

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2015
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NAME OF PROVIDER OR SUPPLIER BROOKDALE MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: August 25, 2015</p> <p>Facility number: 010887 Provider number: 01887 AIM number: N/A</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5</p>	R 0000		
R 0026 Bldg. 00	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on record review and interview, the facility failed to ensure a resident was made aware of their resident rights for 1 of 7 residents reviewed for resident rights in a total sample of 7. (Resident #3)</p> <p>Finding includes:</p> <p>The record for Resident #3 was reviewed on 8/25/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure.</p> <p>There was lack of indication in the record to indicate the resident had received or signed the resident rights acknowledgement.</p> <p>Interview with the Health and Wellness Director on 8/25/15 at 10:50 a.m. indicated she could not find the signed resident rights acknowledgement.</p>	R 0026	<p>What corrective action(s) will be Accomplished for those residents found to Have been affected by the alleged deficient practice? · No current residents have been affected by the alleged deficient practice. The Executive Director has contacted responsible party to review Resident Rights with resident and/or Responsible Party, and has obtained signatures verifying their review. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Other residents currently residing in the community have the potential to be affected by the alleged deficient practice. · An audit was completed by the Executive Director/Business Office manager/Designee to verify the presence of signatures on Resident Rights and other required notification forms. What measures will be put in place or what systemic</p>	09/30/2015

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R 0035 Bldg. 00	410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan.		changes will the facility make to ensure the alleged deficient practice does not recur? · The Management Team has been re-educated by the District Director of Clinical Services on the requirement to obtain signatures on Resident Rights forms. · This signature and review process is to be completed prior to move-in or on the day of move-in and will be part of the Admission Packets for all residents going forward. · The ED /Designee will review with resident and Responsible Party prior to move in, and as required by state regulation. · A tickler file has been created which will provide a checklist of required documents to be reviewed with each new move – in. How will the corrective actions be monitored? · New move in check list will be audited by the Business Office Manager/Executive Director/Designee within 24 hours of move-in for all new residents to verify ongoing compliance. · The Copy of Resident Rights signature page will be kept in business file, and available upon request. · Date of compliance: 9-30-15				

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	<p>(2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.</p> <p>(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement.</p> <p>(4) Refuse any treatment or service, including medication.</p> <p>(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.</p> <p>(6) Be afforded confidentiality of treatment.</p> <p>(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on record review and interview, the facility failed to maintain an updated service plan related to ADLs (Activities of Daily Living) and contracted services for 1 of 7 residents reviewed. (Resident #4)</p> <p>Finding includes:</p>	R 0035	<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><i>The cited residents have had</i></p>	09/30/2015

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	<p>The record for Resident #4 was reviewed on 8/25/15 at 9:45 a.m. Diagnoses included, but were not limited to, acute respiratory failure, dementia, difficulty walking, history of falls, chronic UTIs (Urinary Tract Infections), spinal stenosis, and epilepsy.</p> <p>Review of Physician's Orders indicated an order for Harbor Light Hospice on 5/1/15.</p> <p>Review of the resident's Service Plan dated 7/16/15 lacked hospice care under "Service Coordination." The Service Plan also indicated, "Resident does not need assistance showering or bathing."</p> <p>An interview was conducted with the Health and Wellness Director on 8/25/15 at 11:45 a.m. She indicated Resident #4 was on hospice services and that should have been included on the Service Plan. She further indicated the resident did need assistance bathing and had prior to hospice services as well.</p>		<p><i>their Personal Service Plans updated by the Health and Wellness Director/Designee to reflect their Hospice status.</i></p> <p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · <i>Other Hospice residents have the potential to be affected by the alleged deficient practice.</i> · <i>The HWD/Licensed Nurse Designee will complete an audit of all current Hospice residents to verify the accuracy of their current Personal Service Plan.</i> <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> · <i>The HWD and ED were re-educated by the District Director of Clinical Services on the requirement to complete a "change of condition" re-assessment or "Data-correction" Service Plan whenever Hospice or other third-party services are initiated and / or discontinued.</i> 	

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and		<ul style="list-style-type: none"> · <i>The ED will complete a final review of all Personal Service Plans prior to locking and reviewing with residents and responsible parties.</i> How will the corrective actions be monitored? · <i>Collaborative Care meetings will be held twice monthly to review the status of each resident.</i> · <i>Home Health and Hospice Providers will be consulted at the time to verify status of the certification.</i> · <i>This information will be communicated to the HWD/ED during these meetings so that the Personal Service Plan may be updated with such changes.</i> · <i>The HWD / ED will be responsible for checking twice monthly that updates have been completed to accurately reflect resident status.</i> 	

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	<p>simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to invite the local fire department to participate in a fire drill at least every 6 months.</p> <p>Finding includes:</p> <p>The fire drill records were reviewed on 8/25/15 at 3:25 p.m. A form provided by the Executive Director indicated the fire department had been invited to participate in a fire drill on 4/11/14 and then again on 4/13/15. There was no indication the fire department had been invited at anytime between those two dates.</p> <p>Interview with the Executive Director on 8/25/15 at 3:35 p.m., indicated the</p>	R 0092	<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>No current residents have been affected by the alleged deficient practice. Fire Department will be contacted for semiannual fire drill by September 15, 2015</p> <p><i>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</i></p>	09/15/2015

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R 0120 Bldg. 00	<p>facility would invite the fire department to come every April and September each year. She further indicated the fire department was invited in April 2015, but had not been invited before that since April 2014.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice</p>		<p><i>Audit will be conducted to ensure that Fire Department is invited to participate in Fire Drills every 6 months</i></p> <p><i>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</i></p> <p><i>Schedule of Fire Department contact will be placed in front of Fire drill binder.</i></p> <p><i>How will the corrective actions be monitored?</i></p> <p><i>Executive Director or designee will conduct audits every 6 months to comply with regulations.</i></p>	

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	<p>education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.</p> <p>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure the required 8 hours were completed for annual inservices which included Resident Rights and Abuse and the lack of the required 3 hours annual dementia training for 3 of 5 licensed staff members. (Health and Wellness Director, LPN #1, and RCA #1)</p> <p>Finding includes:</p> <p>Review of facility staff personal files on</p>	R 0120	<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><i>The associates found to be non-compliant will participate in a 3 hour in service on dementia by September 30, 2015</i></p>	10/31/2015

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	<p>8/25/15 at 4:30 p.m., indicated LPN #1 and RCA #2 had not completed annual inservices related to Resident Rights or Abuse for the calendar year 2014. The Health and Wellness Director, LPN #1, and RCA #1 had not completed the required 3 hours annual dementia training for the calendar year 2014.</p> <p>An inservice for staff was completed in one hour on 10/30/14 which included dining experience, nurse competencies, medication administration, and age sensitivity.</p> <p>An inservice for staff was completed in one hour on 2/26/15 which included Resident Rights and Abuse, laundry, personal connections, infection control, safety awareness, and dementia.</p> <p>No other inservices the facility had completed for the Calendar year 2014 was provided.</p> <p>Interview with the Executive Director on 8/25/15 at 4:58 p.m., indicated approximately two hours of inservices were provided over the past year to cover the rules and topics.</p>		<p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> An audit of personnel training records will be completed by the Business Office Manager/Designee to verify that other associates will be in compliance with this regulation. <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> The Business Office Manager and the Management Team have been re-educated by the District Director of Clinical Services on the state required Dementia Training regulation. Ongoing in-services will be offered at various dates and times each month to accommodate associate schedules for ongoing training. <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> ED or designee will audit compliance through review of 	

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	<p>medication aides.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed, related to a laboratory (lab) test not completed as ordered and blood pressure parameters not followed for medication administration for 1 of 7 residents reviewed for physicians' orders in a total sample of 7. (Resident #3)</p> <p>Finding includes:</p> <p>The record for Resident #3 was reviewed on 8/25/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, end stage renal disease, hypertension, and congestive heart failure.</p> <p>A Pharmacy Note to the Attending Physician, dated 6/11/15, indicated the resident had a low platelet count and was receiving low dose Aspirin therapy. The Physician response written on the note and dated 7/1/15 indicated, "Pt (patient) on HD (hemodialysis) and has heparin (a blood thinning medication) flush, check PT/INR (Prothrombin Time/International Normalized Ratio, a laboratory test for blood clotting) and PTT (Partial Thromboplastin Time, a laboratory test for blood clotting)." The order was indicated as noted by the facility on 7/2/15.</p>	R 0241	<p>What corrective action(s) will be Accomplished for those residents found to Have been affected by the alleged deficient practice? · For cited residents, the doctor was notified and lab completed immediately.</p> <p>· New orders were received, as applicable and blood pressure parameters were established for those residents whom the physician felt required additional checks. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · A medication Administration Record audit was completed by the Licensed Nurse designee to verify that residents requiring BP checks related to their medications had parameters listed. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · Nursing Staff was re-educated on the need for parameters for certain drugs and the need to determine if the physician would like additional blood pressure checks assigned.</p> <p>How will the corrective actions be monitored? · Health and wellness director will perform monthly auditing on all pharmacy consults for the next 3 months. · HWD will complete</p>	09/30/2015

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	<p>Review of the lab results indicated the PT/INR had been completed on 7/8/15. There was lack of documentation in the record to indicate the PTT had been completed as ordered by the Physician.</p> <p>Review of the August 2015 Physician Order Summary (POS) indicated an order for carvedilol (Coreg, a blood pressure medication) 3.125 milligrams (mg) 1 tablet twice daily, hold if SBP (systolic blood pressure) < (less than) 60. The POS also indicated an order to take the resident's blood pressure daily in the morning and hold blood pressure medication if DBP (diastolic blood pressure) < (less than) 60.</p> <p>Review of the August 2015 Medication Administration Record (MAR) indicated the following: -8/10/15 8 a.m. blood pressure 132/55 -8/21/15 8 a.m. blood pressure 115/54 The carvedilol medication was signed off as administered on both 8/10/15 and 8/21/15.</p> <p>Review of the August 2015 MAR and the July 2015 MAR indicated there were no blood pressure readings indicated for the 4 p.m. dose of the carvedilol medication.</p> <p>Interview with the Health and Wellness</p>		<p><i>monthly audits on all residents that have parameters, ongoing to monitor compliance. · A log will be kept of audits performed.</i></p>				

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	<p>Services Manager. At that time, Kitchen Aide #1 was observed washing dishes. He had a full beard and was not observed to be wearing a beard guard.</p> <p>During the tour, there was a full sanitation bucket sitting in the kitchen sink. The chemical levels were tested by the Dining Services Manager and registered at 100 ppm (parts per million). At that time, the Dining Services Manager indicated the chemical level needed to ensure proper sanitation of kitchen surfaces was 200 ppm and proceeded to dump the bucket out. She further indicated the sanitation bucket solution was usually changed every four hours and that one had been poured around 6:45 a.m.</p> <p>Review of the sanitation bucket log indicated no monitoring of the sanitation bucket levels had been done at all in August 2015 and only one entry was made in July 2015.</p> <p>A policy titled "Sanitation and Safety" was provided by the Health and Wellness Director on 8/25/15 at 1:00 p.m. The policy indicated, ".... Use of Sani Pails ... Sanitizing solution should be tested and changed every 2 hours."</p> <p>2. During a return visit to the kitchen on</p>		<p>How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Other kitchen workers with beards have the potential to require beard guards. • <input type="checkbox"/> Beard guards will be available by to all kitchen staff when necessary • <input type="checkbox"/> Sanitation bucket will be refreshed every 2 hours by all dining staff • <input type="checkbox"/> Log binder will be kept in kitchen <p>What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?</p> <ul style="list-style-type: none"> • <input type="checkbox"/> Kitchen staff was re-educated on the need to cover facial hair while performing duties in the kitchen and/or food preparation areas. • <input type="checkbox"/> Kitchen staff was re-educated on sanitation buckets and logs <p>How will the corrective actions be monitored?</p> <ul style="list-style-type: none"> • <input type="checkbox"/> The dietary manager/designee will monitor compliance daily; Beard guards 	

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NAME OF PROVIDER OR SUPPLIER BROOKDALE MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8253 VIRGINIA ST MERRILLVILLE, IN 46410
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R 0349 Bldg. 00	<p>8/25/15 at 12:10 p.m., the Dining Services Manager and Kitchen Aide #1 were observed preparing food for lunch. At that time, Kitchen Aide #1 was observed handling food without a beard guard in place.</p> <p>At that time, the Dining Services Manager and Kitchen Aide #1 both indicated they were unaware of the requirement for facial hair to be covered during food preparation and service.</p> <p>During continuous observation of lunch service on 8/25/15, Kitchen Aide #1 was observed to serve food to the residents throughout without a beard guard in place.</p> <p>A policy titled "Hair Restraints" was provided by the Health and Wellness Director on 8/25/15 at 1:00 p.m. The policy indicated, "All associates involved in food preparation must wear hair restraints ... 4. Beards of 1/2" or longer must be covered also."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an</p>		<p><i>are now available at the entrance for ease of use.</i></p> <ul style="list-style-type: none"> • <input type="checkbox"/> <i>Dietary manager/designee will monitor daily compliance of sanitary bucket and log</i> • <input type="checkbox"/> <i>Sanitation bucket and logs will be audited for compliance weekly by ED/Designee for the next 3 months</i> 	

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	<p>employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurate related to incorrect medication orders for a resident from a recent return from the hospital for 1 of 7 residents reviewed for clinical records in the sample of 7. (Resident #5)</p> <p>Finding includes:</p> <p>The record for Resident #5 was reviewed on 8/25/15 at 10:40 a.m. The resident's diagnoses included, but were not limited to, hypertension and coronary artery disease.</p> <p>Review of the resident's Service Plan dated 4/30/15, indicated the resident self-managed their own medications. This included setting the medications up daily herself, self-administering the medications and safely storing the medication.</p> <p>Review of a Self Medication Administration Review dated 7/10/15, indicated the resident was deemed able to</p>	R 0349	<p>What corrective action(s) will be Accomplished for those residents found to Have been affected by the alleged deficient practice? · The Health and Wellness Director notified the MD and updated Physician Orders, as applicable. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? · Other residents who return from the hospital or other healthcare setting with new orders have the potential to be affected by the alleged deficient practice. · Health and Wellness Director will audit recent return admissions from the hospital to verify compliance with transcription. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? · All nurses will be re-educated on Medication-Transcription of Orders. This training will be provided by the Health and Wellness Director and be completed by September 30, 2015. How will the corrective</p>	09/30/2015

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	<p>safely administer medications to herself and had a physicians order to do so.</p> <p>Review of the August 2015 Physician's Order Summary (POS), indicated the resident was to receive Cardizem CD (blood pressure medication) 360 milligrams (mg) daily and Ferrous Sulfate (medication to treat iron deficiency) 65 mg daily.</p> <p>Review of a discharge summary from the hospital dated 8/12/15, indicated the resident was admitted to the hospital on 8/5/15 through 8/12/15 with diagnoses of a small bowel obstruction and low blood potassium. The discharge summary included a list of all current medications to continue to be taken at home. The list did not include the Cardizem CD or the Ferrous Sulfate medications.</p> <p>Review of the August 12, 2015 POS did not include the Cardizem CD or the Ferrous Sulfate medications to be administered.</p> <p>Interview with the Health and Wellness Director on 8/25/15 at 3:38 p.m., indicated when the resident returned from the hospital on 8/12/15 another Self Medication Administration Assessment had not been completed because the resident did not have a cognitive change</p>		<p>actions be monitored? · Health and Wellness Director /Licensed Nurse Designee will audit future return admissions from the hospital or other health care setting with each occurrence and will direct corrective action based on findings.</p>	

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	<p>of condition since her stay in the hospital. She indicated since the resident's medications list had changed from the prior August 2015 POS, the admitting nurse should have called the Physician and clarified the orders. If the medications were to be discontinued the nurse would be responsible to make sure the resident was aware not to continue to take the medications. She further indicated she would speak to the resident to see if the resident had continued to take the Cardizem CD and the Ferrous Sulfate medication since being back from the hospital and also she would call and clarify with the Physician what the orders should be. Further interview with the Health and Wellness Director at 3:55 p.m., indicated she had spoken to the resident and the resident indicated she had been taking the Cardizem CD and the Ferrous Sulfate along with the rest of her other medications since being back from the hospital. She indicated she also clarified the orders with the Physician. The Physician indicated the resident was supposed to still take the medications after discharging from the hospital and the discharge summary had been incorrect not to list the Cardizem CD and the Ferrous Sulfate as medications to continue. She indicated it was an error on the facilities part not to clarify with the Physician about the medications</p>			

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	when the resident had returned from the hospital. She further indicated she would update the current POS including the medications Cardizem CD and the Ferrous Sulfate to be administered by the resident.				