

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/21/2013
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 3/20/13. This visit included the PSR to the Investigation of Complaint IN00123605 completed on 3/20/13.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00128357 and Complaint IN00127581.</p> <p>Survey dates: May 20 & 21, 2013</p> <p>Facility number: 010739 Provider number: 155764 AIM number: 200856890</p> <p>Survey Team: Kathleen (Kitty) Vargas, RN TC Heather Tuttle, RN Lara Richards, RN Cynthia Stramel, RN Janelyn Kulik, RN</p> <p>Census Bed Type: SNF/NF: 9 SNF: 39 Residential: 59 Total: 107</p>	F000000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p> <p>This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.</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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	<p>Census Payor Source: Medicare: 33 Medicaid: 7 Other: 67 Total: 107</p> <p>Residential sample: 3</p> <p>Spring Mills Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the recertification and State Licensure Survey.</p> <p>Quality review completed on May 23, 2013, by Janelyn Kulik, RN.</p>				

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F000502 SS=A	<p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure a resident's protime/INR (Protime/International Normalized Ratio) (a lab test to assess bleeding) was obtained by the local hospital's laboratory services for 1 of 4 residents reviewed for laboratory services. (Resident #19)</p> <p>Findings include:</p> <p>The record for Resident #19 was reviewed on 5/20/13 at 2:43 p.m. The resident had diagnoses that included, but were not limited to, arrhythmia (abnormal heart rhythm) and hypothyroidism.</p> <p>The April 2013 Physician Order Sheet (POS) indicated the resident received coumadin (an anticoagulant medication) 5 milligrams daily. The April 2013 POS also indicated a PT/INR was to be obtained every two weeks on Tuesday.</p> <p>Review of the April 2013 Medication Administration Record indicated the resident was to have a PT/INR</p>	F000502	<p>F502</p> <p>It is the intent of this facility to assure protime/INR's are obtained as ordered.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i></p> <p>Resident #19 obtained a PT/INR by the hospital lab on 5/6/2013.</p> <p><i>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:</i></p> <p>Residents receiving anticoagulant medication were assessed to ensure lab tests were completed as ordered. This facility has elected to use the hospital lab for all PT/INRs.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>Licensed nurses will be in-serviced on obtaining and tracking lab orders from the hospital lab by the Director of Health Services (DHS)/designee. DHS/designee will monitor all anticoagulant orders to ensure labs are ordered and obtained as ordered. DHS/designee will report findings to QAA monthly. QAA will</p>	06/07/2013

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	<p>completed on 4/24/13. Review of the lab results indicated there was no PT/INR results from the local hospital laboratory.</p> <p>Review of the form titled, "Resident Coag (coagulation) Testing Audit" indicated the resident's PT/INR was due to be obtained on 4/23/13. There was an entry dated 4/24/13, that indicated, "missed, MD (physician) aware lab to do."</p> <p>Interview with the Director of Nursing on 5/20/13 at 3:05 p.m., indicated the PT/INR was to be drawn on 4/23/13. On 4/24/13 staff noted that the lab was not drawn as ordered by the hospital lab.</p> <p>Interview with the Director of Nursing on 5/21/13 at 9:40 a.m., indicated the resident's PT/INR was obtained on 4/23/13, by the facility staff using a Coagchek system (a machine that can analyze a blood sample and provide a reading for a PT/INR).</p> <p>The Director of Nursing was interviewed on 5/21/13 at 11:41 a.m. She indicated Resident #19's Physician wanted the PT/INR to be obtained by the local hospital laboratory. The Physician did not want the PT/INR to be obtained by</p>		<p>monitor monthly for 90 days or until 100% compliance is completed.</p> <p><i>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:</i></p> <p>QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed:</i> June 7, 2013</p>	

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	<p>the facility staff. The Director of Nursing indicated she did not know why the hospital's laboratory services did not obtain the blood test on 4/23/13. She indicated a requisition form was completed for the hospital lab to draw the protime/INR.</p> <p>3.1-49(a)</p>				

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F000507 SS=A	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>Based on record review and interview, the facility failed to ensure the results of all laboratory tests were maintained in the clinical record, related to the lack of a protime/INR (Protime/International Normalized Ratio) (a lab test to assess bleeding) result for 1 of 4 residents reviewed for laboratory services. (Resident #19)</p> <p>Findings include:</p> <p>The record for Resident #19 was reviewed on 5/20/13 at 2:43 p.m. The resident had diagnoses that included, but was not limited to, arrhythmia (abnormal heart rhythm) and hypothyroidism.</p> <p>The April 2013 Physician Order Sheet (POS) indicated the resident received coumadin (an anticoagulant medication) 5 milligrams daily. The April 2013 POS also indicated a PT/INR was to be obtained every two weeks on Tuesday.</p> <p>Review of the April 2013 Medication Administration Record indicated the</p>	F000507	<p>F507</p> <p>It is the intent of this facility to ensure the results of all laboratory tests are maintained in the clinical record related to protime/INR results.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i></p> <p>Resident #19 obtained a protime/INR from the hospital lab on 5/6/2013 and the report was placed on the resident's Medical Record.</p> <p><i>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:</i></p> <p>Residents receiving anticoagulant medication were assessed to ensure lab tests were completed as ordered. This facility has elected to use the hospital lab for all PT/INRs.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>Licensed nurses will be in-serviced on obtaining and tracking lab orders from the hospital lab by the Director</p>	06/07/2013	

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	<p>resident was to have a PT/INR completed on 4/24/13. Review of the lab results indicated there was no PT/INR results in the clinical record.</p> <p>Review of the form titled, "Resident Coag (coagulation) Testing Audit" indicated the resident PT/INR was due to be obtained on 4/23/13. There was an entry dated 4/24/13 that indicated, "missed, MD (physician) aware lab to do."</p> <p>Interview with the Director of Nursing on 5/21/13 at 9:40 a.m., indicated the resident's PT/INR was obtained on 4/23/13, by the facility staff using a Coagchek system (a machine that can analyze a blood sample and provide a reading for a PT/INR). She indicated there was no documentation of the result of that coag result in the clinical record. The Director of Nursing indicated the protime result obtained by the facility should have been documented in the clinical record.</p> <p>3.1-49(f)(4)</p>		<p>of Health Services (DHS)/designee. DHS/designee will monitor all anticoagulant orders to ensure labs are ordered and obtained as ordered. DHS/designee will report findings to QAA monthly. QAA will monitor monthly for 90 days or until 100% compliance is completed.</p> <p><i>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:</i></p> <p>QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed:</i> June 7, 2013</p>		

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F000514 SS=B	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to Physician orders for foley catheters and physical restraints for 2 of 3 residents reviewed for foley catheters and for 1 of 3 residents reviewed for physical restraints. (Residents #48, #171, and #183)</p> <p>Findings include:</p> <p>1. On 5/20/13 at 1:11 p.m. and 2:18 p.m., Resident #171 was observed in her room in bed. The resident was observed to have a foley catheter in use. The foley catheter drainage bag was hanging from the right side of the resident's bed frame and was visible from the door.</p>	F000514	<p>F514</p> <p>It is the intent of this facility to maintain clinical records that are complete and accurately documented related to Physician orders for Foley catheters and physical restraints. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i> Resident #171 obtained a Physician order for the Foley catheter on 5/20/2013. Resident #48 obtained a current Physician order for the self-releasing alarm belt on 5/21/2013. Resident #183 obtained a Physician order for the Foley catheter on 5/22/2013. <i>How other residents having the potential to be affected by the same</i></p>	06/07/2013			

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	<p>The record for Resident #171 was reviewed on 5/20/13 at 1:52 p.m.</p> <p>Review of the resident's readmission orders dated 5/11/13, indicated there was no Physician order for the foley catheter.</p> <p>Review of the Medication Administration Record and the Treatment Administration Record for the month of May 2013, indicated there was no Physician order for the foley catheter.</p> <p>Interview with the Director of Nursing on 5/20/13 at 3:30 p.m., indicated an order should have been obtained for the resident's foley catheter upon readmission.</p> <p>2. On 5/20/13 at 1:16 p.m. and 3:17 p.m., Resident #48 was observed in her wheelchair. The resident had a self-releasing alarm belt in use.</p> <p>The record for Resident #48 was reviewed on 5/20/13 at 3:10 p.m.</p> <p>Review of the resident's readmission Physician orders dated 5/13/13, indicated there was no order for the self releasing alarm belt.</p>		<p><i>deficient practice will be identified and what corrective action(s) will be taken:</i></p> <p>All residents with a Foley catheter and/or restraints were assessed to ensure appropriate orders were obtained. Any deficiencies noted were corrected at that time.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>Licensed Nurses will be in-serviced on obtaining orders for Foley catheters and restraints by the Director of Health Services (DHS) or designee. The DHS/designee will report findings to the QAA monthly. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><i>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:</i></p> <p>QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 90 days or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed:</i> June 7, 2013</p>				

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	<p>Interview with the Director of Nursing and Corporate Nurse Consultant on 5/21/13 at 11:59 a.m., indicated the resident had previously had orders for the self release alarm belt. Further interview with the Director of Nursing at 2:15 p.m., indicated the resident had a Physician's order dated 5/3/13 for the self releasing alarm belt but it was not carried over when the resident was readmitted on 5/13/13.</p> <p>3. Resident #183 was observed on 5/20/13 at 1:41 p.m., sitting in her wheel chair in her room reading the newspaper. She had a foley catheter (plastic tube placed in the bladder to drain urine). The urine drainage bag had a dignity cover and was hanging on the bottom of her wheel chair.</p> <p>The resident's record was reviewed on 5/20/13 at 3:07 p.m. Her diagnoses included, but were not limited to, neurogenic bladder with chronic cystitis.</p> <p>The discharges order form from the hospital, dated 3/6/13, indicated the resident had her foley catheter changed today.</p> <p>Review of the nursing notes from March 2013 through May 2013,</p>			

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	<p>indicated there were no physician orders for the resident to have a foley catheter.</p> <p>Review of the May 2013 Physician Order Sheet (POS) indicated there were no orders for the foley catheter.</p> <p>Interview with the Director of Nursing on 5/21/13 at 8:42 a.m., indicated the resident had been admitted to the facility with a foley catheter. She further indicated there were no physician orders for the foley catheter.</p> <p>3.1-50(a)(1)</p>				

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	The submission of this plan of correction does not indicate an admission of Spring Mill Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Spring Mill Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (Title 18 and 19). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.		

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was assessed to self administer their own medications for 1 of 3 residents reviewed. (Resident #C)</p> <p>Findings include:</p> <p>On 5/20/13 at 9:30 a.m., Resident #C was observed in her apartment sitting in her recliner chair. The resident's door was open at the time. At that time, there was one bottle of Nystop Powder and eight pills of Chlor-trimeton that were packaged laying on the bed. There was one bottle of Robitussin cough syrup on the floor by her chair. There was one bottle of Tylenol pills on top of her chest of drawers, and there were</p>	R000216	<p>R216</p> <p>It is the intent of this facility to ensure each resident is assessed to self administer their own medications. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i> <i>Due to this citation being related to a complaint survey, no resident identification was obtained.</i> <i>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:</i> All residents with medications by the bedside were assessed to determine the ability to self administer medications. Orders were obtained for any of those residents, and the</p>	06/07/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>eight Claritin pills in the package on a table by her bed.</p> <p>Interview with the resident at that time, indicated she had really bad allergies, so she takes the medications when she needs to.</p> <p>The record for Resident #C was reviewed on 5/20/13 at 12:55 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, high blood pressure, chronic low back pain, and overactive bladder.</p> <p>Review of the 5/13 Physician Order Sheet, indicated there was no order for the resident to self administer her own medications.</p> <p>Review of the current 2/20/13 Service Plan indicated the resident was alert and oriented. The Service Plan indicated the resident does not self administer her own medications and needed assistance with obtaining her medication.</p> <p>Interview with the Assisted Living Director on 5/20/13 at 2:00 p.m., indicated the resident did not self administer her own medications. She further indicated the resident leaves the facility and goes to the store and</p>		<p>resident service plans were updated to reflect any of the changes.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <p>Licensed Nurses were in serviced on 5/22/2013 by the Director of Health Services (DHS)/designee concerning self administration of medication and obtaining the MD order to self administer medication. The DHS/designee will monitor randomly 5 residents per week to ensure no medications are at bedside and if so that the resident has an assessment and Physician order to self administer medications. This audit will be completed on all shifts. The DHS/designee will report findings to QAA monthly for 3 months or until 100% compliance is obtained.</p> <p><i>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:</i></p> <p>QAA will continue to monitor for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 3 months or until 100% compliance is obtained.</p> <p><i>Date systemic changes will be completed:</i> June 7, 2013</p>				

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	will buy those medications. The Assisted Living Director indicated the resident should not have had those medications in her room.				

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R000295	<p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, record review, and interview, the facility failed to ensure a resident's medications were properly secured related to medications found in a resident's room for 1 of 3 residents reviewed in the sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>On 5/20/13 at 9:30 a.m., Resident #C was observed in her apartment sitting in her recliner chair. The resident's door was open at the time. At that time, there was one bottle of Nystop Powder and eight pills of Chlor-trimeton that were packaged laying on the bed. There was one bottle of Robitussin cough syrup on the floor by her chair. There was one bottle of Tylenol pills on top of her chest of drawers, and there were eight Claritin pills in the package on a table by her bed.</p> <p>Interview with the resident at that time, indicated she had really bad allergies, so she takes the medication when she needs to.</p>	R000295	<p>R295</p> <p>It is the intent of this facility to ensure resident's medications are properly secured. <i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i> Due to this citation being related to a complaint survey, no resident identification was obtained. <i>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:</i> All residents with medications by the bedside were assessed to determine the ability to self administer medications. Orders were obtained for any of those residents, and the resident service plans were updated to reflect any of the changes. All meds were secured in a locked box located in the resident's room. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i> Licensed Nurses were in serviced on 5/22/2013 by the Director of Health Services (DHS)/designee concerning self administration of medications.</p>	06/07/2013	

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	<p>The record for Resident #C was reviewed on 5/20/13 at 12:55 p.m. The resident's diagnoses included, but were not limited to, anxiety, depression, high blood pressure, chronic low back pain, and overactive bladder.</p> <p>Review of the 5/13 Physician Order Sheet, indicated there was no order for the resident to self administer her own medications.</p> <p>Review of Physician's Orders dated 4/11/12, indicated "loratidine (Claritin) 10 milligrams (mg) one daily as needed. Resident may keep in lock box in room. Resident buys over the counter medications."</p> <p>On 5/20/13 at 1:36 p.m., QMA #1 entered the resident's room. At that time, there was a small black lock box located on the floor under the resident's dresser. The QMA then opened the box and there was nothing inside. She indicated at that time, this was a box provided to the resident. The QMA indicated at one time, we were giving her a sleeping pill after dinner and she would lock it up in the box and take the pill when she was going to bed. The QMA further indicated the resident did not self administer her own medications</p>		<p>The Nurses were in serviced on the assessment tool to self administration of medications, obtaining Physician orders to self administer medication and the storage of these medications in a secure box in the resident's room. The DHS/designee will monitor randomly 5 residents per week to ensure no medications are at bedside and if so, that the resident has an assessment and a Physician orders to self administer medications. This audit will be completed on all shifts. The DHS/designee will report findings to the QAA monthly for 3 months or until 100% compliance is obtained. <i>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:</i> QAA will continue to monitor for trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for 3 months or until 100% compliance is obtained. Date systemic changes will be completed: June 7, 2013</p>		

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	<p>and was unaware how the resident obtained the Claritin, Tylenol, Nystop Powder, Chor-trimeton, and the cough syrup.</p> <p>On 5/20/13 at 2:00 p.m., the Assisted Living Director entered the resident's room. She was unaware the resident had the above mentioned medications in her room. She further indicated the resident goes shopping and buys most of her things. The Assisted Living Director indicated the resident did not self administer her own medications.</p>			