

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 11 - 15, 2014</p> <p>Facility Number: 000506 Provider Number: 155474 AIM number: 100266530</p> <p>Survey team: Julie Wagoner, RN, TC Honey Kuhn, RN Deb Kammeyer, RN Lora Swanson, RN</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 03 Medicaid: 58 Other: 12 Total: 73</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality Review completed on August 23, 2014, by Brenda Meredith, R.N.</p>	F000000	<p>Please accept this Plan of Correction as the Credible Allegation for the survey conducted on August 15, 2014. Submission of this plan of correction is not an admission by Signature Healthcare of Bremen that the deficiencies alleged in the survey are accurate or depict the quality of nursing care and services provided the residents of this health care facility. This plan of correction is submitted timely and in accordance with Sate and Federal Regulatory Guidelines. We respectfully request Desk Review of the Plan of Correction for the survey completed on Augsut 15, 2014.</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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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interviews, the facility failed to ensure the Abuse policy and procedure regarding training of new staff was followed for 3 of 10 employees reviewed. (Employee #20, 25, and 26)</p> <p>Finding includes:</p> <p>Review of personnel files was conducted on 08/15/14 between 2:30 P.M. - 4:15 P.M. The personnel files of the following employees did not contain any documentation of initial abuse training:</p> <ul style="list-style-type: none"> a. Employee #20, a laundry staff member with a hire date of 04/24/14 b. Employee #25, a nursing staff member with a hire date of 08/06/14 c. Employee #26, a nursing staff member with a hire date of 05/26/14 	F000226	<p>CORRECTIVE ACTION: Employee files audited to ensure that documentation of abuse training is employee files.</p> <p>HOW OTHERS IDENTIFIED: Employee files audited to ensure all abuse training has been conducted and documentation of training is in the file. Any employee found to need abuse training will complete the training and documentation will be placed in employee file.</p> <p>PREVENTATIVE MEASURES: All new hires will have abuse training during general orientation. Documentation of the abuse training will be placed in employee file. MONITORING: All employee files will be audited to ensure that all abuse education and documentation is in employee file by BOM and or designee within 72 hours of completion general orientation.</p>	09/14/2014

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F000272 SS=D	<p>During an interview on 08/15/14 at 4:00 P.M., the Director of Nursing indicated the abuse training was to be completed with the general orientation to the facility but there was no signed acknowledgement and no pre/post test documentation in the files for Employees #20, 25, and 26.</p> <p>During an interview at the Exit Conference, conducted on 08/15/14 at 4:30 P.M., the Administrator indicated the former employee responsible for maintaining personnel files had not been doing her job and was no longer employed at the facility. She indicated the personnel files were to have contained abuse training documentation.</p> <p>3.1-28(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;</p>		This will be completed on an ongoing basis. All findings of audits will be presented in QAPI monthly. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.				

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	<p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to comprehensively assess the oral care needs of 1 of 3 residents reviewed for dental needs. (Resident #89)</p> <p>Findings include:</p> <p>On 8-12-14 at 9:37 A.M., Resident #89 was observed to have a white film between and along the lower base of his front lower teeth. The upper teeth were not observed.</p> <p>During an interview, on 8-12-14 at 9:54 A.M., LPN #4. indicated Resident #89's</p>	F000272	<p>CORRECTIVE ACTION: Care Plan for resident #89 was reviewed and updated related to oral care. Social Service Director to address resident being evaluated by dentist related to fit of dentures. HOW OTHERS IDENTIFIED: Care Plans for all residents audited to ensure oral care is properly addressed. PREVENTATIVE MEASURES: In-service all nursing staff related to oral care and providing oral care per Care Plan. Oral Care updated on Nurse Aide Assignment Sheets. In-service all C.N.A.'s on following Nurse Aide Assignment Sheets. MONITORING: Oral Care will be monitored through</p>	09/14/2014			

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	<p>tooth brush looked unused and the resident's dentures were in a cup in his drawer.</p> <p>On 8-13-14 at 2:48 P.M., a review of the clinical record for Resident # 89 was conducted. The record indicated the resident was admitted on 2-3-14. The resident's diagnosis included, but were not limited to: senile dementia, history of falls, muscle weakness and hypothyroidism.</p> <p>On 8-13-14 at 2:55 P.M., a review of a form, titled "Medical Nutrition Therapy Assessment," dated 2-3-14, indicated the resident had full upper dentures and was on a mechanical soft diet.</p> <p>On 8-13-14 at 3:00 P.M., a Social Service Review, dated 6-6-14, indicated Resident #89'S BIMS (Brief Interview Mental Status) score was 2, which indicated he was severely cognitively impaired. The review indicated the resident was combative and/or resistant with care. He required total care and was dependant on staff for all Activities of Daily Living (ADL's), dressing, mobility and was fed by staff. The Mood/Behavior section indicated the resident's behaviors occurred primarily when care was given.</p>		<p>observation of resident care and documentation to ensure Care Plan is being followed. To be monitored by DON and/or Designee. Oral Care tab has been activated on the Kiosk for documentation purposes. Observation of 10% of the Average Daily Census will be conducted 3 times per week for 4 weeks; then weekly for 4 weeks; then randomly for 4 months. All findings will be reviewed at QAPI monthly. ADDENDUM:Monitoring will continue through quarterly Abaqis review. Any area triggering will have further investigation conducted and action plan created as needed. Action plans will continue to be presented at QAPI until item reaches 95% compliance rate.</p>				

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	<p>On 8-13-14 at 3:15 P.M., a review of the careplan for ADL's indicated there was a plan to address the resident's Self Care Deficit in regards to: bed mobility, dressing, bathing and mouth care. The interventions included , but were not limited to, provide extensive assist, explain all procedures and purpose prior to performing task and encourage self-performance. There was no mention of dentures on the care plan.</p> <p>On 8-14-14 at 9:24 A.M., the resident was observed being placed in a shower chair and taken to the shower room by CNA #1.</p> <p>During an interview on 8-14-14 at 9:55 A.M., CNA #1 indicated the resident was finished with his AM care. CNA #1 was asked why the resident's dentures were not placed in his mouth and she indicated that she had never placed them in his mouth and was not sure why he did not wear them. CNA #1 consulted with another staff member, CNA #2. CNA #2 had no explanation as to why the resident's upper dentures were not used. CNA #1 was then asked to observe the resident's teeth. She agreed the resident had a white substance along the gum line and a broken off tooth. She further indicated she had not brushed the resident's teeth and indicated the</p>			

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	<p>resident's teeth may have been brushed earlier in the morning The resident's drawer was observed with CNA #1. The drawer contained the resident's personal items which included the upper dentures in a denture cup and a toothbrush. CNA #1 indicated the tooth brush was dry and had no evidence of recent use. CNA #1 was observed asking LPN #3 (resident's nurse) why the resident's dentures were not used and LPN #3 indicated she had "no idea."</p> <p>On 8-14-14 at 1:19 P.M., a review of a form titled "Speech Pathology Evaluation - Dysphagia and Communication" was presented by the Social Service Director, dated 2-18-14. The form indicated the resident "...had several missing teeth on the bottom and ill fitting dentures...." The Social Service Director indicated the reason the resident did not wear the upper denture was due to them not fitting. The social worker was unaware that staff had no idea why the dentures were not worn and why it was not addressed on the resident's careplan.</p> <p>On 8-15-14 at 8:45 A.M., a review of the MDS (Minimum Data Set) Significant Change Assessment completed on 2-10-14, and Quarterly Assessments, dated 3-10-14 and 6-16-14, indicated the resident's oral and dental status was not</p>			

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F000279 SS=D	<p>assessed.</p> <p>3.1-31(c)(9)</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, 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 interviews, the facility failed to ensure anticoagulant use and an atrial fibrillation condition were care planned for 1 of 5 residents reviewed for unnecessary medication. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record for Resident #57 was</p>	F000279	CORRECTIVE ACTION: Care Plan for resident #57 was updated to reflect the use of Pradaxa medication. Monitoring of Pradaxa use has been added to the MAR for this resident to include: monitor for bruising/bleeding and report to physician. HOW OTHERS IDENTIFIED: All Care plans for residents receiving Pradaxa/Anti-coagulant have	09/14/2014			

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	<p>reviewed on 8/13/14 at 10:00 A.M. Resident #57 was admitted to the facility on 01/16/14 with diagnosis, including but not limited to, senile dementia, personal history of falls, hypertension, atrial fibrillation, cardiac dysrhythmias, and pathological fracture of the vertebra.</p> <p>The current physician's orders for Resident #57 included the anticoagulant medication, Pradaxa 150 mg one tablet twice a day.</p> <p>The current health care plans for Resident #57 for August 2014 and the current Medication Administration Record (MAR) for August 2014 indicated there was no care plan related to the resident's Pradaxa medication use and no other monitoring other than the medication administration on the MAR.</p> <p>During an interview, on 08/14/14 at 11:11 A.M., LPN #30 indicated Pradaxa was used for diabetes primarily. She indicated she thought the pharmacy had recommended the medication for several of the resident's at the facility, but it was very costly. She indicated she did not know if the medication use was something that should be addressed in a care plan.</p> <p>During an interview, on 08/14/14 at 2:00</p>		<p>been reviewed to ensure appropriate Care Plan is in place.</p> <p>PREVENTATIVE MEASURES: In-service all licensed nursing staff related to anticoagulant usage including initiation of Care Plan and types of monitoring. Care Plan to be initiated when any new order for an anticoagulant is received.</p> <p>MONITORING: Care Plans to be reviewed quarterly to ensure appropriate interventions for anticoagulant use. All physician orders will be reviewed during morning clinical meeting for any new orders for anticoagulant medications. To be monitored by DON and/or Designee. The Care Plan will be initiated at that time for the medication and MAR updated to include monitoring of medication use. All findings will be reviewed at monthly QAPI meeting. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.</p>	

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	<p>P.M., LPN #31 indicated she did not know exactly why Resident #57 required the Pradaxa medication. She looked in a 2013 Drug handbook, located at the nurses station and looked at the resident's diagnoses and indicated the Pradaxa was probably given for atrial fibrillation. She indicated the resident's blood pressure was being monitored due to the medication use. When asked if there was anything else that should be monitored for residents taking Pradaxa, she looked again at the drug book and indicated "maybe bleeding and strokes." She indicated the medication use and atrial fibrillation should have been care planned. She indicated there was no specific monitoring ordered other than routine blood pressure and monthly vital signs (temperature, blood pressure, pulse, respiration assessments).</p> <p>During an interview on 8/14/14 at 1:20 P.M., the MDS nurse, RN #32 indicated anticoagulant use should be care planned and the potential side effects monitored. She indicated there was no care plan for Resident #57 regarding his atrial fibrillation diagnosis and the Pradaxa use.</p> <p>3.1-35(a)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to follow the care plan regarding post fall interventions for 1 of 3 residents reviewed for accidents and falls (Resident #11) and 1 of 2 residents reviewed for oral care needs. (Residents #61)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 08/13/14 at 11:17 A.M. Resident #11 was admitted to the facility on 04/15/14 with diagnoses, including but not limited to, muscle weakness, personal history of falls, neuralgia, coronary arteriosclerosis, vascular dementia, depressive disorder, late effect cardiovascular disease, chronic pain syndrome, hypertension, osteoarthritis, and spinal stenosis.</p> <p>A Physician's progress note, dated 04/16/14, indicated the resident had been admitted to an acute care facility for weakness and had experienced 3 falls in three nights. When the resident was</p>	F000282	<p>CORRECTIVE ACTION: 1 – Resident #11 evaluated by Physical Therapy on 8/28/14. Care Plan updated to include appropriate fall interventions. 2 – Resident #61's Care Plan was updated to include oral care.</p> <p>HOW OTHERS IDENTIFIED: 1 – Continue to review all falls and recommend therapy screen/evaluation. Review all falls during morning clinical meeting to ensure Care Plan is updated with appropriate interventions. Follow up at clinical meeting until screen and/or evaluation has been completed by appropriate department. 2 – Care Plans of all residents audited to ensure oral care is properly addressed.</p> <p>PREVENTATIVE MEASURES: 1 – In-service therapy staff on completion of therapy screens and evaluations to be completed timely and documentation of those screens and/or evaluations is appropriately placed in resident chart. 2 – In-service all nursing staff related to oral care and providing oral care per Care Plan. Oral Care updated on Nurse Aide Assignment Sheets. In-service all C.N.A.'s on following Nurse Aide Assignment</p>	09/14/2014			

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	<p>admitted to the long term care facility, on 04/15/14, an initial nursing evaluation indicated the resident was a high risk for falls.</p> <p>A care plan related to cognitive loss, initiated on 04/16/14, indicated the resident had inappropriate behavior of attempting to get out of bed when contraindicated.</p> <p>A care plan related to falls, initiated on 04/15/14, and reviewed as current on 07/25/14, indicated the resident was to be screened for fall risk,observed for side effects of any drugs, to have any drug side effects reported to the physician, was to have a call light within reach, have adequate glare free lighting, and an area free of clutter, to be provided with a wheelchair, to be reminded to lock her brakes on the wheelchair, and to continue to be reminded to call for assistance, and to have a TAB alarm clip alarm that attached to her wheelchair and the back of her clothing. The TAB alarm was added on 07/03/14.</p> <p>Review of the fall investigations indicated the resident fell on 07/03/14 while trying to transfer herself from the bed to her chair. At the time, a therapy screen was ordered and a TAB alarm was put in place. The care plan was revised</p>		<p>Sheets. MONITORING: 1 - Follow up on all therapy screens and/or evaluation referrals at morning clinical meeting until screen and/or evaluation has been completed by appropriate department. To be monitored by Rehab Manager and/or Designee. All findings from clinical meeting related to therapy screens and/or evaluations will be reviewed at monthly QAPI meeting. 2 - Oral Care will be monitored through observation of resident care and documentation to ensure Care Plan is being followed. Oral Care tab has been activated on the Kiosk for documentation purposes. Observation of 10% of the Average Daily Census will be conducted 3 times per week for 4 weeks; then weekly for 4 weeks; then randomly for 4 months. To be monitored by DON and/or Designee. All findings will be reviewed at QAPI monthly. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling. ADDENDUM:Monitoring will continue through quarterly Abaqis review. Any area triggering will have further investigation conducted and action plan created as needed. Action plans will continue to be presented at QAPI until item reaches 95% compliance rate.</p>				

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	<p>to include the TAB alarm.</p> <p>A Rehabilitation Screen, completed on 07/07/14, indicated a recommendation was made for the resident to have Physical therapy evaluation and treatment secondary to unsteadiness and the resident desired physical therapy to address her back pain.</p> <p>There was no therapy evaluation noted in the clinical record after the 07/03/14 fall. The therapy section of the chart, reviewed on 08/14/14 at 11:05 A.M., indicated the resident was discharged from physical therapy on 06/03/14 and there was no further therapy documentation available.</p> <p>Interview with the Rehabilitation manager, Employee #33 and Employee #34, the Physical Therapy Assistant, on 08/14/14 at 2:45 P.M., indicated there was no documentation a therapy evaluation was completed per the therapy screen recommendation made on 07/03/14. Employee #33 indicated the former physical therapist would have completed the evaluation, was no longer employed with the facility.</p> <p>Nursing notes and a fall investigation, completed on 07/24/14, indicated the resident fell while trying to transfer</p>						

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	<p>herself to the toilet. The tab alarm was sounding but staff were unable to prevent the fall. In addition, the resident also fell again on 07/25/14 while trying to sit back down onto her bed. Fall investigations, completed for both the 07/24/14 and 07/25/14 fall, indicated a therapy screen was to be completed for both falls.</p> <p>Interview with Employee #33 and 34, on 08/14/14 at 2:45 P.M. indicated there was no documentation a therapy screen had been completed after the two falls on 07/24/14 and 07/25/14. Employee #33 indicated either the documentation was removed by the previous facility corporation or the former therapist did not complete the appropriate documentation. Employee #34, when interviewed on 08/14/14 at 2:45 P.M. indicated she remembered working with Resident #11 when she was first admitted but she did not specifically remember completing a therapy screen after the 07/24/14 and 07/25/14 falls.</p> <p>2. During a family interview, on 8-11-14 at 3:41 P.M., Resident #61's wife indicated oral care was not done daily. She further indicated the resident was blind and staff needed to explain procedures prior to performing them on the resident.</p> <p>On 8-12-14 at 9:40 A.M., Resident #61</p>			

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	<p>teeth were observed to have a white substance on lower teeth near the gum line and resident's breath had an unpleasant odor.</p> <p>The clinical record of Resident #61 was reviewed on 8-13-14 at 12:17. The resident's diagnoses included, but were not limited to: dementia with behaviors, blindness/low vision, depressive disorder, and general anxiety.</p> <p>The careplan for Resident #61 included a plan to address an ADL (Activity of Daily Living) Deficit. The plan indicated the resident needed assistance with bed mobility, transfers, bathing eating, and mouth care. Interventions included, but were not limited to: report changes in ADL self performance to nurse, provide adaptive/safety equipment-hoyer, provide total dependence assistance, and escort to activity programs consistent with resident's interests. Another careplan indicated the resident had a "Behavior Problem" evidenced by: uncooperative, combative and resistive with care. The interventions included but were not limited to: explain care to the resident in advance, monitor behavior episodes, approach in calm manner and reproach resident later.</p> <p>A form titled "Dental Exam," dated</p>						

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	<p>6-12-14, indicated " ...heavy plaque and tarter heavy bleeding. pt [patient] unable to be scaled [method to scrape tartar off of teeth] even with sedation. pt needs brushing twice a day by staff..."</p> <p>During an interview on 8-14-14 at 2:00 P.M., CNA #5 indicated she had given Resident #61 his AM (morning) care this morning. CNA #5 further indicated she had not brushed the resident's teeth today due to him being uncooperative and combative. The tooth brush was observed with CNA #5 in a drawer that contained the resident's personal care items. CNA #5 agreed the tooth brush was dry and appeared used. She further indicated she had not reproached the resident to provide oral care later on that morning or after he had eaten his lunch.</p> <p>On 8-14-14 at 3:38 P.M., a CNA worksheet indicated in bold type "BRUSH TEETH DAILY."</p> <p>On 8-15-14 at 1:32 P.M., a Behavior/Intervention Monthly Flow Record for August 2014 indicated the resident had no behaviors documented, including being combative with care or resistant or uncooperative with care on 8-14-14.</p> <p>3.1-35(g)(2)</p>						

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to provide oral care for 2 of 3 sampled residents, in a universe of 35 residents observed for oral care. (Resident #89 and Resident #61)</p> <p>Findings include:</p> <p>1. On 8-12-14 at 9:37 A.M., Resident #89 was observed to have a white film between and along the lower base of his front lower teeth. The upper teeth were not observed.</p> <p>During an interview on 8-12-14 at 9:54 A.M., LPN #4 indicated the tooth brush looked unused and the resident's dentures were in a cup in a drawer.</p> <p>On 8-13-14 at 2:48 P.M., a review of the clinical record for Resident # 89 was conducted. The record indicated the resident was admitted on 2-3-14. The resident's diagnosis included, but were not limited to, senile dementia, history of</p>	F000312	<p>CORRECTIVE ACTION: Care Plan for resident #89 and #61 was reviewed and updated related to oral care. HOW OTHERS IDENTIFIED: Care Plans of all residents audited to ensure Care Plans properly address oral care. PREVENTATIVE MEASURES: In-service all nursing staff related to oral care and providing oral care per Care Plan. Oral care updated on Nurse Aide Assignment Sheet. In-service all C.N.A's on following Nurse Aide Assignment Sheets. MONITORING: Oral Care will be monitored through observation of resident care and documentation to ensure Care Plan is being followed. Oral Care tab has been activated on the Kiosk for documentation purposes. Observation of 10% of the Average Daily Census will be conducted 3 times per week for 4 weeks; then weekly for 4 weeks; then randomly for 4 months. To be monitored by DON and/or Designee. All findings will be reviewed at QAPI monthly. Any deficient practice will be</p>	09/14/2014

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	<p>falls, muscle weakness and hypothyroidism.</p> <p>A Careplan for ADL's (Activity of Daily Living) indicated resident was a Self Care Deficit in regards to: bed mobility, dressing, bathing and mouth care. The interventions included but were not limited to: provide extensive assist, explain all procedures and purpose prior to performing task and encourage self-performance. There was no mention of dentures on the care plan.</p> <p>On 8-14-14 at 9:24 A.M., the resident was observed being place in shower chair and taken to shower room by CNA #1.</p> <p>During an interview on 8-14-14 at 9:55 A.M., CNA #1 indicated the resident was finished with his AM care. CNA #1 was asked why the resident's dentures were not placed in his mouth and she indicated that she had never placed them in his mouth and wasn't sure why he didn't wear them. CNA #1 consulted with CNA #2 and CNA #2 had no explanation as to why the resident's upper dentures weren't used. CNA #1 was then asked to observe the resident's teeth. She agreed the resident had a white substance along the gum line and a broken off tooth. She further indicated she had not brushed the resident's teeth and indicated the</p>		<p>addressed with re-education, in-servicing, and/or counseling.ADDENDUM:Monitoring will continue through quarterly Abaqis review. Any area triggering will have further investigation conducted and action plan created as needed. Action plans will continue to be presented at QAPI until item reaches 95% compliance rate.</p>		

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	<p>resident's teeth may have been brushed earlier in the AM. The resident's drawer was observed with CNA #1. The drawer contained the resident's personal items which included the upper denture in a denture cup and a toothbrush. CNA #1 indicated the tooth brush was dry and had no evidence of use recently. CNA #1 was observed asking LPN #3 (resident's nurse) why the resident's dentures weren't used and LPN #3 indicated she had no idea.</p> <p>2. During a family interview on 8-11-14 at 3:41 P.M., Resident #61's wife indicated oral care was not done daily for her husband.</p> <p>On 8-12-14 at 9:40 A.M., Resident #61 teeth were observed to have a white substance on lower teeth near the gum line and resident's breath had an unpleasant odor.</p> <p>The clinical record of Resident #61 was reviewed on 8-13-14 at 12:17 P.M. The resident's diagnoses included, but were not limited to, dementia with behaviors, blindness/low vision depressive disorder, and general anxiety.</p> <p>The Social Service Annual Review, dated 6-23-14, indicated resident required total care by staff for all ADL's (Activity of</p>			

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	<p>Daily Living) such as dressing, grooming, transfers, mobility. The resident was uncooperative and combative with care therefore the staff needed to explain care slowly and do not rush.</p> <p>The careplan indicated the resident had behaviors (history of being physically abusive and resistive to care) related to dementia. Interventions included but were not limited to: report to physician changes in behavior, reduce stressors such as sudden movements/being startled, reproach later, monitor behaviors, and intervene as needed. Another careplan indicated the resident was ADL Deficit and needed assistance with bed mobility, transfers, bathing, eating, and mouth care. Interventions included but was not limited to: report changes in ADL self performance to nurse, provide adaptive/safety equipment a hoyer, and provide total dependent assistance.</p> <p>During an interview on 8-14-14 at 2:00 P.M., CNA #5 indicated she had given Resident #61 his AM care. CNA #5 further indicated she had not brushed the resident's teeth today, due to him being uncooperative and combative. The tooth brush was observed with CNA #5 in a drawer that contained the resident's</p>				

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F000329 SS=D	<p>personal care items. CNA #5 agreed the tooth brush was dry and appeared used. She further indicated she had not reproached the resident to provide oral care later on that morning or after lunch.</p> <p>On 8-14-14 at 3:38 P.M., a review of the CNA worksheet indicated in bold type "BRUSH TEETH DAILY."</p> <p>3.1-38(b)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>			

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	<p>Based on record review and interviews, the facility failed to ensure there was adequate monitoring for anticoagulant medication for 1 of 1 residents on anticoagulant medication in a sample of 5 residents reviewed for unnecessary medications. (Resident #57)</p> <p>Findings include:</p> <p>The clinical record for Resident #57 was reviewed on 8/13/14 at 10:00 A.M. Resident #57 was admitted to the facility on 01/16/14 with diagnosis, including but not limited to, senile dementia, personal history of falls, hypertension, atrial fibrillation, cardiac dysrhythmias, and pathological fracture of the vertebra.</p> <p>The current physician's orders for Resident #57 included the anticoagulant medication, Pradaxa 150 mg one tablet twice a day.</p> <p>The current health care plans for Resident #57 for August 2014 and the current Medication Administration Record (MAR) for August 2014 indicated there was no care plan related to the resident's Pradaxa medication use and no other monitoring other than the medication administration on the MAR.</p> <p>During an interview, on 08/14/14 at</p>	F000329	CORRECTIVE ACTION: Care Plan for resident #57 was updated to reflect the use of Pradaxa medication. Monitoring of Pradaxa use has been added to the MAR for this resident to include: monitor for bruising/bleeding and report to physician. HOW OTHERS IDENTIFIED: All Care plans for residents receiving Pradaxa/Anti-coagulant have been reviewed to ensure appropriate Care Plan is in place. PREVENTATIVE MEASURES: In-service all licensed nursing staff related to anticoagulant usage including initiation of Care Plan and types of monitoring. Car Plan to be initiated when any new order for an anticoagulant is received. MONITORING: Care Plans to be reviewed quarterly to ensure appropriate interventions for anticoagulant use. All physician orders will be reviewed during morning clinical meeting for any new orders for anticoagulant medications. The Care Plan will be initiated at that time for the medication and MAR updated to include monitoring of medication use. To be monitored by DON and/or Designee. All findings will be reviewed at monthly QAPI meeting. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.	09/14/2014			

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	<p>11:11 A.M., LPN #30 indicated Pradaxa was used for diabetes primarily. She indicated she thought the pharmacy had recommended the medication for several of the resident's at the facility, but it was very costly. She indicated she did not know if the medication use was something that should be addressed in a care plan.</p> <p>During an interview, on 08/14/14 at 2:00 P.M., LPN #31 indicated she did not know exactly why Resident #57 required the Pradaxa medication. She looked in a 2013 Drug handbook, located at the nurses station and looked at the resident's diagnoses and indicated the Pradaxa was probably given for atrial fibrillation. She indicated the resident's blood pressure was being monitored due to the medication use. When asked if there was anything else that should be monitored for residents taking Pradaxa, she looked again at the drug book and indicated "maybe bleeding and strokes." She indicated the medication use and atrial fibrillation should have been care planned. She indicated there was no specific monitoring ordered other than routine blood pressure and monthly vital signs (temperature, blood pressure, pulse, respiration assessments).</p> <p>3.1-48(a)(3)</p>						

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F000356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to post a Daily Resident Census on their Daily Staffing form for 3 of 5 survey days. (8/11,12 and 13/2104)</p>	F000356	CORRECTIVE ACTION: Resident census has been updated on the form and is being updated daily. HOW OTHERS IDENTIFIED: Correction of changing the daily census to the Daily Staffing sheet	08/15/2014			

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	<p>Findings include:</p> <p>On 8-11-14 at 10:45 A.M., during initial tour a form titled "Bremen Health Care Center Daily Staffing" dated 8-11-14-14 was observed posted on a hallway, near the entrance. The form stated Resident Census at Start of Shift however it was left blank.</p> <p>On 8-12-14 at 3:30 P.M., the form titled "Bremen Health Care Center Daily Staffing" dated 8-12-14 was observed posted near the entrance and the Resident Census at Start of the Shift was left blank for 1st and 2nd shift.</p> <p>On 8-13-14 at 10:00 A.M. and at 2:00 P.M. the form titled "Bremen Health Care Center Daily Staffing" dated 8-13-14 was observed posted without the Resident Census information completed for each shift.</p> <p>During an interview on 8-14-14 at 3:10 P.M., Employee #6 indicated she completed the Daily Staffing form for each shift. Employee #6 did not include the Resident Census for each day as she was unaware the Resident Census needed to be completed on each Daily Staffing form, for each shift.</p>		<p>addresses all parties viewing the Daily Staffing sheet. PREVENTATIVE MEASURES: Correcting the form will prevent further occurrence in the future. MONITORING: Daily Staffing form will be monitored 3 times per week for 4 weeks; then weekly for 4 weeks; and then monthly for 4 months to ensure the daily census is present. To be monitored by ED and/or Designee. All findings will be reviewed at monthly QAPI meeting. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.</p> <p>ADDENDUM:Monitoring will continue through quarterly Abaqis review. Any area triggering will have further investigation conducted and action plan created as needed. Action plans will continue to be presented at QAPI until item reaches 95% compliance rate.</p>		

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food was prepared and served under sanitary conditions in one of one kitchens, and one of three dining rooms. This had the potential to affect all 72 resident's in the facility who consumed food.</p> <p>Findings include:</p> <p>During the observation of the meal service, conducted on 8/11/14 from 11:35 A.M.-12:10 P.M., the following was noted: Cook #11 checked the food temperatures on the steam table, while doing this she cleaned the end of a thermometer with an alcohol pad, the alcohol pad fell onto the floor and Cook #11 picked the alcohol pad up and threw it in the trash can. She did not wash her hands and continued to temp foods with a clean thermometer. After checking the temperatures on the steam table Cook #11 removed bowels from a shelf placing them on a serving cart, after doing this she wiped the middle shelf off with a</p>	F000371	<p>CORRECTIVE ACTION: All staff in-serviced on proper food handling and hand-washing. HOW OTHERS IDENTIFIED: In-servicing all staff will address all residents residing in facility and all future admissions. PREVENTATIVE MEASURES: In-servicing staff will address all residents in the facility and any new admissions. MONITORING: Meal Observation will occur 3 times per week for 4 weeks; then weekly for 4 weeks; then monthly for 4 months to ensure dietary and nursing staff are properly washing hands and handling food. To be monitored by ED and/or Designee. All findings will be reviewed at monthly QAPI meeting. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling. ADDENDUM:Monitoring will continue through quarterly Abaqis review. Any area triggering will have further investigation conducted and action plan created as needed. Action plans will continue to be presented at QAPI until item reaches 95%</p>	09/14/2014

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	<p>cleaning rag and did not wash her hands and started to serve food.</p> <p>Cook #11, when she did wash her hands, was noted to only wash her hands for 8 seconds at a time.</p> <p>Dietary Aide #12, who was observed assembling the meal trays, had washed her hands, and then readjusted her glasses and scratched her hair under her cap, she did not wash her hands after this and continued to assemble the trays.</p> <p>On 8/11/14 at 12:28 P.M., LPN#13 was observed serving Resident #19 his meal tray in the south dining room. After LPN #13 removed the plates and cups from the resident's tray and placed them on the table, she pulled out a slice of bread from the wax paper wrapping and buttered the bread with her bare hands.</p> <p>On 8/13/14 at 11:45 A.M., Cook #11, washed her hands for 12 seconds, put on gloves, and then touched serving bowls, grabbed the handle of a serving cart to move it over and then continued meal service picking up hamburger buns without washing her hands or changing her gloves.</p> <p>On 8/13/14 at 2:45 P.M., an interview with the Dietary Manager indicated her</p>		compliance rate.		

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	<p>expectation for hand washing would be that all staff wash their hands for 20 seconds.</p> <p>On 8/14/14 at 11:00 A.M., review of the current policy titled "Policy" received from the Dietary Manager indicated "...It is the policy of the Dietary Department to use single use gloves to protect both patrons and employees from contagious and food borne illnesses..."Except when washing fruits and vegetables...food employees may not contact exposed ready to eat food with their bare hands and shall use suitable utensils such as a deli tissue, spatulas, tongs, single use gloves, or dispensing equipment...Employees will:...Change disposable gloves between tasks and not wear them continuously...Change gloves if move from one task to another...Change gloves and wash hands after sneezing, coughing, or touching their hair and/or face...." A review of the current policy titled "Handwashing/Hand Hygiene" received from the Dietary Manager indicated "...5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...g. before and after assisting a resident with meals...s. after handling soiled equipment or utensils...."</p>			

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F000515 SS=E	<p>3.1-21(i)(3)</p> <p>483.75(l)(2) RETENTION OF RESIDENT CLINICAL RECORDS Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.</p> <p>Based on record review and interviews, the facility failed to ensure 4 of 10 closed records were available for review. (Residents #4, 67, 90 and 91)</p> <p>Findings include:</p> <p>On 08/11/14 at 12:30 P.M., a list containing 10 discharged resident names and their closed clinical records were requested.</p> <p>On 08/13/14 at 10:25 A.M., the Administrator indicated she was unable to provide 4 of the 10 closed clinical records for review. She indicated the former corporation had removed the records from the facility and the current corporation was unable to obtain the records in a timely fashion. She indicated the 4 records which were unavailable were the closed clinical records for Resident #4, 67, 90 and 91.</p>	F000515	<p>CORRECTIVE ACTION: Clinical records cited were provided to the Team Leader during survey on 8/14/14 when they arrived from the offsite storage. HOW OTHERS IDENTIFIED: All closed records for residents that have been admitted since 5/1/14 are available for access on site. Only closed records up to 4/30/14 were stored offsite through previous corporation. PREVENTATIVE MEASURES: Closed records for residents admitted since May 1, 2014 are available for access onsite and should address residents currently residing in the facility and new admissions to the facility. MONITORING: All closed records will be retained on site per facility policy. An ongoing list of all records sent to offsite storage will be kept to ensure properly tracking of all charts. To be monitored by Medical Records and/or Designee. This will be reviewed monthly at QAPI meeting. Any deficient practice will be addressed with</p>	08/15/2014

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F009999	<p>3.1-50(b)(1)</p> <p>STATE FINDINGS</p> <p>1. 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IAC 16-26-28-13-3.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to ensure the files of 3 of 10 employees reviewed contained documentation of references. (Employees #23, 24, and 25)</p> <p>Findings include:</p> <p>During the review of personnel files, conducted on 08/15/13 between 2:30 P.M. - 4:00 P.M. , the personnel file of Employee #23, with a hire date of 07/10/14, Employee #24, with a hire date of 06/24/14, and Employee #25, with a</p>	F009999	<p>re-education, in-servicing, and/or counseling.</p> <p>CORRECTIVE ACTION: 1 – All employee files audited for completed reference checks. 2 – Employee #22 that was cited successfully renewed her certification on 8/18/14. New expiration date is 6/27/2016 3 – All files audited for completion of job descriptions. 4 –All employee files audited for documentation of general orientation. 5 –All employee files audited for completion of job specific orientations. 6 – All employee files audited for Mantoux documentation. HOW OTHERS IDENTIFIED: All employee files audited to ensure the presence of required information. PREVENTATIVE MEASURES: A checklist of all required information will be completed on all new hires. This is to ensure proper completion and filing of all documentation. The checklist will include General Orientation, Job Specific Orientation, Reference Checks, and Mantoux documentation. Certification and/or licensure is to be reviewed monthly to ensure that everyone has renewed their certification and/or licensure appropriately. MONITORING: All employee files will be audited</p>	09/14/2014	

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	<p>hire date of 08/06/14, did not have any documentation references had been checked when they were hired.</p> <p>Interview with Employee #35, the business office manager, on 08/15/14 at 4:16 P.M., indicated the reference documentation for Employees #23, 24, and 25 were "not available."</p> <p>Interview with the Administrator, during the Exit Conference, conducted on 08/15/14 at 4:30 P.M., indicated the former employee responsible for maintaining personnel files had not been doing her job and was no longer employed at the facility. She indicated the personnel files were to have contained reference documentation.</p> <p>3.1-14(a)</p> <p>2. 3.1-14 PERSONNEL (f) 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:</p> <p>(1) Is a full-time employee in a training and competency evaluation program approved by the division, or</p> <p>(2) can prove that he or she has recently successfully completed a training and</p>		<p>within 72 hours of completing general orientation to ensure that employee checklist is present and completed. To monitor completion of employee files a list of employees needing to complete any documentation will be reviewed weekly to ensure that all documentation is completed. Job specific orientation should be completed and placed in employee file within 30 days of starting orientation to their specific job duties. To be monitored by BOM and/or Designee. All findings from monitoring of the employee files will be reviewed monthly at QAPI. Any deficient practice will be addressed with re-education, in-servicing, and/or counseling.</p>				

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	<p>competency evaluation program approved by the division and has not yet been included in the registry;</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to ensure 1 of 32 nursing aides working in the facility had current nursing assistant certification. (Employee #22)</p> <p>Finding includes:</p> <p>During review of the certifications and nursing licenses for employees, conducted on 08/15/14 between 3:00 P.M. - 4:15 P.M., there was no certification available for Employee #22, a nursing assistant with a hire date of 07/02/96.</p> <p>Interview with the Director of Nursing, on 08/15/14 at 4:15 P.M. indicated there was no certification for Employee #22 and she was being removed from the nursing schedule until the issue was resolved.</p> <p>3.1-14(f)(1) 3.1-14(f)(2)</p> <p>3. 3.1-14 PERSONNEL</p>			

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	<p>(p) Initial orientation of all staff must be conducted and documented and shall include the following:</p> <p>(1) Instruction on the needs of the specialized population or populations served in the facility, for example: (A) Aged; (B) developmentally disabled; (C) mentally ill; (D) children, or (E) care of cognitively impaired; residents....</p> <p>(3) Instruction in first aide, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions.</p> <p>(4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned....</p> <p>(6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care....</p> <p>These state rules were not met as evidenced by:</p> <p>Based on record review and interviews, the facility failed to ensure 4 of 10 personnel files reviewed contained documentation the employees received a job description (Employees 20, 21, 24, and 25). In addition, 6 of 10 personnel files reviewed did not contain</p>						

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	<p>documentation of a general orientation to the facility including instruction on first aide, emergency procedures, universal precautions, and fire and disaster preparedness. (Employees 20, 21, 23, 24, 25, and 26) The facility failed to ensure 3 of 10 personnel files reviewed contained documentation of job specific orientations. (Employee #20, 23, and 24)</p> <p>Findings include:</p> <p>During review of the employee files, conducted on 08/15/14 between 2:30 P.M. - 4:15 P.M., the following documentation was not located in the personnel files:</p> <ul style="list-style-type: none"> a. Employee #20, with a hire date of 04/02/14, had no job description and no general and no job specific orientation documentation b. Employee #21, a nursing staff member with a hire date of 06/15/14, had no job description and no general orientation documentation c. Employee #23, a nursing staff member with a hire date of 07/10/14, had no general or job specific orientation documentation d. Employee #24, a nursing staff member with a hire date of 06/24/14 had no job description, no general orientation, and no job specific orientation documentation. 			

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	<p>e. Employee #25, a nursing staff member with a hire date of 08/06/14, had no job description, no general or job specific orientation</p> <p>f. Employee #26, a nursing staff member with a hire date of 05/26/14, had no job description and no general orientation to the facility documentation.</p> <p>Interview with the Director of Nursing, on 08/15/14 at 4:14 P.M., indicated there was no further information available for the missing documentation for the personnel files for Employees #20, 21, 23, 24, 25, and 26.</p> <p>3.1-14(p)(1) 3.1-14(p)(3) 3.1-14(p)(4) 3.1-14(p)(6)</p> <p>4. 3.1-14 PERSONNEL (f) A physical examination shall be required for each employee of a 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 from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be</p>			

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	<p>documented. The result shall be recorded in millimeters of induction with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on review of personnel files and interviews, the facility failed to ensure 1 of 10 employees had a physical examination, including a two step Mantoux test. (Employee #25)</p> <p>Finding includes:</p> <p>During review of the personnel files, conducted on 08/15/14 between 2:30 P.M. - 4:15 P.M., the file for Employee #25, a nursing staff member with a hire date of 08/06/14, did not contain any documentation of a physical examination or any Mantoux tuberculin skin testing.</p> <p>Interview with Employee #35, on 08/15/14 at 4:20 P.M. indicated there was no documentation of a physical or Mantoux testing available for Employee #25.</p> <p>3.1-14(t)</p>				

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