STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155386	A. BUILDING 00 B. WING	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN46721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00089892. Complaint IN00089892- Substantiated. No deficiencies related to the allegations are cited. Survey dates(s): May 9, 10, 11, & 12, 2011. Facility number: 000574 Provider number: 155386 AIM number: 100266430 Survey team: Sue Brooker, RD -TC Christine Fodrea, RN Sheryl Roth, RN Angie Strass, RN (5/10, 5/11, 5/12, 2011) Rick Blain, RN (5/11, 5/12, 2011) Census bed type: SNF/NF: 90	F0000	The Laurels of DeKalb wishes to have this submitted plan of correction stand as its allegation of compliance. The date of alleged compliance is 6/11/11.Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 90 Census payor type: Medicare: 9 Medicaid: 54 Other: 27 Total: 90 Sample: 19 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on May 17, 2011 by Bev Faulkner, RN			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure documentation of assessment for eye infection/itching for 1 of 1 residents reviewed with eye infections in a sample of 19 residents reviewed for assessments. (Resident #4)	F0272	Resident #4's eye infection has resolved. No negative outcome resulted from this observation.All Resident's medical records have been reviewed. Any resident receiving eye treatments will be assessed and documentation provided in the clinical record.Licensed nurses will be in-serviced on documentation of assessments on 5/26/11. All telephone orders and 24 hour	06/11/2011

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	Findings include: Resident #4's record was reviewed on 5/9/11 at 2:00 p.m. The record indicated Resident #4's diagnoses included, but were not limited to, post traumatic stress disorder (PTSD), delirium, renal insufficiency, benign prostatic hypertrophy (BPH) and cerebrovascular accident (CVA). A Physician Progress Note, dated 4/15/11 and signed by the Nurse Practitioner, indicated Resident #4 was seen for a thirty day progress visit. The note further indicated the resident had a few minor vague complaints including itchy eyes. A new order was listed for an ointment to the eyes every shift for two weeks. There was no documentation in the nurses' notes of any assessment or complaint regarding the eyes of the resident. A "Interdisciplinary Care Plan," dated 4/15/11, indicated Resident		report sheets will be reviewed by the Unit Managers/Designee for Residents displaying signs and symptoms of eye infections/itching. Nursing progress notes will be reviewed by Unit Managers/Designee for documentation of assessments for 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly thereafter until resolved.Unit Manager/Designee will report any abnormal findings to the Director of Nursing. The Director of Nursing will report these findings to the Quality Assurance Committee for the next 3 months (Addendum: and quarterly thereafter for 1 year.) The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will review the progress of findings and offer input as necessary to the Quality Assurance Committee.The Administrator is responsible for continued compliance with the regulation.	

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	#4 had a problem with dry eyes with a goal of no signs or symptoms of dry eyes. The only intervention listed included ointment as ordered. An untitled assessment form, dated 4/19/11, and completed by Resident #4's eye doctor, indicated the resident was being seen for lost eyeglasses and eyes that itched and hurt. There was no documentation in the nurses' notes regarding the assessment of the resident's eyes or any symptoms that he was having in this area. The April 2011, Medication Record for Resident #4, listed a new antibiotic eye ointment order, dated 4/19/11, to be applied at bedtime every night for ten days. The resident was also receiving Lacrilube eye ointment three times a day starting 4/17/11 and artificial tears three times a day starting 3/28/11. A "Interdisciplinary Care Plan,"			

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	dated 4/19/11, indicated Resident #4 had a problem with eye drainage with a goal of no drainage or no signs and symptoms of infection. The only intervention listed included eye medication as ordered. There was no further documentation in Resident #4's record indicating the facility had re-assessed the eyes for continuing signs and symptoms of itching or infection while being treated with the antibiotic ointment and artificial tears. There was no documentation that Resident #4 had been assessed for resolution of the infection once the antibiotic ointment had been discontinued on 4/29/11. On 5/12/11 at 1:10 p.m., the Director of Nursing provided the Documentation policy, dated 3/11, and indicated the policy was the one currently used by the facility. The policy included, but was not limited to: "...Documentation should not be 'block' or 'shift' entries. Entries need to be made			

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	when they occur...Be complete when documenting, making certain that everything significant to the guest's condition and course of treatment is recorded...All physician visits/contacts should be documented in the progress notes...." LPN #20 was interviewed on 5/11/11 at 2:00 p.m. During the interview, LPN #20 indicated when a resident is placed on an antibiotic or medication for an eye infection, charting would be completed routinely for the duration of the medication and would include items such as eye redness, drainage, body temperature, etc. 3.1-31(a)			

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F0280 SS=A	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review and interview, the facility failed to update the nutrition care plan for 2 of 19 residents (Resident #4 and Resident #47) reviewed with care plans in a sample of 19. Findings include: 1. Resident #4's record was reviewed on 5/9/11 at 2:00 p.m. The record indicated Resident #4's diagnoses included, but were not limited to, post traumatic stress disorder (PTSD), delirium, renal insufficiency, benign prostatic	F0280	Resident # 4's Nutritional care plan was updated on 5/12/11 to reflect the Resident's current weight goal by the Certified Dietary Manager. No negative outcome resulted from this observation.Resident #47 no longer resides at the facility.All Residents' Nutritional care plans have been reviewed and have been updated to reflect the status of each resident.The Dietary Manager/Designee will review all Resident Nutritional care plans monthly for 2 months. All Nutritional care plans will be updated accordingly. All finding will be reported to the Administrator monthly and to the Quality Assurance Committee for the next 2 months (Addenum: and then quarterly thereafter for 1 year). The Quality Assurance	06/11/2011

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	hypertrophy (BPH) and cerebrovascular accident (CVA). The nutrition "Plan of Care," dated 11/5/10 with a goal date of 7/21/11, indicated Resident #4 had a goal to maintain his weight within 5% of 139 pounds. The "Nutritional Data sheet, dated 3/24/11 by the Certified Dietary Manager, indicated Resident #4 weighed 139.4 pounds. The "Progress Notes," dated 3/30/11 by the Registered Dietitian, indicated Resident #4 weighed 139 pounds. The "Progress Notes," dated 4/13/11 by the Registered Dietitian, indicated the facility's admission weight was incorrect. Hospital weights were 114 - 119 pounds. The note further indicated the weight for April to be 111 pounds. The "Progress Notes," dated 4/20/11 by the Registered Dietitian,		Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will review the progress of findings and offer input as necessary to the Quality Assurance Committee.The Administrator is responsible for continue compliance with the regulation.	

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	indicated Resident #4 weighed 116.4 pounds. The Director of Nursing (DON) was interviewed on 5/12/11 at 9:10 a.m. During the interview, the DON indicated the facility had now updated the care plan to show the correct weight of 116 pounds. 2. Resident #47's record was reviewed 5/10/2011 at 8:10 a.m. Resident #47's diagnoses included but were not limited to; malnutrition, dementia, and high blood pressure. A physician's order for Jevity 1.5 at 200 ml per hour every 4 hours as a bolus was received on 4/14/2011. On 5/5/2011, a physician's order was received to begin Osmolyte high calorie, high protein when available. The Medication Administration			

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	record for 5/2011 indicated Resident #47 had begun receiving Osmolyte high calorie, high protein on 5/8/2011. A review of care plans produced the following; a care plan, dated 4/14/2011 and updated 5/5/2011, titled nutrition: at risk for weight changes indicated to begin Osmolyte when it became available. A second care plan, dated 4/14/2011, titled nutrition: risk of dehydration indicated to provide Jevity as ordered. A third care plan, dated 4/14/2011, titled potential for gastrointestinal distress indicated Jevity was to be given per tube as ordered. A fourth care plan, dated 4/14/2011, titled potential for skin breakdown indicated provide Jevity as ordered per tube. A fifth care plan, dated 4/14/2011, titled skin: pressure area to buttocks indicated see nutrition care plan for diet change. In an interview on 5/12/2011 at 10:45 a.m., the Director of Nursing			

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	indicated there was no policy regarding care plan updates. She additionally indicated care plans should be kept current. In an interview on 5/12/2011 at 1:52 p.m., the Minimum Data Set Coordinator indicated although there was no policy regarding care plan updates, care plans were to be updated with new orders. 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure positioning devices were released as ordered by the physician for 2 of 2 residents reviewed with lap trays in a total sample of 19. (Resident #10, and Resident #47).	F0282	Resident # 47 no longer resides in the facility.Resident # 10's comprehensive care plan has been reviewed and reflects the physicians' order to monitor the positioning device every 30 minutes and release every 2 hours. No negative outcome resulted from this observation.All Residents using lap trays have been identified. The physicians orders have been reviewed and the comprehensive care plan updated to reflect the status of	06/11/2011

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	Findings include: 1. Resident #10's record was reviewed on 5/9/2011 at 12:05 p.m. Resident #10's diagnoses included but were not limited to; dementia, depression, and Parkinson's disease. In a continuous observation on 5/10/2011 between 8:30 a.m. and 11:30 a.m., Resident #10 was observed in his wheelchair with a lap tray on, in his room in front of the television between 8:30 a.m. and 9:15 a.m., at ball toss in the activity area between 9:15 a.m. and 9:30 a.m., sitting in his room between 9:30 a.m. and 11:00 a.m., and sitting in the hallway between 11:00 a.m. and 11:30 a.m. Resident #10 was not toileted nor his lap tray released during this time. A physician's order, dated 5/5/2011, indicated Resident #10 was to have a wheelchair tray and be monitored every 30 minutes and released every 2 hours.		each resident. The licensed nurses will be in-serviced on 5/26/11 on monitoring every 30 minutes and releasing lap trays every 2 hours for care.The licensed nurses will monitor and ensure that all residents using lap trays will be checked every 30 minutes and released every 2 hours for care.The Unit Managers/Designee will monitor compliance 3 times a week for 4 weeks, then weekly times 4 weeks, and then monthly thereafter.The Director of Nursing will report the findings to the Quality Assurance Committee monthly for 3 months (Addendum: and then quarterly therafter for 1 year.) The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will revew the progress of findings any offer input as necessary.The Administrator is responsible for continued compliance with the regulation.	

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	In an interview on 5/12/2011 at 9:10 a.m., the Director of Nursing indicated their restraint policy was not specific for releasing restraint, but Lippincott's manual was utilized as a part of their policy. A copy of Lippincott's manual pages utilized in the facility was provided by the Director of Nursing on 5/12/2011 at 9:10 a.m. Page 194 indicated under guidelines, e. Residents who are restrained should be released, exercised, toileted and checked for skin redness every 2 hours. 2. Resident #47's record was reviewed 5/10/2011 at 8:10 a.m. Resident #47's diagnoses included but were not limited to; malnutrition, dementia, and high blood pressure. In a continuous observation on 5/10/2011 between 12:45 p.m. and 3:15 p.m.; Resident #47 was observed sitting in his wheel chair with a lap tray on, between 12:45			

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	p.m. and 1:45 p.m. in the hall between 1:45 p.m. and 2:00 p.m. enjoying a puzzle in the activity area, between 2 p.m. and 3:15 p.m. in the hall. Resident #47 was not toileted nor his lap tray released. A physician's order, dated 5/2/2011, indicated use wheel chair tray when up in wheel chair monitor every 30 minutes and release every 2 hours. In an interview on 5/12/2011 at 9:10 a.m., the Director of Nursing indicated the restraint policy used by the facility was not specific for release, however Lippincott's manual was utilized as a part of their policy. 3.1-35(g)(2)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview	F0312	Resident # 47 no longer resides in the facility.Resident # 10 had	06/11/2011

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	and record review, the facility failed to ensure toileting per plan of care for 2 of 6 residents reviewed for toileting in a sample of 19 (Resident #10, and Resident #47). Findings include: 1. Resident #10's record was reviewed on 5/9/2011 at 12:05 p.m. Resident #10's diagnoses included but were not limited to; dementia, depression, and Parkinson's disease. In a continuous observation on 5/10/2011 between 8:30 a.m. and 11:30 a.m., Resident #10 was observed in his wheelchair with a lap tray on, in his room in front of the television between 8:30 a.m. and 9:15 a.m., at ball toss in the activity area between 9:15 a.m. and 9:30 a.m., sitting in his room between 9:30 a.m. and 11:00 a.m., and sitting in the hallway between 11:00 a.m. and 11:30 a.m. Resident #10 was not toileted during this time. Resident #10 was not observed to have been toileted at		no negative outcome resulting from this observation.All dependent Residents have been identified. All nursing staff will be in-serviced on 5/26/11 on toileting dependent residents as documented per plan of care.The nursing staff will monitor and ensure that all dependent residents are toileted per plan of care.The Unit Managers/Designee will monitor compliance 3 times a week for 4 weeks, then weekly times 4 weeks, and then monthly thereafter.The Director of Nursing will report the findings to the Quality Assurance Committee monthly for 3 months (Addendum: and then quarterly thereafter for 1 year.) The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will revew the progress of findings any offer input as necessary.The Administrator is responsible for continued compliance with the regulation.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	this time, his clothing was dry and he was not observed to have been incontinent. In an interview on 5/11/2011 at 1:25 p.m., LPN #4 indicated Resident #10 was to be toileted before and after meals and when requested. In an interview on 5/12/2011 at 9:10 a.m., the Director of Nursing indicated Lippincott's manual was utilized as a part of their policy. A copy of Lippincott's manual pages utilized in the facility was provided by the Director of Nursing on 5/12/2011 at 9:10 a.m. Page 194 indicated under guidelines, e. Residents who are restrained should be released, exercised, toileted and checked for skin redness every 2 hours. 2. Resident #47's record was reviewed 5/10/2011 at 8:10 a.m. Resident #47's diagnoses included but were not limited to;			

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	155386	A. BUILDING 00 B. WING	05/12/2011

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	malnutrition, dementia, and high blood pressure. In a continuous observation on 5/10/2011 between 12:45 p.m. and 3:15 p.m.; Resident #47 was observed sitting in his wheel chair with a lap tray on, between 12:45 p.m. and 1:45 p.m. in the hall, between 1:45 p.m. and 2:00 p.m. enjoying a puzzle in the activity area, between 2 p.m. and 3:15 p.m. in the hall. Resident #47 was not toileted nor his lap tray released. At 3:15 p.m. CNA #10 was observed to take Resident #47 to his room for toileting. He was not observed to have been incontinent nor did he have wet clothing at that time. A care plan, dated 4/14/2011, titled incontinence indicated to toilet frequently. In an interview on 5/11/2011 at 1:25 p.m., LPN #4 indicated Resident #47 was to be toileted before and after meals and when requested.			

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	In an interview on 5/12/2011 at 9:10 a.m., the Director of Nursing indicated Lippincott's manual was utilized as a part of their policy. 3.1-38(a)(3)(A)			
F0406 SS=D	If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. Based on observation, interview and record review, the facility failed to follow-up on a PASAAR recommendation to ensure psychiatric history and evaluation was obtained for 1 of 19 residents reviewed for specialized services in a sample of 19 residents. (Resident #4)	F0406	Resident #4 was referred to psychiatric services on 5/12/11. No negative outcomes were identified during this observation.All Resident's PASARR have been reviewed by Social Service Director/Designee and any recommendations have been addressed. The Social Service Director/Designee will refer Residents to specialized services as recommended in the PASARR.The Social Service Director/Designee will monitor the regulation for compliance monthly for 3 months and will report any	06/11/2011

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	Findings include: The "PreAdmission Screening Determination (PASAAR)," form, dated 3/23/11, indicated Resident #4 was mentally ill but required less intensive services. The diagnoses included depression disorder, anxiety disorder and post traumatic stress disorder. The services to be provided by the facility included yearly resident review, psychiatric evaluation, medication monitoring, medication administration, and other. Other services listed [It is unknown if the (name of local hospital) is treating him for psychiatric issues. "...This could be looked into for help with depression. He indicated to me he was involved with the (name of local hospital) for treatment but no note of this was in chart...."] A "Brief Interview for Mental Status (BIMS)," dated 3/29/11, indicated Resident #4 scored a 10 (moderately impaired).		abnormal findings to the Administrator. The Administrator will report these findings to the Quality Assurance Committee for the next 3 months (Addenum: and then quarterly thereafter for 1 year). The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will review the progress of findings and offer input as necessary to the Quality Assurance Committee.The Administrator is responsible for continued compliance with the regulation.	

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	The nurses "Progress Notes," dated 5/5/11 at 7:00 a.m., indicated Resident #4 had refused his medication. The nurses "Progress Notes," dated 5/6/11 at 9:00 p.m., indicated Resident #4 was alert and oriented to self/room and surroundings. The note further indicated the resident was unable to recall the nurse's name after five minutes. The Social Service Director was interviewed on 5/10/11 at 2:45 p.m. During the interview, the Social Services Director indicated she had never followed up on the admission PASAAR recommendations before today. She further indicated the resident will never accept this and indicated he has been depressed his whole life. The "Behavior Documentation Record.," dated 3/26/11, indicated Resident #4 states that he is a burden for everyone and has made statements of death and how he			

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	wishes he was dead. A second behavior record indicated the resident removes his personal alarms and transfers himself. On 5/10/11 at 1:10 p.m., Resident #4 was observed sitting up in his wheelchair in the lounge near the nurse's station. He was overhead stating someone had come up to him asking if he saw a psychiatrist, she didn't tell me why. He further stated, they wanted to send him to the third floor and talk with someone, told him he was aggressive with what he said. Stated "I've seen a lot of death, sometimes I just want to go to sleep and not wake up," An unidentified staff member was attempting to reassure the resident when she told him they just wanted to make sure he was ok. He then stated, "Well if I was, I wouldn't say those things." 3.1-23(a)			

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F0514 SS=D	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. 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. Based on record review and interview, the facility failed to ensure physician progress notes and physician dictated notes were available in the clinical record for 1 of 19 residents reviewed for progress notes in a sample of 19 residents. (Resident #4) The facility also failed to ensure the eye doctor for 1 of 1 resident reviewed for ophthalmology visits wrote and signed a note at each visit in a sample of 19 residents (Residents #4)	F0514	Resident #4's physician progress notes were obtained and placed in the clinical record. No negative outcome resulted from this observation.All clinical records have been reviewed to ensure all progress notes are present. All residents will have progress notes in the clinical record after being seen by a physician.The Medical Director has been in-serviced on this regulation on 5/24/11. The Medical Director will in-service the necessary attending physicians on this regulation by 6/11/11. The physician will communicate with the facility on each resident and the date in which they were seen. Medical Records will review the resident list provided by the physician and ensure progress notes are	06/11/2011

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	Findings include: 1 Resident #4's record was reviewed on 5/9/11 at 2:00 p.m. The record indicated Resident #4's diagnoses included, but were not limited to, post traumatic stress disorder (PTSD), delirium, renal insufficiency, benign prostatic hypertrophy (BPH) and cerebrovascular accident (CVA). A "Physician Progress Note," dated 4/15/11 and signed by the Nurse Practitioner, indicated Resident #4 was seen for a thirty day progress visit and that a full note was dictated. The note further indicated to "See orders." No dictated note for 4/15/11 was located in the chart. A nursing "Progress Notes," dated 4/19/11 at 10:45 a.m., indicated Resident #4 was seen by the eye doctor. The note further indicated a new order was received and processed. During review of the record, no Progress Note was noted in the chart.		obtained and placed in the clinical record.Medical Records will monitor compliance weekly times 3 months and report any abnormal findings to the Director of Nursing. The Director of Nursing will report these findings to the Quality Assurance Committee monthly for 3 months (Addenum: and then quarterly therafter for 1 year.) The Quality Assurance Committee will monitor any negative trends until resolved and initiate additional education and/or monitoring as the need is identified. The Medical Director will revew the progress of findings any offer input as necessary.The Administrator is responsible for continued compliance with the regulation.	

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	RN #21 was interviewed on 5/10/11 at 12:47 p.m. During the interview, RN #21 indicated all physician progress notes should be filed in the chart During an interview on 5/11/11 at 11:00 a.m., with RN #21, she indicated physician progress notes are usually kept in the chart under consults. She further verified there were no reports in the chart for Resident #4. On 5/11/11 at 11:15 a.m., the Director of Nursing provided a copy of the dictation from 4/15/11 from the Nurse Practitioner that was just faxed to the facility from the office. The noted indicated the resident was seen on 4/15/11 for a 30-day progress visit and that Resident #4 had complaints of nasal stuffiness and itchy eyes and that new orders were written. During an interview on 5/11/11 at 11:10 a.m., with the DON, she			

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	indicated she had made a call out to the office to get a copy of the progress note from the eye doctor. The Director of Nursing was interviewed on 5/11/11 at 1:00 p.m., She was unaware of why the eye doctor's note was not in the resident's chart. She further indicated the doctor's office had just faxed over a copy of the assessment from the visit. The DON provided the faxed copy of the eye doctor's visit, dated 4/19/11. The fax confirmation indicated the facility received the note on 5/11/11 at 10:32 (no a.m. or p.m. listed). The Medical Director was interviewed on 5/12/11 at 11:18 a.m. He indicated he was unaware of why the eye doctor's visit note was not in the resident's chart. He further indicated, the eye doctor usually has a form that he completes which stays in the resident's chart. 3.1-50(a)(1) 3.1-50(a)(3)			

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	3.1-50(a)(4) 3.1-50(e)(5)			