STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A BUILDING 00		
		155656	A. BUILDING B. WING		01/08/2015
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		ORTHGATE BLVD	
CANTER	BURY NURSING	AND REHABILITATION CENTER		WAYNE, IN 46835	
	1			1	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
			E00000	This Plan of Correction	
		or the Investigation of	F000000	constitutes this facility's written	n
	Complaint IN00	0162064 and IN00162066.		allegation of compliance for the deficiencies cited. This	
	Complaint IN00	0162064- Substantiated.		submission of this plan of	
	_	ated to the allegations are		correction is not an admission	of
		_		or agreement with the	-
	cited at F282, F	307, aliu F329.		deficiencies or conclusions	
				contained in the Department's	I
	_	0162066- Substantiated.		inspection report. We respect	
	Deficiencies rel	ated to the allegations are		request a desk review. We ha	
	cited at F282.			included our re-education and	
				monitoring tools for your convenience. Please feel free	to
	Survey dates: Ja	anuary 7, and 8, 2015		contact Maya Kaczmarek at	10
				(260)580-6025 should you ne	ed
	 Facility number	: 000275		additional information to assis	
	Provider number			you with your consideration.	
	AIM number:	100290930			
	Survey team:				
	Christine Fodre	a, RN			
	Census bed type	e:			
	SNF/NF: 100				
	Total: 100				
	10141.	o .			
	Census payor ty	ı n e.			
	Medicare: 8	, ρο.			
	Medicaid: 77				
	Other: 15				
	Total: 100	0			
	Sample: 6				
LABORATOR	I RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

UDNU11

Facility ID:

000275

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE					
		155656	B. WIN	G		01/08/	2015
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER				2827 NO	ADDRESS, CITY, STATE, ZIP CODE DRTHGATE BLVD VAYNE, IN 46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	cited in accordar 16.2-3.1.	es reflect state findings nce with 410 IAC completed on January 9, Fry RN.					
F000282 SS=D	CARE PLAN The services prov facility must be propersons in accord written plan of car Based on intervi the facility failed orders for a med residents review physician orders (Resident #G) Findings include Resident #G's re 1-7-2015 at 3:10 diagnoses include to, diabetes, high Schizoaffective of A physician's ord indicated to begin	ew and record review, I to follow physician ication for 1 of 3 ed for following in a sample of 6. cord was reviewed PM. Resident #G's led, but were not limited in blood pressure, and	F00	0282	F 282: Services By Qualified Persons/Per Care Plan Corrective action for alleged deficient practice: 1. Resident #G reviewed and is receiving medications as ordered. Identification of others with potential to be affected by alleged deficient practice: 1. Residents receiving Coumadin are at risk. 100% audit completed on residents receiving Coumadin to ensure medications administered per order and therapeutic lab monitoring of PT/INR accurate. Systematic changes in place for alleged deficient practice: 1. Licensed nurses will be re-educated on policy regarding		02/02/2015

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If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. BUILDING 00			COMPLETED	
		155656	B. WING 01/08/2015			01/08/2015
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
CANTED		ND DELIADILITATION CENTED			ORTHGATE BLVD	
CANTER	BURT NURSING A	ND REHABILITATION CENTER		FURIV	VAYNE, IN 46835	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	(milligrams) dail	ly.			anticoagulant therapy and	
		-			therapeutic monitoring of	
	A review of Med	lication Administration			medications. Re-education will	
					include monthly rewrite process.	
	` ′	lated 12-2014, indicated			2. Coumadin changes will be	
		eived Coumadin 4 mg on			reviewed daily, Monday-Friday, in	
	12-31-2014.				DCR (daily clinical review).	
					How corrective action will be	
	A review of Resi	ident #G's MAR dated			monitored to ensure alleged	
		Coumadin 3 mg had			deficient practice does not reoccur:	
		_			 Nurse managers will audit 	
	_	or on January 1, 2, 3, 4,			MARS (medication administration	
	5, and 6.				record) with each Coumadin	
					medication change/new order and	
	A review of Resi	ident #G's lab results			Coumadin systems audit Logs	
	dated 12-30-201	4 indicated the PT/INR			weekly x 6 months then monthly	
	results were 18 3	and 1.7 respectively.			thereafter to ensure medications	
	results were 10.5	and 1.7 respectively.			administered per order and	
		1 1 1 10 11 11			therapeutic monitoring accurate.	
		ident #G's lab results			Identified trends will be reviewed in	
	dated 1-7-2015 i	ndicated the PT/INR			QA montly x three months and	
	results were 33.6	and 3.0 respectively.			quarterly thereafter to determine	
					further education and/or further	
	In an interview of	on 1-8-2015 at 2:14 PM,			monitoring needs. Identified	
		Jursing indicated the			non-compliance will result in one to	
					one re-education up to and	
		anscription error during			including termination. Any	
	•	e further indicated			identified trends will be forwarded	
	medications were	e to be given as ordered.			to the administrator for review and	
					presented to QA to determine	
	This Federal tag	relates to Complaint			further education needs.	
	IN00162046, and	•				
	, , , ,				Date of Compliance:	
	2.1.25(~)(2)					
	3.1-35(g)(2)				February 2, 2015	
F000309	483.25					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 155656 01/08/2015 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2827 NORTHGATE BLVD CANTERBURY NURSING AND REHABILITATION CENTER FORT WAYNE. IN 46835 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. F000309 02/02/2015 F 309: Provide Care/Services for Highest Well Being Based on interview and record review, the facility failed to assess changes in Corrective action for alleged resident status for 2 of 3 residents deficient practice: reviewed with changes in medical status Resident #E no longer resides in a sample of 6. (Resident #E and in facility. Resident #H has received Resident #H) an assess(ess)ment of current condition and non-symptomatic for further change in condition at this Findings include: 1. Resident #E's record was reviewed Identification of others with 1-8-2015 at 1:39 PM. Resident #E's potential to be affected by alleged diagnoses included, but were not limited deficient practice: Residents with change of to, high blood pressure, anemia, and condition/new onset of symptoms blood clots are at risk. 100% audit to be completed on residents for change A Nurse's Note dated 12-13-2014 at 5:00 in condition/new onset PM included: "Resident appears acting symptoms, changes in medical differently as stated in report all night and status all day with chest pains." Systematic changes in place for alleged deficient practice: There were no Nursing Notes between Licensed nurses will be 12-12-2014 at 10:48 PM through re-educated on policy regarding 12-13-2014 at 5:00 PM to indicate Interact III system and documentation requirements. Resident #E had chest pain, the characteristics, or the level of the pain. How corrective action will be

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
155656		B. WIN			01/08/2015	
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		2827 N	ORTHGATE BLVD	
CANTER	BURY NURSING A	AND REHABILITATION CENTER		FORT V	VAYNE, IN 46835	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LISC IDENTIFYING INFORMATION)	+	TAG	·	DATE
		on 1-8-2015 at 2:46 PM,			monitored to ensure alleged	
		d Resident condition was			deficient practice does not reoccur: 1. Nurse managers will review	
	to be assessed w	then it changed, and the			residents with identified changes in	
	change was to be	e documented.			condition/new onset symptoms for	
					resident assessment of condition	
	2. Resident #H's	record was reviewed			daily x 14 days; then weekly x 8	
	1-8-2015 at 2:37	PM. Resident #H's			weeks; then 5 random monthly x 6	
	diagnoses includ	led, but were not limited			months. Identified trends will be	
	_	ixia (physical dysfunction			reviewed in QA monthly x three	
		lesions), restless leg			months and quarterly thereafter to	
	syndrome, and Parkinson's Disease. A Nurse's Note dated 1-2-2015 at 5:00				determine education and/ or furthe	r
					monitoring needs. Identified non-compliance will result in one to	
					one re-education up to and	
		obtain a urine specimen			including termination. Any	
		_			identified trends will be forwarded	
		ere was no indication why			to the administrator for review and	
	the urine was be	ing tested.			presented to QA to determine	
	A 1	1 1 4 11 2 2015			further educational needs.	
		der dated 1-2-2015				
		e the urine tested by			Date of Compliance:	
	-	ture and sensitivity due to			February 2, 2015	
	the symptom of	burning.				
		se's Notes indicated the				
	_	e were no Nurse's Notes				
	dated 1-1-2015.					
	indications Resid	dent #H was having any				
	urinary sympton	ns on 1-2-2015, in either				
	the 5:00 PM or 7	7:00 PM note, when the				
	urine specimen v	was obtained, nor was				
	there a description					
	_	There were no Nurse's				
	notes dated betw					
		riew. Nurse's notes dated				
		M indicated an order for				
	1-6-2015 at 1 PN	vi indicated an order for	1			

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

PRINTED: 01/26/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/08/2015			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	mg (milligrams) days. There was urinary symptom	algesic antibiotic) 100 three times per day for 3 still no indication of as or of the FResident #H's urine.					
	the Director of N should have been documenting uring and of the charact between the time	nary symptoms, if any, steristics of the urine the urine was obtained the time the resident					
	This Federal tag IN00162064. 3.1-37(a)	relates to Complaint					
F000329 SS=D	483.25(I) DRUG REGIMEN UNNECESSARY I						
	Each resident's driftom unnecessary drug is any drug with dose (including du excessive duration monitoring; or with for its use; or in the	ug regimen must be free drugs. An unnecessary then used in excessive plicate therapy); or for a; or without adequate out adequate indications the presence of adverse ich indicate the dose					

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUC		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00 C		COMPLETED	
		155656	B. WING 01/08/2015					
NAME OF PROVIDER OR SUPPLIER CANTERBURY NURSING AND REHABILITATION CENTER			•	2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD VAYNE, IN 46835			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		d or discontinued; or any ne reasons above.						
	resident, the facili residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use receive gradual debehavioral interve	rehensive assessment of a ty must ensure that ve not used antipsychotic en these drugs unless g therapy is necessary to ndition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue						
			F00	0329	F 329: Drug Regimen is Free From		02/02/2015	
	the facility failed effects of a med antibiotics while antibiotics for 1 antibiotics. (Res further failed to free of duplicate of 3 residents re in a sample of 6. Findings include 1. Resident #E's 1-8-2015 at 1:39				Unnecessary Drugs Corrective action for alleged non-compliance: Resident #E no longer resides in facility. Identification of others with potential to be affected by alleged deficient practice: Residents with new orders are at risk. 100% new order audit to be completed on residents to ensure order accurate follow-up and transcription. Systematic changes in place for alleged deficient practice: 1. Licensed nurses will receive re-education on order transcription			
	to, high blood problems blood clots.	ressure, anemia, and der dated 12-2-2014			process and lab tracking policy. 2. Licensed nurses will complet verification of written orders shift-to-shift by dating/initialling verification on order copies.	e		
	*	e Resident #E Coumadin			How corrective action will be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		155656	B. WING 01/08/2015			01/08/2015
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	8				
CANTED		ND DELIABILITATION CENTED			ORTHGATE BLVD	
CANTER	BURT NURSING A	ND REHABILITATION CENTER		FORT	VAYNE, IN 46835	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	(an anticoagulan	t) 5 mg (milligrams)			monitored to ensure alleged	
	daily.				deficient practice does not reoccur:	
	j				1. Nurse managers will review	
	A Dhygician's or	der dated 11-26-2014			new orders daily x 14 days; then	
	1				weekly x 8 weeks; then (5 random)	
		Resident #E Levaquin			monthly x 6 months. Identified	
	(an antibiotic) 50	00 mg daily for 10 days.			trends will be reviewed in QA	
					monthly x three months and	
	A Physician's or	der dated 12-3-2014			quarterly thereafter to determine	
	indicated to give	Resident #E Levaquin			education and/ or further	
	500 mg daily for	•			monitoring needs. Identified	
		10 4475.			non-compliance will result in one to	
	A C A M	DA (Amarian			one re-education up to and	
		DA.com (American			including termination. Any	
		rs) on 1-8-2015 at 3:12			identified trends will be forwarded	
	PM, indicated to	check PT/INR levels			to the administrator for review and	
	every 3 days wh	ile the resident is on			presented to QA to determine	
	antibiotics.				further educational needs.	
					Date of Compliance:	
	A review of Rec	ident #E's Medication			February 2, 2015	
		Record (MAR) dated				
	12-2014, indicat					
	instruction under	r the medication box to				
	check Resident #	E's PT/INR every third				
	day while the res	sident was on the				
	antibiotic.					
	A ravious of lab	results dated 12-5-2014				
		ent #E's PT/INR was 14.1				
		vely. There were no				
	results for the dates of 12-9 and 12-12					
	available for rev	iew.				
	In an interview o	on 1-8-2014 at 2:14 PM,				
		Sursing indicated she had				
	checked with the	e lab, and the PT/INR had				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	A. BUILDING 00			COMPLETED	
		155656	B. WING		-	01/08	/2015	
			F		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹			ORTHGATE BLVD			
	BURY NURSING A	AND REHABILITATION CENTER			VAYNE, IN 46835			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	not been drawn	according to protocol.						
	1	order dated 11-26-2014						
		e Resident #E Levaquin						
	(an antibiotic) 5	00 mg daily for 10 days						
	(with stop date b	being after the dose on						
	12-6).							
	A Physician's or	der dated 12-3-2014						
	indicated to give	e Resident #E Levaquin						
	500 mg daily for	r 10 days (with start date						
	being 12-3).							
	The Nurse Pract	itioner's progress note						
		indicated Resident #E						
		and was on Levaquin.						
		dication the Nurse						
		aware Resident #E was						
	already on Leva	•						
	1 -	ald be given as a double						
	dose.							
		ident #E's MAR dated						
		ed Levaquin 500 mg had						
	been given twice	e on 12-3, 4, 5, and 6,						
	2014.							
	A review of Nurse's Notes do not indicate the Nurse Practitioner was made aware of							
	the double order							
	A review of fda.	gov (Food and Drug						
		indicated the accepted						
	dosages of Leva	_						

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

PRINTED: 01/26/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	LETED		
155656		B. WING		01/08/2015				
	PROVIDER OR SUPPLIEI	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION		
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
	administration was 500 mg or 750 mg daily. In an interview on 1-8-2015 at 2:14 PM, the Director of Nursing indicated Resident #E should not have received a double dose of the antibiotic. This Federal tag relates to Complaint IN00162064. 3.1-48(b)(1)							

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