

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/26/2011
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NAME OF PROVIDER OR SUPPLIER  CHICAGOLAND CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00096027 completed on 9/28/11. This visit resulted in a partially extended survey-immediate jeopardy.</p> <p>Complaint IN00096027 - not corrected.</p> <p>Survey dates: October 24 and 25, 2011 Extended survey date: October 26, 2011</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Survey team: Janelyn Kulik, RN, TC Lara Richards, RN (October 25 and 26, 2011) Janet Adams, RN (October 25, 2011)</p> <p>Census bed type: SNF: 24 SNF/NF: 104 Residential: 42 Total: 170</p> <p>Census payor type: Medicare: 27 Medicaid: 72</p>	F0000		

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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F0323 SS=J	<p>Other: 71 Total: 170</p> <p>Sample: 8 Supplemental sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review 11/01/11 by Suzanne Williams, RN</p> <p>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.</p>	F0323	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. What corrective action(s) will be accomplished for those residents to have been affected by the deficient practice:</p> <p>a. Resident E, has been assessed for side rails on 10/25/11, side rails have been removed. Resident is in low bed with floor mats on either side of the bed, care plan updated.</p> <p>b. Resident M has been assessed for side rails on 10/25/11 and the side rails have been removed, placed in regular perimeter mattress.</p> <p>II. How other residents having the potential to be affected</p>	11/11/2011	

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			by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by the alleged deficient practice.a. All residents with side rails were assessed on 10/25/11 with care plans updated.b. All residents who did not demonstrate mental and physical capabilities to utilize the side rail for bed mobility had their side rails removed on 10/25/11c. All residents who utilize side rails for bed mobility had their side rails tested to assure the rails meet the FDA guideline for safety on 10/25/11 III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:a. Directed inservices were completed for all staff on side rail safety and reporting of unusual occurrence directly to the administrator 24 hours a day, 10/25-10/26/11. b. Nurses were educated that side rail assessments are complete only by nurse manager and only the administrator or DON must approve all side rail placement.c. The maintenance department was educated on 10/25/11 that side rails cannot be attached to a bed without the approval of the Administrator or DON. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:a. The clinical		

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	Based on record review, observation and interview, the facility failed to ensure interventions were in place for a resident who was observed with her head		team will review all residents with side rails on their beds weekly for four weeks. The Review will be held each Monday at the morning clinical staff meeting. The facility QA team will monitor side rail use during daily QA rounds to assure no side rails were placed without proper assessment and approval from the administrator or DON. Non-compliance will be documented on a corrective action form that will be forwarded to the Director of Nursing/designee who will provide findings to the QA committee monthly for 6 months.b. Random interviews with pre-determined questions on abuse/unusual occurrence will be conducted b social service/designee as follows:1. Nine staff members from nursing departments (three per shift) and two staff members from non-nursing departments(one per shift) daily for one month.2. Then three times per week for one month same number of staff members.3. Then two times per week for one month, same number of staff members.4. Then once per week for three months.5. All random interviews will be submitted to the quality assurance committee for discussion.		

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	<p>positioned over the gap between the mattress and side rail with her feet on the floor and failed to assess the resident's need for side rails after the observation, resulting in the resident subsequently having an incident with her head getting wedged between the mattress and the side rail and her feet out of the bed and on the floor, for 1 of 2 residents reviewed who had an air mattress and side rails in a sample of 8. (Resident #E) In addition to the resident in immediate jeopardy, the facility failed to assess the need for side rails after a different resident was found with his face on the side rail for 1 or 3 residents reviewed with half side rails and an air mattress in a supplemental sample of 3. (Resident #M)</p> <p>The immediate jeopardy began on 10/06/11 when Resident #E was observed with her head over the gap between the mattress and the side rail and with her feet out of the bed and on the floor, and no interventions were put into place for resident's safety. The Executive Director and Director of Nursing were notified of the immediate jeopardy at 2:35 p.m. on 10/25/11. The immediate jeopardy was removed on 10/26/11 at 10:50 a.m., but non compliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate</p>			

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	<p>jeopardy.</p> <p>Findings include:</p> <p>1. On 10/24/11 at 2:27 p.m. Resident #E was observed lying on her back slightly to the left side of the bed with a body pillow on each side of the bed and bilateral half side rails in the up position. The resident was sleeping.</p> <p>On 10/25/11 at 1:35 p.m. the resident was observed lying in the middle of the bed on her right side. There were body pillows on both sides of the bed and bilateral half side rails were in the up position. There was a 3.5 cm space between the air mattress and the side rails. The resident had a light brown scabbed area to the middle of her right shin and a scratch to her upper right cheek with a pin point scab at the bottom portion of the scratch.</p> <p>Resident #E's record was reviewed on 10/25/11 at 12:30 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, diabetes mellitus, hard of hearing, osteoarthritis, osteoporosis, hypertension, anxiety, and insomnia.</p> <p>A nursing note dated 10/6/11 at 11:00 p.m., indicated the entry was documented by RN #2. The writer was walking down</p>				

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	<p>the hall and observed, when looking in the room, that Resident #E was turned to the left side of the bed and appeared to be very close to the edge of the bed. The resident was found to have her feet off the bed and on the floor mat. Her arms were crossed on her chest. Her face was between the mattress and the side rail. The rest of her body was angled with her feet on the floor. The bed was in the low position and a body pillow was off of the bed to the left side. CNA #1 and LPN #1 slowly brought the resident out from between mattress and side rail to lying on her back in bed. The resident was assessed fully at that time. She was able to do range of motion to all extremities with no distress noted. There were red areas noted to the resident's bilateral cheeks and a reddened area along her temple. Her skin was slightly red in the right arm pit and along the right side of her chest along the right arm pit. When found, the resident's arms had been across her chest, with her left hand under her right arm. There were no other red areas found on the resident. There were no skin tears and no bruising at this time. The physician was paged twice with no return call, and a call was made to her daughter with no answer or answering machine.</p> <p>A nursing note dated 10/7/11 at 7:30 a.m., indicated the resident was up in her</p>				

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	<p>wheelchair with no signs or symptoms of distress noted. The resident was up at breakfast eating well. There was no redness noted to her cheeks or right temple. Her chest was clear from marks or redness. There were no skin tears or bruises noted.</p> <p>A nursing note dated 10/20/11 at 10:45 p.m. indicated the entry was documented by RN #1. During last rounds, the resident was observed with half of her body on the floor mat, arms folded, and legs contracted with her left leg resting on top of her right leg. Her neck and head were wedged between the half side rail and air mattress. The resident's eyes were open and there were no signs of loss of consciousness. The resident was unable to verbalize how this occurred. The resident's neck and head were carefully removed from wedged position with assist of two CNAs. The resident showed no signs of pain. The resident said, "Is it gum." She was assessed prior to moving with no obvious signs of fractures or dislocations. The resident did not follow commands. Her lower extremities were severely contracted with limited range of motion. The resident's ear lobes were red with redness extending from the left base of the neck to the right base of the neck. Her cheeks were flushed. She was assisted in to bed. Her body was assessed</p>				

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	<p>and noted were a left mid thigh bruise, light purple in color measuring 4.5 cm (centimeters) by 0.5 cm; a left mid rib abrasion which was superficial, red in color, measuring 1.6 cm by 0.8 cm; a right shin abrasion, measuring 1.8 cm by 1 cm; and a right forearm bruise that was bright red in color, measuring 3 cm by 3.2 cm. She squeezes eyes tightly for pupil check, her blood pressure was 140/70, apical pulse 80, respirations 20, temperature 97.1, and oxygen saturation of 97%. The resident was in the center of the air mattress on the right side with body pillows on each side under the sheet to secure. The bed was in the low position, with floor mats in place on each side of the bed. The physician was paged due to being unable to contact by phone. The resident's daughter was notified by phone. Fifteen minute safety checks were initiated and staff were informed.</p> <p>A nursing note dated 10/21/11 at 4:30 a.m., indicated the resident was resting comfortably in bed and was easily aroused. Staff were unable to check pupils due to the resident being uncooperative. Her blood pressure was 122/70, pulse was 72, respirations were 18 and temperature was 98.0. Her range of motion was limited related to the resident being unable to follow directions. The physician was notified of the</p>				

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	<p>resident's condition. There were no signs or symptoms of pain or discomfort.</p> <p>A Significant Change Minimum Data Set Assessment (MDS) dated 9/14/11, indicated the resident was sometimes understood and sometimes understands. She scored a 0 on her Brief Interview for Mental Status (BIMS), which indicated she was severely impaired cognitively. She required extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist for bed mobility and extensive assistance with two plus person physical assist for transfers.</p> <p>A care plan initiated on 6/20/11 indicated a problem of requiring assist for all aspects of her Activities of Daily Living (ADLs). The approaches included, but were not limited to, offer verbal cues and/or hand over hand assist to encourage resident to use half side rails. Staff may have to place her right hand on the rail and tell the resident to hold on.</p> <p>A Side Rail Evaluation form indicated a side rail assessment was completed on 9/7/11. The form indicated the evaluation could be completed for admission, re-admission, quarterly, annual, significant change or other. The resident was to have left and right half side rails to</p>				

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	<p>serve as an enabler.</p> <p>The Proper Use of Side Rails policy was provided by the Executive Director on 10/25/11 and reviewed on 10/26/11 at 9:20 a.m. The policy indicated, "Side Rails will be used only to ensure the safety of the resident and as a mobility aid. Side rails may never be used as a restraint unless necessary to treat a resident's medical condition and with an order from the physician."</p> <p>The General Guidelines included, but were not limited to, side rails may be used to assist in mobility and transfer of residents, an assessment will be made to determine the resident's symptoms or reason for using side rails (When used for mobility or transfer, an assessment will include a review of the resident's: bed mobility and ability to transfer between positions, to and from bed or chair, to stand and toilet.), the resident will be checked frequently for safety, and when side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk of entrapment.</p> <p>Interview with the Executive Director and the Director of Nursing on 10/25/11 at 12:00 p.m., indicated there had been an incident with Resident #E on 10/20/11, and the information they had been given</p>				

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	<p>on the incident was not the same as what had been documented in the resident's record. They indicated the supervisor had been informed the resident just rolled over in bed. The supervisor assessed the resident and found no issues at that time. They then indicated on 10/24/11 they were informed of the incident of the resident being wedged between the mattress and the side rail. When further interviews were completed, the nurse documenting the incident on 10/20/11 indicated the resident was wedged between the mattress and the side rail, and the supervisor indicated she had been informed the resident just rolled over.</p> <p>Interview with RN #1 on 10/25/11 at 3:25 p.m. indicated the resident's head was wedged between the mattress and the side rail on 10/20/11. The bottom half of her head was between the mattress and the side rail and her face was above the mattress. The resident would not have been able to remove herself from the position. She further indicated she cradled the resident's head and pushed on the mattress to remove the resident's head from between the mattress and the side rail.</p> <p>Interview with RN #2 on 10/25/11 at 5:45 p.m., indicated the resident was never stuck or wedged between the mattress and</p>				

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	<p>side rail on 10/6/11. The resident's head was laying on the space between the side rail and the mattress.</p> <p>Interview with the DoN on 10/25/11 at 1:40 p.m. indicated the incident had not been reported to Indiana State Department of Health.</p> <p>Interview with the Executive Director on 10/25/11 at 2:00 p.m., indicated she had not been aware of the incident that occurred on 10/6/11. She further indicated the only interventions put into place were fifteen minute checks which were started on 10/20/11.</p> <p>2. On 10/25/11 at 4:20 p.m. Resident #M was observed in his room in bed. The head of the resident's bed was elevated and two half side rails, which were padded, were in the upright position.</p> <p>The record for Resident #M was reviewed on 10/25/11 at 4:40 p.m. The resident's diagnoses included, but were not limited to, dementia and end-stage Alzheimer's disease. An entry in the Nursing Progress Notes dated 9/25/11 at 12:00 a.m., indicated the resident was observed lying on his right side with his face on the side rail. A red area to the right side of the resident's nose with an indentation was observed.</p>				

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	<p>An entry in the Nursing Progress Notes dated 9/30/11 at 4:30 a.m., indicated the resident received a left forearm skin tear from the side rail which measured 2.5 centimeters (cm) x 1.5 cm (upper forearm) and 1.0 cm x 1.0 cm (lower forearm).</p> <p>Documentation in the Nursing Progress Notes dated 10/21/11 at 3:30 a.m., indicated the resident was turned sideways in bed with the pad alarm under his back and the left abdominal area was under the side rail. The resident was repositioned in bed and three skin tears were observed to the lower left abdomen.</p> <p>There was no incident/accident investigation summary related to the resident's face against the side rail on 9/25/11.</p> <p>The incident/accident investigation summary dated 10/3/11, related to the skin tear to the left forearm, indicated the resident's side rails would be padded.</p> <p>A Side Rail Evaluation dated 9/24/11, indicated the resident had 1/2 side rails to the left and right side of his bed, and the side rails were being used as an enabler to promote independence.</p>			

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	<p>The next Side Rail Evaluation was dated 10/25/11, which indicated the resident's side rails were not indicated at this time and would be removed.</p> <p>Interview with the Director of Nursing on 10/26/11 at 10:35 a.m., indicated the resident should have been re-assessed for the need of the side rails after the incident on 9/25/11. She further indicated an incident/accident investigation summary had not been completed for the incident on 9/25/11.</p> <p>The immediate jeopardy that began on 10/6/11 was removed on 10/26/11 when the facility had completed side rail assessments on all residents, side rails were removed for residents who did not demonstrate mental and physical capabilities to utilize the side rails, and staff was educated on no side rails were to be placed on residents' beds without the Administrators or Director of Nursing approval, re-educated on the abuse and reporting of unusual occurrences and side rail safety, and nurses were re-educated on the policy for reporting unusual occurrences to the Administration immediately twenty four hours a day regardless of the time of day. The clinical team will be reviewing all residents with side rails on their beds weekly for four weeks and share the list with the facility</p>				

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F9999	<p>QA (Quality Assurance) team. The QA team will monitor side rail use during daily QA rounds to assure no side rails are placed without proper assessment and review their findings with the QA team for six months. To assure the education on abuse, reporting, and unusual occurrences was successful, random interviews will be conducted. The random interviews will be submitted to the quality assurance committee. Noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because of the need for continued reviewing and monitoring of side rail use.</p> <p>This Federal Tag related to Complaint IN00096027.</p> <p>This deficiency was cited on 9/28/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>State finding:</p>	F9999	F9999I. What corrective action(s) will be accomplished for those residents found to have <b>been</b>	11/11/2011	

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	<p><b>Administration and Management</b></p> <p>The Administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the Administrator shall include, but are not limited to, the following: Immediately informing the division by telephone, followed by written notice within twenty-hour hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents....</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure an incident of unusual occurrence was reported to the Indiana State Department of Health for 1 of 2 residents reviewed who had an air mattress and side rails in a sample of 8, related to a dependent resident's head being wedged between the air mattress and the half side rails. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's record was reviewed on 10/25/11 at 12:30 p.m. The resident's diagnoses included, but were not limited</p>		<p><b>affected by the deficient practice:</b> a. A state reportable of unusual occurrence was completed on 10/26/11 regarding Resident #E. b. Resident E, has been assessed for side rails on 10/25/11, side rails have been removed. Resident is in low bed with floor mats on either side of the bed, care plan updated.c. Resident M has been assessed for side rails on 10/25/11 and the side rails have been removed, placed in regular perimeter mattress How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:All residents have the potential to be affected by the alleged deficient practice. a. All residents with side rails were assessed on 10/25/11 with care plans updated.b. All residents who did not demonstrate mental and physical capabilities to utilize the side rail for bed mobility had their side rails removed on 10/25/11.c. All resident who utilize side rails for bed mobility had their side rails tested to assure the rails meet the FDA guideline for safety on 10/25/11 III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice</p>		

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	<p>to, Alzheimer's disease, dementia, diabetes mellitus, hard of hearing, osteoarthritis, osteoporosis, hypertension, anxiety, and insomnia.</p> <p>A Significant Change Minimum Data Set Assessment (MDS) dated 9/14/11, indicated the resident was sometimes understood and sometimes understands. She scored a 0 on her Brief Interview for Mental Status (BIMS), which indicated she was severely impaired cognitively. She required extensive assistance (resident involved in activity, staff provide weight-bearing support) with one person physical assist for bed mobility and extensive assistance with two plus person physical assist for transfers.</p> <p>A nursing note dated 10/20/11 at 10:45 p.m. indicated the entry was documented by RN #1. During last rounds, the resident was observed with half of her body on the floor mat, arms folded, and legs contracted with her left leg resting on top of her right leg. Her neck and head were wedged between the half side rail and air mattress. The resident's eyes were open and there were no signs of loss of consciousness. The resident was unable to verbalize how this occurred. The resident's neck and head were carefully removed from wedged position with assist of two CNAs. The resident showed no</p>		<p>does not recur:a. Directed inservices were completed for all staff on reporting of unusual occurrence directly to the administrator 24 hours a day, 10/25-10/26/11. b. When the Administrator is on vacation the responsibility for reporting will go to the Director of Nursing. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur ,i.e., what quality assurance program will be put into place: a. Each morning, manager's/designee will inquire if any unusual occurrence occurred within the past 24 hours and immediately notify the administrator/designee.b. On weekends, the manager will complete a detailed weekend manager report in which unusual occurrences will be addressed and this report will be discussed at the Monday morning meeting. If an unusual occurrence is to be documented the Manager on duty will call the administrator/designee immediately to report the occurrence. The provider respectfully requests that this 2567 Plan of Correction be considered the letter of credible allegation and request a post survey review on or after 11-11-11.</p>		

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	<p>signs of pain. The resident said, "Is it gum." She was assessed prior to moving with no obvious signs of fractures or dislocations. The resident did not follow commands. Her lower extremities were severely contracted with limited range of motion. The resident's ear lobes were red with redness extending from the left base of the neck to the right base of the neck. Her cheeks were flushed. She was assisted in to bed. Her body was assessed and noted were a left mid thigh bruise, light purple in color measuring 4.5 cm (centimeters) by 0.5 cm; a left mid rib abrasion which was superficial, red in color, measuring 1.6 cm by 0.8 cm; a right shin abrasion, measuring 1.8 cm by 1 cm; and a right forearm bruise that was bright red in color, measuring 3 cm by 3.2 cm. She squeezes eyes tightly for pupil check, her blood pressure was 140/70, apical pulse 80, respirations 20, temperature 97.1, and oxygen saturation of 97%. The resident was in the center of the air mattress on the right side with body pillows on each side under the sheet to secure. The bed was in the low position, with floor mats in place on each side of the bed. The physician was paged due to being unable to contact by phone. The resident's daughter was notified by phone. Fifteen minute safety checks were initiated and staff were informed.</p>				

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	<p>Interview with the Executive Director and the Director of Nursing on 10/25/11 at 12:00 p.m., indicated there had been an incident with Resident #E on 10/20/11, and the information they had been given on the incident was not the same as what had been documented in the resident's record. They indicated the supervisor had been informed the resident just rolled over in bed. The supervisor assessed the resident and found no issues at that time. They then indicated on 10/24/11 they were informed of the incident of the resident being wedged between the mattress and the side rail. When further interviews were completed, the nurse documenting the incident on 10/20/11 indicated the resident was wedged between the mattress and the side rail, and the supervisor indicated she had been informed the resident just rolled over.</p> <p>Interview with RN #1 on 10/25/11 at 3:25 p.m. indicated the resident's head was wedged between the mattress and the side rail on 10/20/11. The bottom half of her head was between the mattress and the side rail and her face was above the mattress. The resident would not have been able to remove herself from the position. She further indicated she cradled the resident's head and pushed on the mattress to remove the resident's head from between the mattress and the side</p>				

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	<p>rail.</p> <p>Interview with the DoN on 10/25/11 at 1:40 p.m. indicated the incident had not been reported to Indiana State Department of Health.</p> <p>3.1-13(g)(1)</p>				