

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00147111 and IN00149692.</p> <p>Complaint IN00147111 unsubstantiated due to lack of evidence.</p> <p>Complaint IN00149692 unsubstantiated due to lack of evidence.</p> <p>Survey dates: June 2, 3, 4, 5, 6, and 9, 2014.</p> <p>Facility number: 000051 Provider number: 155121 AIM number: 100275490</p> <p>Survey team: Rita Mullen, RN, TC Bobette Messman, RN Maria Pantaleo, RN Holly Duckworth, RN</p> <p>Census bed type: SNF/NF: 110 SNF: 15 Total: 125</p> <p>Census payor type: Medicare: 24 Medicaid: 84</p>	F000000	Rosewalk Village of Lafayette respectfully requests desk review for this survey	

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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F000282 SS=D	<p>Other: 17 Total: 125</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on June 11, 2014.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician orders and plan of care for 1 of 5 residents reviewed for unnecessary medications (Resident #11).</p> <p>Findings include:</p> <p>The clinical record for Resident #11 was reviewed on 6/5/14 at 10:38 a.m. Diagnoses included, but were not limited to, dementia, depression, anxiety, atrial fibrillation with rapid ventricular response, rheumatic heart disease, hypertension, lower extremity edema, hypokalemia.</p> <p>1. A physician order, dated 3/30/11, indicated, "Digoxin 125 MCG TAB</p>	F000282	Policy & Procedure for the medication error for Resident #11 was followed. No adverse side affects were noted for Resident #11. Counseling completed for the nurse responsible for not ensuring the June MAR included the correct medication. All residents have the potential to be affected. No additional missing apical pulses were identified nor additional medication errors with rewrites upon review. Licensed nurses have been inserviced on documenting apical pulses as appropriate with medication administration. System also in place to ensure two nurses check the rewrites from month to month. All rewrites require a second check with signatures. Nurse management checking MARs daily x 2 weeks or until 100% compliance is achieved. Will	07/09/2014	

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	<p>(0.125 MG) Take one tablet by mouth once daily hold if pulse < [less than] 60..."</p> <p>A care plan, dated 3/31/2011, indicated, "Resident is at risk for adverse drug reaction r/t [related to] digoxin use...check apical pulse prior to administering medication."</p> <p>The Medication Administration Record (MAR) for February 2014 through June 2014 were reviewed. Apical pulse rates were not found on the MAR for the dates of 2/1/14, 2/3/14, 2/14/14, 3/9/14, and 5/2/14. On 2/21/14, an apical pulse of 58 was recorded for the resident. Digoxin is recorded as administered.</p> <p>During an interview with LPN #1 on 6/6/14 at 10:04 a.m., she indicated the apical pulse for Digoxin should be documented on the MAR when digoxin is given to the resident. She indicated it can also be documented under vital signs in the computer sometimes.</p> <p>Following the interview, LPN #1 checked the computer for the missing apical pulse dates on MAR. None of the missing data could be found.</p> <p>2. A physician's order dated 5/27/14 at 11:00 p.m., indicated " D/C [discontinue]</p>		then begin checking 3x/week ongoing. Results will be shared with CQI committee for evaluation for minimum of 6 months. Any trends noted will result in development of new planAll corrective actions will be completed on or before 7/9/14	

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	<p>Citalopram 30 mg QD [every day]....start Citalopram 20 mg QED."</p> <p>The MAR for May 2014 was reviewed and contained the order for Citalopram 20 mg beginning 5/27/14. Resident #11 received Citalopram 20 mg May 28 through May 31, 2014.</p> <p>The MAR for June 2014 was reviewed. The order for Citalopram 20 mg was not present on the MAR.</p> <p>No physician order was in the clinical record authorizing a discontinuation of Citalopram 20 mg.</p> <p>During an interview on 6/6/14 at 10:04 a.m., LPN #1 indicated Resident #11 was not receiving any Citalopram. She indicated the physician had discontinued the order for 30 mg on 5/27/14. LPN #1 was unaware of an order for 20 mg.</p> <p>During an Interview on 6/6/14 at 10:50 a.m., the Director of Nursing indicated the change in medication was indicated on the May 2014 MAR. When the rewrites for June 2014 were completed, the rewrites did not include Citalopram 20 mg. The resident did not receive Citalopram for the month of June.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review, and interview, the facility failed to complete appropriate assessment and accurate evaluation of effectiveness of PRN (as needed) medications. This deficient practice affected 2 of 6 residents reviewed for unnecessary medications. (Residents #205 and #196)</p> <p>Findings include:</p> <p>1. During a record review done on 6/6/14 at 2:00 p.m., a review of the Medication Administration Record (MAR) indicated Resident #205 had orders for Oxycodone IR 10 milligrams (mg) with directions to administer one tablet by mouth every 6 hours as needed for mild pain. A second order was noted as Oxycodone IR 20 mg every 6 hours as needed for severe pain.</p> <p>The MAR for dates 6/1/14 through 6/30/14 was found to have 13 doses administered. The narcotics sign out sheet for June indicated 24 doses signed</p>	F000309	<p>A pain assessment was completed for resident #205 and resident #196. MD notified and reviewed medication. No adverse affects noted for either resident. All residents have the potential to be affected. A review of MAR documentation revealed incomplete post administration documentation for PRN medication on the MAR, however, often times documented in nursing notes. Education completed with those nurses identified to have incomplete documentation. Licensed nurses inserviced on Medication Pass Procedure with focus on post administration documentation on MAR. Also reviewed importance of notifying MD with any PRN medication taken routinely for review of medication effectiveness. Nursing management will review MAR post administration documentation daily x 2 weeks or until 100% compliance is achieved. Will then begin checking 3x/week ongoing. Results will be shared with CQI committee for evaluation for</p>	07/09/2014			

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	<p>out. The MAR for June 2014 indicated 14 of 24 doses received were assessed for effectiveness.</p> <p>A review of policy titled "Medication Pass Procedure" dated with revision on 3/2013, it was indicated " Medication administration will be recorded on the MAR or Treatment Administration Record (TAR) after given." "...document reason for giving and effectiveness ..." This policy was received from DON on 6/9/14 at 9:55 a.m.</p> <p>During an interview with the Director of Nursing (DON) and Executive Director (ED) on 6/6/14 at 2:30 p.m., the DON indicated it is expected that MAR is completed post administration of the PRN medication with reason and effectiveness documented and signed off.</p> <p>2.) The record for Resident #196 was reviewed on 6/6/2014 at 9:00 a.m. Diagnoses for Resident #196 included, but were not limited to , left lower leg cellulitis, type 2 diabetes mellitus, coronary artery disease, high blood pressure, hyperlipidemia, atrial fibrillation, dementia, depression, anemia and osteoporosis</p>		<p>minimum of 6 months. Any trends noted will result in development of new plan. All corrections will be made on or before 7/9/14</p>				

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	<p>A physicians order, dated 4/24/2014 indicated acetaminophen 500 mg tablets, take 2 tablets (1000 mg) by mouth every 6 hours as needed for pain</p> <p>The May 2014 MAR, indicated the acetaminophen was administered on 5/1, 5/21, 5/23, and 5/29 with no assessment for medication effectiveness.</p> <p>The June 2014 MAR, indicated the acetaminophen was administered on 6/3, with no assessment for medication effectiveness.</p> <p>During an interview with the Director of Nursing, on 6/9/2014 at 11:00 a.m., she indicated the staff did not complete an assessment for the as needed order for acetaminophen given on 5/1,5/21, 5/23, 5/29 and 6/3/2014.</p> <p>3.1-37(a)</p>			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure that the resident environment remained as free of hazards as is possible for 27 residents out of 27 residents residing in the Alzheimer unit, and for 98 residents out of 98 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility on 6/2/2014 at 9:50 a.m., the following was observed:</p> <ol style="list-style-type: none"> 1. Push pins were located on the wall in the hallway outside of resident room 111 and accessible to all residents in the Alzheimer unit. 2. The overhead exit signs on both the first and second floors were loose and the exit sign outside room 224 was dislodged 	F000323	No residents were found to be affected. Push pins were removed from the wall outside of resident room 111 on 6/3/14 which were being utilized to hang resident craft projects. No other push pins were found when unit was inspected. All exit signs including the sign outside room 224 were checked by maintenance and secured on 6/3/14. All residents residing on the Alzheimer unit have the potential to be affected by the use of push pins in the wall. Push pins were immediately removed and will no longer be utilized to hang craft projects or for any other reason. All residents on 1st and 2nd floors have the potential to be affected by loose exit signs. All exit signs were checked by maintenance and secured on 6/3/14. Memory Care Coordinator has completed an inservice with staff on the Alzheimer unit to instruct them never to utilize push pins in the	07/09/2014

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	and hanging down from the ceiling panel. During an interview, on 6/3/2014 at 3:15 p.m., with the Executive Director, she indicated the push pins could be dangerous for residents on the Alzheimer unit and the exit signs should not be loose. 3.1-45(a)(1)		wall for any reason to keep the environment free from hazards. A schedule for checking environmental issues has been initiated. Maintenance is checking the building environment per the schedule for any potential hazards which may need corrected to help keep the environment free from any hazardsMemory Care Coordinator will monitor Alzheimer unit for any utilization of push pins and report results to CQI committee for minimum of 6 months. Maintenance will submit completed scheduled items to CQI committee monthly ongoing. CQI committee will review for any trends or problem areas. Change of plan will be initiated as appropriateAll corrective actions will be completed on or before 7/9/14				
F000371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to properly date and store foods in the dry	F000371	No residents were found to have been affectedAll residents receiving food from the kitchen			07/09/2014	

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	<p>storage area and 1 of 1 walk-in freezer in the kitchen. This had the potential to affect 123 of 125 residents receiving food from the kitchen.</p> <p>Findings include:</p> <p>During an initial tour of the kitchen, on 6/02/14 at 9:50 a.m., one bag of diced carrots were observed opened and unsealed in the walk-in freezer. The carrots were exposed to air and the product was not dated with an open date.</p> <p>In the dry storage area, one sleeve of crackers had been opened and placed back in the box. The cracker sleeve and the box were not sealed or dated with an open date.</p> <p>A box of fettuccini and a box of spaghetti were also observed to be unsealed and exposed to air. The boxes were bulging open at the seams rather than opened from the sealed opening.</p> <p>During an interview on 6/02/14 at 10:15 a.m., the Dietary Manager indicated the spaghetti and fettuccini had possibly been dropped and busted open, because neither had been used. She indicated that the policy for the carrots would be to tie the bag in a knot in order to reseal the bag and to date it with the date it was opened.</p>		<p>are identified as having the potential to be affected. The open bag of carrots in the walk in freezer was immediately disposed of. The open crackers, spaghetti and fettuccini in dry storage were immediately disposed of. Dietary staff inserviced on proper storage of food. All food storage areas checked for any additional food stored improperly. None was found. Dietary supervisor will complete sanitation review to check for improperly stored food daily x 2 weeks or until 100% compliance is achieved. Will then complete sanitation review weekly thereafter. Results will be shared with CQI committee for evaluation. New plan will be developed with any trends noted All corrections will be completed on or before July 9, 2014</p>	

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F000428 SS=D	<p>She indicated that all products should be thrown away.</p> <p>A policy was reviewed on 6/4/14 at 11:15 a.m. The policy, titled, " Food Storage," dated April 2011, indicated: "...Leftover food or food items that have been opened are stored in covered containers or wrapped securely. The food must clearly be labeled on the day it was prepared or opened and marked to indicate the date by which the food shall be consumed or discarded...Frozen Foods:... d) Foods should be covered, labeled, and dated...."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview,</p>	F000428	Licensed pharmacy review was completed for Resident #196 All residents have the potential to be	07/09/2014

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	<p>the facility failed to ensure the drug regimen, for 1 of 5 residents reviewed for unnecessary medications, was reviewed at least once a month by a licensed pharmacist. (Resident #196)</p> <p>Findings include:</p> <p>The record of Resident # 196 was reviewed on 6/6/2014 at 9:00 a.m. Diagnoses for Resident #196 included, but were not limited to, left lower leg cellulitis, type 2 diabetes mellitus, coronary artery disease, high blood pressure, hyperlipidemia, atrial fibrillation, dementia, depression, anemia and osteoporosis.</p> <p>The record review for Resident #196 did not include a licensed pharmacist review for the month of May 2014.</p> <p>On 6/6/2014 at 12:50 p.m., during an interview with the Director of Nursing, she indicated the May 2014 drug regimen review had not been done by a licensed pharmacist.</p> <p>3.1-25(h)</p>		<p>affected. Upon review of the pharmacy report it was noted that all other residents drug regimens were reviewed by a licensed pharmacist for the month of May Licensed pharmacist was made aware of the drug regimen for resident #196 which had been missed for the month of May. She was made aware that she needs to review every resident in the facility each month. She was unable to locate chart to complete review in May. She will now ask for assistance to locate chart should that situation again arise. Pharmacy report will be reviewed by DNS or designee monthly to ensure all residents drug regimens have been reviewed by licensed pharmacist. Results will be shared with CQI committee monthly for evaluation. Any trends noted will result in development of a new plan. All corrective actions will be completed on or before 7/9/14</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure a clean, sanitary, and home like environment related to 7 of 7 facility hallway floors and 7 of 40 observed resident rooms (Room's # 109, 132, 145, 146, 214, 222, and 223).</p> <p>Findings include:</p> <p>1. During the initial tour on 6/2/2014 at 9:50 a.m., the following was observed:</p> <p>a.) Resident room entrance doorways and bathroom doorways for Room 145, 214 and 223 were cracked, chipped and peeling.</p> <p>b.) The hallways for North, South, and East (First floor), and West, South, East and North, (Second floor) , were observed to have loose, stained, cracked, chipped and gouged overhead ceiling tiles.</p> <p>c.) The overhead exit signs on both the first and second floors were observed to be loose and the exit sign outside room</p>	F000465	<p>Resident room doorways and bathroom doorways for rooms 145, 214, 223 were painted 6/6/14. All ceiling tiles with cracks, chips, stains gouges or any type of damage were replaced throughout the building by end of day on 6/4/14. All exit signs were checked and secured or replaced on 6/3/14. Room 109 bathroom doorway was painted. Room 146 floor tile was replaced. Room 132 bathroom toilet was cleaned and recaulked. Room 222 entrance and bathroom doorways were painted, walls patched and painted. All residents in the building have the potential to be affected. A schedule for checking environmental issues has been initiated. Maintenance is checking the building environment per the schedule for any potential areas which need cleaning, painting, repairing or replacing. Staff have also been inserviced to inform maintenance of any issues needing attention in the building. Maintenance will submit completed scheduled items to CQI committee monthly ongoing. CQI committee will review for any trends or problem</p>	07/09/2014

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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>224 was dislodged and hanging down from the ceiling panel.</p> <p>2. During resident room observations on 6/3/2014, and 6/4/2014, the following was observed:</p> <p>a.) Room 109, 6/3/2014, at 9:44 a.m., the bathroom doorway was cracked, chipped and peeling.</p> <p>b.) Room 146, 6/4/2014, at 10:25 a.m., the resident room floor tile was stained and marked throughout room.</p> <p>c.) Room 132, 6/4/2014 at 9:25 a.m., the bathroom toilet had a brown discoloration around the base.</p> <p>d.) Room 222, 6/3/2014 at 3:11 p.m., the entrance doorways and bathroom doorways were cracked, chipped and peeling and the wall facing resident beds were observed to have 15 holes in wall.</p> <p>On 6/2/2014 at 10:45 a.m., during the environmental tour with the Administrator, and Maintenance Supervisor, they indicated they were unaware the exit signs were loose, the amount of ceiling tiles needing repair, and resident rooms needing repairs to walls, doors and bathrooms.</p>		<p>areas Change of plan will be initiated as appropriate. All corrections will be complete on or before 7/9/14</p>				

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F000514 SS=D	<p>3.1-19(f)</p> <p>483.75(l)(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 record review, and interview, the facility failed to ensure the medical records were complete and accurate as it pertains to assessment, accurate transfer of medications from May 2014 Medication Administration Record (MAR) to June 2014 MAR and effectiveness of PRN(as needed) medication for 3 of 7 records reviewed for unnecessary medication. (Residents #205, #196 and #11)</p>	F000514	<p>Medical records and drug regimens for residents #205, #196 and #11 were reviewed. Clinical assessments completed on each resident with no adverse affects noted. MD notified and also reviewed record and medications. Policy and procedure for medication error for residents #11 was followed. Counseling completed for the nurse responsible for not ensuring the June MAR included correct medicationAll residents</p>	07/09/2014			

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	<p>Findings include:</p> <p>1. During a record review done on 6/6/14 at 2:00 p.m., a review of the Medication Administration Record (MAR) indicated Resident #205 had orders for Oxycodone IR, a narcotic, 10 milligrams (mg) with directions to administer one tablet by mouth every 6 hours as needed for mild pain. A second order was noted as Oxycodone IR 20 mg every 6 hours as needed for severe pain.</p> <p>Review of June 2014 MAR indicated 14 of 24 doses received were assessed for effectiveness.</p> <p>Review of policy titled "Medication Pass Procedure" dated with revision on 3/2013, it was indicated " Medication administration will be recorded on the MAR or Treatment Administration Record (TAR) after given." "...document reason for giving and effectiveness ..." This policy was received from DON on 6/9/14 at 9:55 a.m.</p> <p>During an interview with Director of Nursing (DON) and executive Director(ED)on 6/6/14 at 2:30 p.m., the DON indicated it is expected that MAR is completed post administration of the PRN medication with reason and</p>		<p>have the potential to be affected. A review of MAR documentation revealed incomplete post administration documentation for PRN medication on the MAR, however, often times documented in nursing notes. Education completed with those nurses identified to have incomplete documentation. No additional medication issues were noted with the MAR review. System also in place to ensure two nurses check the rewrites from month to month. All rewrites require a second check with signatures. Licensed nurses inserviced on Medication Pass Procedure with focus on post administration documentation on MAR. Also reviewed importance of notifying MD with any PRN medication taken routinely for review of medication effectiveness. Nursing management will review MAR post administration documentation daily x 2 weeks or until 100% compliance is achieved. Will then begin checking 3x/week ongoing. Results will be shared with CQI committee for evaluation for 6 months. Any trends noted will result in development of new plan. All corrections to be completed on or before 7/9/14</p>	

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	<p>effectiveness documented and signed off.</p> <p>2.) Τη ρεχορδ φορ Ρεσιδεντ #196 ωασ ρεπιεωεδ ον 6/6/2014 ατ 9:00 α.μ. Διαγνοσεσ φορ Ρεσιδεντ #196 ινχλυδεδ, βυτ ωερε νοτ λιμιτεδ το , λεφτ λοωερ λεγ χελλυλιτισ, τυπε 2 διαβετες μελλιτυσ, χοροναρψ αρτερψ δισεασε, ηιγη βλοοδ πρεσσυρε, ηψπερλιπιδεμια, ατριαλ φιβριλλατιον, δεμεντια, δεπρεσσιον, ανεμια ανδ οστεοποροσισ</p> <p>Α πηψσιχιανσ ορδερ, δατεδ 4/24/2014 ινδιχατεδ αχεταμινοπηεν 500 μγ ταβλετσ, τακε 2 ταβλετσ (1000 μγ) βψ μουτη επερψ 6 ηουρσ ασ νεεδεδ φορ παιν</p> <p>Τηε Μαψ 2014 MAP, ινδιχατεδ τηε αχεταμινοπηεν μεδιχατιον ωασ αδμινιστερεδ ον 5/1, 5/21, 5/23, ανδ 5/29 βυτ τηερε ωασ νο δοχυμεντατιον φορ μεδιχατιον εφφεχιτωενεσσ.</p> <p>Τηε θυνε 2014 MAP, ινδιχατεδ τηε αχεταμινοπηεν μεδιχατιον ωασ αδμινιστερεδ ον 6/3, βυτ τηερε ωασ νο δοχυμεντατιον φορ τηε μεδιχατιον εφφεχιτωενεσσ.</p> <p>Δυριγγ αν ιντερπειεω ωιτη τηε Διρεχτορ οφ Νυρσινγ, ον 6/9/2014 ατ</p>						

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	<p>11:00 α.μ., στη ινδιχατεδ της σταφφ σηουλδ ηαπε δοχυμεντ της εφφεχτιπενεσσ φορ τηε ασ νεεδεδ ορδερ φορ αχεταμινοπηεν γιπεν ον 5/1,5/21, 5/23, 5/29 ανδ 6/3/2014.</p> <p>3. Τηε χλινιχαλ ρεχορδ φορ Ρεσιδεντ #11 ωασ ρεπιεωεδ ον 6/5/14 ατ 10:38 α.μ. Διαγνοσεσ ινχλυδεδ, βυτ ωερε νοτ λιμιτεδ το, δεμεντια, δεπρεσσιον, ανξιετψ, ατριαλ φιβριλλατιον ωιτη ραπιδ πεντριχυλαρ ρεσπονσε, ρηευματιχ ηεαρτ δισεασε, ηψπερτενσιον, λοωερ εξτρεμιτψ εδεμα, ηψποκαλεμια.</p> <p>Α πηψσιχιανεσ ορδερ φορ Ρεσιδεντ #11, δατεδ 5/27/14 ατ 11:00 π.μ., ινδιχατεδ √ Δ/Χ [δισχοντινυε] Χιταλοπραμ 30 μγ ΘΔ [επερψ δαψ]...σταρτ Χιταλοπραμ 20 μγ ΘΔ.√</p> <p>Τηε MAP φορ Μαψ 2014 ωασ ρεπιεωεδ ανδ χονταινεδ τηε ορδερ φορ χιταλοπραμ 20μγ βεγιννινγ 5/27/14. Ρεσιδεντ #11 ρεχειπεδ χιταλοπραμ 20 μγ Μαψ 28 τηρουγη Μαψ 31, 2014.</p> <p>Τηε MAP φορ θυνε 2014 ωασ ρεπιεωεδ. Τηε ορδερ φορ χιταλοπραμ 20 μγ ωασ νοτ πρεσεντ ον τηε MAP.</p> <p>Δυρινγ αν Ιντερπiew ον 6/6/14 ατ</p>			

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	<p>10:50 α.μ., της Διρεχτορ οφ Νυρσινγ ινδιχατεδ της χηανγε ιν μεδιχατιον ωασ ινδιχατεδ ον της Μαρ 2014 ΜΑΡ. Ωηεν της ρεωριτες φορ θυνε 2014 ωερε χομπλετεδ, της ρεωριτες διδ νοτ ινχλυδε χιταλοπραμ 20 μγ. Ρεσιδεντ #11 διδ νοτ ρεχειψε χιταλοπραμ φορ της μοντη οφ θυνε.</p> <p>3.1-50(φ)(2) 3.1-50(α)(2)</p>				