

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/17/2011
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NAME OF PROVIDER OR SUPPLIER  LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN46410
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F0000	<p>This visit was for the Investigation of Complaints IN00099207 and IN00099726.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 9/21/11. This visit included the PSR to the Investigation of Complaints IN00096562 and IN00096566 completed on 9/21/11.</p> <p>This visit was in conjunction with a PSR to the Investigation of Complaints IN00095696 and IN00095938 completed on 9/8/11.</p> <p>Complaint IN00099207-Substantiated. Federal and State deficiencies related to the allegations are cited at F282.</p> <p>Complaint IN00099726-Substantiated. Federal and State deficiencies related to the allegations are cited at F322, F333, and F328.</p> <p>Survey dates: November 9, 14, 15, and 17, 2011</p> <p>Facility Number: 000577 Provider Number: 155650 AIM Number: 100266950</p>	F0000	Lincolnshire Health & Rehab is requesting a paper compliance review in lieu of an onsite post survey revisit.	

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: Regina Sanders, RN-TC Sheila Sizemore, RN Kelly Sizemore, RN Marcia Mital, RN (November 14, 15, and 17, 2011)</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 24 Medicaid: 59 Other: 7 Total: 90</p> <p>Sample: 12</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/18/11 Cathy Emswiller RN</p>			
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F0282 SS=D	<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 observation, record review, and interview, the facility failed to ensure physician's orders were followed related to medications for 2 of 12 residents reviewed for physician's orders in sample of 12. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 11/15/11 at 10:15 a.m. Resident #D's diagnoses included, but were not limited to, dementia, hypertension, hemiplegia, and depressive disorder.</p> <p>A physician's order, dated 10/31/11, indicated "discontinue Aricept (Alzheimer drug) 23 mg (milligram), start Aricept 10 mg po (by mouth) daily..."</p> <p>A Medication Administration Record (MAR), dated November 2011, indicated Aricept 23 mg was initialed as given daily at 9 p.m. on November 1-14. Aricept 10 mg was also initialed as given daily at 9 a.m. on November 1-15.</p> <p>During an observation of medications in the med cart, on 11/15/11 at 11:05 a.m., with RN #5, there was a card of Aricept</p>	F0282	<p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist.</b></p> <p><b>This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.</b> Plan of correction F 282 1) Immediate action taken for those residents identified: Resident D, Aricept 23mg was discontinued and removed from the MAR on 11-15-2011. A med error report was filled out and the physician was notified. Resident C, the facility had self-identified the med error through a quality assurance audit. Resident C was informed of the omission as well as the physician, per the facility policy regarding the order for the fentanyl patch. A med error report was filled out when the error was identified. Regarding the vancomycin for resident C, surveyors were provided with a time-line of the doses of vancomycin that were delivered by the pharmacy and received by the resident. Physician documentation was noted of the awareness of refusal by the resident to receive the vancomycin. 2) How other residents were identified: All</p>	12/08/2011

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	<p>10 mg and a card of Aricept 23 mg. During an interview at the time of the observation, RN #5 indicated both Aricept 10 mg and 23 mg were being given.</p> <p>During an interview with RN #5, on 11/15/11 at 11:10 a.m., she indicated Aricept 23 mg should have been discontinued on 10/31/11.</p> <p>2. Resident #C's record was reviewed on 11/15/11 at 10:20 a.m. The resident's diagnoses included, but were not limited to post gangrenous small bowel and post exploratory laparoscopy.</p> <p>A) During an interview on 11/14/11 at 12:15 p.m., Resident #C indicated the facility had not been giving her pain patch correctly.</p> <p>The resident's Admission/5 Day Minimum Data Set Assessment, dated 10/20/11, indicated the resident was cognitively intact.</p> <p>The resident's Active Orders, dated 10/11, indicated an order, dated 10/13/11 with a start date of 10/14/11 for Fentanyl (narcotic pain patch) 50 MCG (micrograms)/hr (hour) transdermal patch, change every 72 hours. The order indicated it was discontinued on 11/01/11.</p> <p>The resident's Active orders, dated 10/11, indicated another order, dated 10/13/11 with a start date of 11/01/11 for Fentanyl 50 MCG/hr transdermal, apply every 72 hours.</p> <p>The resident's Active orders, dated 10/11, indicated another order, dated 10/13/11 with a start date of 11/09/11 for Fentanyl 50 MCG/hr</p>		<p>residents charts were reviewed as part of the facility's system for quality assurance prior to the survey. Any issues identified were addressed appropriately by the facility however, cited as evidence in the 2567. Another audit was completed of all current residents physicians' orders for accuracy and assurance that orders are being followed correctly. 3) System in place: Licensed Nurses were in-serviced on 11/22/2011, regarding following physician orders and medication administration. The physician's orders and progress notes will be reviewed daily during the morning clinical meeting for proper input into the new eMAR system and care plan. Any findings will be addressed. The eMAR coordinator will continue to complete 1:1 training with those nurses/staff needing additional assistance with the new system.4) How the actions will be monitored and what quality assurance program will be put into place: The IDT will review physician orders 5 times per week during the morning clinical meeting. Unit Managers, or designee, will review physician orders and 24 hour report no less than 5 times per week for quality assurance. The DON/Designee will be responsible for the coordination and monitoring of compliance. The facility will provide irrefutable evidence of compliance as of 12-7-11</p>				

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	<p>transdermal daily every three days.</p> <p>The resident's Medication Administration Record (MAR), dated 10/11, indicated the Fentanyl transdermal patch 50 MCG/hr was applied on 10/16/11 at 10:12 p.m. (three days after the order was obtained). The MAR lacked documentation to indicate another Fentanyl patch had been applied 72 hours later. The next documentation on the 10/11 MAR, indicated N/A on 10/30/11. The MAR coding indicate N/A meant not applicable.</p> <p>The resident's MAR, dated 11/11, indicated the next time a Fentanyl transdermal patch had been applied was 11/09/11, which was 24 days after the initial patch had been applied on 10/16/11.</p> <p>A controlled substance record, dated 10/15/11 at 10:02 a.m., received from the Director of Nursing on 11/17/11 at 9:15 a.m., indicated the Fentanyl 50 mcg/hr patch had been applied on 10/16/11 at 9 a.m., 10/20/11 at 9 a.m. (4 days later), 10/23/11 at 9 a.m., 10/28/11 at 6 p.m. (5 days later), and 11/03/11 at 9 a.m.(6 days later).</p> <p>During an interview on 11/15/11 at 2:10 p.m., the Director of Nursing indicated a Medication Error Report had been filled out when they found the error.</p> <p>A Medication Error Report, dated 11/09/11, indicated the resident had not been receiving the patch as ordered due to an order was placed in the computer incorrectly. This was 24 days after the medication error had occurred.</p> <p>B) A physician's order, dated 10/18/11 with a start dated of 10/19/11, indicated an order for Vancomycin (antibiotic) 1000 mg (milligrams) intravenous (IV) daily.</p>				

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	<p>The resident's MAR, dated 10/11, indicated on 10/21/11 the resident had not been given the medication. The MAR indicated, "N/A" (not applicable).</p> <p>There was a lack of documentation in the resident's nurses' notes, dated 10/21/11, to indicate why the Vancomycin had not been given.</p> <p>During an interview on 11/15/11 at 2 p.m., the Director of Nursing indicated she was unsure why the Vancomycin had not been given on 10/21/11.</p> <p>During an interview on 11/15/11 at 2:10 p.m., LPN #8 indicated the Vancomycin had not been given because the Vancomycin had been discontinued on 10/18/11.</p> <p>A telephone interview on 11/16/11 at 9:10 a.m., Pharmacist #7 indicated they had received an order to discontinue the Vancomycin on 10/23/11.</p> <p>This deficiency was cited on 09/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(1)</p>				

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F0322 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident with a feeding tube received the feeding as ordered for 1 of 3 residents reviewed with feeding tubes in a sample of 12 residents. (Resident# B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 11/14/11 at 8:55 a.m. Resident #B's diagnoses included, but were not limited to, stroke, Alzheimer's disease, and hypertension.</p> <p>A physician's order, dated 11/4/11, indicated "Jevity (liquid feeding) 1.5 85 ml (milliliters)/hr (an hour) times 20 hours on at 12 p.m. and off at 8 a.m..."</p> <p>A care plan, dated 11/2/11, indicated "Resident receives a tube feeding for total nutrition/hydration...Provide tube feeding &amp; flushes per order..."</p> <p>Resident #B was observed on 11/14/11 at</p>	F0322	<p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist.</b></p> <p><b>This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.</b> Plan of Correction F 322 1) Immediate action taken: Regarding Resident B, the physician was notified that the tube feeding had not been connected. However , the physician's order was to run the feeding over 20 hours. An order was received that the tube feeding may be held while the resident is at therapy. 2) How other residents were identified: No other residents were affected. The nurses were inserviced on setting feeding pumps for duration and total CC infusion and on/off times were removed from the physician's orders. 3) System in place: Licensed Nurses were in-serviced 11/22/2011 regarding following physician orders. Therapy will take the feeding pump with the resident to</p>	12/08/2011			

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	<p>2:10 p.m., in the therapy room. The resident did not have her tube feeding infusing.</p> <p>Resident #B was observed on 11/14/11 at 11/14/11 at 2:15 p.m., in therapy with ST (Speech Therapist) #2 with out her tube feeding infusing. ST #2 indicated the resident had been in occupational therapy before she began treatment at 1:48 p.m. without her tube feeding infusing.</p> <p>During an interview on 11/14/11 at 2:17 p.m., COTA (Certified Occupational Therapy Assistant) #3 indicated the resident had been doing therapy with her since 1:05 p.m. She indicated she had spoken to nursing about the resident's tube feeding being off and the nurse was suppose to come down and hook up the tube feeding.</p> <p>During an interview on 11/14/11 at 2:20 p.m., LPN #4 indicated she had hooked up the resident's tube feeding at 12:00 p.m.</p> <p>During an interview on 11/14/11 at 2:22 p.m., the B Wing Unit Manager indicated the resident's tube feeding was disconnected for therapy. She indicated the resident had returned from a doctors appointment and then was taken to therapy.</p>		<p>therapy unless otherwise ordered by physician. All feeding orders will be clarified as needed to eliminate times from the order. All residents on feeding tubes utilizing pumps will be set to infuse for the duration/total volume as ordered. 4) How the actions will be monitored and what quality assurance program will be implemented: The DON/Designee will monitor residents with feeding tubes on scheduled rounds by members of the quality assurance team at least 5 times weekly. The facility will provide irrefutable evidence of compliance as of 12-7-11</p>		

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	<p>During an interview on 11/14/11 at 2:24 p.m., the B Wing Unit Manager and LPN #4 both indicated they did not know who had disconnected the resident's tube feeding.</p> <p>During an interview on 11/14/11 at 2:25 p.m., the ADON (Assistant Director of Nurses) indicated the resident's tube feeding should have been infusing. She indicated she was going to check to see who had disconnected the feeding.</p> <p>Resident B was observed on 11/14/11 at 2:29 p.m., in her room without her tube feeding infusing.</p> <p>During an interview on the above date and time, LPN #4 indicated she was going to connect the resident's tube feeding.</p> <p>This Federal tag relates to Complaint IN00099726.</p> <p>This deficiency was cited on 9/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-44(a)(2)</p>				

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F0328 SS=D	<p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on record review and interview, the facility failed to ensure a PICC (Peripherally Inserted Central Catheter) was assessed for length and arm circumference for 1 of 3 residents with PICC lines in a sample of 12 residents. (Resident #B)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 11/14/11 at 8:55 a.m. Resident #B's diagnoses included, but were not limited to, stroke, Alzheimer's disease, and hypertension.</p> <p>The resident's admission/readmission nursing observations, dated 10/25/11, lacked documentation to indicate the resident had a PICC line.</p> <p>The nurses' notes, dated 10/25/11 indicated: 7:30 p.m., "resident returned to facility...resident alert and verbally</p>	F0328	<p><b>The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist.</b></p> <p><b>This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care</b> Plan of Correction F 3281) Immediate action taken: Resident B no longer has a PICC line. It is important to note that the resident's PICC line was inserted just prior to her transport from the hospital and the resident arrived with the measurements of the line on admission 10-25-11. As stated in the 2567, the MD order was to measure the circumference and length on "admission" and weekly. This was obviously an error as the order was obtained the day after admission on 10-26-11 as confirmed by the 2567. The intent of the order was for weekly measurements to be completed. The admission note in the chart does contain an assessment of</p>	12/08/2011	

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	<p>responsive with confusion noted.." 8:15 p.m., "writer spoke with (physician name), new orders to re-admit resident to room (number) continues previous nursing home orders, add vancomycin (antibiotic)...pharmacy to dose vanco (vancomycin) levels..." There was a lack of an assessment of the resident's PICC line.</p> <p>A hospital PICC line assessment, dated 10/25/11, indicated the resident had the PICC line inserted on 10/25/11 at 3:45 p.m.</p> <p>The physician's orders, dated 10/26/11, indicated: "Measure arm circumference on admission, with each dressing change, and PRN (as needed)..." "Measure external catheter length on admission, with each dressing change, and PRN..."</p> <p>During an interview on 11/14/11 at 11:15 a.m., LPN #6 indicated she did an assessment of the resident's PICC line when she did the dressing change on 10/31/11. She indicated she measured the resident's arm circumference and external length of the catheter on 10/31/11. She indicated no one did an assessment upon admission.</p>		<p>the PICC line.2) How other residents were identified: Three other residents in the facility have a PICC line. The length of the external catheter and circumference are being measured. 3) System in place: Licensed Nurses were in-serviced on 11/22/2011 regarding following physician orders and proper assessment and documentation of PICC lines and mid-lines. On admission/re-admission or when the nurse receives an order for a PICC/mid-line, the information will be put into the computer and a mid-line/PICC line flow sheet will be generated; includes measuring the length of the external catheter and circumference with dressing change; the measurements will be documented in the progress notes. 4) How the actions will be monitored and what quality assurance program in place: The IDT will review physician orders 5 times per week during the morning clinical meeting. Unit Managers or designee will review physician orders and 24 hour report no less than 5 times weekly. The DON/designee will be responsible for the coordination of monitoring. The facility will provide irrefutable evidence of compliance as of 12-7-11</p>		

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	<p>During an interview on 11/14/11 at 2:42 p.m., the DoN (Director of Nurses) indicated the resident had the PICC line when she came back from the hospital. She indicated she did not know why the nurse didn't assess the PICC line. She indicated the PICC line should have been assessed.</p> <p>This Federal tag relates to Complaint IN00099726.</p> <p>This deficiency was cited on 9/21/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-46(a)(2)</p>				
F0333 SS=D	<p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the</p>	F0333	<b>The filing of this plan of correction does not constitute an admission that the alleged</b>	12/08/2011	

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	<p>facility failed to ensure residents were free of significant medication errors for 2 of 12 residents reviewed for significant medication errors in a sample of 12. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 11/15/11 at 10:15 a.m. Resident #D's diagnoses included, but were not limited to, dementia, hypertension, hemiplegia, and depressive disorder.</p> <p>A physician's order, dated 10/31/11, indicated "discontinue Aricept (Alzheimer drug) 23 mg (milligram), start Aricept 10 mg po (by mouth) daily..."</p> <p>A Medication Administration Record (MAR), dated November 2011, indicated Aricept 23 mg was initialed as given daily at 9 p.m. on November 1-14. Aricept 10 mg was also initialed as given daily at 9 a.m. on November 1-15.</p> <p>During an observation of medications in the med cart, on 11/15/11 at 11:05 a.m., with RN #5, there was a card of Aricept 10 mg and a card of Aricept 23 mg. During an interview at the time of the observation, RN #5 indicated both Aricept 10 mg and 23 mg were being given.</p>		<p><b>deficiency did in fact exist.</b></p> <p><b>This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care.</b> F 3331) Immediate action taken for those residents identified: Regarding Resident D, Aricept 23mg was discontinued and removed from the MAR on 11-15-2011. A med error report was filled out and the physician was notified. Regarding Resident C, the facility had self-identified the med error regarding the order for the fentanyl patch, and a med error report had been filled out when the error was identified. Regarding the vancomycin for Resident C; surveyors were presented with a time-line of the doses of vancomycin that were delivered by the pharmacy and received by the resident. Physician documentation was noted of the awareness of refusal by resident to receive the vancomycin. 2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected and all current resident physician orders have been reviewed for accuracy and assurance that orders are being followed correctly. 3) What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>		

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	<p>During an interview with RN #5, on 11/15/11 at 11:10 a.m., she indicated Aricept 23 mg should have been discontinued on 10/31/11.</p> <p>2. Resident #C's record was reviewed on 11/15/11 at 10:20 a.m. The resident's diagnoses included, but were not limited to post gangrenous small bowel and post exploratory laparoscopy.</p> <p>During an interview on 11/14/11 at 12:15 p.m., Resident #C indicated the facility had not been giving her pain patch correctly.</p> <p>The resident's Admission/5 Day Minimum Data Set Assessment, dated 10/20/11, indicated the resident was cognitively intact.</p> <p>The resident's Active Orders, dated 10/11, indicated an order, dated 10/13/11 with a start date of 10/14/11 for Fentanyl (narcotic pain patch) 50 MCG (micrograms)/hr (hour) transdermal patch, change every 72 hours. The order indicated it was discontinued on 11/01/11.</p> <p>The resident's Active orders, dated 10/11, indicated another order, dated 10/13/11 with a start date of 11/01/11 for Fentanyl 50 MCG/hr transdermal, apply every 72 hours.</p> <p>The resident's Active orders, dated 10/11, indicated another order, dated 10/13/11 with a start date of 11/09/11 for Fentanyl 50 MCG/hr transdermal daily every three days.</p> <p>The resident's Medication Administration Record (MAR), dated 10/11, indicated the Fentanyl transdermal patch 50 MCG/hr was applied on 10/16/11 at 10:12 p.m. (three days after the order</p>		<p>practice does not recur: Licensed Nurses were in-serviced by the corporate consultant on 11/22/2011 regarding following physician orders and medication administration. The electronic medical record and progress notes will be reviewed daily during the morning clinical meeting and any findings will be addressed.</p> <p>4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The IDT will review physician orders 5 x a week during the morning clinical meeting. Unit Managers, or designee, will review physician orders &amp; 24 hour report no less than 5 X weekly. Findings will be recorded on an audit tool (QA Audit for Physician Orders/Pertinent Charting) and forwarded to the DON. 5) Date of Compliance: 12/8/11</p>		

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	<p>was obtained). The MAR lacked documentation to indicate another Fentanyl patch had been applied 72 hours later. The next documentation on the 10/11 MAR, indicated N/A on 10/30/11. The MAR coding indicate N/A meant not applicable.</p> <p>The resident's MAR, dated 11/11, indicated the next time a Fentanyl transdermal patch had been applied was 11/09/11, which was 24 days after the initial patch had been applied on 10/16/11.</p> <p>A controlled substance record, dated 10/15/11 at 10:02 a.m., received from the Director of Nursing on 11/17/11 at 9:15 a.m., indicated the Fentanyl 50 mcg/hr patch had been applied on 10/16/11 at 9 a.m., 10/20/11 at 9 a.m. (4 days later), 10/23/11 at 9 a.m., 10/28/11 at 6 p.m. (5 days later), and 11/03/11 at 9 a.m.(6 days later).</p> <p>During an interview on 11/15/11 at 2:10 p.m., the Director of Nursing indicated a Medication Error Report had been filled out when they found the error.</p> <p>A Medication Error Report, dated 11/09/11, indicated the resident had not been receiving the patch as ordered due to an order was placed in the computer incorrectly. This was 24 days after the medication error had occurred.</p> <p>This Federal tag relates to complaint IN00099726</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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