STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 27 and 28, 2015 Facility number: 011970 Provider number: 011970 AIM number: N/A Census bed type: Residential: 45 Total: 45 Censor payor type: Other: 45 Total: 45 Sample: 8 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read,			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to date and sign employee mantoux testing /tuberculin skin testing (TB) when reading the test for a positive or negative response for 2 of 3 records reviewed for tuberculin testing (E#1, E#3). The facility also failed to give TB tests in a timely manner	R 0121	All employees who were found to not have a Mantoux TB Testhad one completed by May 27, 2015. The Director of Nursing now understands thatemployees or volunteers who have contact with residents on a regular basis(defined as being in the building weekly) will be required to have a Mantoux TBTest as	08/01/2015

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	for new employees for 1 of 3 new employees reviewed for a timely TB test (E#4). Findings include: Employee records were reviewed on 5/27/15 at 2:50 p.m. The following employees had mantoux tests (TB) that were not dated or signed when the results were recorded: a. E#1, hired 6/16/08, was given an annual TB test on 1/30/15. The test results were recorded as negative (0 millimeters of induration). The results were not dated or signed. b. E#3, hired 2/4/15, was given a first step TB test on 1/30/15. The test results were recorded as negative (0 millimeters of induration). The results were not dated or signed. E#3 was given a second step TB test on 2/10/15. The test results were recorded as negative (0 millimeters of induration). The results were not dated or signed. c. E#4, hired 1/5/15, was not given a TB test until 5/27/15. During a 5/27/15, 3:00 p.m., interview, the Director of Nursing indicated she had not been dating and signing the TB tests		required by state regulations. Employees will be given the 1st step on their date of hire orwithin 3 months prior to their date of hire. Department heads will give the Directorof Nursing a list of their employees who regularly work at the facility toassure compliance with 410 IAC 16.2-5-1.4(f)(1-4). The policy related to preemployment TB Tests willbe revised to include that all employees of United Faith Housing who havecontact with residents on a regular basis will comply with the Health ScreenPolicy. All department heads will beinserviced on this policy to assure compliance in the future. The Director of Nursing will monitor theprogram on a regular basis. The form used for employee TB tests had one signature anddate spot. This form will be revised toinclude a place for the date and signature both when the test is administeredand read. The Director of Nursing will use this form to document administrationof employee TB tests. The administrator willmonitor these changes on a regular basis to be sure the deficient practice willnot occur in the future. Completion date on these changes will be on or before August 1st, 2015.	

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	when she read them. She indicated she had only documented the reading/induration. The DON indicated she had not given E#4 a TB test upon hire. She additionally indicated she had been unaware she needed to give TB tests to employees who had dual area jobs and worked in both the unlicensed and licensed building.			
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure the carpeting in the common areas were well maintained and clean for the north elevator and the first and second floor hallways leading to resident apartments. This deficient practice had the potential to impact 45 of 45 residents residing in the facility. Findings include: During the environmental tour with the Facilities Manager, the Housekeeping Supervisor, the Maintenance Supervisor, and the Administrator on 5/28/15 at 10:00 a.m., soiled and worn areas were identified throughout the facility including, but not limited to the	R 0144	Work orders were issued for the carpet spots identified tobe cleaned 6-22-2015. Maintenance will cleanall listed areas in next thirty days having them completed on or before July 25st,2015. The maintenance supervisor shall develop a preventive program andcleaning schedule to assure new spots are addressed in a timely manner. The maintenance and housekeeping staff will beinserviced on the new program. The maintenance supervisor will be responsibleto monitor the program. For spots whichwill not come out with cleaning by facility staff, a professional carpetcleaner will be brought in to try to remove the spots. If the spots cannot be removed, a program tohave the	07/26/2015

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	following: First floor carpet, in the hallway outside apartment 105, had a worn and stained area approximately the size of a large dinner plate. First floor carpet, in the hallway outside apartment 108, had 1 worn area and 1 stained area both approximately the size of a man's fist, First floor carpet, in the hallway outside apartment 126, had 3 stained areas, ranging in sizes with the largest being approximately the size of small plate. First floor carpet, in the hallway next to the north elevator, had a stained triangular area, approximately 15 inches by 15 inches. First floor carpet, in the hallway leading to kitchen, had 3 to 4 stained areas, each approximately the size of a half dollar. Second floor carpet, in the hallway outside apartment 202, had 1 stained area approximately a 3 inch circle. Second floor carpet, in the hallway outside apartment 205, was 1 stained area approximately size of a sandwich plate.		carpet repaired or replaced will be initiated. The administrator will monitor this processfor compliance.	

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	Second floor carpet, in the hallway outside north elevator, were greater than 15 areas stained, approximately the size of quarters and half dollars. Second floor carpet, in the hallway outside apartment 219, was 1 stained area approximately 3 inches by 4 inches. Second floor carpet, in the hallway outside apartment 224, was 1 stained area approximately the size of a small plate. (All size descriptions were provided by facility staff.) The Maintenance Supervisor indicated some of the carpet had been replaced 3 to 4 months ago. The Housekeeping Supervisor indicated the carpets were cleaned professionally two times a year. The rest of the time the housekeeping staff cleaned the spots themselves. The Housekeeping Supervisor indicated many of the spots were cleaned but just kept coming back. The Facilities Manager indicated the carpet was a concern because it was approximately 14 years old.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to			

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	admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to complete timely semi-annual assessments for 2 of 3 residents reviewed, who had resided in the facility the length of time to require a semiannual assessment (Residents #R25 and #R46). Findings include: During a 5/27/15, 11:20 a.m., interview, the Director of Nursing indicated she had not completed semi-annual assessments for residents. She indicated she had only completed annual assessments. She indicated she was unaware semiannual assessments were required. 1. Resident #R46's clinical record was reviewed on 5/27/15 at 11:10 a.m. Resident #R46's current diagnoses included, but were not limited to, diabetes mellitus and neuropathy. Resident #R46 had an assessment completed 12/2/14 and a preceding assessment completed 2/8/14 (a period of 10 months). The clinical record lacked a semiannual (every 6 month) assessment.	R 0214	The director of Nursing completed assessments for Residents#46 and #25 by May 27, 2015. All residents will be reviewed to ensure we are incompliance with 410 IAC 16.2-5-4(e)(1). For any resident who has not had an assessmentcompleted in the last 6 months, one will be completed by the Director ofNursing or her designee. Going forward,assessments will be completed upon admission, and at least every 6 monthsthereafter on all residents at Vermillion Place. The Director of Nursing is responsible toassure the assessments are completed on a timely basis. The Administrator will monitor these changeson a routine basis to ensure VermillionPlace remains in compliance.	07/26/2015

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	2. Resident #R25's clinical record was reviewed on 5/28/15 at 9:20 a.m. Resident #R25's current diagnoses included, but were not limited to, hypertension and end stage renal disease. Resident #R25 had a most current assessment completed 8/20/14. Resident #R25 was due for a semiannual assessment 2/20/15. Resident #R25 had not had any assessment completed since 8/20/14.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. A. Based on record review, observation, and interview, the facility failed to ensure nurses obtained glucometer readings for which sliding scale insulin administration was ordered, failed to administer sliding scale insulin in accordance with physician's orders, and failed to obtain daily weights in accordance with physician's orders for 1 of 1 resident reviewed with sliding scale insulin and daily weights. (Resident #R9)	R 0241	Accuchecks will be completed per doctor's orders andrecorded in both the MAR and the glucometer log. The Director of Nursing or her designee willreview all diabetic residents to assure blood sugar levels have been checkedand recorded appropriately in both the MAR and the glucometer log and that allphysician orders are being followed. The glucometer log was revised so it iseasier to follow. Nurses were inserviced on this process. DONwill monitor MAR	07/26/2015

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	B. Based on record record review and interview, the facility failed to ensure a resident readmitted to the facility after a long term care facility stay had a signed physician order for a catheter for 1 of 1 resident reviewed for catheter use. (Resident #R25) Findings include: A1. Resident #R9 was observed during a blood sugar reading and insulin administration on 5/27/15 at 12:00 p.m., with RN #1 without incident. The clinical record for Resident #R9 was reviewed on 5/27/15 at 3:15 p.m. The diagnoses for Resident #R9 included, but were not limited to, diabetes, chronic renal disease, and depression. Current physician orders for Resident #R9 included, but were not limited to, the following: a. Blood sugar monitoring before meals and at bedtime. The original date of this order was 5/5/15. b. Humalog (insulin) per sliding scale was ordered as follows: 141-180 = 1 unit 181-220 = 2 units		and glucometer logs on a regular basis to be sure blood sugarlevels are recorded and any insulin given is appropriately. Weights have been recorded for resident #9. The physician's order for resident #9 wasreviewed and is being maintained per physician's orders. DON will monitor thisto be sure orders are followed as prescribed. Resident #25's catheter has been removed perphysician's order. The director of nursing or her designee willreview all admission orders for accuracy and completeness. A chart audit will be completed to documentthis review. Administrator will monitor on a routine basis.	

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	221-260 = 4 units 261-300 = 6 units 301-380 = 7 units 381-420 = 9 units 421-460 = 10 units if greater than 461 = 12 units The original date of this order was 5/5/15. Review of the May 2015, Medication Administration Record (MAR) and the May 2015, glucometer log indicated the incorrect dose of insulin was documented as having been given, or the blood sugar result was not documented on the following dates and times May 6, 8:00 a.m., conflicting blood sugar results documented as 141 on the glucometer log, and a 273 result documented on the MAR. The sliding scale insulin coverage was given, 6 units, based on the 273 result. May 6, 4:00 p.m., no blood sugar result was documented. May 6, 10:00 p.m., no blood sugar result was documented. May 7, 8:00 a.m., the blood sugar result was 171, and no insulin was documented as given. The resident should have received 1 unit of insulin			

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	May 7, 11:00 a.m., the blood sugar result was 251, and no insulin was documented as given. The resident should have received 4 units of insulin. May 7, 4:00 p.m., the blood sugar result was 226, and 6 units of insulin was documented as given. The resident should have received 4 units of insulin. May 7, 10:00 p.m., the blood sugar result was 156, and no insulin was documented as given. The resident should have received 1 unit of insulin. May 8, 4:00 p.m., no blood sugar result was documented. May 8, 10:00 p.m., no blood sugar result was documented. May 9, 8:00 a.m., no blood sugar result was documented. May 9, 10:00 p.m., the blood sugar result was 267, and 12 units of insulin was documented as given. The resident should have received 6 units of insulin. May 10, 8:00 a.m., no blood sugar result was documented. May 10, 11:00 a.m., the blood sugar			

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	result was 172 and no insulin was documented as given. The resident should have received 1 unit of insulin. May 10, 4:00 p.m., no blood sugar result was documented. May 10, 10:00 p.m., no blood sugar result was documented. May 11, 8:00 a.m., conflicting blood sugar results documented as 198 on the glucometer log, and results of 248 and 168 documented on the MAR. No insulin was documented as given. The resident should have received 1, 2, or 4 units of insulin based on the documented blood sugar results. May 11, 11:00 a.m., conflicting blood sugar results documented as 141 on the glucometer log, and a 164 result documented on the MAR. No insulin was documented as given. The resident should have received 1 unit of insulin based on the documented blood sugar results. May 12, 8:00 a.m., conflicting blood sugar results documented as 208 on the glucometer log, and a 228 result documented on the MAR. No insulin was documented as given. The resident should have received 2 or 4 units of			

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	insulin based on the documented blood sugar results. May 12, 11:00 a.m., the blood sugar result was 169 and no insulin was documented as given. The resident should have received 1 unit of insulin. May 12, 10:00 p.m., no blood sugar result was documented. May 13, 8:00 a.m., the blood sugar result was 160 and no insulin was documented as given. The resident should have received 1 unit of insulin. May 14, 8:00 a.m., conflicting blood sugar results documented as 248 on the glucometer log, and a 178 result documented on the MAR. No insulin was documented as given. The resident should have received 1 or 4 units of insulin based on the documented blood sugar results. May 15, 8:00 a.m., conflicting blood sugar results documented as 177 on the glucometer log, and a 209 result documented on the MAR. No insulin was documented as given. The resident should have received 1 or 2 units of insulin based on the documented blood sugar results.			

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	May 15, 11:00 a.m., conflicting blood sugar results documented as 153 on the glucometer log, and a 151 result documented on the MAR. No insulin was documented as given. The resident should have received 1 unit of insulin based on the documented blood sugar results. May 15, 4:00 p.m., the blood sugar result was 181 and 1 unit of insulin was documented as given. The resident should have received 2 units of insulin. May 16, 8:00 a.m., the blood sugar result was 102 and 1 unit of insulin was documented as given. The resident should have received 2 units of insulin. May 16, 10:00 p.m., the blood sugar result was 149 and no insulin was documented as given. The resident should have received 1 unit of insulin. May 18, 11:00 a.m., no blood sugar result was documented. May 18, 10:00 p.m., the blood sugar result was 268 and 4 units of insulin was documented as given. The resident should have received 6 units of insulin. May 19, 10:00 p.m., the blood sugar result was 261 and 4 units of insulin was			

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	documented as given. The resident should have received 6 units of insulin. May 21, 8:00 a.m., the blood sugar result was 227 and 6 units of insulin was documented as given. The resident should have received 4 units of insulin. May 21, 10:00 p.m., no blood sugar result was documented. May 22, 4:00 p.m., the blood sugar result was 203 and 1 unit of insulin was documented as given. The resident should have received 2 units of insulin. May 26, 8:00 a.m., no blood sugar result was documented. May 26, 11:00 a.m., no blood sugar result was documented. During an interview with the Director of Nursing (DON) on 5/28/15 at 3:30 p.m., she indicated the blood sugar results should be documented on either the glucometer log or the MAR. She indicated she did not know why there were conflicting blood sugar results on the glucometer log and the MAR. When asked which blood sugar result was used to determine the sliding scale coverage to be given to the resident, the DON changed the subject.			

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VERMILLION PLACE	449 MAIN ST ANDERSON, IN 46016

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	A2. The clinical record for Resident #R9 was reviewed on 5/27/15 at 3:15 p.m. The diagnoses for Resident #R9 included, but were not limited to, diabetes, chronic renal disease, and depression. A current physician order for Resident #R9, signed 5/1/15, was for the resident to have daily weights. Review of the May 2015, MAR, lacked documented daily weights for Resident #R9. During an interview with the DON on 5/28/15 at 1:19 p.m., she indicated they were not obtaining daily weights for Resident #R9.B1. During a 5/27/15, 10:15 a.m., interview, the Director of Nursing indicated Resident #R25 had a indwelling catheter in place. She indicated he wore a leg bag and did his own catheter care. Resident #R25's clinical record was reviewed on 5/28/15 at 9:20 a.m. Resident #R25's current diagnoses included, but were not limited to, hypertension and end stage renal disease. Resident #R25 had no physician's order for an indwelling catheter or orders for catheter care. The clinical record indicated the resident was readmitted to			

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	the facility on 5/19/15. During a 5/28/15, 10:27 a.m. interview, the Director of Nursing indicated the facility did not have an order for Resident #R25's catheter. She indicated the facility knew the resident would only use the catheter for a short while. She indicated the catheter had just been discontinued at Resident #R25's morning visit with his doctor. A current, undated, facility policy titled "Medication Administration", which was provided by the Director of Nursing on 5/28/15 at 2:15 p.m., indicated: "It is the policy of this facility that all mediations and treatments shall be ordered by a physician and administered by a licensed nurse, or a QMA under the supervision of a licensed nurse."			
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interview,	R 0242	Resident #9's record has been reviewed and future entriesshall	07/26/2015

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	the facility failed to notify the physician of blood sugar levels which may have required intervention by the physician for 1 of 2 diabetic residents. (Resident #R9) Findings include: The clinical record for Resident #R9 was reviewed on 5/27/15 at 3:15 p.m. The diagnoses for Resident #R9 included, but were not limited to, diabetes, chronic renal disease, and depression. A nurse's note, dated 5/6/15 at 11:35 p.m., indicated the resident's blood sugar was 31. The resident's blood sugar was rechecked with a different glucometer. The results were 30, 31, 30, 31, and 31. The entry did not indicate the physician had been notified of the blood sugar level. A nurse's note, dated 5/17/15 at 4:00 p.m., indicated the resident's blood sugar was "only 38." The entry did not indicate the physician had been notified of the blood sugar level. A nurse's note, dated 6/20/15 at 8:30 p.m., indicated the resident's blood sugar was 29. The entry did not indicate the physician had been notified of the blood sugar level.		show whether the physician was notified if order does not state otherwise.The physician revised his order related to when he wants to be notified. Achart audit was completed to see if any other residents were affected by thisissue. No other residents were found to be out of compliance. DON inservicednurses on physician notification process. If nurses notify physician of anissue, this will be documented on the 24 hour report. DON will monitor thisprocess.	

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	During an interview on 5/28/15 at 3:35 p.m., the Director of Nursing (DON) indicated Resident #R9's blood sugar goes up and down. She indicated when the resident's blood sugar was low at lunch time, in the 30's, the facility would hold her routine insulin. She further indicated there was no documentation of the physician having been notified of holding the routine insulin and/or the resident's blood sugar levels.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure the Qualified Medication Aide (QMA) obtained authorization prior to giving an "as needed" medication for 1 of 1 resident reviewed for "as needed" medication administration (Resident #R22). This	R 0246	Tylenol was made routine per physician's order for resident#22. Written orders are now on filestating Tylenol be given nightly at 3am. A chart audit was completed to assureno other residents were affected by this violation. QMAs have been inservicedto obtain nurse's authorization to administer	07/26/2015

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	deficient practice had the potential to impact 41 residents who received medications administered by the facility out of 45 residents residing in the facility. Findings include: During an interview on 5/27/15 at 3:00 p.m., the Director of Nursing (DON) indicated one QMA worked in the facility on the 10:00 p.m. to 6:00 a.m. shift. A nurse did not come into the facility until 6:00 a.m. The DON indicated the QMA did not call her, or any other nurse, to get authorization prior to giving "as needed" medications. If there was a written order for the medication, then the QMA would give it to the resident. The clinical record for Resident #R22 was reviewed on 5/28/15 at 12:45 p.m. Diagnosis for Resident #R22 included, but were not limited to, hypertension, osteoarthritis, and depression. During the review of the May, 2015 Medication Administration Record, with the DON, on 5/28/15 at 1:15 p.m., the DON indicated the QMA administered an "as needed" medication to Resident #R22 without obtaining prior authorization on 5/18/15, 5/19/15, 5/20/15, 5/22/15, 5/23/15, 5/27/15, and 5/28/15. A current, undated, facility policy titled		any PRN Medication. VermillionPlace's Policy was reviewed for PRN Medication protocol adding that the nursewho authorized the QMA to give PRN Medications will sign Med Book indicatingauthorization was given. This process will be monitored by DON.	

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	"Medication Administration", which was provided by the Director of Nursing on 5/28/15 at 2:15 p.m., indicated: "It is the policy of this facility that all mediations and treatments shall be ordered by a physician and administered by a licensed nurse, or a QMA under the supervision of a licensed nurse."			
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents 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 within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on interview and record review, the facility failed to document the reading	R 0410	Resident #46 and resident #25's clinical records have beencorrected by being signed	07/26/2015

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	of Residents' tuberculin skin test (TB test) in accordance with professional standards and facility policy for 2 of 5 residents reviewed for TB testing. (Residents #R46 and #R25). Findings Include 1. Resident #R46's clinical record was reviewed on 5/27/15 at 11:10 a.m. Resident #R46's current diagnoses included, but were not limited to, diabetes mellitus and neuropathy. Resident #R46 was given an annual TB test on 11/7/14. The test results were recorded as negative (0 millimeters of induration). The results were not dated or signed. 2. Resident #R25's clinical record was reviewed on 5/28/15 at 9:20 a.m. Resident #R25's current diagnoses included, but were not limited to, hypertension and end stage renal disease. Resident #R25 was given an annual TB test on 3/3/15. The test results were recorded as negative (0 millimeters of induration). The results were not dated or signed. During a 5/27/15, 3:00 p.m., interview, the Director of Nursing indicated she had not been dating and signing the TB tests when she read them. She indicated she		and dated. Going forward the DON understands thatthere must be a signiture. We now document the day a Mantoux TB Test is givenand the day a Mantoux TB Test is read with signatures required for bothentries. This change will be monitored by the administrator to ensurecompliance with 410 IAC 16.2-5-12(e)(f)(g).	

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	had only documented the reading/induration. A current, undated, facility policy titled "Tuberculin Skin Testing Of Residents", which was provided by the Director of Nursing on 5/28/15 at 2:15 p.m., indicated the following: "A TB skin test shall be completed...read at 48 to 72 hours. The results shall be recorded in millimeters of induration with the date given, date read, and by who [sic] administered and read."			