

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2015
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NAME OF PROVIDER OR SUPPLIER  MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00172047 and IN00172251.</p> <p>Complaint IN00172047 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-279 and F-309.</p> <p>Complaint IN00172251 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: May 6, 7 and 14, 2015</p> <p>Facility number: 012225 Provider number: 155780 AIM number: 200983560</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 12 Medicaid: 52 Other: 9 Total: 73</p>	F 000	By submitting the enclosed Plan of Correction, Madison Health Care Center (the Facility) is not admitting or agreeing to the accuracy of any specific findings or allegations listed on this 2567. The Facility reserves the right to contest the findings or allegations listed in this 2567 and is submitting responses to these allegations pursuant to regulatory obligations. The Facility requests that this Plan of Correction be considered its allegation of compliance effective June 13, 2015 to the complaint survey conducted on May 14, 2015.	

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 223 SS=G Bldg. 00	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was protected from abuse according to the facility policy which resulted in the resident sustaining a bloody lip, for 1 of 1 resident reviewed for abuse in a sample of 6 (Resident #F).</p> <p>Findings include:</p> <p>The clinical record for Resident #F was reviewed on 5/6/15 at 10:50 a.m. Diagnoses for Resident #F included, but were not limited to dementia, chronic venous insufficiency, coronary artery</p>	F 223	Resident #F no longer resides in the facility, however when the resident's son "squeezed the residents mouth open," the son was told to stop immediately by the nurses and leave the facility. Upon examination of the resident's mouth, no injuries were observed to her mouth or lips. The police were notified immediately and came to facility. APS was also notified. Son was notified that his visits would be supervised and that APS and the Police had been noted. All residents have the potential to be affected by the deficient practice. There have been no allegations or observations of	06/13/2015

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	<p>disease, reflux, depression, gout and chronic kidney disease. The resident was admitted on 7/18/14, and discharged on 4/20/15 (unable to observe).</p> <p>A care plan conference meeting held 2/5/15, with Resident #F's son indicated he was concerned about the resident not eating enough and requested an appetite stimulant. At this time the facility spoke to the son regarding his approach and how uncomfortable it makes his mother and staff feel.</p> <p>A care plan dated 3/2/15, indicated Resident #F's son (POA) has episodes of socially inappropriate behavior as evidenced by, force feeding his mother and yelling at her to eat and take her meds.</p> <p>A reportable incident dated 4/1/15, indicated another resident reported she thought she overheard her roommate's son, slap her roommate, Resident #F (no date). A reportable incident dated 4/2/15, indicated Resident #F's son returned the next day and was visibly upset regarding his mother's refusal to eat and then squeezed her mouth open, causing it to bleed. Staff asked resident's son to leave and the Administrator and Director of Nursing (DON) were notified immediately.</p>		<p>incidents of abuse with any other resident</p> <p>All staff will be in-serviced on the abuse protocol, identification and reporting. This in-service will include dealing with family members who actions could be considered abuse. The systemic change to prevent reoccurrence is that nursing staff will be given specific training so they can monitor residents' interactions with family, other residents, staff, visitors, etc. to identify and prevent abuse. The staff have been informed, that any type of occurrences should be reported to the administrator immediately so proper interventions can occur to assure the safety of the resident.</p> <p>Five alert and oriented residents and five families of cognitively impaired will be interviewed weekly x 4 weeks, Monthly times 3 months and then quarterly. All deficient practices will be reported accordingly to appropriate agencies and QA will monitor based on the outcome of the interviews.</p>	

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	<p>A nurses note written by LPN #4 and dated 4/2/15 at 9:45 p.m., indicated the resident refused to take her medications and the son was informed. He indicated to the nurse she should provide him the medications and he would get Resident #F to take the meds. He yelled at her and attempted to squeeze open her mouth, which caused the left side to bleed. LPN #4 told the son to stop, because this was abuse.</p> <p>During an interview on 5/6/15 at 12:30 p.m., with the DON, Social Services and LPN #4, they indicated, the resident's son yelled at his mother in the dining room several times for refusing to eat and drink as he wanted her to. The son was then notified his visitation with his mother would be supervised after the event on 4/2/15.</p> <p>3.1-27(a)(1)</p>			

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F 225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is</p>			

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	<p>verified appropriate corrective action must be taken.</p> <p>The facility failed to prevent abuse (Resident #F) and failed to ensure a criminal background check was completed according to facility policy for 1 of 5 employees reviewed for criminal background checks (CNA #2).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 5/6/15 at 10:50 a.m. Diagnoses for Resident #F included, but were not limited to dementia, chronic venous insufficiency, coronary artery disease, reflux, depression, gout and chronic kidney disease. The resident was admitted on 7/18/14, and discharged on 4/20/15 (unable to observe).</p> <p>A care plan conference meeting held 2/5/15, with Resident #F's son indicated he was concerned about the resident not eating enough and requested an appetite stimulant. At this time the facility spoke to the son regarding his approach and how uncomfortable it makes his mother and staff feel.</p> <p>A care plan dated 3/2/15, indicated Resident #F's son (POA) has episodes of socially inappropriate behavior as evidenced by, force feeding his mother</p>	F 225	<p>1a. Resident # F no longer resides in the facility, however when the resident's son "squeezed the resident's mouth open," the son was told to stop immediately by the nurse and leave the facility. Upon examination of the resident's mouth, no injuries were observed to her mouth or lips. The police were notified immediately and came to the facility. APS was also notified and son was notified that his visits would be supervised and that APS and the Police had been notified.</p> <p>1b. All residents have the potential to be affected by the deficient practice. There have been no allegations or observations of incidents of abuse with any other resident.</p> <p>1c. All staff will be in-serviced on the abuse protocol, identification and reporting. This in-service will include dealing with family members who actions could be considered abuse. The systemic change to prevent reoccurrence is that the staff will be given specific training so they can monitor residents' interactions with family, other residents, staff, visitors, etc. to identify and prevent abuse. The staff have been informed that any type of occurrence should be reported to the administrator immediately so proper interventions can occur.</p> <p>1d. Five alert and oriented</p>	06/13/2015

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	<p>and yelling at her to eat and take her meds.</p> <p>A reportable incident dated 4/1/15, indicated another resident reported she thought she overheard her roommate's son, slap her roommate, Resident #F (no date). A reportable incident dated 4/2/15, indicated Resident #F's son returned the next day and was visibly upset regarding his mother's refusal to eat and then squeezed her mouth open, causing it to bleed. Staff asked resident's son to leave and the Administrator and Director of Nursing (DON) were notified immediately.</p> <p>A nurses note written by LPN #4 and dated 4/2/15 at 9:45 p.m., indicated the resident refused to take her medications and the son was informed. He indicated to the nurse she should provide him the medications and he would get Resident #F to take the meds. He yelled at her and attempted to squeeze open her mouth which caused the left side to bleed. LPN #4 told the son to stop because this was abuse.</p> <p>During an interview on 5/6/15 at 12:30 p.m., with the DON, Social Services and LPN #4, they indicated, the resident's son yelled at his mother in the dining room several times for refusing to eat and drink</p>		<p>residents and fivefamilies of cognitively impaired will be interviewed weekly x 4 weeks. Monthlytimes 3 months and then quarterly. Alldeficient practices will be reported accordingly to appropriate agencies and QAwill monitor with recommendations according to interviews.</p> <p>2a. A background check was completed on 5/7/2015for CNA #2. The background check had no findings for this employee.</p> <p>2b. All residents have the potential to beaffected by the deficient practice, therefor our system has been altered toassure that background checks have been completed on all new employees inaccordance with regulations.</p> <p>2c. The HRDirector shall complete a 100% audit of current employee files to ensure that acriminal background check has been completed for each current employee. Anyother files lacking a criminal background check shall be identified and acriminal background check shall be completed for employees in question. HR Director has been in-serviced on theimportance of criminal background checks being completed.</p> <p>2d. The HR Director shall make monthly audits toensure that all new hire employees have a criminal background completed asrequired per policy. Audits will be conducted monthly for 6 months and findingsreported to</p>	

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	<p>as he wanted her to. The son was then notified his visitation with his mother would be supervised after the event on 4/2/15.</p> <p>On 5/7/15 at 10:00 a.m., the Administrator provided the policy for Abuse Prevention dated 7/2011, and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "...III Preventing Resident Abuse. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse. 1. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment."</p> <p>2. Newly hired employee records were reviewed on 5/7/15 at 10:00 a.m.</p> <p>The record lacked documentation of a criminal background check for CNA # 2.</p> <p>During an interview on 5/7/15 at 2:40 p.m., the Administrator indicated the background check could not be located for this employee.</p> <p>On 5/7/15 at 10:00 a.m., the Administrator provided the policy for</p>		<p>the QA committee for their review. QA committee shall determine if it is necessary to extend these audits beyond the 6 months.</p>	

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F 226 SS=D Bldg. 00	<p>Abuse Prevention dated 7/2011 and indicated the policy was the one currently being used by the facility.</p> <p>"I. Background Screening Investigations ... 1. The personnel director, or other person designated by the Administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>3.1-28(1)(a)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure implementation of the facility's abuse</p>	F 226	1a. Resident # F no longer resides in the facility, however when the resident's son "squeezed the resident's	06/13/2015

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	<p>policy to prevent abuse of a resident and obtain a criminal background check for new employees according to the facility policy for 1 of 1 residents reviewed for abuse in a sample of 6 and 1 of 5 new employees reviewed for criminal background checks (Resident #F, CNA #2).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 5/6/15 at 10:50 a.m. Diagnoses for Resident #F included, but were not limited to dementia, chronic venous insufficiency, coronary artery disease, reflux, depression, gout and chronic kidney disease. The resident was admitted on 7/18/14, and discharged on 4/20/15 (unable to observe).</p> <p>A care plan conference meeting held 2/5/15, with Resident #F's son indicated he was concerned about the resident not eating enough and requested an appetite stimulant. At this time the facility spoke to the son regarding his approach and how uncomfortable it makes his mother and staff feel.</p> <p>A care plan dated 3/2/15, indicated Resident #F's son (POA) has episodes of socially inappropriate behavior as evidenced by, force feeding his mother</p>		<p>mouthopen," the son was told to stop immediately by the nurse and leave the facility. Upon examination of the resident's mouth, no injuries were observed to her mouth or lips. The police were notified immediately and came to the facility. APS was also notified and son was notified that his visits would be supervised and that APS and the Police had been notified.</p> <p>1b. All residents have the potential to be affected by the deficient practice. There have been no allegations or observations of incidents of abuse with any other resident.</p> <p>1c. All staff will be in-serviced on the abuse protocol, identification and reporting. This in-service will include dealing with family members who actions could be considered abuse. The systemic change to prevent reoccurrence is that nursing staff will be given specific training so they can monitor residents' interactions with family, other residents, staff, visitors, etc. to identify and prevent abuse. The staff have been informed, that any type of occurrences should be reported to the administrator immediately so proper interventions can occur to assure the safety of the resident.</p> <p>1d. Five alert and oriented residents and five families of cognitively impaired will be interviewed weekly x 4 weeks. Monthly times 3 months and then</p>	

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	<p>and yelling at her to eat and take her meds.</p> <p>A reportable incident dated 4/1/15, indicated another resident reported she thought she overheard her roommate's son, slap her roommate, Resident #F (no date). A reportable incident dated 4/2/15, indicated Resident #F's son returned the next day and was visibly upset regarding his mother's refusal to eat and then squeezed her mouth open, causing it to bleed. Staff asked resident's son to leave and the Administrator and Director of Nursing (DON) were notified immediately.</p> <p>A nurses note written by LPN #4 and dated 4/2/15 at 9:45 p.m., indicated the resident refused to take her medications and the son was informed. He indicated to the nurse she should provide him the medications and he would get Resident #F to take the meds. He yelled at her and attempted to squeeze open her mouth which caused the left side to bleed. LPN #4 told the son to stop because this was abuse.</p> <p>During an interview on 5/6/15 at 12:30 p.m., with the DON, Social Services and LPN #4, they indicated, the resident's son yelled at his mother in the dining room several times for refusing to eat and drink</p>		<p>quarterly. All deficient practices will be reported accordingly to appropriate agencies and QA will monitor with recommendations according to interviews.</p> <p>2a. A background check was completed on 5/7/2015 for CNA #2. The background check had no findings for this employee.</p> <p>2b. All residents have the potential to be affected by the deficient practice.</p> <p>2c. The HR Director shall complete a 100% audit of current employee files to ensure that a criminal background check has been completed for each current employee. Any other files lacking a criminal background check shall be identified and a criminal background check shall be completed for employee(s) in question.</p> <p>2d. The HR Director shall make monthly audits to ensure that all new hire employees have a criminal background completed as required per policy. She shall conduct these audits monthly for 6 months and report her findings to the QA committee for their review. QA committee shall determine if it is necessary to extend these audits beyond the 6 months.</p>	

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	<p>as he wanted her to. The son was then notified his visitation with his mother would be supervised after the event on 4/2/15.</p> <p>On 5/7/15 at 10:00 a.m., the Administrator provided the policy for Abuse Prevention dated 7/2011, and indicated the policy was the one currently being used by the facility. Review of the policy indicated, "...III Preventing Resident Abuse. Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse. 1. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment."</p> <p>2. Newly hired employee records were reviewed on 5/7/15 at 10:00 a.m.</p> <p>The record lacked documentation of a criminal background check for CNA # 2.</p> <p>During an interview on 5/7/15 at 2:40 p.m., the Administrator indicated the background check could not be located for this employee.</p> <p>On 5/7/15 at 10:00 a.m., the Administrator provided the policy for</p>			

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F 279 SS=D Bldg. 00	<p>Abuse Prevention dated 7/2011 and indicated the policy was the one currently being used by the facility.</p> <p>"I. Background Screening Investigations ... 1. The personnel director, or other person designated by the Administrator, will conduct employment background checks, reference checks and criminal conviction checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment."</p> <p>3.1-28(a)</p> <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,</p>			

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	<p>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 record review and interview, the facility failed to ensure specific care plans were developed for 2 of 6 residents reviewed for care plans in a sample of 6 (Resident #B and #F).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 5/6/15 at 3:30 p.m. Diagnoses for Resident #B included, but were not limited to end stage renal disease that required dialysis, failure to thrive and dementia.</p> <p>The physician's orders for April 2015, indicated the resident was to have dialysis (original order 10/30/13) on Monday, Wednesday and Friday and the dialysis dressing (original order 12/26/14) was to be removed every evening at bedtime on Monday, Wednesday and Friday.</p> <p>The record lacked documentation of a care plan that specifically addressed the removal of the dialysis dressing at bedtime.</p>	F 279	<p>1a. Resident# B no longer resides in the facility</p> <p>1b. All Dialysis resident's Care Plans will be revised to include specific pre and post dialysis care.</p> <p>1c. The MDS coordinator will be in serviced on the importance of including areas related to a pre and post dialysis care</p> <p>1d. Facility will randomly review 5 comprehensive care plans which will be audited weekly x 3, monthly x 3, and quarterly x3. Any areas that are found to be deficient will be reported to the QA to make recommendations.</p> <p>2a. Resident # F no longer resides in the facility, however when the resident's son "squeezed the resident's mouth open," the son was told to stop immediately by the nurse and leave the facility. Upon examination of the resident's mouth, no injuries were observed to her mouth or lips. The police were notified immediately and came to the facility. APS was also notified and son was notified that his visits would be supervised and that APS and the Police had been notified.</p> <p>2b. All residents have the</p>	06/13/2015

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	<p>During an interview with the Director of Nursing (DON) on 5/6/15 at 3:45 p.m., she indicated a care plan specifically addressing the removal of the dialysis dressing at night could not be found.</p> <p>2. The clinical record for Resident #F was reviewed on 5/6/15 at 10:50 a.m. Diagnoses for Resident #F included, but were not limited to dementia, depression, and chronic kidney disease.</p> <p>A care plan dated 3/2/15, indicated Resident #F's son (POA) has episodes of socially inappropriate behavior as evidenced by, force feeding his mother and yelling at her to eat and take her meds.</p> <p>A reportable incident dated 4/1/15, indicated another resident reported she thought she overheard her roommate's son, slap her roommate, Resident #F (no date). A reportable incident dated 4/2/15, indicated Resident #F's son returned the next day and was visibly upset regarding his mother's refusal to eat and then squeezed her mouth open, causing it to bleed.</p> <p>A nurses note written by LPN #4 and dated 4/2/15 at 9:45 p.m., indicated the resident refused to take her medications</p>		<p>potential to beaffected by the deficient practice. There have been no allegations or observations of incidents of abuse with any other resident.</p> <p>2c. The MDScoordinator and SS Director will be in-serviced on the importance of careplanning specific approaches that will facilitate the staff's ability to deal with difficult families.</p> <p>2d.Facility will randomly review 5 comprehensive care plans which will be audited weekly x 3, monthly x 3, and quarterly x3. Any areas that are found to be deficient will be reported to the QA to make recommendations.</p>	

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F 309 SS=D Bldg. 00	<p>and the son was informed. He indicated to the nurse she should provide him the medications and he would get Resident #F to take the meds. He yelled at her and attempted to squeeze open her mouth which caused the left side to bleed. LPN #4 told the son to stop because this was abuse.</p> <p>The record lacked documentation of a care plan that specifically addressed what the staff should do to protect the resident from abuse.</p> <p>During an interview with the DON on 5/6/15 at 2:00 p.m., she indicated there wasn't a specific care plan detailing instructions to the staff to protect the resident from abuse.</p> <p>This Federal tag relates to Complaint IN00172047.</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to follow the physician's orders for dialysis care for 1 of 3 resident reviewed for dialysis in a sample of 6 (Resident #B).</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 5/6/15 at 3:30 p.m. Diagnoses for Resident #B included, but were not limited to end stage renal disease that required dialysis, failure to thrive and dementia.</p> <p>The physician's orders for April 2015, indicated the resident was to have dialysis (original order date 10/30/13) on Monday, Wednesday and Friday and the dialysis dressing (original order 12/26/14) was to be removed every evening at bedtime on Monday, Wednesday and Friday.</p> <p>A note dated 3/27/15, from the dialysis clinic indicated Resident #B arrived at the clinic for his regular dialysis procedure with the arteriovenous graft (AVG) dressing from 3/25/15, still on the fistula.</p>	F 309	<p>Resident #B no longer resides in the facility.</p> <p>AllDialysis resident's charts have been reviewed to ensure that physician ordersare being followed.</p> <p>All nurseswill be in-serviced to ensure that all physician orders will be followed relatingto dialysis residents. They will also be in-serviced on ensuring that dressingchanges are done according to the plan of care The MAR for 5 (if applicable) residents receiving dialysis will be reviewed twice weekly x4, twice monthly x3, and quarterly x3 to ensure that physician orders are being followed appropriately. Monitoring will randomly occur to cover 7 days/week and all shifts Any areasof deficient practice will be monitored by QA and recommendations will be made accordingly</p>	06/13/2015

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F 441 SS=D Bldg. 00	<p>Review of the medication administration record (MAR) for March 25, 2015, lacked documentation the dressing had been removed according to the physician's orders.</p> <p>During an interview with RN #3 from the dialysis clinic on 5/6/15 at 3:55 p.m., she indicated the resident had to be sent out to have the AVG declotted and the dialysis treatment would have to be rescheduled.</p> <p>This Federal tag relates to Complaint IN00172047.</p> <p>3.1-37(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual</p>			

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	<p>resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on record review and interview, the facility failed to ensure new employees were given tuberculin (TB) skin tests according to their policy for 2 of 5 employees reviewed for TB skin tests (LPN #1 and CNA #2).</p> <p>Findings include:</p> <p>New employee records were reviewed on 5/7/15 at 10:00 a.m., and the following employees lacked documentation of TB skin tests:</p> <p>LPN #1 hired 3/12/15, had no</p>	F 441	<p>LPN #1 was given a 1st step TB skin test on 05/18/2015. The test was read on 05/20/2015. LPN #1 was given a 2nd step TB skin test on 05/25/2015 and it was read on 05/27/2015. CNA #2 was given a 1st step TB skin test on 05/06/2015, the test was read on 05/08/2015. CNA #2 was given a 2nd step TB skin test on 05/18/2015 and was read on 05/20/2015.</p> <p>HR to audit all employee records to ensure that all TB skin tests have been administered appropriately per policy.</p> <p>The facility administered 1st step TB skin tests on all current employees on 05/18/2015 –</p>	06/13/2015

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	<p>documentation of receiving a 1st step or 2nd step TB skin test.</p> <p>CNA #2 hired 3/12/15, had a 1st step TB skin test on 3/11/15. The record lacked documentation the employee received a 2nd step TB test.</p> <p>During an interview with the Administrator on 5/7/15 at 2:40 p.m., he indicated the missing TB tests could not be found.</p> <p>On 5/7/15 at 2:40 p.m., the Administrator provided the undated policy for TB skin tests and indicated the policy was the one currently being used by the facility. "... (1) At the time of employment, or within one (1) month prior to employment ... employees and nonpaid personnel of facilities shall be screened for tuberculosis. 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 ..."</p> <p>3.1-14(t)(1)</p>		<p>05/20/2015. These tests were read on 5/20/2015 –05/22/2015 (as appropriate). The facility shall administer a 2ndstep TB skin test on 06/01/2015 – 06/03/2015. These tests shall be read06/03/2015 – 06/05/2015 (as appropriate). Facility shall administer 1stand 2nd step TB skin tests upon hire but shall administer 1stand 2nd step skin tests in the month of May for all current staff moving forward. Department heads will be in-served on making sure TB skinchecks are administered according to regulations. Nursing admin will completed 5 new employee audits monthly to ensure that new hire employees are administered 1st and 2nd step TB skin tests upon hire. The facility shall conduct these audits monthly for 6 months and report the findings to the QA committee for their review. QA committee shall determine if it is necessary to extend these audits beyond the 6 months.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2015

FORM APPROVED

OMB NO. 0938-0391

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