

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 09/27/2013
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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 Recertification and State Lincensure Survey.</p> <p>This visit was in conjunction with the4 Investigation of Complaint IN00136571.</p> <p>Survey dates: September 23, 24, 25, 26 & 27, 2013</p> <p>Facility number: 010739 Provider number: 155764 AIM number: 200856890</p> <p>Survey team: Cynthia Stramel, R.N., T.C. Lara Richards, R.N. Heather Hite, R.N. Jennifer Redlin, R.N. Janelyn Kulik, R.N. 9/24 & 9/27/13</p> <p>Census bed type: SNF: 42 SNF/NF: 9 Residential: 66 Total: 117</p> <p>Census Payor Type: Medicare: 40 Medicaid: 7 Private: 70 Total: 117</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.This facility asks that this Plan of Correction and it's supporting documentation be considered for desk review for compliance.</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>Residential Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 30, 2013, by Janelyn Kulik, RN.</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review and interview, the facility failed to ensure bed alarms were in place for 1 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Resident #75)</p> <p>Findings include:</p> <p>On 9/25/13 at 10:22 a.m., a bed alarm was observed attached to the assist rail on Resident #75's bed. The unit was not turned on and there was no cord attaching the alarm to a sensor pad. The resident was not in her bed at this time. At 11:00 a.m. and 2:25 p.m., the resident was observed in her room in bed. Again, the bed alarm was hanging from the assist rail and was not turned on nor plugged in.</p> <p>On 9/26/13 at 8:22 a.m., 12:20 p.m., and 3:30 p.m., the resident was in her room in bed. The bed alarm was hanging from the assist rail and was not turned on nor plugged in.</p> <p>The record for Resident #75 was</p>	F000282	<p>F282It is the intent of this facility to ensure that bed alarms are in place for residents with a plan of care for a bed alarm.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The care plan for resident #75 was updated to show that the bed alarm had been discontinued.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:Residents with a plan of care for a bed alarm have the potential of being affected by this alleged deficiency. An audit of residents care planned for a bed alarm was completed and alarms were checked for placement and proper operation.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:An audit tool has been developed to monitor all residents who are care planned for a bed alarms. This audit tool will check all residents with bed alarms, three times weekly on varying shifts. . Any concerns of non-compliance will be reviewed</p>	10/23/2013

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	<p>reviewed on 9/24/13 at 1:46 p.m. The resident's diagnoses included, but were not limited to, fall and Parkinson's.</p> <p>Review of the Fall Circumstance Assessment and Intervention form dated 8/26/13 at 3:10 a.m., indicated the resident was found on the floor. The resident indicated that she was trying to take herself to the bathroom and she did not call for help when she was trying to put herself back to bed.</p> <p>The plan of care dated 8/22/13, indicated the resident was at risk for fall and injury related to Parkinson's. An approach dated 8/26/13, indicated the resident was to have a pad alarm in bed.</p> <p>A Physician's order dated 8/30/13, indicated the resident was to have an alarm to her bed and to check for functioning and placement every shift.</p> <p>Interview with the Unit Manager on 9/26/13 at 3:30 p.m., indicated the sensor pad was located underneath the resident's bed and was not plugged in.</p> <p>3.1-35(g)(2)</p>		<p>at the daily clinical management meetings. Clinical staff and Management staff (Ambassadors) were in-serviced on verifying during their rounds that residents care planned for a bed alarm have that alarm in place and in working operation. 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: The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. Date systemic changes will be completed: October 23, 2013</p>		

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F000323 SS=D	<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, record review and interview, the facility failed to ensure bed alarms were in place for 1 of 3 residents reviewed for accidents of the 5 residents who met the criteria for accidents. (Resident #75)</p> <p>Findings include:</p> <p>On 9/25/13 at 10:22 a.m., a bed alarm was observed attached to the assist rail on Resident #75's bed. The unit was not turned on and there was no cord attaching the alarm to a sensor pad. The resident was not in her bed at this time. At 11:00 a.m. and 2:25 p.m., the resident was observed in her room in bed. Again, the bed alarm was hanging from the assist rail and was not turned on nor plugged in.</p> <p>On 9/26/13 at 8:22 a.m., 12:20 p.m., and 3:30 p.m., the resident was in her room in bed. The bed alarm was hanging from the assist rail and was not turned on nor plugged in.</p>	F000323	F323It is the intent of this facility to ensure that this environment remains free of accident hazardsWhat corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The care plan for resident #75 was updated to show that the bed alarm had been discontinued.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:Residents with a plan of care for a bed alarm have the potential of being affected by this alleged deficiency. An audit of residents care planned for a bed alarm was completed and alarms were checked for placement and proper operation.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An audit tool has been developed to monitor all residents who are care planned for a bed alarms. This audit tool will check all residents, three times weekly on varying shifts. . Any concerns of non-compliance will be reviewed at the daily	10/23/2013			

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	<p>The record for Resident #75 was reviewed on 9/24/13 at 1:46 p.m. The resident's diagnoses included, but were not limited to, fall and Parkinson's.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated 8/16/13, indicated the resident needed extensive assistance with transfers and had fallen in the last 2-6 months prior to admission.</p> <p>Review of the Fall Circumstance Assessment and Intervention form dated 8/26/13 at 3:10 a.m., indicated the resident was found on the floor. The resident indicated that she was trying to take herself to the bathroom and she did not call for help when she was trying to put herself back to bed.</p> <p>The plan of care dated 8/22/13, indicated the resident was at risk for fall and injury related to Parkinson's. An approach dated 8/26/13, indicated the resident was to have a pad alarm in bed.</p> <p>A Physician's order dated 8/30/13, indicated the resident was to have an alarm to her bed and to check for functioning and placement every shift.</p> <p>Interview with the Unit Manager on</p>		<p>clinical management meetings. Clinical staff and Management staff (Ambassadors) were in-serviced on verifying during their rounds that residents care planned for a bed alarm have that alarm in place and in working operation. 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: The DHS/designee will review the audit tools for compliance. Any concerns of non-compliance will be corrected immediately and reported to the Interdisciplinary Team Meetings for review. Monitoring will continue for 90 days and reviewed monthly by the Quality Assurance Committee. After 90 days the QA committee will determine if substantial compliance is met and if the need for additional monitoring is warranted. Date systemic changes will be completed: October 23, 2013</p>		

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	9/26/13 at 3:30 p.m., indicated the sensor pad was located underneath the resident's bed and was not plugged in. 3.1-45(a)(2)				

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F000371 SS=E	<p>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, record review and interview, the facility failed to ensure food was prepared and distributed under sanitary conditions related to cutting food with bare hands and not changing gloves and/or washing hands after touching multiple food preparation items as well as food on the steam table for 1 resident on the TCU unit (Transitional Care Unit) (#147) and for 1 of 3 units throughout the facility. This had the potential to affect the fourteen residents who received an oral diet on Healthcare Unit 2.</p> <p>Findings include:</p> <p>1. On 9/23/13 at 1:04 p.m., CNA #1 brought Resident #147's lunch tray to his room. The resident proceeded to ask the CNA to cut his hot dog in half for him. The CNA placed her bare hand on the hot dog bun and cut it in half with a knife.</p> <p>Interview with the Unit Manager on</p>	F000371	F371It is the intent of this facility to ensure that food is prepared and distributed under sanitary conditions.What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #147 and the Residents in attendance at the Health Care 2 dining room showed no signs or symptoms of ill affects from the alleged deficient practice.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:Any resident eating a room tray or in the Health Care 2 dining room had the potential of being affected by this alleged deficient practice. Dietary staff was in-serviced on the practice of food service with no hand contact. Nursing staff was in-serviced on the proper procedure of preparing a room tray for a resident, including proper hand washing procedures and preparing of food items without touching the food with the hands.What measures will be put into place or what systemic changes will be made to	10/23/2013			

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	9/27/13 at 10:00 a.m., indicated the CNA should not have touched the resident's food with her bare hand.		ensure that the deficient practice does not recur:The Dietary Manager/designee will do 4 random audits of dining rooms weekly, audit to include breakfast, lunch and/ or dinner to assure that proper serving procedures are followed. The DON/designee will monitor 4 random room tray services weekly, audit to include breakfast, lunch and/ or dinner to assure proper procedures are followed in tray preparation. 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:Weekly audits will be reviewed by the Interdisciplinary team weekly for compliance. Any concerns of non-compliance will be corrected immediately. Audits will continue for 90 days or until full compliance is determined by the Quality Assurance Committee. The QA committee will review these audits monthly for 90 days and determine if further monitoring is warranted.Date systemic changes will be completed: October 23, 2013		
	2. On 9/23/13 at 12:10 p.m., in Health Care Unit 2 dining room, Dietary Aide (DA) #1 was observed preparing plates for lunch service. She had on gloves and would pick up hot dog buns with gloved hands. She				

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	<p>would then put shredded cheese on the hotdog with gloved hands. Between plates, she would touch the service cart and meal tickets. She would then proceed to touch hotdog buns and cheese again. Gloves were not changed between plates.</p> <p>At 12:25 p.m. Dietary Aide #2 arrived and gave DA #1 tongs. DA #1 then used the tongs for the shredded cheese, but continued to use her gloved hands to pick up the hotdog buns.</p> <p>Interview with DA #1 and DA #2 at 12:40 p.m., indicated the food should not be touched with gloved hands and tongs should have been used.</p> <p>A copy of the policy Food Production Guidelines-Sanitation and Safety was received from the Nurse Consultant on 9/27/13 at 12:00 p.m. The policy was dated 2009 and identified as current. The policy indicated, "9. Suitable utensils, such as forks, knives, tongs or scoops shall be provided to minimize handling of food. Gloves may be worn for a single purpose, i.e. touching ready-to-eat food."</p> <p>3.1-2.1(i)(3)</p>				

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the facility was clean, orderly, and in a state of good repair related to dusty ceiling vents, stained carpet, stained floor tile and scratched and marred chairs. This had the potential to affect the sixty-six residents residing in the residential facility.</p> <p>Findings include:</p> <p>During the Environmental tour on 9/27/13 at 11:18 a.m., with the Maintenance and Housekeeping Supervisors, the following was observed:</p> <p>a. Areas of stained carpeting were observed in Room #127. Two residents resided in this room.</p> <p>b. The base of the South stair door was discolored and marred.</p> <p>c. Seven chairs located in the Pub area were scratched and marred on the arms and legs.</p> <p>d. Ten chairs located in the Main</p>	R000144	<p>R144 It is the intent of this facility to ensure this facility is clean, orderly and in a state of good repair. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: a. The carpet was cleaned in room #127b. A kick plate for the door to the South Stairs was installed. c. The pub chairs were refinished. d. The main dining room chairs were refinished. e. The floor tile in Room #216's bathroom is scheduled for replacement. f. The floor tile in Room #210's bathroom is scheduled for replacement. The bathroom ceiling vent was cleaned. g. The floor tile in Room #236's bathroom is scheduled for replacement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents on the A/L unit have the potential to be affected by these alleged deficient practices. No actual harm was noted for any residents on this unit. Assisted Living chairs and bathroom floors are included on routine checks lists for monitoring for repair/replacement. Cleaning of</p>	10/23/2013

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	<p>dining room were scratched and marred on the arms and legs.</p> <p>e. The floor tile located in the bathroom of Room #216 had a gray discoloration around the base of the toilet. Two residents resided in this room.</p> <p>f. The floor tile located in the bathroom of Room #210 had a gray discoloration around the base of the toilet. The ceiling vent in the bathroom was observed with a large accumulation of dust. One resident resided in this room.</p> <p>g. The floor tile located in the bathroom of Room #236 had a gray discoloration around the base of the toilet. Two residents resided in this room.</p> <p>Interview with the Maintenance and Housekeeping Supervisors at the time, indicated the above areas were in need of cleaning and/or repair.</p>		<p>bathroom vents is included on routine check lists for housekeeping. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Director of Plant Operations/designee will monitor the condition of chairs in the dining room and pub areas of Assisted Living. As chairs become marred or damaged, they will be scheduled for repairs. An audit of all the bathroom floors on the Assisted Living unit was completed and any floors showing discoloration will be cleaned or replaced as needed. The Director of Plant Operations/designee will include the bathroom floors as a part of routine apartment inspections for repairs and maintenance. An audit of all stairway doors was completed. Any doors noted needing paint/repairs were corrected. The Director of Plant Operations/designee will include the stairway doors as a part of routine inspections for repairs and maintenance. Housekeeping and Maintenance staff were in-serviced on the importance of cleaning all vents and reporting to their supervisor any furniture or flooring conditions that would warrant repairs/replacement 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: The Director of</p>	

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			Plant Operations/designee will provide an update of repair/replacement of noted items to the Executive Director/designee. The Director of Plant Operations/designee will be responsible for monitoring of these areas for any needed repairs/replacement and will notify the Executive Director. This monitoring will be on-going. Any non-compliance issues will be reviewed by Quality Assurance Committee for direction of returning facility to compliance. Date systemic changes will be completed: October 23, 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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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview, the facility failed to ensure Physician prescribed medications were administered as ordered for 2 of 6 residents reviewed related to not following sliding scale insulin (medication used for high blood sugar levels) and obtaining heart rates prior to giving a medications used to treat heart failure. (Residents #2 and #4)</p> <p>Findings include:</p> <p>1. The Record for Resident #4 was reviewed on 9/27/13 at 10:15 a.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and depression.</p> <p>Review of the September, 2013 Physician Order Statement, indicated the resident was to have her blood sugar checked four times a day. She was to receive Novolin R (insulin) according to the following scale: blood sugars 60-150, no coverage, 151-200, 2 units of insulin, 201-250, 4</p>	R000241	<p>R241</p> <p>It is the intent of this facility to ensure that Physician prescribed medications are administered as ordered. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #4 was assessed with no signs/symptoms of negative affects due to alleged practice. Resident #2 was assessed with no signs/symptoms of negative affects due to alleged practice. 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: An audit of all current residents that receive insulin on a sliding scale format have been reviewed for correct administration of sliding scale insulin with no negative outcomes noted. An audit of all Current residents that require a heart rate per physician orders prior to medication administration have been reviewed and no negative</p>	10/23/2013			

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	<p>units of insulin, 251-300, 6 units of insulin, 301-350, 8 units of insulin, 351-400, 10 units of insulin, and greater than 400 12 units of insulin and notify the Physician.</p> <p>Review of the September, 2013 Medication Administration Record, indicated on 9/2/13 at 11:00 a.m., the resident had a blood sugar of 356. Ten units of insulin was given. It was also documented that the resident's blood sugar was 237 and no insulin was given. On 9/3/13 at 4:00 p.m., the resident had a blood sugar of 202 and no insulin was given. The resident should have received 4 units of insulin. On 9/4/13 at 4:00 p.m., the resident had a blood sugar of 242, no insulin was given. The resident should have received 4 units of insulin. At 9:00 p.m., the resident had a blood sugar of 206 and no insulin was given. The resident should have received 4 units of insulin. On 9/7/13 at 11:00 a.m., the resident had a blood sugar of 268 and no insulin was given. The resident should have received 4 units of insulin. On 9/14/13 at 11:00 a.m., the resident had a blood sugar of 300 and the resident received 10 units of insulin. The resident should have received 6 units of insulin. On 9/16/13 at 9:00 p.m., the resident had a blood sugar</p>		<p>outcomes noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:Nursing staff have been in-serviced on following physicians orders for sliding scale insulin per blood sugar readings and administering correct amount of units of insulin. Nursing staff has been in-serviced on the protocols of obtaining the heart rate prior to administering medications that require monitoring of a heart rate. 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:The Assisted Living Director/designee will review the medication administration record for the correct units of insulin per sliding scale 5 times weekly for 8 weeks, then 3 times weekly for 8 weeks then one time weekly for 8 weeks. The Assisted Living Director/ designee will audit and review the medication administration record for heart rate 5 times weekly for 8 weeks, then 3 times weekly for 8 weeks then one time weekly for 8 weeks. Results of the weekly audits will be reported to the Director of Health Services/designee. Any non-compliance findings will be reviewed each month by the Quality Assurance Committee. After a period of 6 months the</p>		

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	<p>of 161 and received no insulin. The resident should have received 2 units of insulin. On 9/23/13 at 4:00 p.m. the resident had a blood sugar of 352 and received no insulin. The resident should have received 10 units of insulin.</p> <p>Interview with the Residential Unit Manager on 9/27/13 at 1:45 p.m. indicated she did not know why the two nurses on the same shift would have documented different blood sugar readings. She also indicated the staff were not using the Medication Administration Form properly. She further indicated the insulin was not given as ordered.</p> <p>2. The record for Resident #2 was reviewed on 9/24/13 at 1:45 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, congestive heart failure, and Stage III kidney disease.</p> <p>Review of the September, 2013 Physician Order Statement, indicated the resident was to received coreg 2.125 mg (milligrams) (medication used to treat heart failure and hypertension) two times a day. The medication was not to be given if the resident's heart rate was lower than</p>		<p>QA committee will determine if audits will continue for any extended period. Date systemic changes will be completed: October 23, 2013</p>				

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	<p>60 beats per minute.</p> <p>Review of the September, 2013 Medication Administration Record, indicated no pulse had been documented on the following days: 9/2/13 at dinner time, 9/3/13 after rising, 9/4/13 at dinner time, 9/5/13 after rising and at dinner time, 9/8/13 after rising and at dinner time, 9/9/13 after rising and at dinner time, 9/10/13 after rising and at dinner time, 9/11/13 after rising and at dinner time, 9/12/13 after rising and at dinner time, 9/13/13 after rising and at dinner time, 9/14/13 after rising and at dinner time, 9/15/13 after rising, 9/16/13 at dinner time, 9/17/13 at dinner time, 9/18/13 after rising and at dinner time, 9/19/13 after rising and at dinner time, 9/20/13 after rising and at dinner time. 9/21/13 after rising and at dinner time, 9/22/13 after rising and at dinner time, 9/23/13 after rising and at dinner time, 9/24/13 after rising and at dinner time, 9/25/13 after rising and at dinner time, and 9/26/13 after rising and at dinner time. The Mediaton Administration Record indicated the medication had been given to the resident 9/1/13 through 9/26/13 twice a day after rising and at dinner time.</p> <p>Interview with the Residential Unit Manager on 9/27/13 at 12:45 p.m.,</p>						

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	indicated the staff had been taking the resident's blood pressure but had not taken the resident's heart rate.				