trained to ambulate Resident B. The surveyors only asked what shift the CNAs worked that had been trained by PTA #6. All residents were identified as having the potential to be affected by physician orders for transfers and ambulation not being followed. Care Plans and CNA Task Lists were reviewed with charge nurses and CNAs throughout healthcare to identify any resident transfer and ambulation issues and to verify that physician orders and therapy recommendations related to ambulating and transferring residents are being followed. Unit charge nurses will update the Care Plan and CNA Task Lists as soon as they receive a physician order that impacts ADL's and care issues that affect the safe delivery of care by the CNAs. 2 nd shift nurses will monitor all new orders and will check to</p>	03/15/2013			

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	<p>statement by CNA #2 indicated the following: "I was in hallway...heard a resident yelling out for help... [Resident B] had to go to the bathroom...helped [Resident B] into standing position...[Resident B] proceeded to walk towards bathroom with walker...[CNA #2] started stripping the bed when [CNA #2] heard [Resident B] say something and fell to the floor in the bathroom doorway and landed on stomach."</p> <p>An interview with Resident B on 2-26-2013 at 3:10 p.m., indicated she fell in the bathroom and hit her head, back and back of leg. She indicated she did not remember much more, but was taken to the hospital by ambulance.</p> <p>An interview with RN #3 on 2-27-2013 at 9:46 a.m., indicated she was the charge nurse on the night shift during Resident B's fall on 1-26-2013 at 12:15 a.m. RN #3 indicated Resident B required a one person assist for transfers and ambulation and use of her walker. RN #3 did not remember if a gait belt was used.</p> <p>An interview with CNA #4 on 2-27-2013 at 11:30 a.m., indicated Resident B required an assist as needed with walker for transfers and</p>		<p>make sure Task Lists have been updated. Quality Assurance Checks will be done weekly for 4 weeks then monthly for 3 months by monitoring new orders. The Q.A. Committee will review findings and make recommendations as needed.</p>				

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	<p>ambulation.</p> <p>An interview with the DON (Director of Nursing) on 2-27-2013 at 11:45 a.m., indicated the Incident Details report submitted did not indicate use of the gait belt.</p> <p>An interview with CNA #2 on 2-27-2013 at 12:12 p.m., indicated Resident B required an assist as needed with walker for transfers and ambulation. CNA #2 was unaware of orders for Resident B which indicated the use of one assist, gait belt and walker with transfers and ambulation. CNA #2 indicated the day shift nurse, LPN #5 , told her Resident B was an "assist as needed for transfers and ambulation."</p> <p>An interview with the Rehabilitation Director on 2-27-2013 at 12:58 p.m., indicated at the time of therapy discharge on 1-26-2013, Resident B required CGA (contact guard assistance, which means holding onto the gait belt) for transfers and ambulation.</p> <p>An interview with PTA #6 on 2-27-2013 at 12:58 p.m., indicated she trained staff on 1-17-2013 and 1-18-2013 on transfers-which required CGA for sit to stand and</p>				

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	<p>CGA for ambulation with front wheeled walker to bathroom or chair.</p> <p>An interview with LPN #5 on 2-27-2013 at 1:10 p.m., indicated Resident B required one assist for transfers and ambulation and used a walker.</p> <p>In an interview with the DON on 2-27-2013 at 4:35 p.m., Resident B's Transfer Summary dated 1-26-2013 indicated Resident B was independent with transfers and ambulation. This information came from the CNA assignment according to the DON. The DON agreed the Transfer Summary dated 1-26-2013 which included the transfer and ambulation information did not match the physician orders for transfer and ambulation dated 1-18-2013 or the therapy recommendations on the Record of Training dated 1-17-2013 and 1-18-2013. The DON indicated the 5 CNAs that were trained by PTA #6 worked 1st and 2nd shifts. The DON was unaware how the 3rd shift CNAs were trained to transfer/ambulate Resident B.</p> <p>An interview with CNA #7 on 2-27-2013 at 4:45 p.m., indicated she was trained on Resident B's transfer and ambulation recommendations by</p>						

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	<p>PTA #6 on 1-17-2013. CNA #7 indicated PTA #6 demonstrated how to transfer and ambulate Resident B with the use of a gait belt which required a hand on the gait belt while transferring and ambulating the resident with her walker.</p> <p>An undated policy "Gait Belt" was provided by the DON on 2-27-2013 at 5:10 p.m., and included but was not limited to the following: "Purpose: To provide support and safety for resident and employee during ambulation, lifting or transferring resident." In an interview at that time, the DON indicated the gait belt was to be used anytime a resident needs assistance with transfers and ambulation. No additional information was provided by the facility related to the ambulation and transfer order.</p> <p>This Federal tag is related to Complaint IN00124497.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<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 adequate supervision and assistance as ordered to prevent a fall and failed to report and investigate a fall, for 2 of 3 residents (Residents B and C) reviewed for falls in a sample of 4.</p> <p>Findings include:</p> <p>1. Resident B's record was reviewed on 2-26-2013 at 11:00 a.m. The annual MDS (Minimum Data Set) assessment dated 12-20-2012 indicated Resident B's BIMS (Brief Interview of Mental Status) was 13/15 (a score of 13-15 indicated cognitively intact), required limited assist of one person for transfers and ambulation and was not steady for transfers and ambulation independently.</p> <p>The Fall Risk assessment done on 12-19-2012 indicated Resident B scored a "10," with a score over 9 indicating at risk for falls.</p>	F000323	<p>1. Please note again that the surveyors did not ask the DON how the 3 rd shift CNAs were trained. They only asked the DON what shift the 5 CNAs worked that were trained. The DON also told the surveyors that the information from the Transfer Summary report was generated from the MDS and Nursing Assessments not from the CNA assignments. All residents were identified as having the potential to be affected by physician orders for transfers and ambulation not being followed. Care Plans and CNA Task Lists were reviewed with charge nurses and CNAs throughout healthcare to identify any resident transfer and ambulation issues and to verify that physician orders and therapy recommendations related to ambulating and transferring residents are being followed. Unit charge nurses will update the Care Plan and CNA Task Lists as soon as they receive a physician order that impacts ADL's and care issues that affect the safe delivery of care by the CNAs. Second shift nurses will monitor all new orders and will check to make sure Task Lists have been</p>	03/15/2013			

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	<p>Physician orders dated 1-18-2013 were written as "per PT (physical therapy) recommendation: discontinue Hoyer lift-resident to transfer and ambulate with 1 assist, walker and gait belt."</p> <p>The Care Plan Snapshot as of 1-26-2013, provided by the DON (Director of Nursing) on 2-27-2013 at 12:15 p.m., indicated Resident B was a risk for injury-falls, with an approach of "Hoyer lift for all transfers" dated 1-15-2013.</p> <p>A review of "Incident Details," dated 1-26-2013 at 12:15 a.m., indicated Resident B "fell face first onto floor", was unable to move bilateral legs and knees, had confusion and a bruise noted to the left eye. Resident B was transferred to the hospital.</p> <p>On 2-26-2013 at 3:10 p.m., Resident B was observed in her room in bed with the call light in reach, oxygen on and a reacher on the bed. An interview with Resident B at this time indicated the resident fell in the bathroom and hit her head, back and the back of her leg. Resident B indicated she did not remember much else and was taken to the emergency room by the EMS (Emergency Medical Service) and admitted to the</p>		<p>updated. Q.A. will be done weekly for 4 weeks then monthly for 3 months by monitoring new orders. The Q.A. Committee will review findings and make recommendations as needed. 2. Again, please note that the DON told the surveyor that she was made aware of Resident C being lowered to the floor on the evening of 2/14/13 by the ADON and continued pursuing the investigation on the morning of 2/15/13. All residents were identified as having the potential to be affected by a lack of notification in a timely manner. 15% of the healthcare charts were audited to identify other possible notification that had not been done in a timely manner. All nursing staff has been in-serviced regarding State and Federal Regulations for criteria on Notification of Changes. In-services also included the definition of what constitutes a fall. Q.A. chart reviews will be done weekly for 4 weeks then monthly for 3 months to ensure those residents' legal representative or family members are notified of changes in a timely manner. The Q.A. Committee will review findings and make recommendations as needed.</p>				

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	<p>hospital.</p> <p>The "Fall Scene Investigation Report" statement by CNA #2 indicated the following: "I was in hallway...heard a resident yelling out for help... [Resident B] had to go to the bathroom...helped [Resident B] into standing position...[Resident B] proceeded to walk towards bathroom with walker...[CNA #2] started stripping the bed when [CNA #2] heard [Resident B] say something and fell to the floor in the bathroom doorway and landed on stomach."</p> <p>An interview with RN #3 on 2-27-2013 at 9:46 a.m., indicated she was the charge nurse on the night shift during the 1-26-2013 fall at 12:15 a.m. RN #3 indicated she did not witness the fall and found the resident on the floor on her stomach in her room. RN #3 indicated Resident B required one person to assist her for transfers and walking with the use of her walker. RN #3 did not remember if the gait belt was used when Resident B was assisted to the bathroom at the time of the fall.</p> <p>An interview with CNA #4 on 2-27-2013 at 11:30 a.m., indicated she and CNA #2 heard a resident yell. Both responded and found</p>						

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	<p>Resident B sitting on her bed in her room and requested assistance to the bathroom. She indicated CNA #2 assisted Resident B to transfer from her bed to standing with her walker and began stripping the bed. CNA #4 left the room to get clean linens. CNA #4 indicated when she returned to the room, Resident B was on the floor in the bathroom doorway.</p> <p>An interview with CNA #2 on 2-27-2013 at 12:12 p.m., indicated she worked the night of Resident B's fall. She and CNA #4 heard someone yell. Both CNAs responded to find Resident B sitting on her bed and requested assistance to the bathroom. CNA #2 indicated she raised Resident B's bed and the resident stood and she asked the resident if she was ok to walk to the bathroom with her walker. CNA #2 indicated Resident B replied she was ok and she stepped away from Resident B and began stripping the bed. Resident B's knee gave out and Resident B fell forward hitting her head, shoulder and knee. CNA #2 indicated the day nurse, LPN #5 reported to her, Resident B was an assist as needed for transfers and ambulation. CNA #2 was not aware of any other orders for assistance for Resident B for transfers and</p>						

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	<p>ambulation, or use of a gait belt.</p> <p>An interview with LPN #5 on 2-27-2013 at 1:10 p.m., indicated Resident B required one assist for transfers and ambulation and used a walker.</p> <p>An interview with the Rehabilitation Director on 2-27-2013 at 12:58 p.m., indicated at the time of therapy discharge on 1-26-2013, Resident B required CGA (contact guard assistance, which means holding onto the gait belt) for transfers and ambulation.</p> <p>An interview with PTA #6 on 2-27-2013 at 12:58 p.m., indicated she trained staff on 1-17-2013 and 1-18-2013 for Resident B on transfers-which required CGA for sit to stand and CGA for ambulation with front wheeled walker to bathroom or chair.</p> <p>An interview with CNA #7 on 2-27-2013 at 4:45 p.m., indicated she was trained on Resident B's transfer and ambulation recommendations by PTA #6 on 1-17-2013. CNA #7 indicated PTA #6 demonstrated how to transfer and ambulate Resident B with the use of a gait belt which required a hand on the gait belt while</p>						

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	<p>transferring and ambulating the resident with her walker.</p> <p>An interview with the DON on 2-27-2013 at 11:45 a.m., indicated the Incident Report submitted did not indicate the use of a gait belt at the time of the fall on 1-26-2013 at 12:15 a.m. or that Resident B had an assisted fall.</p> <p>The DON was interviewed on 2-27-2013 at 4:35 p.m., regarding Resident B's Transfer Summary dated 1-26-2013, which indicated Resident B was independent with transfers and ambulation. The DON indicated this information came from the CNA assignment. The DON indicated the Transfer Summary dated 1-26-2013, which included the transfer and ambulation information, did not match the physician orders for transfer and ambulation dated 1-18-2013 or the therapy recommendations on the Record of Training dated 1-17-2013 and 1-18-2013 or the Care Plan snapshot as of 1-26-2013. The DON indicated the five CNAs who were trained by PTA #6 worked 1st and 2nd shifts. The DON was unaware how the 3rd shift CNAs were trained to transfer/ambulate Resident B.</p>				

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	<p>2. The clinical record of Resident C was reviewed on 2-26-13 at 2:30 p.m.</p> <p>The facility's Incident Details of a fall investigation indicated Resident C had fallen in his room during a transfer from his wheelchair to his recliner with assist of one CNA on 2-8-13 at 2:00 p.m. The incident was not investigated until 2-15-13.</p> <p>The nurse's progress notes on 2-8-13 at 6:53 a.m. and at 11:11 p.m., indicated no problem behaviors were noted. There was no other documentation in nurse's progress notes on 2-8-13.</p> <p>In an interview with CNA #1 on 2-27-13 at 11:35 a.m., she indicated when she transferred Resident C from his wheelchair to his recliner on 2-08-13, his knees gave way. She indicated she tried to get the wheelchair under him, but grabbed him around the waist and lowered him to the ground and went to get help. She indicated CNA #8 came to help get resident back into his recliner. She indicated they used a gait belt and assist of two to get him up. She indicated LPN #5 came in while the resident was still on the floor.</p> <p>In an interview with CNA #8 on</p>						

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	<p>2/27/13 at 11:45 a.m., she indicated she answered the call light and CNA # 1 indicated she had lowered Resident C to the floor and needed help. CNA #8 yelled for the nurse, and LPN #5 came to resident's room. CNA #8 indicated Resident C was assisted to his feet with the gait belt and assist of both CNAs. She indicated the gait belt was placed around the resident just below the breast bone, and she held the gait belt in the front and back of the resident, with a CNA on each side of him. They stood the resident, and LPN #5 moved the recliner behind the resident, and they sat him down in the recliner. CNA #8 indicated the nurse checked on the resident.</p> <p>In an interview with LPN #5 on 2/27/13 at 1:05 p.m., she indicated she was called to Resident C's room by the CNA. Resident C was on the floor with loose bowel movement on the floor and all over the resident. She indicated CNA #1 reported the resident's knees gave out, and the CNA #1 tried to grab him and put the wheelchair under him, but lowered him to the floor. LPN #5 indicated there were no injuries, and the CNAs cleaned him and got him into his recliner. LPN #5 indicated she returned to the nurse's station, and</p>				

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	<p>gave report to the next shift nurse. LPN # 5 indicated she did not complete an incident report or notify the supervisor. She indicated she did not think of it as a fall.</p> <p>In an interview with the DON (Director of Nursing) on 2/27/13 at 4:20 p.m., she indicated she was not aware the resident had fallen until the morning of 2-15-13. The DON indicated the 2nd shift ADON (Assistant Director of Nursing) #9 was notified by the local hospital on 2/14/13, that the resident was transferred to a different hospital due to a flail chest, fractured ribs and a bruise on his right hip. The ADON #9 began an investigation that evening on 2/14/13. The DON indicated during staff interviews for the investigation, CNA # 1 indicated Resident C was lowered to the floor on 2/8/13. The DON indicated the staff nurse did not report Resident C's fall to the supervisor and did not complete an incident report or investigation into the fall.</p> <p>The facility's Accident/Incident Policy dated 2012 indicated, "...Complete... Accident/Incident Report as soon as possible...to the Nursing Supervisor as soon as possible during the tour of duty in which the incident occurred...The completed</p>			

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	<p>Accident/Incident report will be filled out immediately...."</p> <p>This Federal tag is related to Complaint IN00124497.</p> <p>3.1-45(a)(2)</p>				