

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/03/2011
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 31, November 1, 2, and 3, 2011</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Survey Team: Karina Gates, BHS TC Marcy Smith RN Patti Allen BSW Leia Alley RN Beth Kolasa RN Courtney Mujic RN Barbara Hughes RN</p> <p>Census Bed Type: SNF/NF: 103 Total: 103</p> <p>Census Payor Type: Medicare: 40 Medicaid: 34 Other: 29 Total: 103</p> <p>Sample: 21</p> <p>These deficiencies also reflect state</p>	F0000	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the Life Safety survey on November 7, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request.</p>	

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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F0282 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/09/11 by Suzanne Williams, RN</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 observation, interview, and record review, the facility failed to ensure physician orders were followed for 3 of 13 residents reviewed for meal observations, in a total sample of 21. (Resident #72, Resident #30, Resident #13)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #72 was reviewed on 10/31/11 at 12:10 p.m.</p> <p>The diagnoses for Resident #72 included, but were not limited to: hypertension, diabetes mellitus, hyperlipidemia, osteomyelitis, open wound on buttocks, and protein malnutrition.</p> <p>The November 2011 Physician Orders had an order, that was started on August, 13, 2010, for a low concentrated sweet diet with regular liquids and double meat protein to all meals.</p>	F0282	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the Recertification and Licensure survey on November 3, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of the facility to ensure that services are provided by qualified professionals in accordance to residents plan of care.1. Resident # 72 immediately received double meat/protein portion for that meal on date of observation. The Dietician reviewed resident # 72 plan of care and D/c'd double meat/protein portion as it was no longer necessary for resident #72. Resident #30 immediately received house shake for that meal on date of observation. Resident #13 immediately</p>	11/28/2011	

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	<p>During observation of Resident #72 eating lunch on 11/1/11 at 12:50 p.m., the resident's meal ticket indicated that the portion size was standard and no special requests for double meat/protein were noted on the ticket.</p> <p>During observation of Resident #72 eating lunch on 11/2/11 at 1:10 p.m., the resident's meal ticket indicated that the portion size was standard and no special requests for double meat/protein were noted on the ticket.</p> <p>During observation of Resident #72 eating dinner on 11/2/11 at 5:15 p.m., the resident's meal ticket indicated that the portion size was standard and no special requests for double meat/protein were noted on the ticket.</p> <p>During an interview with LPN #1 on 11/2/11 at 5:15 p.m., she indicated that the portion size of meat/protein on Resident #72 tray was a single serving.</p> <p>During an interview with the RD (registered dietician) on 11/2/11 at 5:45 p.m., she indicated that she was aware of Resident #72's physician order for double meat/protein and she was unsure of why Resident #72 did not get double meat/protein.</p>		<p>received LCS diet for that meal on date of observation. The dietician immediately clarified doctor order and changed order to reflect LCS diet. Resident # 72, #30 and #13 have been monitored by Dietician routinely to help ensure diet orders are being followed per plan of care.2. The Dietician and Dietary Manager on November 17, 2011 completed review of current residents diet plan of care to ensure they are receiving correct diet. No other residents found to be affected.3. Dietician and Staff Development Coordinator re- inserviced staff on November 4,5, 6 and 9th 2011 regarding accuracy and importance of following written plan of care for residents diet to include reading tray cards prior to providing meal to residents to help ensure continued compliance. 4. The Dietician reviews daily during clinical meeting new resident admission diet orders to help ensure continued compliance. The Dietician and/or designee will randomly review diet orders for 10% of current residents in monthly quality assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor for quality compliance.5. Administrator will ensure compliance by November 28 2011.</p>		

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	<p>2. Resident #30's clinical record was reviewed on 11/01/2011 at 2:00 p.m. The record contained diagnoses that included, but were not limited to, diabetes, hyperlipidemia, and depression.</p> <p>A physician order dated 10/28/2011 indicated, add house shakes with meals three times a day due to weight loss.</p> <p>During observation of Resident #30's lunch time meal on 11/01/2011 at 12:45 p.m., the resident was not served a house shake. During observation of Resident #30's dinner time meal on 11/02/2011 at 5:45 p.m., the resident was not served a house shake.</p> <p>Interview with the Registered Dietician on 11/02/2011 at 5:50 p.m. indicated Resident #30 is supposed to receive a house shake with each meal, and she was unsure as to why the resident did not receive the shakes.</p>	F0282	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the Recertification and Licensure survey on November 3, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of the facility to ensure that services are provided by qualified professionals in accordance to residents plan of care.1. Resident # 72 immediately received double meat/protein portion for that meal on date of observation. The Dietician reviewed resident # 72 plan of care and D/c'd double meat/protein portion as it was no longer necessary for resident #72. Resident #30 immediately received house shake for that meal on date of observation. Resident #13 immediately received LCS diet for that meal on date of observation. The dietician immediately clarified doctor order and changed order to reflect LCS diet. Resident # 72, #30 and #13 have been monitored by Dietician routinely to help ensure diet orders are being followed per plan of care.2. The Dietician and Dietary Manager on November 17, 2011 completed</p>	11/28/2011	

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	<p>3. The record of Resident #13 was reviewed on 11/2/11 at 9:30 a.m. Diagnoses for Resident #13 included, but were not limited to, diabetes mellitus, high blood pressure, congestive heart failure and renal failure. She was admitted to the facility on 9/29/11.</p> <p>A care plan for Resident #13, dated</p>		<p>review of current residents diet plan of care to ensure they are receiving correct diet. No other residents found to be affected.3. Dietician and Staff Development Coordinator re- inserviced staff on November 4,5, 6 and 9th 2011 regarding accuracy and importance of following written plan of care for residents diet to include reading tray cards prior to providing meal to residents to help ensure continued compliance. 4. The Dietician reviews daily during clinical meeting new resident admission diet orders to help ensure continued compliance. The Dietician and/or designee will randomly review diet orders for 10% of current residents in monthly quality assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor for quality compliance.5. Administrator will ensure compliance by November 28 2011.</p>		

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	<p>9/30/11, indicated a problem of the resident being at risk for nutritional decline secondary to having diabetes mellitus. An approach was "Provide meals per physician's diet orders."</p> <p>A care plan for Resident #13, dated 10/12/11, indicated a problem of the resident being at risk for complications associated with hypertension. An approach was "Provide diet as ordered."</p> <p>A care plan for Resident #13, dated 10/12/11, indicated a problem for the resident being at risk for "Uncontrolled/Unstable Glucose levels" related to her diabetes mellitus. An approach was "Serve diet per order."</p> <p>A recapitulated physician's order for November 2011, with an original order date of 9/29/11, indicated Resident #13 should have a LCS, NAS diet (limited concentrated sweets, no added salt).</p> <p>Review of Medical Nutrition Therapy Assessment, dated 10/1/11, indicated "Nutrition Prescription: Reg[ular] LCS, NAS."</p> <p>During a dinner observation in the dining room on 11/2/11 at 5:10 p.m. Licensed Practical Nurse #7 indicated the food Resident #13 was eating was indicated on</p>				

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F0329 SS=D	<p>the tray slip sitting next to her plate. The tray slip indicated she had received a "Regular" diet.</p> <p>During an interview with the Dietary Manager and the Registered Dietician on 11/3/11 at 11:00 a.m. they indicated they were not sure why Resident #13 was not receiving a LCS/NAS diet. They indicated they would follow up on this.</p> <p>3.1-35(g)(2)</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure an indication for</p>	F0329	Enclosed, please find our plan of correction for the deficiencies as identified during the	11/28/2011	

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	<p>use of PRN (as needed) pain medication. The facility failed to ensure pre-assessment and post assessment of the resident's pain before and after administration of PRN pain medication for 1 of 6 residents reviewed for receiving pain medication in a total sample of 21. (Resident #3)</p> <p>Findings include: The clinical record for Resident #3 was reviewed on 10/31/11 at 1:50 p.m.</p> <p>The diagnoses for Resident #3 included, but were not limited to, chronic pain, hypothyroidism, and bilateral below the hip amputation.</p> <p>The July 2011 MAR (Medication Administration Record) was reviewed on 11/1/11 at 10:15 a.m. It indicated Percocet 5/325mg (milligram) was given on 7/7/11 (10:00 p.m.), 7/15/11 (4:50 p.m.), 7/20/11 (no time indicated), 7/22/11 (no time indicated), and 7/29/11 (5:00 p.m.). There was no documentation to indicate the resident was assessed for the location or intensity/nature of pain prior to administering pain medication or for the effectiveness of the medication after the pain medication was given.</p> <p>Resident #3's care plan for pain, dated 6/1/11, was reviewed on 11/3/11 at 11:00</p>		<p>Recertification and State Licensure survey on November 3, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure that each resident drug regmimen is free from any unnecessary drugs.1. Resident # 3 medication administration record and chart orders have been reviewed. The Director of Nursing and/or designee will monitor Resident #3 medication three times weekly to help ensure continued compliance.2. The Director of Nursing and Assistant Director of Nursing reviewed current residents receiving PRN pain medicine to ensure they have been assessed prior to and after PRN pain medicine have been given on November 17, 2011. 3. Staff Development Coordinator re-inserviced staff on documenting pre/post assessment on PRN pain medicine to ensure no unnecessary use of medication was provided on November 5, 2011 and again November 17, 2011. The Director of Nursing and/or designee will review medication administration records on residents receiving PRN pain</p>		

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F0368 SS=D	<p>a.m. The care plan indicated an approach was to observe effectiveness of PRN (as needed) medications.</p> <p>In an interview with the DoN (Director of Nursing) on 11/3/11 at 9:22 a.m., she indicated the expectation of a nurse when a resident has pain, is to assess the intensity and location of the pain and to evaluate the effectiveness of the pain medication after it is administered.</p> <p>3.1-48(a)(6)</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on observation, interview, and record review, the facility failed to provide a bed time snack for 2 of 57 residents residing on the 200 hall in a total census of 103. (Resident #13 and</p>	F0368	<p>medicine three times weekly to ensure accurate and timely documentation and appropriateness of medication are necessary to help ensure continued compliance.4. The Director of Nursing and/or designee will review 10% of current residents in monthly Quality Assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor quality compliance. Administrator will ensure compliance by November 28, 2011.</p> <p>Enclosed, please find our plan of correction for the deficiencies as identified during the Recertification and State Licensure survey on November 3, 2011. The facility respectfully requests a desk review of our</p>	11/28/2011	

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	<p>Resident #29)</p> <p>Findings include:</p> <p>LPN #3 was interviewed on 11/02/2011 at 8:10 p.m. LPN #3 indicated at 7:30 p.m. dietary brings the labeled snacks for residents who have diabetes, special requests, and physician ordered snacks. The residents can request to be put on the list if they want a snack. Anyone else who isn't on the list can let the nurse know that they want one or call down to the desk.</p> <p>CNA #2 was interviewed on 11/02/2011 at 8:12 p.m. CNA #2 indicated she passes the labeled snacks and then if anyone refuses it, they put it back in the tub in case anyone asks for a snack. If any resident wants a snack, she indicated she can also always get them something from the unit pantry.</p> <p>Resident #13 was interviewed on 11/02/2011 at 8:25 p.m. Resident #13 indicated that the resident was not offered a snack but would like one.</p> <p>Resident #29 was interviewed on 11/02/2011 at 8:20 p.m. Resident #29 indicated that the resident was not offered a snack but would like one. Resident #29 was then observed to be given a snack by</p>		<p>plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure each resident is offered a bed time snack.1. Resident # 13 no longer resides at facility. Resident # 29 is offered a bed time snack nightly and is monitored routinely to help ensure continued compliance.2. The Dietician and Dietary Manager completed review of current residents at facility on November 17, 2011 to ensure residents are being offered a bed time snack. The review determined that the facilities current residents are being offered a bed time snack and no further residents were effected. 3. The Staff Development Coordinator re-inserviced staff on November 2, 4,5 and 6th 2011 to review that residents must be offered a bed time snack.4. The Dietician and Dietary manager will meet with new admissions to ensure a bed time snack is offered. The Dietician and/or designee will audit 10% of current residents and review in monthly Quality Assurance meeting for any recommendations the next three months and quarterly thereafter to ensure and monitor for quality compliance. 5. Administrator will ensure</p>		

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	<p>CNA #2 at 8:21 p.m. The snack consisted of a sandwich, a ice cream cup, and crackers. Resident #29 was checked at 8:35 p.m. and had eaten all the food.</p> <p>Interview with the Executive Director (ED) on 11/02/2011 at 8:55 p.m. indicated that she had a program in place and had inserviced staff. She also indicated that staff was educated to verbally offer each resident a snack; this was her expectation of all her staff.</p> <p>Review of the Snacks and Supplements Policy and Procedure, provided by the ED on 11/03/2011 at 9:45 a.m., indicated, "a snack at bedtime is offered to all residents, except when contraindicated by medical condition or diet order. Procedure 11. offer the resident the snack or supplement."</p> <p>3.1-21(f)</p>		compliance by November 28, 2011.		

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F0441 SS=D	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record review, the facility failed to ensure hand hygiene practices and infection control practices were followed after urinary catheter care and wound care for 1 of 1 resident</p>	F0441	Enclosed, please find our plan of correction for the deficiencies as identified during the Recertification and State Licensure survey on November 3, 2011. The facility respectfully	11/28/2011

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	<p>reviewed for urinary catheter care and wound care, in a total sample of 21. (Resident #72)</p> <p>Findings include:</p> <p>During an observation after catheter care was performed by CNA #1, for Resident #72, on 11/1/11 at 9:45 a.m., CNA #1 did not remove her gloves and perform hand hygiene before she positioned the resident and touched the resident's bed linens.</p> <p>In a policy for catheter care received on 11/2/11 at 3:10 p.m. from the DoN (Director of Nursing), the policy indicated "...Remove gloves. Perform hand hygiene."</p> <p>During an observation of wound care performed on Resident #72 by LPN #8 and LPN #5, LPN#5 picked up discarded trash and a trash bag and then touched/moved the resident's privacy curtain without removing her gloves and performing hand hygiene.</p> <p>In a policy for hand hygiene received on 11/3/11 at 12:30 p.m., from the DoN, the policy indicates "Hand Hygiene is be performed...after removal of medical/surgical or utility gloves; intermittently after gloves are removed,</p>		<p>requests a desk review of our plan of correction. We believe that historically we have demonstrated committment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure hand hygiene practices and infection control practices are followed.1. Resident # 72 privacy current has been removed and laundered to help ensure proper infection control has been followed. 2. The Director of Nursing has conducted rounds and observations with staff's hand washing and infection control techniques. The Director of Nursing and Staff Development Coordinator and/or designee will inservice and/or counsel staff members as indicated regarding guidance on handing washing and infection control practices. No further residents have been found to be effected.3. The Staff Development Coordinator re-inserviced staff on proper hand hygiene and infection control practices on November 1, 2011 and November 8, 2011. The Staff Development Coordinator includes infection control policy/procedure and proper hand hygiene observation during the orientation of facility staff. The Director of Nursing or designee will conduct routine daily rounds to observe proper infection</p>		

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F0514 SS=A	<p>between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environment."</p> <p>3.1-18(I)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation of the MAR (medication administration record) for 1 of 21 residents whose records were reviewed in the sample of 21. (Resident #59)</p> <p>Findings included:</p>	F0514	<p>control techniques are being utilized by facility staff and on the spot corrections will be made immediately.4. The Director of Nursing or designee will monitor through direct observation and review of Infection Control logs to assure proper technique is utilized including hand washing. This data will be reviewed and analyzed monthly for three months and then quarterly at the Quality Assurance meeting to ensure and monitor quality compliance.Administrator will ensure compliance by November 28, 2011.</p> <p>Enclosed, please find our plan of correction for the deficiencies as identified during the Recertification and State Licensure survey on November 3, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate</p>	11/28/2011	

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	<p>The record of Resident #59 was reviewed on 10/31/11 at 2:00 p.m. Diagnoses for Resident #59 included, but were not limited to, high blood pressure, anemia and renal cell cancer.</p> <p>A care plan for Resident #59, dated 10/18/11, indicated a problem of altered cardiac function related to a diagnosis of hypertension (high blood pressure). The goal was for the resident to maintain "adequate cardiac output as evidenced by stable vital signs..." An approach was, "Monitor vital signs, as indicated..."</p> <p>Another care plan, dated 10/18/11, indicated a problem of Resident #59 being at risk for fatigue and weakness related to her anemia. An approach was "Monitor vital signs as indicated/ordered."</p> <p>Another care plan, dated 10/18/11, indicated Resident #59 had a diagnosis of hypertension and was "at risk for complications associated with it." The goal was "The resident will exhibit no signs and symptoms if hypertension." An approach was "Monitor blood pressure as ordered."</p> <p>A recapitulated physician order for November 2011, with an original date of 10/5/11, indicated Resident #59 was to have her blood pressure and heart rate</p>		<p>your consideration of this request. It is the practice of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.1. Resident # 59 no longer has orders or careplan to monitor daily blood pressure effective November 13th, 2011.2. The Director of Nursing reviewed current residents for orders on blood pressure monitoring daily to ensure daily documentation has been completed. No further residents have been affected. 3. Staff Development Coordinator inserviced staff on blood pressure documentation and appropriate documentation on November 3rd, 4th, 5th and 6th to help ensure continued compliance.4. Director of Nursing and/or designee will review 10% of current residents in monthly Quality Assurance meeting for review and recommendations for the next three months and quarterly thereafter to ensure and monitor quality compliance.5. Administrator will ensure compliance by November 28th 2011.</p>		

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	<p>checked every day.</p> <p>Initial review, on 11/1/11, of the MAR for October 2011, indicated Resident #59's blood pressure and heart rate were not checked on October 21, 24 and 28, 2011. There were blank spaces on the MAR under "B/P (blood pressure) H/R (heart rate) Dly (daily) for these days. Review of the nurses' notes did not indicate a blood pressure or heart rate for the resident on these days.</p> <p>Further information was requested from the Director of Nursing (DoN) on 11/1/11 at 11:30 a.m. regarding the missing blood pressures and heart rates on October 21, 24, and 28, 2011. On 11/2/11 at 3:10 p.m. the DoN provided a copy of the October 2011, MAR with blood pressures and heart rates written in on October 21, 24 and 28, 2011. The DoN indicated at this time, after viewing a copy of the MAR without blood pressures and heart rates on these days, she did not know where the blood pressures and heart rates on the copy of the October MAR she provided were originally documented. She indicated she would look for further information regarding the original documentation of the blood and heart rates for October 21, 24 and 28, 2011 on the copy she provided.</p> <p>No further information was provided</p>				

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	<p>regarding the missing blood pressures on the original MAR for October, 21, 24 and 28, 2011, by final exit on 11/3/11 at 12:50 p.m.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				