

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155226	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2015
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NAME OF PROVIDER OR SUPPLIER  NORTH CAPITOL NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00182892.</p> <p>Complaint IN00182892-Substantiated. No deficiencies related to the allegations are cited.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00183671.</p> <p>Survey dates: September 30, October 1, 2, 5, 6, 7, 8, &amp; 9, 2015.</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 17 Medicaid: 78 Other: 14 Total: 109</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F 0000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY RE-VISIT on or after 11.08.15.</p>	
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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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F 0157 SS=D Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 30576 on October 17, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a Physician of antipsychotic medication unavailability/missed administration for 1 of 5 residents reviewed for unnecessary medication (Resident #38).</p> <p>Findings include:</p> <p>The clinical record for Resident #38 was reviewed on 10/7/15 at 10:15 a.m. The diagnoses for Resident #38 included, but were not limited to, schizophrenia, depression, and dementia according to the September 2015 Physician's Orders.</p> <p>The September 2015 Physician's Orders indicated an order for haloperidol decanoate (antipsychotic) 75 mg (milligrams) to be administered intramuscularly every 2 weeks on Friday.</p> <p>The September MAR (medication administration record) indicated on 9/11/15 and 9/25/15 the haloperidol decanoate was not given because the medication was unavailable. A comment/documentation on 9/25/15 indicated the pharmacy was contacted. No other documentation on the MAR or in the clinical record indicated the</p>	F 0157	<p>F157 It is the practice of this provider to notify a Physician of antipsychotic medication unavailability/missed administration. <b>What corrective action will be accomplished for those residents found to have been affected?</b> Physician was notified of missed antipsychotic medication for resident #38. New order received to discontinue medication. Family notified of discontinuation and resident was placed on monitoring for adverse reactions of discontinuation with none noted. <b>How other residents will be identified and what correction action taken?</b> All residents residing in facility have the potential to be affected by the alleged deficient practice. All licensed nurses will be in serviced on the Change of Condition policy provided by DNS/designee by November 08, 2015. All residents having a condition change in status will be assessed by licensed nurse and Physician will be notified in a timely manner of the condition change. Nursing staff educated/in serviced on the importance timely documentation, timely notification to Physician for orders, accurate information relayed to the Physician for orders, and family member notification. DNS/designee will run facility report to audit documentation on</p>	11/08/2015

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	<p>haloperidol decanoate was administered as ordered in September.</p> <p>The 8/12/15 psychiatric notes, written by CNS (Clinical Nurse Specialist) #11, indicated no changes to the medication regimen and a decrease to the haloperidol decanoate was clinically contraindicated at that time.</p> <p>A Physician Progress Note, dated 9/18/15, indicated, "Plan per psych- (symbol for no) changes per meds (symbol for at) this time...Pt. (patient) laying in bed. No behaviors noted (symbol for at) this time...Assessment/Chronic Diagnoses: schizophrenia Plan: cont (continue) tx (treatment)...."</p> <p>During an interview with the Director of Nursing (DON), on 10/9/15 at 12:42 p.m., the DON indicated the haloperidol decanoate was not given as ordered in September. The DON further indicated the Physician should've been contacted regarding the unavailability/missed administration of the medication and she will look further into the notification.</p> <p>On 10/9/15 at 2:00 p.m., the DON indicated the facility was unable to locate physician notification that the haloperidol decanoate was not given as ordered</p>		<p>routine basis. Education will continue to be given to licensed nursing staff. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> All licensed nurses will be in serviced on the Change of Condition policy provided by DNS/designeeby November 08, 2015. All residents reviewed by DNS/designee to ensure per policy that all appropriate notifications related to missed antipsychotic medications were made and followed up complete by November 08, 2015. Missed medication administration report will be reviewed daily Monday through Friday with Saturday/Sunday and holidays reviewed on the following business day. DNS/Designee to ensure MD notification is made for medications that are noted unavailable per policy. <b>How the corrective action will be monitored?</b> DNS or designee to complete Continuous Quality Improvement tool on Change of Condition weekly for one month, bi-weekly for two months, and then monthly for three months. The change of condition audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95%threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will</p>				

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F 0167 SS=C Bldg. 00	<p>during the month of September. The DON further indicated the Physician should've been notified the medication was not given as ordered.</p> <p>A policy, titled Resident Change of Condition, dated 1/2015, was received from the DON on 10/9/15 at 2:31 p.m. The policy indicated, "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...."</p> <p>3.1-5(a)</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on observation and interview, the facility failed to ensure a notice/sign of location/availability of survey results was posted. This had the potential to affect 109 of 109 residents residing in the facility.</p>	F 0167	<p>result in disciplinary action up to and including separation of the responsible employee. <b>By what date the systemic change will be completed?</b> November 08, 2015.</p> <p>F167 It is the practice of this provider to provide each resident the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. It is also the practice of this provider to make the</p>	11/08/2015

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	<p>Findings include:</p> <p>1a. During an observation of the facility's first floor lobby, on 10/8/15 at 9:20 a.m., a posting of the location of the facility's survey results was not observed.</p> <p>During an interview with the Administrator, on 10/8/15 at 9:26 a.m., the Administrator indicated he was unable to locate a posting of the location of the survey results. The Administrator further indicated there used to be sign but it might've been removed when the lobby was painted.</p> <p>1b. An observation, on 10/8/15 at 9:40 a.m., of the facility's locked/memory care unit a posting of the location of the survey results was not located on the unit.</p> <p>On 10/8/15 at 9:45 a.m., during an interview, RN #10 indicated the survey results binder was located behind the nurse's station, but there was no sign/posting of where the survey results binder was kept.</p> <p>3.1-3(b)(1)</p>		<p>results available for examination and posted where they are readily accessible with a notice of their availability. <b>What corrective action will be accomplished or those residents found to have been affected?</b> No residents identified. Survey Binder has been posted in wall pocket that is located in the facility front lobby and near the locked/memory care unit nurses station. A posting has also been placed in the lobby and on the locked/memory care unit notifying residents/visitors of location of survey results. <b>How other residents will be identified and what correction action taken?</b> All residents who reside infacility have the potential to be affected by this alleged deficient practice. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> CEC/designee will educate all staff on the placement of survey results and posting notifying residents/visitors of location of survey results. <b>How the corrective action will be monitored?</b> DNS or designee to complete visual check of placement of survey results binder and posting monthly and review during the Quality Assurance meeting for six months, after which the CQI team will re-evaluate the continued need for the audit. Deficiency in this practice will result in disciplinary action up to and including separation of the</p>				

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a vision careplan was developed for 1 of 3 residents reviewed for vision. (Resident #39)</p> <p>Findings include:</p> <p>The clinical record for Resident #39 was reviewed on 10/7/15 at 10:15 a.m. The</p>			F 0279	<p>responsible employee. <b>By what date the systemic change will be completed?</b> November 08, 2015.</p> <p>F279 It is the practice of this provider to ensure that a comprehensive care plan is developed for each resident based on the assessment in accordance with State and Federal law. <b>What corrective action will be accomplished for those residents found to have been affected?</b> Vision comprehensive care plan has been put in place and updated for resident #39. <b>How other</b></p>		11/08/2015

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	<p>diagnoses for Resident #39 included, but were not limited to, anxiety, depression, diabetes mellitus according to the diagnoses in the electronic medical record.</p> <p>The MDS (minimum data set) assessment, dated 2/11/15, indicated Resident #39's vision was moderately impaired. The CAA (care area assessment) worksheet, dated 2/13/15, indicated Resident #39 had "Difficulty seeing television, reading material of interest, or participating in activities of interest because of vision problem...WILL PROCEED TO CARE PLAN..."</p> <p>A Vision Careplan was not located in the clinical record.</p> <p>During an interview with the MDS Coordinator, on 10/7/15 at 11:41 a.m., she indicated she was not able to locate the vision careplan that was triggered on the MDS and will make a careplan at that time.</p> <p>A policy titled, IDT Care Plan Review, dated 4/2014, was received from the Director of Nursing on 10/9/15 at 1:40 p.m. The policy indicated, "...It is the policy of this facility that each resident will have a comprehensive care plan</p>		<p><b>residents will be identified and what correction action taken?</b> All residents have the potential to be affected by this alleged deficient practice. Social Service will complete audit utilizing the most recent MDS assessment. Social services will ensure comprehensive care plan is in placed and updated in accordance with accepted professional standards and practices for all residents who trigger for vision impairment.</p> <p><b>What systemic changes will be made to ensure the deficient practice does not recur?</b>The DNS/Designee will educate facility social services department and IDT on comprehensive care plans. IDT will review and update all resident care plans upon admission, significant change, quarterly, annually and per Medicare MDS schedule. The social service director/designee will educate the social service department on the development of care plans triggered by the CAA. <b>How the corrective action will be monitored?</b> A care plan review continuous quality improvement audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by a nurse manager or designee. The care plan review CQI audit tool will be reviewed monthly by the CQI committee for six months after</p>	

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F 0280 SS=D Bldg. 00	<p>developed based on comprehensive assessment...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure a resident/family member was invited to a resident's care plan meeting per facility policy for 1 of 3 residents reviewed for care plan participation. (Resident #86)</p>	F 0280	<p>which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <b>By what date the systemic change will be completed?</b> November 08, 2015.</p> <p>F280 It is the practice of this provider to provide to ensure that resident/family members are invited to a resident's care plan meeting in accordance with accepted professional standards and practices. <b>What corrective</b></p>	11/08/2015

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	<p>Findings include:</p> <p>The clinical record for Resident #86 was reviewed on 10/1/15 at 11:00 a.m. The diagnoses for Resident #86 included, but were not limited to, end stage renal disease.</p> <p>An interview was conducted with Resident #86 on 10/1/15 at 2:07 p.m. He indicated he was not invited to his care plan meetings.</p> <p>An interview was conducted with SSA (Social Services Assistant) #2 on 10/5/15 at 10:31 a.m. She indicated the MDS (minimum data set) Coordinator gave her a list of residents who required a care plan meeting. She indicated she put the care plan invitation in the mail 7 days prior to the care plan meeting. She indicated she kept a care plan notification log and made a copy of the care plan invitation to verify a resident/family member was invited to their care plan meeting.</p> <p>The 8/4/15 IDT (Interdisciplinary Team) Care Plan/MDS Schedule was provided by SSD (Social Services Director) #1 on 10/5/15 at 10:52 a.m. It indicated Resident #86 required a care plan meeting due to his 8/11/15 significant</p>		<p><b>action will be accomplished for those residents found to have been affected?</b> Resident#86 and family members have been invited to attend care conference meeting to review current plan of care. Social Service will complete audit utilizing the MDS schedules from the 2015 calendar year to ensure that all residents/family members currently residing in facility have received invitation for care plan meeting. <b>How other residents will be identified and what correction action taken?</b> All residents have the potential to be affected by this alleged deficient practice. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> Social Service Director/Designee will in service the social service department on the facility care plan review policy. Invitation cards for careplan meeting will be sent to each resident and family member utilizing the MDS schedule. Social services will maintain a invitation log for all invites sent to the resident/family members. <b>How the corrective action will be monitored?</b> A care plan review continuous quality improvement audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by a nurse manager or designee. The care plan review CQI audit tool will be reviewed</p>				

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	<p>change assessment.</p> <p>An interview was conducted with the MDS Coordinator on 10/5/15 at 11:04 a.m. She indicated Resident #86's daughter attended care plan meetings via teleconference.</p> <p>An interview was conducted with SSA #2 on 10/5/15 at 11:07 a.m. She indicated she was supposed to send out a care plan invitation for significant change assessments. She indicated, for Resident #86, she would have given an invitation to Resident #86 and to his primary contact. The July, August, and September, 2015 Care Plan Notification Logs and care plan invitations were reviewed with SSA #2 at this time. SSA #2 could not locate Resident #86's name on the logs or a copy of an invitation to a care plan meeting for his August 11, 2015 significant change assessment. The 2015 Care Plan Notification Logs and care plan invitations indicated the last time Resident #86 or a family member was invited to a care plan meeting was in May, 2015.</p> <p>The IDT Care Plan Review Policy was provided by the DON (Director of Nursing) on 10/9/15 at 1:40 p.m. It indicated, "Care Plan review will be based on the MDS schedule for those</p>		<p>monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <b>By what date the systemic change will be completed?</b> November 08, 2015.</p>		

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F 0282 SS=D Bldg. 00	<p>residents who have had an Admission, Annual, Significant Change or Quarterly MDS completed at a minimum of every 90 days...Resident, resident's families or others as designated by resident will be invited to care plan review."</p> <p>3.1-35(c)(2)(C) 3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 interview and record review, the facility failed to address a conflict between the ordered administration time of a nutritional supplement and dialysis schedule for 1 of 3 residents reviewed for nutrition. (Resident #86)</p> <p>Findings include:</p> <p>The clinical record for Resident #86 was reviewed on 10/1/15 at 11:00 a.m. The diagnoses for Resident #86 included, but were not limited to: end stage renal disease and left heel ulcer.</p> <p>The October, 2015 Physician's Orders for Resident #86 indicated (brand name of</p>	F 0282	<p>F282 It is the practice of this provider to provide or arrange services by a qualified person in accordance with each resident's written plan of care. <b>What corrective action will be accomplished for those residents found to have been affected?</b> Resident#86's physician was notified that supplement was not given as ordered. Resident#86 received a physician order to change administration time for nutritional supplements. Supplement will be given as order at alternate times on dialysis days. <b>How other residents will be identified and what correction action taken?</b>All residents have the potential to be affected by the</p>	11/08/2015

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	<p>nutritional/medical food supplement) three times daily at 8:00 a.m., 12:00 p.m., and 4:00 p.m., effective 9/8/15 for impaired skin integrity. The orders indicated Resident #86 needed to be at dialysis by 10:15 a.m., every Tuesday, Thursday, and Saturday, effective 8/3/15.</p> <p>The September and October, 2015 MARs (medication administration records) for Resident #86 indicated he did not receive his 12:00 p.m. administration of (name brand of nutritional/medical food supplement) on the following dates, for the following reasons:</p> <p>9/12/15, Saturday - resident at dialysis 9/15/15, Tuesday - resident unavailable, dialysis 9/17/15, Thursday - resident unavailable 9/19/15, Saturday - resident unavailable 9/24/15, Thursday - resident unavailable 9/26/15, Saturday - resident unavailable, dialysis 10/1/15, Thursday - resident unavailable 10/3/15, Saturday - resident unavailable, LOA (leave of absence) @ dialysis 10/6/15, Tuesday - resident unavailable, dialysis</p> <p>An interview was conducted with the DON (Director of Nursing) on 10/8/15 at 11:10 a.m. She indicated if a resident is at dialysis during a scheduled medication</p>		<p>alleged deficient practice. Physician orders for all residents that have orders for dialysis have been reviewed by DNS/Designee for accuracy and potential for missed medications or supplements. Physician orders have been changed and updated where indicated. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> All licensed nurses will be in serviced by DNS/Designee on the policy of following physician orders and plan of care by November 08, 2015. All dialysis residents upon admission and at the time a new order is received will have IDT/ DNS/Designee review for reconciliation of the physician orders and times to ensure appropriateness. All residents who have missed medications/supplements will prompt notification of the MD and family, with documentation to support notification. Deficient practices will immediately be brought to the attention of the Director of Nursing Services and immediate corrective action will be taken. <b>How the corrective action will be monitored?</b> A Medical record administration and Dialysis Continuous Quality Improvement audit tool will be completed for six months with audits being completed once weekly for one month, bi-weekly for two months, and then monthly for three months by a nurse manager or</p>	

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F 0496 SS=A Bldg. 00	<p>administration time, they would reschedule the times, and contact the doctor to change the times, to perhaps an evening dose. She indicated for Resident #86 and his (brand name of nutritional/medical food supplement), it would be a matter of changing the administration times to maybe 8:00 a.m., 4:00 p.m., and 8:00 p.m.</p> <p>An interview was conducted with the DON 10/8/15 at 12:31 p.m. She indicated Resident #86's (brand name of nutritional/medical food supplement) administration times would be changed, and his nurse practitioner was not notified of the need to change the administration times of his (brand name of nutritional/medical food supplement).</p> <p>3.1-35(g)(2)</p> <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included</p>		<p>designee. The Medical record administration and Dialysis CQI audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <b>By what date the systemic change will be completed</b> November 08, 2015.</p>	

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	<p>in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on interview and record review, the facility failed to follow up to ensure a staff member became registered as a nurse aide for 1 of 43 CNA's (Certified Nursing Assistants) reviewed for nurse aide registration. (CNA #7)</p> <p>Findings include:</p> <p>The Employee Records form was reviewed on 10/9/15 at 3:00 p.m. CNA #7 was listed as a Certified Nursing Assistant. No verification of nurse aide certification was provided by the facility for CNA #7.</p> <p>On 3/9/15 at 3:39 p.m., the CEC (Clinical</p>	F 0496	F0496 It is the practice of this provider to ensure that all staff has appropriate licensure. <b>What corrective action will be accomplished for those residents found to have been affected?</b> No residents identified. Staff member is no longer employed by facility. <b>How other residents will be identified and what correction action taken?</b> All resident have the potential to be affected by the alleged deficient practice. DNS/ Designee completed facility audit to ensure that all required staff have appropriate licensure. <b>What systemic changes will be made to ensure the deficient practice does not recur?</b> DNS/Designee will educate CEC/ IDT on the	11/08/2015

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	<p>Education Coordinator) provided a copy of CNA #7's certificate of successful completion of a nurse aide training program, effective 3/26/14.</p> <p>An interview was conducted with the CEC on 10/9/15 at 3:45 p.m. She indicated it was her responsibility to follow up and ensure a CNA was registered, and she "just missed it" with CNA #7.</p> <p>An interview was conducted with the DON (Director of Nursing) on 10/9/15 at 3:50 p.m. She indicated verification of CNA registration was typically done prior to a CNA's start of employment.</p> <p>The CEC provided a copy of the timecard for CNA #7 on 10/9/15 at 3:39 p.m. The dates of 9/22/15, 9/23/15, and 9/25/15 were circled. The CEC indicated those were the 3 days CNA #7 worked in the facility as a nurse aide.</p> <p>3.1-14(e)(2)</p>		<p>facility policy regarding staff licensure. Payroll Coordinator will complete additional license verification upon completion of all employee data sheets where an employee moves from any department into the nursing department. <b>How the corrective action will be monitored?</b> DNS/Designee will complete the License audit tool monthly for six months. The License audit tool will be reviewed monthly by the CQI committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved, an action plan will be developed and implemented. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee. <b>By what date the systemic change will be completed</b> November 08, 2015.</p>	