

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G702		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/02/2013	
NAME OF PROVIDER OR SUPPLIER  CAREY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7891 E 296TH ST ATLANTA, IN 46031			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: June 24, 25, 26, July 1, and 2, 2013.</p> <p>Facility Number: 003179 Provider Number: 15G702 AIMS Number: 200403780</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/12/13 by Ruth Shackelford, QIDP.</p>	W000000	General Comments				

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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W000112	<p><b>483.410(c)(2) CLIENT RECORDS</b> The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client #1) and 1 additional client (client #4), the facility failed to keep each client's personal information confidential by posting client #1 and #4's new medications and physician's orders.</p> <p>Findings include:</p> <p>On 6/24/13 from 2:55pm until 6:12pm, observation and interviews were conducted at the group home. At 4:35pm, the RM (Residential Manager) and GHS (Group Home Staff) #1 both indicated posted on the front of the medication cabinet in the hallway at eye level was a paper that indicated "Please Check for New Meds (Medications) and New Orders. [Client #1]: Donepezil (for Dementia) 8pm. [Client #4] Lisinopril (for blood pressure) tab (tablet) 7am DC'd (Discontinued), Lisinopril tab 7am &amp; (and) 7pm, take BP (Blood Pressure) before administration and hold if systolic pressure is less than 100. Keep track in MAR (Medication Administration Record). Tramadol (for pain) 7am, 7pm. Zithromax (antibiotic) 7am thru (through)</p>	W000112	<p><b>W112 Client Records</b></p> <p>This item outlines that the agency failed to keep client's personal information confidential. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure to keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</li> <li>· All staff will be trained that clients' personal confidential information is not to be posted in view of anyone that has access to the home.</li> <li>· Specifically for client # 1 and # 4 med medications and physician's orders were removed immediately on 6/24/13 upon the surveyor questioning/interviewing the Residential Manager.</li> </ul>	08/01/2013			

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	<p>June 1st (sic)." At 4:35pm, the RM and GHS #1 both indicated client #1 and #4's first and last names were on the posted sheet of paper with each client's medications and order changes from their physicians. At 4:35pm, the RM and GHS #1 both indicated visitors, staff, and other clients had access to the posted information in the group home.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/2/13 at 1:00pm. The QIDP indicated clients' full names and their personal information should not have been posted on the cabinet where visitors, staff, and other clients to the home had access.</p> <p>9-3-1(a)</p>		<ul style="list-style-type: none"> <li>· The Residential Manager or the Director of Group Homes will complete weekly checks at the group home to ensure no confidential information is posted in view of anyone that has access to the home.</li> <li>· See attached copies of training verification forms and copy of weekly verification to ensure no personal confidential information is posted.</li> <li>· This form will be posted in the office at the group home and a copy will be scanned and emailed to the Director of Group Homes every week:</li> </ul> <p>Week #1</p> <p>Week #2</p> <p>Week #3</p> <p>Week #4</p> <p>Week # 5</p> <p>January</p>		

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			February	
			March	
			April	

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			May	
			June	
			July	

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			August	
			September	
			October	

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			November	
			December	

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W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. Based on record review and interview for 1 of 3 sampled clients (client #3), the facility failed to obtain a dental assessment which included an extraoral and intraoral dental examination annually.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 6/25/13 at 11:00am. Client #3's record did not indicate a dental assessment.</p> <p>An interview with the facility LPN (Licensed Practical Nurse) and QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/2/13 at 1:00pm. The LPN and QIDP both indicated no dental examination had been completed for client #3 within the past twelve months during her stay at the facility. The QIDP provided a 12/19/11 Dental Assessment which indicated "that the office (Doctor's Office) would call back to schedule a follow up appt. (appointment)." The QIDP stated the RM (Residential Manager) had "called monthly for the past several months to get a current appointment scheduled," but indicated the dentist office had not</p>	W000352	<p><b>W352 Protection of Clients Rights</b></p> <p>This item outlines that the agency failed to obtain a dental assessment which included an extraoral and intraoral dental examination. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The Residential Nurse and/or Residential Manager will ensure comprehensive dental diagnostic services include periodic examination and diagnosis is performed at least annually unless documented by the dentist.</li> <li>· Quarterly medical audits will be conducted by the Residential Nurse with the assistance of the Residential Manager to ensure that all required or necessary medical appointments are completed in a timely manner.</li> </ul>	08/01/2013			

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	returned calls.  9-3-6(a)		Client #3 was seen by Dr. Simpson (dentist) on 7/25/13 at 10a.m. See attached copy of appointment form.		

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview for 1 of 5 clients (client #6) observed during the evening medication pass, the facility failed to administer medications as prescribed by client #6's physician.</p> <p>Findings include:</p> <p>On 6/24/13 at 4:30pm, Group Home Staff (GHS) #1 requested client #6 to come to the medication area. GHS #1 selected client #6's Risperdal medication (for behaviors) 2mg (milligrams), and compared the medication card instructions to client #6's 6/2013 MAR (Medication Administration Record). GHS #1 identified that client #6's dose of Risperdal medication was not in the card, and indicated client #6 had already been given his 5:00pm dose of Risperdal 2mg at the 12:00pm (noon) medication administration time. GHS #1 requested assistance from the Residential Manager (RM). The RM came to the medication area, checked client #6's medication card, and confirmed client #6 was given his 5:00pm dose of Risperdal 2mg at the 12:00pm (noon) medication administration time. GHS #1 and the RM</p>	W000368	<p><b>W368 Drug Administration</b></p> <p>This item outlines that the agency failed to assure that all drugs were administered in compliance with the physician's orders. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility must ensure the system for drug administration assures that all drugs are administered in compliance with the physician's orders.</li> <li>· The staff involved in the incident regarding physician's orders not being followed on 6/24/13 with client #6 received disciplinary actions and retraining.</li> <li>· Additionally, the Residential Manager or the Residential Nurse will conduct at least one weekly medication administration observation for 3 months, if no</li> </ul>	08/01/2013			

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	<p>further reviewed client #6's medication cards and discovered client #6's "Buspar (for behaviors) 10mg, 1 tab 3 x day (three times a day) (at) 7am, 12N (noon), (and) 7pm" was not administered at 12:00pm (noon). Client #6 was requested to come to the medication area a second time and GHS #1 prepared client #6's Buspar medication for administration. Client #6 came to the medication area, and took his "Buspar 10mg" medication.</p> <p>On 6/24/13 at 5:06pm, client #6's 6/2013 MAR and 5/2013 "Physician's Orders (signed by client #6's physician)" indicated "Buspar 10mg," one tablet three times a day at "7am, 12N, (and) 7pm," and "Risperdal 2mg, 1/2 tab morning, 1/2 tab evening, 1 tab bedtime," and "7am, 5pm, (and) 8pm."</p> <p>An interview with the agency's LPN (License Practical Nurse) was conducted on 6/25/13 at 9:45am. The Agency LPN indicated the facility followed the Core A/Core B Medication Training for staff to administer medications. The agency LPN indicated facility staff should follow each client's physician's orders when administering medications in the group home. The LPN indicated client #6's physician orders were not followed when facility staff did not administer each medication according to the physician's</p>		<p>errors then med administration observations will reduce to twice monthly.</p> <p>· See attached copy of the Med Pass Observation Form.</p>				

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	<p>order. The agency LPN indicated facility staff should have given client #6's medications at the correct time for each medication.</p> <p>On 6/25/13 at 10:15am, a record review was completed of the facility's policy and procedures, 11/07 "Medication Administration by Staff" which indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 6/25/13 at 10:15am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p>				

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W000426	<p><b>483.470(d)(3) CLIENT BATHROOMS</b></p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), to ensure the temperature of the water did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p> <p>On 6/24/13 from 2:55pm until 6:12pm, and on 6/25/13 from 6:25am until 8:39am, observation was completed at the group home with clients #1, #2, #3, #4, #5, and #6. On 6/24/13 at 3:15pm, GHS (Group Home Staff) #1 assisted client #1 to fill a glass with water from the kitchen sink. GHS #1 indicated to client #1 to wait until GHS #1 set the water on the cold side of the handle and stated "because the water gets too hot." At 3:15pm, GHS #1 filled a water glass with cold water and handed the glass to client #1. From 3:15pm until 3:25pm, GHS #1 set the sink faucet handle to the hot side, rinsed then washed her hands, and steam was observed rising from the kitchen sink.</p>	W000426	<p><b>W426 Client Bathrooms</b></p> <p>This item outlines that the agency failed to ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure that areas of the home where consumers who have not been trained to regulate water temperatures are exposed to hot water, ensuring that the water temperature does not exceed 100 degrees Fahrenheit.</li> <li>· Water temperature was adjusted on the hot water heater.</li> <li>· Daily water temps will be checked at varying times and locations to ensure water</li> </ul>	08/01/2013			

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	<p>On 6/24/13 at 3:25pm, the Residential Manager (RM) indicated the kitchen sink was 118.3 degrees Fahrenheit. At 3:25pm, the RM indicated clients #1, #2, #3, #4, #5, and #6 could not independently mix hot water and did not recognize dangers of hot water. At 3:50pm, the RM indicated the hallway bathroom sink was 118.6 degrees Fahrenheit. From 2:55pm until 6:12pm, clients #1, #2, #3, #4, #5, and #6 were prompted to turn on the water to wash their hands in the sinks. On 6/25/13 at 6:25am, the QIDP (Qualified Intellectual Disabilities Professional) indicated the kitchen sink was 120 degrees Fahrenheit. The QIDP indicated clients #1, #2, #3, #4, #5, and #6 did not recognize the danger of hot water and did not have the independent skill to mix hot water. At 7:15am, the hallway bathroom sink water temperature was 120.1 degrees Fahrenheit. At 6:30am, the RM indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 did not have the skill to mix the water temperature below 110 degrees Fahrenheit.</p> <p>On 6/25/13 at 9:45am, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP stated clients #1, #2, #3, #4, #5, and #6 "did not recognize the risks of hot water." The QIDP indicated monitoring of the</p>		<p>temperature is maintained between 100 and 110 degrees Fahrenheit for 2 months. If no problems with water temperatures in excess of 110 degrees Fahrenheit will resume to weekly water temp checks. See attached copy of daily hot water temp checks and attached copy of weekly safety verification log.</p> <p>See attached training verification from 7/24/13.</p>				

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	<p>group home water temperature log was completed by the overnight staff and the water temperature was not to exceed 110 degrees Fahrenheit.</p> <p>On 6/25/13 at 11:00am, a review of client #1, #2, and #3's undated "Water Temperature Control" assessments indicated clients #1, #2, and #3 were not able to mix hot water above 110 degrees Fahrenheit.</p> <p>9-3-7(a)</p>			

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W000436	<p><b>483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to teach and encourage client #1 to use her walker and failed to ensure clients #2 and #3's wheelchairs were in good repair and equipped with foot rests.</p> <p>Findings include:</p> <p>1. On 6/24/13 from 2:55pm until 6:12pm, observation was completed at the group home with client #1. At 2:55pm, client #1 was seated at the dining room table playing bingo and no walker was observed. From 2:55pm until 3:15pm, client #1 sat in a wheelchair, stood up, walked around the dining room, kitchen, living room, and down the hallway to her bedroom and did not use a walker or a wheelchair. At 3:55pm, client #1 was using a wheelchair and went to the kitchen. Client #1 got up from the wheelchair, walked throughout the kitchen area and did not use a walker or a wheelchair. At 4:06pm, client #1 sat in a wheelchair and was assisted to the</p>	W000436	<p><b>W436 Space and Equipment</b></p> <p>The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>· The facility will ensure to furnish, maintain in good repair and teach clients to use and to make informed choices about the use of adaptive devices identified by the interdisciplinary team as needed by the consumers.</li> <li>· Staff will be trained to encourage consumers to make informed choices about the use of their adaptive equipment as prescribed by physician.</li> <li>· Client #1 has a new order from her PCP Dr. Powell to use wheelchair full time for mobility. See attached copy of the order.</li> </ul>	08/01/2013			

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	<p>bathroom by staff. At 5:15pm, client #1's walker was observed inside her bedroom. From 4:06pm until 6:12pm, client #1 was observed to transfer to and from a wheelchair to a dining room chair and move throughout the facility in a wheelchair.</p> <p>Client #1's record was reviewed on 6/26/13 at 10:15am. Client #1's 10/18/12 ISP (Individual Support Plan) indicated "Adaptive Equipment List...Wheelchair, Use for mobility for long distances, Walker, Use for mobility...." Client #1's 6/1/13 "Physician's Order" indicated "May use wheelchair on community outings."</p> <p>On 7/2/13 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #1 could use a wheelchair inside or outside the home because of recent falls. The QIDP indicated client #1 should have been taught or encouraged to use a wheelchair or her walker inside the group home because of client #1's mobility risks.</p> <p>2. On 6/24/13 from 3:25pm until 6:12pm, and on 6/25/13 from 7:30am until 8:39am, client #2 sat in his wheelchair and his right and left legs were without support from his seated upright position</p>		<ul style="list-style-type: none"> <li>· Client #2 was assessed by Home Health Depot on 7/22/13 for the use of current leg rest, due to atrophy in legs it was recommended that Client #2 needs to be re-evaluated by an occupational therapist to determine the type of support needed for legs and foot rest. Nick Harrison from Home Health Depot will contact Dr. Powell for a referral for Client #2 to have an occupational therapy evaluation. Evaluation will be scheduled. See attached report from Home Health Depot.</li> <li>· Client #3's chest strap for harness was repaired by Home Health Depot on 7/22/13. See attached report from Home Health Depot.</li> <li>· Staff training will be held on 7/24/13 to review procedure for the use of the equipment repair form. See attached training verification and copy of blank form.</li> </ul>				

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	<p>and reclined position in his wheelchair. Client #2's molded wheelchair did not have foot or leg rests on the wheelchair for client #2's leg supports during both observation periods.</p> <p>Client #2's records were reviewed on 6/25/13 at 10:45am. Client #2's 10/16/12 ISP indicated "Adaptive Equipment List...Wheelchair, Use for mobility." Client #2's ISP indicated he required staff assistance for transfers to and from his wheelchair and mobility.</p> <p>On 7/2/13 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #2 used a wheelchair for mobility and required staff assistance for transfers and body positioning. The QIDP indicated client #2 should have had his legs supported or touching the ground when he was in an upright position in the wheelchair. The QIDP indicated no leg rests or leg supports were available at the group home for client #2's wheelchair.</p> <p>3. On 6/24/13 from 3:25pm until 6:12pm, and on 6/25/13 from 7:30am until 8:39am, client #3 sat in her wheelchair with a chest strap to secure her inside her wheelchair. Client #3's right chest strap was broken and would not</p>						

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	<p>attach securely in position and hung from her shoulder. On 6/24/13 from 3:25pm until 6:12pm, client #3's right and left legs were without support from her seated upright position in her wheelchair. Client #3's molded wheelchair did not have foot or leg rests on the wheelchair for client #3's leg supports.</p> <p>Client #3's records were reviewed on 6/25/13 at 11:00am. Client #3's 10/16/12 ISP indicated "Adaptive Equipment List...Orthotic right lower extremity...Wheelchair." Client #3's ISP indicated she required staff assistance for transfers to and from her wheelchair and mobility.</p> <p>On 7/2/13 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #3 used her wheelchair inside or outside the home. The QIDP indicated client #3 should have had foot/leg supports on the wheelchair. The QIDP provided a 2/11/13 "Service Work Order" which indicated a request for wheelchair repairs for client #3's chest strap and wheelchair repairs.</p> <p>9-3-7(a)</p>						

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W000460	<p><b>483.480(a)(1)</b> <b>FOOD AND NUTRITION SERVICES</b> Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (#2) who received thickened liquids, the facility failed to ensure client #2 received the recommended thickness of his liquids as prescribed.</p> <p>Findings include:</p> <p>During observations at the group home on 6/24/13 at 5:45pm, GHS (Group Home Staff) #4 thickened client #2's drinks with a thickening powder and stated "it's nectar" consistency. GHS #4 took a fork, stirred the mixture in the cup, raised the fork upwards, and stated as she showed the mixture quickly running off the fork "nectar." The mixture was a smooth runny mixture. At 6:00pm, client #2 fed himself bites of pureed food and drank nectar thickened liquids, then coughed after drinking. At 6:00pm, the RM (Residential Manager) indicated client #2's liquids were to be honey thickened.</p> <p>During observation and interview at the group home on 6/25/13 at 8:30am, GHS #2 and GHS #4 both indicated client #2's liquids were thickened to a "nectar" consistency. At 8:37am, client #2 fed</p>	W000460	<p><b>W460 Food and Nutrition</b> The plan of correction for this tag is as follows: · The Residential Manager and the Residential Nurse will ensure that each client receive a nourishing, well-balanced diet including modified and specially prescribed diets. · All staff will be retrained on liquid consistency pertaining to Client #2 liquid consistency (honey thick) as prescribed by the physician. · The Residential Manager and the Residential Manager will conduct one weekly meal observation for two months if no errors will be re-evaluated. · See copy of group home observation form blank.</p>	08/01/2013

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	<p>himself prepared thickened liquids to nectar consistency for apple juice and sixteen ounces of chocolate ensure (a protein drink).</p> <p>Client #2's record was reviewed on 6/25/13 at 10:45am. Client #2's 10/16/12 ISP (Individual Support Plan) indicated client #2 was on a pureed diet with honey thickened liquids. Client #2's 6/2013 "Physician's Order" indicated "Pureed (diet) per Speech Eval (Evaluation), Honey thickened liquids." Client #2's 6/2013 "Dining Dysphagia Management Plan" indicated "...Food Texture: Puree. Fluid Texture: Honey-like No naturally honey thick liquids. Thicken liquids to the viscosity of honey (sic)."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/2/13 at 1:00pm. The QIDP indicated client #2's liquids should have been honey consistency thickened.</p> <p>9-3-8(a)</p>						

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W009999	<p>State Findings 460 IAC 9-3-3 Facility staffing Authority: IC 12-28-5-19 Affected: IC 4-21.5:12-28-5-12; IC 22-12</p> <p>Sec. 3. (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result was significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed for 1 of 3 employee records (Group Home Staff #1) reviewed to complete an annual Mantoux (tuberculin skin test).</p>	W009999	<p><b>W9999 Final Observations</b></p> <p>The plan of correction for this tag is as follows:</p> <ul style="list-style-type: none"> <li>The facility will ensure prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux tuberculosis skin test or chest x-ray was completed.</li> <li>Chest x-ray was prescribed and complete on 7/2/13 for group home staff #1. See copy of Group Home staff #1 result of chest x-ray results.</li> </ul>	07/02/2013			

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	<p>Findings include:</p> <p>A record review was conducted on 6/25/13 at 11:50am, with the agency's Human Resource Director (HRD). The HRD and the employee record for GHS #1 indicated GHS #1 was hired on 8/31/12 and no Mantoux (PPD) was available for review. HRD indicated she would look for GHS #1's Mantoux test.</p> <p>On 7/2/13 at 1pm, the QIDP (Qualified Intellectual Disabilities Professional) was interviewed. The QIDP indicated GHS #1 had had a Mantoux skin test upon hire however there was no record GHS #1's Mantoux skin test was read.</p> <p>9-3-3(e)</p>				