STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00187170. Complaint IN00187170- Substantiated. Federal/State deficiencies related to the allegations are cited at F252, F309, F315, F353 and F9999. Survey dates: November 24 and 25, 2015. Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census bed type: SNF/NF: 107 Total: 107 Census payor type: Medicare: 32 Medicaid: 62 Other: 13 Total: 107 Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**ThisPlan of Correction is the centers credible allegation of compliance** **Preparationand /or execution of this plan of correction does not constitute admissionor agreement by the Provider of the truth of the facts alleged or conclusionsset forth in the statement of deficiencies. The plan of correction isprepared and/or executed solely because it is required by the provisions of federaland state law.** **It isrespectfully requested that this plan of correction be considered for paper compliance.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	QR completed by 11474 on December 2, 2015.			
F 0176 SS=D Bldg. 00	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. Based on observation, interview and record review, the facility failed to ensure a resident was assessed for self-medication administration of respiratory medication prior to self-administering for 1 of 5 residents observed for medication administration. (Resident B) Findings include: 1. The clinical record for Resident B was reviewed on 11/24/15 at 2:00 p.m. Diagnoses for Resident B included, but were not limited to, pain, colostomy, chronic kidney disease, anxiety, diabetes mellitus and Chronic Obstructive Pulmonary Disease (COPD).	F 0176	Aself administration of medication assessment was completed on Resident B on12-3-15. . AnIDT round was completed, care plan reviewed and updated. Aself administration of medication audit was completed on 12-7-15 by Nursing management for residents currently receiving routine nebulizer treatments. Those that were assessed to be able to selfadminister had an IDT round, with care plan reviewed and updated by 12-11-15 by the IDT Newresidents with routine nebulizer treatments will be assessed upon admission by the IDT Anyresident that self administers medication will be monitored for continuedability to self administer on a quarterly basis and with any significantchange. Nursingstaff re-education was completed on	12/25/2015

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	During medication administration observation on 11/24/15 at 9:28 a.m., LPN #4 gave Resident B his oral medications. LPN #4 then poured DuoNeb (bronchodilator) 2.5 mg/3mL into a nebulizer cup and gave it to Resident B to administer. Resident B placed the nebulizer strap over his head and LPN #4 left the room to continue medication administration. During an interview on 11/24/15 at 3:45 p.m., Resident B indicated he usually administered a lot of his own respiratory treatments. During an observation on 11/25/15 at 9:13 a.m., Resident B was seated in his room with a nebulizer mask on. The nurse was down the hall at the medication cart. Review of a current Care Plan, initiated 5/8/15 and updated 11/3/15, indicated, "[Name of resident] has impaired cognitive function/dementia...." The interventions included, but were not limited to, "Administer medications as ordered." Another Care Plan, initiated 8/11/15, indicated "Decline with walking skill due to: weakness related to diagnosis of: COPD." The interventions included, but were not limited to, "...Oxygen, monitor for shortness of		Self Administration of Medication protocol andNebulizer treatments on 12-1 and 12-2-15. (Attachment A) by DON Randomchecks will be conducted by the Unit Managers three times a week for fourweeks. (Attachment B). Ifno issues found, random checks will be conducted weekly time four weeks andthen monthly for four months. Thecheck lists will be submitted to the Business Leadership Team forweekly/monthly review. TheBusiness Leadership Team will submit results to the Quality Assurance Committeeoverseen by the Administrator for continued compliance.	

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	breath...." During an interview on 11/25/15 at 9:35 a.m., Unit Manager #5 indicated Resident B did not self-administer his own medications and the nurses were to remain at the bedside during the breathing treatment. Review of a facility policy titled "Self-Administration of Medication" provided by Unit Manager #5 on 11/25/15 at 2:00 p.m., indicated the following: "POLICY It is the policy of this facility to allow residents who request self-administration of medication to do so if the facility Interdisciplinary Team has determined the resident is capable of doing so in a safe manner that does not present a risk to other residents of the facility. ...2. If the resident expresses a desire to self-administer..., the facility will not allow the resident to self-administer meds until the following procedures are done: a. A Licensed Nurse will complete the Self-Administration Assessment... b. The assessment...review with the Interdisciplinary Team (IDT) for approval. c. ...resident will do a return			

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	demonstration to the IDT.... ...4. If the IDT approves...steps taken before self-administering can begin: a. The resident's physician will be contacted for approval." This Federal tag relates to Complaint IN00187170. 3.1-11(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to ensure appropriate care and maintenance for urinary catheters for 2 of 2 residents reviewed for urinary catheters. (Resident C and Resident F)	F 0315	Newcatheter drainage bags were changed on all residents identified in the survey(C and F) on 11-24-15 by Nursing Management. An audit wascompleted on all residents with catheters on 11-24-15 by Nursing Management and no	12/25/2015

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	Findings include: 1. The clinical record for Resident C was reviewed on 11/24/15 at 4:10 p.m. Diagnoses included, but were not limited to, urinary retention, spinal stenosis, diabetes mellitus and sacral spina bifida. The most recent Quarterly Minimum Data Set (MDS) assessment dated 10/5/15, indicated Resident C was cognitively intact. During an observation on 11/24/15 at 9:28 a.m., Resident C's urinary catheter bag and tubing were observed on the floor. During an observation and interview on 11/24/15 at 3:50 p.m., Resident C indicated he was unaware his catheter bag and tubing were on the floor. He indicated he had a suprapubic catheter and had been on antibiotics in the past for urinary tract infections. Review of a current Care Plan, initiated 5/29/15 and updated 7/10/15, indicated, "[Name of resident] has a Suprapubic Catheter: r/t [related to] a Neurogenic Bladder." Interventions included, but were not limited to, "Position catheter bag and tubing below the level of the bladder and away from entrance room		changes in theplan of care were needed. Nursingstaff were re-educated on appropriate catheter care on 11-24-15 and 12-1 and12-2-15 by Director of Staff Development and DON GuardianAngel rounds were revised to include monitoring of catheter bag placement andare completed on a daily basis. (Attachment C) GuardianAngel rounds are reviewed by the Business Leadership team on a weekly basis formonitoring. Business Leadership teamsubmits results to the Quality Assurance Committee overseen by theAdministrator on a monthly basis. Results will be monitored for the next six months.	

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	door." 2. The clinical record for Resident was reviewed on 11/25/15 at 12:02 p.m. Diagnoses included, but were not limited to, epilepsy, constipation, convulsions, sacral spina bifida and palliative care. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 9/3/15, indicated Resident F was severely cognitively impaired. During an observation on 11/24/15 at 10:50 a.m., Resident F's urinary catheter bag and tubing were observed on the floor, on a floor mat. Review of a current Care Plan, initiated 3/27/15 and updated 8/24/15, indicated, "[Name of resident] is high Risk for Urinary Tract Infection due to: Suprapubic Catheter DX [diagnosis] Neurogenic Bladder." Interventions included, but were not limited to, "Ensure catheter tubing and drainage bag are properly positioned to prevent urinary back-flow or contamination." During an observation and interview with the Director of Nursing on 11/24/15 at 11:20 a.m., both Resident C's and Resident F's catheter bags and tubing were observed on the floor. The DON indicated "they [catheters] should not be			

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	on the floor." Review of a facility policy titled "CATHETER ASSOCIATED URINARY TRACT INFECTION (CAUTI) PREVENTION" provided by Administrator on 11/24/15 at 12:15 p.m., indicated the following: "PURPOSE; To ensure appropriate technique in the care and maintenance of foley catheters. POLICY: ...IX. Keep the collection bag and tubing off the floor. This Federal tag relates to Complaint IN00187170. 3.1-41(a)(2)			
F 0353 SS=D Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to			

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	provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interview and record review, the facility failed to provide sufficient nursing and CNA staff to meet the needs of residents related to basic care and medication administration for 4 of 5 residents who were interviewed for staffing. (Resident's B, C, D and G) Findings include: 1. The clinical record for Resident B was reviewed on 11/24/15 at 2:00 p.m. Diagnoses for Resident B included, but were not limited to, pain, colostomy, chronic kidney disease, anxiety, diabetes mellitus and Chronic Obstructive Pulmonary Disease (COPD). The most recent Quarterly Minimum Date Set (MDS) assessment, dated 11/2/15, indicated Resident B was cognitively intact. During an interview on 11/24/15 at 3:45 p.m., Resident B indicated the facility	F 0353	Areview of the current staffing pattern was completed on 11-30-15. No changes were needed. Nursingstaff were re-educated on 12-1 and 12-2-15 Director of Staff Development and DON, about appropriate call lightanswering times. DepartmentDirectors re-educated on answering call lights by Administrator 12-11-15 GuardianAngel rounds were revised to include monitoring of timeliness of call lightsbeing answered 12-11-15 by Administrator. (Attachment C) Randomcall light audit (Attachment D) will be conducted on five residents on a dailybasis by the Unit Managers for four weeks. If no issues are found, the random audits willbe conducted weekly for four weeks and then monthly there after for fourmonths. GuardianAngel rounds are monitored on a weekly basis by the Business Leadership team.The random call light audit will also be submitted for review by the BusinessLeadership team on a weekly/monthly basis. The	12/25/2015

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	was always short staffed. He indicated it was worse on second shift and occasionally third shift. He indicated his colostomy bag recently came undone and he had stool all over himself and his room. He indicated he waited up to two hours for help. 2. The clinical record for Resident C was reviewed on 11/24/15 at 4:10 p.m. Diagnoses included, but were not limited to, urinary retention, spinal stenosis, diabetes mellitus and sacral spina bifida. The most recent Quarterly Minimum Date Set (MDS) assessment, dated 10/5/15, indicated Resident C was cognitively intact. During an interview on 11/24/15 at 3:50 p.m., Resident C indicated there were not enough people to care for dependent residents. He indicated it was worse on third shift. Resident C indicated he has waited up to 30 minutes for help and it has caused him to be incontinent, but he could not blame any one shift. 3. The clinical record for Resident D was reviewed on 11/25/15 at 10:00 a.m. Diagnoses included, but were not limited to, Huntington's disease, major depression, palliative care and epilepsy. The most recent Significant Change Minimum Date Set (MDS) assessment,		Business Leadership team will summit results to the QualityAssurance Committee overseen by the Administrator for continued compliance.	

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	dated 9/18/15, indicated Resident D was cognitively intact. During an interview on 11/25/15 at 9:15 a.m., Resident D indicated there were "not enough people here [in facility] to help." She indicated she had fallen in her room or bathroom before and it had taken up to 30 minutes for someone to come and help her. 4. The clinical record for Resident G was reviewed on 11/24/15 at 3:05 p.m. Diagnoses included, but were not limited to, amputation, heart failure, diabetes mellitus, blind and weakness. The most recent 14-day Minimum Date Set (MDS) assessment, dated 11/23/15, indicated Resident G was cognitively intact. During an interview on 11/25/15 at 11:20 a.m., Resident G indicated it took one hour for a nurse to come and give her pain medication. She indicated she kept putting on her call-light and CNA would answer and tell her the nurse was busy, but she would be right in. She indicated the nurse apologized for the wait, but indicated she was busy. Resident G indicated the short staffing was worse on third shift. Review of the Resident Census and Conditions form, provided by the			

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	Director of Nursing (DON) on 11/25/15 at 12:15 p.m., indicated 75 of 108 residents were occasionally or frequently incontinent of bladder and 44 of 108 were incontinent of bowel. 101 of 108 were an assist of one or two staff persons for bathing and dressing. 99 of 101 were an assist on one or two staff persons for transferring, toilet use and eating. 17 of 108 residents received respiratory treatments. Confidential CNA and Nurse interviews for staff working 11/24-11/25/15 were completed. Exact times and dates were withheld to maintain anonymity. RN #7 indicated the census recently increased, so when another nurse or QMA worked, it helped a lot. CNA # 8 indicated it was difficult because you were not assigned to a specific area and it was hard to get to know the residents. She indicated she often told the residents the nurse was busy when they needed something. CNA #9 indicated the census had picked up and she felt like the nurses were at a shortage. LPN #10 indicated it was very difficult on the weekend to get your work done			

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	because there was not a wound nurse on the weekend. LPN #11 indicated there was no wound nurse on the weekend and it was hard to get your work done. This Federal tag relates to Complaint IN00187170. 3.1-17(a)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure resident rooms were cleaned as scheduled for 4 of 6 residents reviewed for environment. (Resident's B, C, D and E) Findings include: 1. The clinical record for Resident B was reviewed on 11/24/15 at 2:00 p.m. Diagnoses for Resident B included, but were not limited to, pain, colostomy, chronic kidney disease, anxiety, diabetes mellitus and Chronic Obstructive Pulmonary Disease (COPD). The most recent Quarterly Minimum Date Set	F 0465	Issues identified for Residents B, C, E, and D during the survey have beenresolved and will be audited daily by the Housekeeping Supervisor or herdesignee. ResidentRoom Deep Cleaning Schedule was revised 11-30-15 by Housekeeping Supervisor so that all rooms are deep cleanedmonthly. (Attachment E) Anaudit of all resident rooms was completed on 12-11-15 by HousekeepingSupervisor and Administrator. Oneto one re-education of housekeeping staff with a return demonstration of skills,was completed 12-11-15 by Lead Housekeeper. (Attachment F)	12/25/2015

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	(MDS) assessment, dated 11/2/15, indicated Resident B was cognitively intact. During an interview on 11/24/15 at 3:45 p.m., Resident B indicated the facility was "pretty clean", except the shared bathroom. He indicated there was often feces under the toilet lid. He indicated he complained often about the bathroom. During an observation on 11/24/15 at 3:45 p.m., the shared bathroom had a small amount of stool under the toilet lid. 2. The clinical record for Resident C was reviewed on 11/24/15 at 4:10 p.m. Diagnoses included, but were not limited to, urinary retention, spinal stenosis, diabetes mellitus and sacral spina bifida. The most recent Quarterly Minimum Date Set (MDS) assessment, dated 10/5/15, indicated Resident C was cognitively intact. During an interview on 11/24/15 at 3:50 p.m., Resident C indicated the main 200 Hall shower room had mold from the ceiling down. He indicated the mold was black in color. During an observation on 11/24/15 at 4:10 p.m., the 200 Hall shower room was observed. The shower room smelled of		GuardianAngel rounds were revised by Administrator on 12-11-15 to include wastebaskets and cleanliness of toilets. (Attachment C) Randomchecks will be completed on each housekeeper by Housekeeping supervisor or herdesignee two times a week for four weeks. (Attachment G) If no issues are found, the random checkswill be conducted one time a week for four weeks and then one time every twoweeks for four more months. Thedeep clean list, Guardian Angel rounds and random checks will be monitoredweekly/monthly by the Business Leadership team. The results will be submitted monthly to the Quality Assurance Committeeoverseen by the Administrator for six months to monitor for continuedcompliance.	

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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804	

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	fresh bleach and no mold was noted. 3. The clinical record for Resident E was reviewed on 11/25/15 at 9:47 a.m. Diagnoses included, but were not limited to, obesity, diabetes mellitus, chronic obstructive pulmonary disease and depression. The most recent 14-day Minimum Date Set (MDS) assessment, dated 11/6/15, indicated Resident E was cognitively intact. During an observation and interview on 11/25/15 at 9:30 a.m., Resident E indicated his trash can had been full for some time. He indicated "they [housekeeping] could do a better job." The trash can was observed to be full of trash and food. 4. The clinical record for Resident D was reviewed on 11/25/15 at 10:00 a.m. Diagnoses included, but were not limited to, Huntington's disease, major depression, palliative care and epilepsy. The most recent Significant Change Minimum Date Set (MDS) assessment, dated 9/18/15, indicated Resident D was cognitively intact. During an observation and interview on 11/25/15 at 9:15 a.m., Resident D indicated the "bathroom could be cleaner, especially the toilet." The bathroom was			

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	observed to have toilet paper all over the floor and the shower floor appeared dirty and unkempt. During an interview on 11/25/15 at 10:20 a.m., the Administrator and Housekeeper #6 indicated the head of Environmental Services was not working this day. A cleaning book was provided and titled "DEEP CLEANING SCHDUALE [sic] FOR WEST". The schedule indicated at least 3 rooms per week were to be deep cleaned. Review of the schedule, indicated only Rooms 101, 102, 103 and 104 had been cleaned during the month of November. No previous schedules could be found for the year 2015. During an interview, Housekeeper #6 indicated he was also doing "floors" until they could get someone else. He indicated he had not deep cleaned any rooms yet this week. He indicated that "deep cleaning" included, cleaning ceiling to floor, bed linens, cleaning the blinds and taking down the curtains to wash. A signed statement provided by the Administrator, on 11/25/15 at 2:15 p.m., indicated Housekeeper #6 cleaned the following rooms in the past 2 months: 101, 102 (three times), 104, 101, 107, 109, 111, 201, 203, 215 and 217 (at least			

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	three times). Two of the four resident rooms were not listed on the deep cleaning sheet and no daily cleaning sheets were provided. This Federal tag relates to Complaint IN00187170. 3.1-19(f)(5)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of the facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. This result shall be recorded in millimeters of induration with the date given, date read, and by	F 9999	Thetwo identified staff will administered new TB tests by 12-16-15 Anaudit of the employee files for new hires in the last 4 months will be completed by 12-17-15 for compliance with the TB Skin Test by Director of Staff Development TheNew Employee Checklist was reviewed by Director of Staff Development on 12-11-15, no changes were needed. Directorof Staff Development received additional training by Corporate Staff Development trainer on 12-8-15 regarding theemployee hiring process. Asystem for administering and tracking Mantoux testing was reinstated by Director of Staff Development for newhires on 12-9-15.	12/25/2015

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	whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure tuberculin skin tests were completed for 2 of 5 employee records reviewed for tuberculin skin tests (Employee #1 and Employee #2). Findings include: Review of Employee records began on 11/25/15 at 10:30 a.m. The following was found: 1. Employee #1's employment record did not indicate completion of a second step tuberculin test. The hire date for Employee # 1 was 8/10/15. 2. Employee #2's employment record did not indicate completion of a second step tuberculin test. The hire date for Employee # 2 was 8/10/15. Review of the "TB Skin Test" received from the Unit Manager, on 11/25/15 at 2:00 p.m., indicated the following:		CompletedNew Employee Checklists and completed Mantoux tests will be submitted to theBusiness Leadership team on a weekly basis for six months. The Business Leadership Team will submitresults on a monthly basis to the Quality Assurance committee, overseen by theAdministrator, for continued compliance	

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	"NEW EMPLOYEES: Those employees that have not had documented negative TB skin test result during the preceding twelve (12) months, the two-step method will be applied. I. Your first Mantoux must be administered and read before you attend New Hire Orientation. II. The second Mantoux must be completed within 7-10 days of your first Mantoux. If this is NOT completed in time, you will have to begin the series again." During an interview with the Director of Nursing (DON) on 11/25/15 at 12:15 p.m., she indicated the previous person who did the employee records no longer worked at the facility. She indicated a new person took the position and they [management] were "not aware the tracking was not being done." She indicated it was "another project they know they have to fix." She provided no additional documentation related to Mantoux testing being done. This Federal tag relates to Complaint IN00187170.			

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