

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2014
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NAME OF PROVIDER OR SUPPLIER PINE KNOLL ASSISTED LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 607 WILSON CREEK RD LAWRENCEBURG, IN 47025
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 28 and 29, 2014</p> <p>Facility number: 001142 Provider number: 001142 AIM number: N/A</p> <p>Survey team: Tammy Forthofer, RN, TL Angela Halcomb, RN Julie Dover, RN Rita Bittner, RN</p> <p>Census Bed Type: Residential: 20</p> <p>Census Payor type: Medicaid: 9 Other: 11 Total: 20</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on September 4, 2014, by Brenda Meredith, R.N.</p>	R000000		
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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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R000121	<p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance</p> <p>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited</p>						

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	<p>to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to provide annual TB (tuberculin) testing in a timely matter for 3 of 5 employee files reviewed. This had the potential to effect 20 of 20 residents currently in the facility. (LPN #1, Dietary Aide #3 and LPN #4)</p> <p>Finding includes:</p> <p>During an employee record review on 8/28/14 at 1:40 p.m., for LPN #1 indicated an annual tuberculosis test was administered on 4/16/13 and read on 4/18/14. LPN #1 annual tuberculosis test was administered on 4/30/14 and read 5/3/14, 14 days pasted the due date.</p> <p>During an employee record review on 8/28/14 at 1:40 p.m., for LPN #4 indicated an annual tuberculosis test was administered on 1/2/13 and read on 1/4/13. LPN #4 annual tuberculosis test was administered on 1/30/14 and read on 2/1/14, 28 days pasted the due date.</p> <p>During an employee record review on 8/28/14 at 1:40 p.m., for Dietary Aide #5 indicated an annual tuberculosis test was administered on 7/24/13 and read on 7/26/13. Dietary aide #5's chart lacked</p>	R000121	<p>Immediately when we realized we had made an error in the annual tuberculin skin test on Dietary Aide #3 we pulled the employee from working on 8/28/14 until she received and had read the tuberculin skin test which was read on 8/30/14, then we allowed her to come back to work. In order to ensure deficient practice will not recur we have set up a system that the LPN supervisor will document on the large calendar in the Med Room when TB test are to be given and to be read. The LPN super will also keep a file on each staff and resident as to the date of the last TB test given. Also, the administrator will keep a file in her office as to when the annual TB test is to be given for each staff and resident and during the first week of each month the administrator will check with the LPN supervisor as to who will be given their annual tuberculin skin test. This change was started on 9-15-14 with the LPN supervisor creating the file. The administrator will be checking each employee's file to get the correct date as to the last TB test given, then check with the LPN Supervisor to be sure they coincide with the employee file. Starting October 1, 2014, the administrator and LPN supervisor will conduct the first meeting to</p>	10/01/2014			

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	<p>annual tuberculosis test for this year.</p> <p>During an interview on 8/28/14 at 2:45 p.m. LPN#1 indicated we give the annual TB test a couple of days before the last annual and read it on the due date. LP #1 indicated that if an employee has not had there annual TB test, they are not able to work until the TB is giving and read, we would pull them from the floor.</p> <p>Review of dietary as worked scheduled on 8/28/14 at 2:55 p.m., indicated dietary aide #5 worked the following days: July 29, 30, August 2, 3, 4, 7, 8, 11, 12, 13, 14, 16, 17, 18, 19, 20, 22, 23 and 24.</p> <p>During an interview on 8/28/14 at 3:00 p.m. The Administrator indicated for Dietary aide #5 we just missed her annual TB testing, we are now aware of it and she will be pulled for the floor.</p> <p>On August 29, 2014 at 10:32 a.m., the Administrator provided a copy of the current policy and procedure for the annual Mantoux. The policy indicated, "It is the policy of this facility that any resident or staff shall have an annual tuberculin skin test eleven to twelve months after their second step and annually there after if the resident has has a non-significant reaction to either their</p>		<p>see that we have everybody that is due for their annual for that month and that they are scheduled on the calendar. The administrator will follow up after their TB test has been given and check to be sure it has been filed in the file box and the form is put in the employees' folder. The administrator will do a review the first of each month for six (6) months and will document that everything is correct. This review will begin October 1, 2014</p>				

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R000349	<p>first or second step."</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 employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure complete clinical documentation on 2 of 5 charts reviewed. (Resident#5 and #8).</p> <p>Finding includes:</p> <p>Resident #8's clinical record was reviewed on 8/28/2014 at 1:40 p.m. The resident's pre admission assessment was on 7/2/2014, no nursing signature or attending physician information was documented on the front of the assessment form. The back of the pre admission form has an area for comments or additional notes, seven lines of documentation was dated 7/2/2014 with no nursing signature or time of completion noted.</p>	R000349	<p>On September 9, 2014 the administrator and LPN supervisor discussed the pre-admission forms that had not been signed. It was decided that there would be an attached note to the pre-amission form verifying the nurse did indeed do this pre-assessment. In order to ensure deficient practice will not recur, a check off list will be created by September 19, 2014 to verify everything that needs to be completed for the pre-admission form. The check off list will be kept with the pre-admission form. The pre-admission form was revised 9-15-14</p>	09/19/2014			

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R000407	<p>Resident #5's clinical record was reviewed on 8/28/2014 at 2:28 p.m. The resident's pre admission form was dated 3/20/2014 at 12:15 p.m. The pre admission form was missing the following assessment documentation: vitals, pain scale, allergies, physical status, orientation to facility and nursing signature.</p> <p>During an interview on 8/28/2014 at 2:32 p.m., LPN #1 indicated all nursing assessment forms are to be filled out completely, signed and dated by the assessing nurse personnel.</p> <p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation and record review, the facility failed to ensure proper hand washing during kitchen observation and</p>	R000407	A conference meeting was conducted with the dietary manager and cook on September 8, 2014 at 10:30 a.m. where we	10/08/2014			

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	<p>serving meal. (Dietary manager and Cook #3)</p> <p>Finding includes:</p> <p>During an observation on 8/28/14 at 10:05 a.m., the dietary manager was observed to enter the kitchen no hand washing or hand gel was observed.</p> <p>During an observation on 8/28/14 at 11:47 a.m., cook #3 was observed to enter the kitchen no hand washing or hand gel was observed. Cook #3 was observed to pick up a tray of drinks and take them to the dining room.</p> <p>During an observation on 8/28/14 at 12:00 p.m., the dietary manager was observed to wash her hands turned the water off with a paper towel and then was observed to dry her hands with the same paper towel she turned the water off with. Dietary manager was then observed serving food for the residents.</p> <p>On August 28, 2014 at 1:29 p.m., the Administrator provided a current copy of the facilities, hand cleaning policy and procedure. The policy and procedure indicated, "13. During food preparation, as often necessary to remove soil and contamination and to prevent cross contamination when changing tasks 15.</p>		<p>discussed the State Survey findings and how we need to improve in this area. In order to ensure deficient practice will not recur, the administrator and or LPN supervisor will for the next 12 months hold an in-service every quarter on Infection Control and the Importance of Hand Washing Properly. Our first in-service is scheduled for Wednesday, October 1, 2014 at 2:00 p.m. Also, there will be random times that the administrator or other personnel will observe dietary staff that they are indeed properly and in timely manner washing their hands. This will be observed three (3) to five (5) times per week and documented on a form that was created on 9-16-14. This random observation will be conducted for the next three months, it will begin on Sept 16, 2014 and end on December 19, 2014</p>				

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	Directly before touching ready-to-eat food or food-contact surfaces 16. Before serving of food...."				