STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155338	A. BUILDING 00 / B. WING	05/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES - PRESTWICK	445 S CR 525 E AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 18, 19, 20, 21, 22, 26 & 27, 2015. Facility number: 000231 Provider number: 155338 AIM number: 100267900 Census bed type: SNF: 16 SNF/NF: 63 Total: 79 Census payor type: Medicare: 6 Medicaid: 55 Other: 18 Total: 79 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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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	Based on observation, interview, and record review, the facility failed to implement interventions for pain management according to plan of care for 1 of 1 resident observed for pain control during a dressing change (Resident #99). Findings include 1. During an observation on 5/22/2015 from 10:35 a.m. through 10:56 a.m., RN (Registered Nurse) #5 changed a pressure ulcer dressing on Resident #99's right, outer ankle. Resident #99 was resting in bed with her eyes closed prior to the dressing change. During the dressing change Resident #99 bit down on her lip, grit her teeth, and squeezed her blanket tightly with her left hand. RN #5 was heard telling Resident #99 she was sorry, but continued with the dressing change without offering pain medication. Resident #99 lifted her head from the pillow, continued biting her lip and and squeezed her bed blankets with a tight grip. RN #5 indicated she "could really see her grimace." RN #5 continued the dressing change. Resident #99 squeezed her blanket with a tight grip and lifted her head up off her pillow. RN #5 continued with the dressing change. Resident #99 lifted her head off the pillow again, grabbed her blanket and squeezed it	F 0282	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to provide or arrange qualified persons in accordance with each resident's written plan of care. Consistent with this practice, the following actions have been taken: I.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	06/26/2015

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	tightly with her left hand. RN #5 indicated to Resident #99 she knew the dressing change was hurting her "so much." When the procedure was done Resident #99 closed her eyes and rested without signs and symptoms of anxiety and pain. During an interview on 05/22/2015 at 10:54 a.m., RN #5 indicated Resident #99 indicated Resident #99 experienced a lot of pain during the dressing change and indicated she was not aware the resident had an order for as needed pain medication or interventions for the pain medication to be administered prior to dressing changes. She indicated routine pain medication was administered at 8:00 a.m. (2 hours and 36 minutes before the dressing change). During an interview on 5/26/15 at 11:42 a.m., Wound Care RN #4 indicated Resident #99's care plan included interventions for pain medication prior to dressing changes and indicated she didn't think it would have made a difference in the resident's tolerance of the procedure because Resident #99's pain was related to contractures and spasticity. Resident #99's record was reviewed on 05/19/2015 at 12:07 P.M. The record indicated Resident #99 was non verbal		The pain assessment of resident #99 was conducted. The medical record of resident #99 was reviewed and the plan of care was with appropriate pain interventions. II. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents having the potential to be affected were those with pressure and surgical wounds. Pain assessments were completed on all potentially affected residents and the care plans were updated as necessary with appropriate pain interventions. III. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;** Licensed nursing personnel will	

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	due to aphasia and having a tracheostomy. A Minimum Data Set assessment tool, dated 4/1/15, indicated Resident #99 was "severely cognitively impaired." An untimed physician's order, dated 4/20/14, indicated acetaminophen 650 milligrams (mg) twice daily as needed for pain. Care plans initiated on 3/9/15 and 3/14/15, and identified as current by the Director of Nursing on 5/26/15 at 10:30 a.m., indicated Resident #99 had a stage four pressure ulcer on her right outer ankle and had a potential for pain. Goals indicated pain would be relieved by a goal of zero. Interventions included administer analgesia per physicians orders (offer prior to treatment/therapy). The Medication Administration Record (MAR), dated May 2015, indicated Resident #99 had been administered the scheduled Tramadol at 8:00 a.m. This record lacked indication acetaminophen 650 mg had been administered on 5/22/15. During an interview on 5/27/2015 at 2:10 p.m., the Director of Nursing (DON) indicated the facility did not have a policy regarding pain interventions for		be re-educated on the Skin Care Guideline to include appropriate pain management during wound care. A QAPI tool has been developed to monitor ongoing compliance titled, "F-282" that theADNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that compliance with proper pain management is observed during wound care. IV. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;** Audit findings will be presented to QAPI committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QAPI committee will review findings and determine need for further monitoring until a threshold of 100% is reached.	

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	pain control. A "Pain Practice Guide Flowchart," dated 2011 and provided by the DON on 5/27/2015 at 2:10 p.m., " ...ASSESS: Does the patient have pain or a condition that is likely to cause pain ...IMPLEMENT: ...Evaluate patients for pain daily and document ...Ongoing management strategies ...EVALUATE .... " 3.1-35(g)(2)			
F 0309 SS=G Bldg. 00	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 psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview, and record review, the facility failed to ensure pain medication was administered prior to a pressure ulcer dressing change resulting in symptoms of anxiety and severe pain that were unrelieved until the procedure was complete for 1 of 1 resident reviewed for pain (Resident #99) and failed to ensure communication of care and health status for 1 of 1 resident	F 0309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	06/26/2015

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	reviewed for dialysis (Resident #75). Findings include: 1. During an observation on 5/22/2015 from 10:35 a.m. through 10:56 a.m., RN (Registered Nurse) #5 changed a pressure ulcer dressing on Resident #99's right, outer ankle. Resident #99 was resting in bed with her eyes closed prior to the dressing change. During the dressing change Resident #99 bit down on her lip, grit her teeth, and squeezed her blanket tightly with her left hand. RN #5 was heard telling Resident #99 she was sorry, but continued with the dressing change without offering pain medication. Resident #99 lifted her head from the pillow, continued biting her lip and and squeezed her bed blankets with a tight grip. RN #5 indicated she "could really see her grimace." RN #5 continued the dressing change. Resident #99 squeezed her blanket with a tight grip and lifted her head up off her pillow. RN #5 continued with the dressing change. Resident #99 lifted her head off the pillow again, grabbed her blanket and squeezed it tightly with her left hand. RN #5 indicated to Resident #99 she knew the dressing change was hurting her "so much." When the procedure was done Resident #99 closed her eyes and rested without signs and symptoms of anxiety		correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to provide care/services to maintain the highest well-being . Consistent with this practice, the following actions have been taken: I.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** An audit was completed to identity other residents having the potential to be affected by the same deficient practice. Those identified were residents for potential for pain related to wound management and residents receiving dialysis therapy. The pain assessment of resident #99 was conducted. The medical record of resident #99 was reviewed and the plan of care was with appropriate pain	

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	and pain. During an interview on 05/22/2015 at 10:54 a.m., RN #5 indicated Resident #99 indicated Resident #99 experienced a lot of pain during the dressing change and indicated she was not aware the resident had an order for as needed pain medication or interventions for the pain medication to be administered prior to dressing changes. She indicated routine pain medication was administered at 8:00 a.m. (2 hours and 36 minutes before the dressing change). During an interview on 5/26/15 at 11:42 a.m., Wound Care RN #4 indicated Resident #99's care plan included interventions for pain medication prior to dressing changes and indicated she didn't think it would have made a difference in the resident's tolerance of the procedure because Resident #99's pain was related to contractures and spasticity. Resident #99's record was reviewed on 05/19/2015 at 12:07 P.M. The record indicated Resident #99 was non verbal due to aphasia and having a tracheostomy. A Minimum Data Set assessment tool, dated 4/1/15, indicated Resident #99 was "severely cognitively impaired."		interventions. The medical record of resident # 75 was reviewed and the documentation reflects compliance with the Dialysis Communication Guideline. II. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents having the potential to be affected were those with pressure and surgical wounds. Pain assessments were completed on all potentially affected residents and the care plans were updated as necessary with appropriate pain interventions. Pain assessments were completed on all potentially affected residents and the care plans were updated as necessary with appropriate pain interventions. The medical records of all residents receiving dialysis services were reviewed to ensure compliance with the Dialysis Communication Guideline.	

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	An untimed physician's order, dated 4/20/14, indicated acetaminophen 650 milligrams (mg) twice daily as needed for pain. Care plans initiated on 3/9/15 and 3/14/15, and identified as current by the Director of Nursing on 5/26/15 at 10:30 a.m., indicated Resident #99 had a stage four pressure ulcer on her right outer ankle and had a potential for pain. Goals indicated pain would be relieved by a goal of zero. Interventions included administer analgesia per physicians orders (offer prior to treatment/therapy). Nurse's notes dated: 3/9/15 at 11:34 a.m., 3/20/15 at 10:45 a.m., 3/23/15 at 12:33 p.m., 3/30/15 at 10:45 a.m., 4/6/15 at 5:55 a.m., 4/20/15 at 3:09 p.m., 5/4/15 at 5:13 p.m., and 5/13/15 at 1:44 p.m., indicated Resident #99 "does experience some pain during dressing changes as exhibited by her facial grimacing. She does have pain medication that nursing will give before dressing changes are to be done...." The March 2015, Medication Administration Record (MAR) lacked indication acetaminophen 650 milligrams (mg) prn (as needed) pain medication had been administered. The April 2015 MAR indicated acetaminophen 650 mg was		III. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;** Licensed nursing personnel will be re-educated on the Skin Care Guideline to include appropriate pain management during wound care. A QAPI tool has been developed to monitor ongoing compliance titled, "F-282 – Services by Qualified Person per Care Plan" that theADNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that compliance with proper pain management is observed during wound care. Licensed nurses will be re-educated on the Dialysis Communication Guideline. A QAPI tool has been developed to monitor ongoing compliance, titled, "F-309 – Dialysis Communication" that the ADNS or designee will monitor daily, on scheduled days of work, Times 4 weeks, compliance with the Dialysis Communication Guideline.	

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	administered on 4/1/15. The record did not indicate prn pain medication was administered on any other dates. The May 2015 MAR indicated acetaminophen 650 milligrams (mg) was administered on 5/22/15 at 11:00 a.m. The record did not indicate prn pain medication was administered on any other dates. During an interview on 5/27/2015 at 2:10 p.m., the Director of Nursing (DON) indicated the facility did not have a policy regarding pain interventions for pain control. A "Pain Practice Guide Flowchart," dated 2011 and provided by the DON on 5/27/2015 at 2:10 p.m., " ...ASSESS: Does the patient have pain or a condition that is likely to cause pain ...IMPLEMENT: ...Evaluate patients for pain daily and document ...Ongoing management strategies ...EVALUATE .... " 2. Resident #75's record was reviewed on 5/22/2015 at 10:30 a.m. The resident's diagnosis included, but was not limited to, end stage renal disease and the record indicated the resident received hemodialysis three days a week.		IV. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;** Audit findings will be presented to QAPI committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QAPI committee will review findings and determine need for further monitoring until a threshold of 100% is reached.	

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	A "Hemodialysis Communication Form" indicated Resident #75 received dialysis on 5/8/2015 and did not indicate staff completed an assessment or checked vital signs prior to sending the resident to the dialysis center. A "Hemodialysis Communication Form" indicated Resident #75 received dialysis on 5/18/2015 and did not indicate the dialysis center provided post-dialysis vital signs and health status. A "Hemodialysis Communication Form" indicated Resident #75 had dialysis on 5/25/2015 and did not indicate the dialysis center provided post-dialysis vital signs. During an interview on 5/26/2015 at 10:32 a.m., Registered Nurse (RN) #2 indicated Resident #75 received dialysis three times a week. A binder that contained a "Hemodialysis Communication Form" was sent to the dialysis center and had not been located upon the resident's return from the center on 5/25/2015. She indicated the binder was not always returned to the facility and indicated it would be retrieved the next time the resident went to the dialysis center.			

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	During an interview on 5/26/2015 at 11:11 a.m., the Administrator indicated the "Hemodialysis Communication Form" was the policy and/or guidelines used to provide the dialysis center with the following: vital signs/weight, dialysis access site and patient status assessment, lab tests, diet order/fluid restrictions, and current medications. The form indicated the dialysis center should have provided the nursing facility with the following information upon resident's completion of daily dialysis: pre-dialysis vital signs and weight, post-dialysis vital signs and weight, patient complications during dialysis, nutrition concerns, medications given during dialysis, laboratory values, post dialysis instructions, new physician orders, and patient status. During an interview on 5/26/2015 at 12:29 p.m., the Administrator indicated the facility should have completed their portion of the communication form before sending the resident to dialysis and the facility staff was responsible for retrieval of the pre-dialysis and post-dialysis information when Resident #75 returned from dialysis. A document titled, "Disease Management			

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	Guideline for Chronic Renal Failure," was provided by the Administrator on 5/26/2015 at 11:11 a.m. indicated, "...NURSING ...Communicate with the dialysis center...." A document titled, "SNF [Skilled Nursing Facility] Outpatient Dialysis Services Agreement," was provided by the Administrator on 5/26/2015 at 11:11 a.m. indicated, "...Resident Information: The Nursing Facility shall ensure that all appropriate medical and administrative information accompanies all residents at the time of transfer or referral to the ESRD Dialysis Unit...." 3.1-37(a)			
F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure a system which monitored consumption of	F 0325	Preparation and/or execution of this plan of correction does not constitute	06/26/2015

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	fortified foods to ensure its efficacy to prevent weight loss for 2 of 3 residents who triggered for nutritional status (Residents #44 and #150). Findings include: 1. During an interview on 5/19/15 at 10:05 a.m., Licensed Practical Nurse (LPN) #32 indicated Resident #44 received high calorie food. She indicated consumption of high calorie food was not documented. During an interview on 5/26/15 at 2:16 p.m., the Minimum Data Set (MDS) Assessment Coordinator indicated the facility only documented supplements ordered by a physician. She indicated the facility did not have a system to document high calorie food recommended by the Dietitian as interventions for potential for/or actual weight loss. Resident #44's record was reviewed on 5/26/15 at 12:45 p.m. A Minimum Data Set (MDS) assessment tool, dated 9/23/15, indicated Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and required encouragement and cueing for eating. A nutritional assessment, dated 1/26/15		admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to maintain the nutritional status of all residents unless unavoidable. Consistent with this practice, the following actions have been taken: I.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The medical record of resident D was reviewed and updated to reflect appropriate documentation of meal consumption to include consumption of supplements and alternate meals offered. Resident B no longer resides at the facility.	

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - PRESTWICK		STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123	

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	at 6:35 p.m., indicated Resident #44 experienced a significant weight loss of 13.7 percent unless than one month with her previous weight recorded as 124.5 on 1/12/15 at the hospital. The record indicated involuntary weight loss related to inadequate oral in take and indicated the resident consumed 25-75% of meals and did not like the facility food. The record indicated enhanced calorie foods were added due to refusals of prescribed nutritional supplements. Consumption records, dated May 2015, indicated Resident #44 consumed 25 to 75 percent of food served. The consumption records lacked indication high caloric enhanced foods were consumed. 2. During an interview on 5/19/15 at 10:205 a.m., Licensed Practical Nurse (LPN) #32 indicated Resident #150 did not receive nutritional supplements. During an interview on 5/26/15 at 2:16 p.m., the Minimum Data Set (MDS)Assessment Coordinator indicated the facility only documented supplements ordered by a physician. She indicated the facility did not have a system to document high calorie food recommended by the Dietician as interventions for potential for/or actual		II. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** An audit was completed to identity other residents having the potential to be affected by the same deficient practice. Those identified were all residents that receive nutritional supplements or fortified foods and are at risk for potential/actual weight loss. The medical records of all residents at risk for potential and or with actual weight loss, receiving meal intake reviewed to ensure proper documentation is present in the record including supplements or fortified foods. III. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;** Licensed nursing personnel, including Certified Nursing Assistants will be re-educated on	

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	weight loss. During an interview on 5/27/2015 at 2:10 p.m., the Director of Nursing (DON) indicated the facility currently did not have a system to monitor intake of enhanced high caloric food used as interventions for weight loss. Resident #150's record was reviewed on 5/26/15 at 11:19 a.m. A Nutrition Assessment, dated 5/5/15 at 2:41 p.m., indicated Resident #150 had a body mass index (BMI) of 18.4, weight 124.4 pounds, and was 69 inches tall. This note indicated he weighed 126.6 pounds on 4/28/15. This note further indicated he was underweight related to inadequate oral intake as evidenced by his BMI of 18.4, intake on admission poor "had improved to 50-100 percent currently." With good intake currently, "will add enhanced food" and continue to monitor weight. A care plan, dated 5/5/15, indicated Resident #150 was at nutritional risk and would maintain or gain weight to a healthy BMI range. Interventions included to provide additional calories/protein at meals per patient preferences. Consumption records, dated 5/2015,		the documentation of meal consumption to include fortified foods and supplements. A QAPI tool has been developed to monitor ongoing compliance titled, "F-325 – Maintaining Nutrition Status" that the ADNS or designee will utilize to monitor daily, on scheduled days of work, times 4 weeks, that documentation of supplements or fortified foods is compliant. IV. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place;** Audit findings will be presented to QAPI committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QAPI committee will review findings and determine need for further monitoring until a threshold of 100% is reached.	

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	indicated Resident #150 consumed 50-100 percent of meals. The records lacked indication high caloric enhanced foods were consumed. A policy titled "Medical Nutrition Therapy and Documentation," dated September, 2014, and identified as current by the Dietician on 5/27/15 at 11:57 a.m., indicated, "It is important to monitor the patient's progress in meeting goals...If nutritional goals are not achieved, and interventions are determined to be ineffective, different or additional pertinent approaches are considered and implemented as indicated... patients at higher nutritional risk may require more frequent monitoring than for those patients who are currently nutritionally stable. Monthly or more frequent monitoring and documentation is suggested for patients who are...experiencing significant weight changes or trends." 3.1-46(a)			
F 9999 SS=D Bldg. 00	3.1-14 PERSONNEL	F 9999	Preparation and/or execution of this plan of correction does not	06/26/2015

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	(t) 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 a department-approved course of instruction in intraderrmal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. 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. 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.		constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility toensure that a physical examination be obtained for each employee within (1) month prior to employment. Consistent with this practice, the following actions have been taken: I.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The personnel files of C.N.A. #8, C.N.A. #9, and RN Supervisor #10 were reviewed and now include proof of tuberculosis screening provided by the facility staff.	

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	This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure 3 out of 5 employees had tuberculosis screening upon hire. This deficiency had the potential to effect 79 out of 79 residents residing at the facility. Findings include: On 5/27/15 at 11:40 a.m., five employee records were reviewed for proof of tuberculosis (TB) screening upon hire. Three employee records failed to show documentation of TB screening upon hire. State form 5440, "Employee Records," provided on 5/18/15 by the Administrator, indicated Certified Nurse Aide (CNA) # 9 began employment on 3/30/15. The human resources form titled, "HCR Manorcare Two Step Mantoux (TB) Test Result," for CNA #9 indicated she had the first step TB test on 5/26/15. State form 5440, "Employee Records," provided on 5/18/15 by the Administrator, indicated Certified		II. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All other personnel files audited to ensure compliance with state rule regarding proof of (TB) screening. III. **What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur;** The Human Resources Director was re-educated on the requirements related proof of (TB) screening upon hire. A QAPI tool titled, "F-9999 – Tuberculosis (TB) Screening" was developed to ensure that proof of (TB) screening is present in the personnel files of all new employees in accordance with the state rule. This will be completed by the Administrator or designee with every new hire, times 4 weeks with to monitor compliance with F-9999. IV. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality**	

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	Nursing Assistant (CNA) #8 started employment on 4/21/15. The human resources form titled, "HCR Manorcare Two Step Mantoux (TB) Test Result," for CNA #8 indicated she had the first step TB test on 5/26/15. State form 5440, "Employee Records," provided on 5/18/15 by the Administrator, indicated Registered Nurse (RN) Supervisor #10 started employment on 4/7/15. On 5/27/15 at 3:10 p.m., the daily nursing assignment schedules from 5/4/15 to 5/17/15 were reviewed, and indicated CNA #8, CNA #9, and RN Supervisor #10 had worked during this timeframe. During an interview on 5/27/15 at 2:35 p.m., the Human Resources (HR) Director indicated she did not have record of RN Supervisor #10's TB screening prior to employment or since hire. She indicated CNA #8 and CNA #9 had the first TB test on 5/26/15 and were scheduled to have the second TB test the next week. During an interview on 5/27/15 at 2:42 p.m., the HR Director indicated she overlooked the TB screening upon hire for RN Supervisor #10 and CNA #9. She		**assurance program will be put into place;** Audit findings will be presented to QAPI committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QAPI committee will review findings and determine need for further monitoring until a threshold of 100% is reached.	

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	indicated she had been informed CNA #8 had a TB test with her previous employer. She indicated CNA #8 had failed to provide documentation of her recent TB screening and the HR Director had recently addressed the lack of TB documentation on 5/26/15. During an interview on 5/27/15 at 3:03 p.m., the Director of Nursing (DON) indicated employees were to have TB screening upon hire and annually per the state regulations. She indicated the facility did not have documentation of TB screening for CNA #8, CNA #9, and RN Supervisor #10. On 5/27/15 at 3:08 p.m., the DON provided the current employee health policy, dated 6/1/02. The policy indicated the facility was to comply with state and federal regulations regarding employee health and ensuring employees were free of communicable diseases. 3.1-14(t)(1)			