

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/13/2015
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170430.</p> <p>Complaint IN00170430 - Substantiated, Federal/State deficiencies related to the allegations are cited at F314, F323, F329, and F441.</p> <p>Survey dates: April 9, 10, and 13, 2015</p> <p>Facility number: 000173 Provider number: 155273 AIM number: 100290920</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 2 Medicaid: 46 Other: 28 Total: 76</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	The center respectfully requests a desk review on the cited deficiencies. Please see the attached audit and tracking forms the center has put in place to ensure continued compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to prevent the development of a pressure ulcer on a resident's heel, failed to document the characteristics of the pressure ulcer, and failed to immediately notify the physician and obtain orders for treatment of the pressure ulcer, resulting in a heel blister and infection, for 1 of 3 residents reviewed for pressure ulcers, in a sample of 7. Resident D</p> <p>Findings include:</p> <p>On 4/9/15 at 10:30 A.M., during the initial tour, RN # 1 indicated Resident D "had a blister on her heel."</p> <p>The clinical record of Resident D was</p>	F 314	<p>F314</p> <ol style="list-style-type: none"> Resident D's physician has been notified and a treatment order received. The resident's family and hospice were also notified. Care plan has been updated. All other resident's have had skin assessments and appropriate documentation and treatments are in place. Licensed nurses have been re-inserviced on the center policy and procedure for skin assessment and documentation. DON or designee will audit Treatment and Resident bathing schedules 5x weekly for 4 weeks, then 3x weekly for 4 weeks, then weekly for 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in the center monthly 	05/06/2015

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	<p>reviewed on 4/10/15 at 9:15 A.M. The resident was admitted on 3/20/15 with diagnoses including, but not limited to, respiratory failure and diabetes mellitus. The resident was documented as receiving hospice care.</p> <p>An Admission Skin Assessment, undated, indicated the resident had a "calloused area" on the resident's left heel.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/27/15, indicated the resident scored a 15 on a cognition test. A score of 15 indicated no memory impairment. The resident required extensive assistance of two + staff for bed mobility, transfer, dressing, and personal hygiene. The MDS assessment indicated the resident was at risk of developing pressure ulcers, had no unhealed pressure ulcers present, and no foot lesions.</p> <p>A computerized resident care plan, undated, indicated: "Skin Integrity Assessment: Prevention and Treatment Care Plan." The following goals were marked with a checkmark: "Will remain free of open areas. Will be cooperative with position changes." None of the pre-printed interventions were marked, including "Manage Friction & Shear,</p>		<p>QAPI meeting times 6 months and quarterly times 2 quarters to determine further recommendations as needed.</p> <p>6. Date of compliance: May 6th</p>	

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	<p>Protect Elbows and Heels if being exposed to Friction, Inspect the skin for s/s [signs/symptoms] of breakdown, Turn and Reposition Program, Skin Protection...."</p> <p>A Physician's order, dated 4/8/15, indicated, "1. Elevate [left] heel off bed @ all times. 2. Skin prep [left] heel blister q [every] shift."</p> <p>Documentation in the Nurse's Notes regarding notification of the physician or family of the pressure area, or a description of the pressure area, was not found.</p> <p>At that time, the Unit Manager was interviewed. She indicated if there was a skin sheet on the resident's pressure ulcer, documenting the measurements and other characteristics of the area, it would be in the "Skin Book." There was not a skin assessment sheet found for Resident D.</p> <p>At that time, the Unit Manager provided the resident's "hospice" clinical record, kept in a separate binder. Documentation regarding a pressure ulcer, or any nursing documentation, was not found in the binder.</p> <p>On 4/10/15 at 10:55 A.M., Resident D was interviewed. Resident D was</p>			

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	<p>observed with a pressure-relieving boot on her left foot. Resident D indicated staff had applied the boot that morning. She indicated her left foot was "tender." Resident D indicated she was unsure when she developed the foot blister, but that "it wasn't there" when she was admitted. CNA # 1 indicated at that time that the blister "popped up out of nowhere." CNA # 1 removed the resident's boot from her left foot, and a large, greyish, fluid filled blister was observed on the resident's left inner heel.</p> <p>On 4/13/15 at 9:25 A.M., the clinical record of Resident D was again reviewed.</p> <p>A Nurse's Note, dated 4/10/15 at 1:00 P.M. and written by the Corporate Nurse Consultant, indicated, "Late entry for 4/8/15. Staff apparently noted blister 3.5 cm x 4 cm on inner left heel. Contacted physician who ordered skin prep initially...Hospice physician ordered Keflex [an antibiotic] TID [three times daily] x 7 days. Area tender to touch...."</p> <p>The resident's hospice record was also reviewed at that time. A "Visit Note Report," dated 4/7/15 at 8:41 P.M., included: "...She has developed a Lg [large] blister to left medial heel area. Previously area was calloused and tender, but issue resolved but now</p>			

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	<p>exacerbated...Lg Flluid filled blister to medial aspect of left heel. Redness noted around blister and along inside of foot, and over top aspect. Foot with edema and increased pain...."</p> <p>On 4/13/15 at 10:30 A.M., the Administrator provided the current facility policy on "Pressure Ulcer Prevention/Treatment," revised April 2009. The policy included: "Assess all residents upon admission...Review assessments and identify individualized interventions...Interventions may include, but are not limited to: Manage Pressure...Off load heel pressure...Review and revise "Skin Integrity Assessment: Prevention and Treatment Care Plan" to reflect interventions to heal pressure ulcers and stabilize, reduce or remove underlying risk factors."</p> <p>This Federal tag relates to Complaint IN00170430.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F 323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a bed alarm was in place, as ordered by the physician, resulting in a fall with a laceration requiring sutures, for 1 of 3 residents reviewed for falls, in a sample of 7. Resident A</p> <p>Findings include:</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> Resident A no longer resides in the center. Residents experiencing falls since March 1, 2015 have been reviewed for appropriate documentation. Care plans and assignment sheets have been updated as appropriate. Licensed staff have been re-inserviced on falls documentation, falls interventions 	05/06/2015

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	<p>The closed clinical record of Resident A was reviewed on 4/9/15 at 11:55 A.M. Diagnoses included, but were not limited to, left femoral neck fracture and overactive bladder.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/29/15, indicated the resident scored a 13 for cognition. A score of 15 indicated no memory impairment. The MDS assessment indicated the resident required extensive assistance of one staff for transfer and ambulation in the room. A test for balance while moving from seated to standing position, moving on and off of the toilet, and surface-to-surface transfer indicated the resident was "Not steady, only able to stabilize with staff assistance."</p> <p>Physician orders, initial date unknown but written on the March 2015 recertification orders, indicated, "Bed and chair alarm for safty [sic]."</p> <p>A care plan, initially dated 12/2/14 and updated 3/3/15, indicated: "Fall/Injury Risk related to: History of Falls, pain, unsteady, poor weight bearing...bladder incontinence at x's [times]...Interventions: Transfer 2A [assistance of two], Resident Supervision</p>		<p>and care plan updates.</p> <p>4. The DON or designee will audit fall events for appropriate documentation, interventions and care plan updates as needed 5 x weekly for 4 weeks, then 3xweekly for 4 weeks, then weekly for 6 months. Identified non-compliance will result in 1:1 re-education up to and including termination. Identified trends will be reviewed in the center monthly QAPI meeting times 6 months and quarterly times 2 quarters to determine further recommendations as needed.</p>	

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	<p>General, Non-skid socks 2/13/15, Obtain Medication Regimen Review with consulting pharmacists PRN [as needed], Non-skid adhesive to floor 3/02/15...."</p> <p>The intervention of a bed and chair alarm was not documented on the care plan.</p> <p>Nurse's Notes included the following notations:</p> <p>2/13/15 at 5:00 P.M.: "Fell while trying to transfer self from w/c [wheelchair] to bed, had on reg [regular] socks. Talked with daughter [name], informed her and that she needed to wear gripper socks. She wants resident to have an alarm on to alert staff when she is trying to get up...."</p> <p>2/15/15 at 6:30 A.M.: "Resident on fall f/u [follow-up]...Reminded to use call light when getting out of bed. Resident now has gripper socks. Bed alarm is on...Will continue to monitor."</p> <p>2/16/15 at 11:00 A.M.: "Res alert [with] confusion. Not using call light to have assistance to BR [bathroom]...call light in reach."</p> <p>2/27/15 at 9:00 P.M.: "Resident continues to get OOB [out of bed] [without] assistance, bed alarm on...."</p> <p>2/28/15 at 8:00 P.M.: "Resident cont to</p>			

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	<p>get OOB [without] assistance. Sitting at nurse desk."</p> <p>2/28/15 at 10:40 P.M.: "Found resident on the floor sitting by the bed...4 cm [centimeters] x .5 cm x 0.3 cm [laceration]." Documentation did not indicate if the bed alarm was on and/or sounding.</p> <p>The resident was transferred to the hospital emergency room on 2/28/15 at 10:50 P.M., and returned to the facility at 2:40 A.M.</p> <p>Nurses notes, dated 2/28/15 [sic] at 2:40 A.M., indicated: "Resident return to facility per w/c [with] family. (6) staples head [no] drainage...Instructed to call for assistance."</p> <p>A Daily Clinical Review entry, dated 3/2/15, indicated: "...Resident observed on floor on 022715 @ 2240 [10:40 P.M.] - had attempted to go to BR [with] out calling for assist...resident had laceration 4 cm x .5 cm x 0.3...returned to facility [with] 6 staples to [right] back of head - non adhesive strips applied to floor @ bedside, in front of recliner, [and] in front of commode - reminded resident again to wear gripper socks...reminded again to use call light...." Documentation did not indicate if the bed alarm was on and/or</p>			

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	<p>sounding.</p> <p>On 4/10/15 at 6:25 A.M., the Corporate Nurse Consultant provided an accident report, dated 2/27/15. The report included: "...Resident yelling out and found her sitting on the floor by the foot of the bed. Laceration to scalp...resident report that slid out of bed [sic]...Conclusion: resident had increased confusion due to UTI [urinary tract infection] which was being tx [treated]." Documentation did not indicate if the bed alarm was on and/or sounding.</p> <p>On 4/10/15 at 9:00 A.M., during an interview with Resident A's family member, he/she indicated that the facility usually used one alarm for the resident, which they would switch between her bed and her wheelchair, depending on where the resident was located at the time. The family member indicated when the family accompanied Resident A back from the hospital following her head laceration, the alarm was observed to be in the resident's wheelchair and not in her bed. The family member indicated that a staff member "admitted a couple of days later that she had forgotten to move the alarm from the wheelchair to the bed."</p> <p>On 4/13/15 at 10:30 A.M., the Administrator provided the current</p>			

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	<p>facility policy on "Fall/Injury Assessment: Prevention and Management Care Plan," revised October 2014. The policy included: "[The corporation] revises the residents Care Plan and/or center practices to reduce the likelihood of another fall. Determining causal factors leading to a resident fall is necessary to provide consistent intervention to help prevent future occurrences. Causal factors may include, but are not limited to:...Unsteady gait...Dizziness...Acute infection...Antidepressant, Sedative/hypnotic...Procedure:...Determine appropriate interventions for identified risk factors.</p> <p>This Federal tag relates to Complaint IN00170430.</p> <p>3.1-45(a)(2)</p>			

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F 329 SS=D Bldg. 00	<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> <p>Based on interview and record review, the facility failed to ensure a resident who was receiving 3 different anti-depressants</p>	F 329	<p>F329</p> <ol style="list-style-type: none"> Resident A no longer resides in the center. Other residents on psychoactive medications have been 	05/06/2015

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	<p>had adequate indications for the use of, or adequate monitoring of, the medications, for 1 of 5 residents reviewed for medication usage, in a sample of 7. Resident A</p> <p>Findings include:</p> <p>The closed clinical record of Resident A was reviewed on 4/9/15 at 11:55 A.M. The resident was admitted to the facility on 12/1/14 with diagnoses including, but not limited to, left femoral neck fracture, overactive bladder, and depression.</p> <p>A Nursing Admission Assessment, dated 12/1/14, indicated the resident was "Alert."</p> <p>Admission Physician orders, dated 12/1/14, indicated, "Trazadone [an anti-depressant] 50 mg @ hs [bedtime] as needed."</p> <p>The Physician's Desk Reference (PDR), 2015, indicated, "Trazadone...Side effects may include: drowsiness, dizziness, light headedness...."</p> <p>Nurse's Notes, dated 12/16/14 at 1:00 P.M., indicated, "...Res [resident] requested Trazadone be changed to be given every HS instead of prn [as needed]. Waiting for new orders...."</p>		<p>reviewed and reductions initiated where appropriate. Care plans including behavioral interventions are in place for all psychoactive medications.</p> <p>3. Licensed nurses and the social services director have been re-inserviced on center policy and procedure for use of antipsychotic drug therapy and on communicating new drug therapies to social services for review and care planning.</p> <p>4. The DON or designee will review new medication orders 5 times weekly. The interdisciplinary team will review care plans on any new antipsychotic medications weekly to ensure appropriate care plans are in place, and dose reduction is initiated if appropriate. Social Services will review antipsychotic medications at a minimum quarterly to ensure gradual dose reductions are implemented per center policy. Identified non-compliance will result in 1:1 re-education up to and including termination. DON and Social Services director will report findings to the center QAPI monthly meeting times 6 months and quarterly times 2 quarters to determine further recommendations as needed.</p>		

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	<p>Nurse's Notes, dated 12/16/14 at 2:00 P.M., indicated, "...N.O. [new order] to change Trazadone from prn to 100 mg po [by mouth] @ hs. Res [and] family made aware."</p> <p>A Physician's order, dated 12/16/14, indicated, "Trazadone 100 mg, Give 1 tablet orally daily at bedtime for insomnia."</p> <p>A dietary note, dated 1/27/15, indicated, "January wt [weight] [down]...House supplements started in December...Requesting Remeron [an anti-depressant] to aid appetite."</p> <p>A Physician's order, dated 1/29/15, indicated, "Remeron 15 mg Q [every] HS."</p> <p>The Physician's Desk Reference, dated 2015, included: "Remeron...Common possible side effects include: Sleepiness, Increased appetite, Dizziness."</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 1/29/15, indicated the resident had a cognition score of 13. A score of 15 indicated no memory impairment.</p> <p>Nurse's Notes, dated 2/23/15 at 3:00</p>			

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	<p>P.M., indicated, "...fax to [name of physician] to [increase] Oxybutrin [a medication used for urinary frequency] and possibly Pyridium [a bladder medication] for urinary urgency and only going small amounts. Urine tested on 2/16/15 and was [negative] for UTI [urinary tract infection]. Family wishes to try to [increase] Oxybutrin also. Waiting for reply."</p> <p>A Physician's order, dated 2/24/15, indicated, "...Increase Oxybutrin 5 mg to BID [twice daily]...Celexa [an anti-depressant] 20 mg po daily."</p> <p>A Daily Clinical Review [DCR] note, dated 2/25/15, indicated, "DCR for med [changes] - having episodes of increased urinary frequency - increased pressure [and] urgency...also order received for Celexa 20 mg po - family has voiced concerns regarding [increased] sadness [and] nursing home placement."</p> <p>The Physician's Desk Reference, 2015, included: "Celexa...Common side effects include drowsiness...."</p> <p>Nurse's Notes, dated 3/4/15 at 9:30 A.M., indicated, "Res alert [with] confusion at times...Res voided in depends. Urine had a foul smell. Request made for UA C&S [urinalysis, culture and sensitivity]...."</p>			

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	<p>Nurse's Notes, dated 3/4/15 at 1:30 P.M., indicated, "[Name of physician] called and aware of [positive] UTI [urinary tract infection]. New order for Bactrim...."</p> <p>Nurse's Notes, dated 3/6/15 at 3:00 A.M., indicated, "Increased confusion - difficulty [with] transfers...Daughter [name] updated she thinks it is the Celexa and don't [sic] want her to have it any longer...."</p> <p>A "Mood and Behavior Symptom Assessment Care Plan," initially dated 12/14 and updated 1/15, indicated: "Potential for side effects related to psychotropic drug use: Trazadone, Diagnosis: Insomnia. Behavioral symptoms drug is intended to treat: sleeplessness. Remeron, Diagnosis: Depression, Behavioral symptoms drug is intended to treat: Decreased appetite. Interventions: Monitor for side effects: Dizziness/Vertigo, Syncope, Unsteady gait. Monitor for drug-related Cognitive/Behavioral impairment: Delirium/Disordered Thinking...."</p> <p>A Care Plan related to the use of Celexa was not found in the clinical record.</p>			

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	<p>The resident was transferred to the hospital on 3/6/15 at 11:30 A.M., due to increased confusion.</p> <p>A hospital history and physical, dated 3/6/15, included: "...Apparently the patient has been getting confused over the last 2 days. She was having difficulty staying awake and did not make sense with her talking...The patient has been on a couple of sedatives like Trazadone and Remeron...Assessment/Plan: Encephalopathy, multifactorial...Dehydration and urosepsis in addition to multi-sedatives are probably responsible for that...Multi-sedative use, I would discontinue Remeron and lower the dose of Trazadone...</p> <p>A hospital discharge summary, dated 3/11/15, indicated, "...The mental status improved after we discontinued some of the sedatives...."</p> <p>On 4/10/15 at 10:00 A.M., during an interview with the Social Services Director (SSD), she indicated she tracked psychoactive medications. She indicated she was unsure if she knew about the resident being started on Celexa. She indicated if she was aware, she would have written the drug on the care plan. She indicated the nursing staff frequently</p>			

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	<p>will await the recommendations from the pharmacy consultant, regarding reducing or changing psychoactive medications.</p> <p>On 4/13/15 at 10:30 A.M., the Administrator provided the current facility policy on "Psychoactive Medication," revised October 2008. The policy included: "...Use psychoactive medications for reasons that may include, but not limited to: Non-drug approaches fail, and Benefits outweigh the risk of potential side effects, Treatment of documented medically supported psychiatric diagnoses and identified Target Behavior, Maintain or improve function...Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/ Care Plan...Review of psychoactive medication may include...Current medications and effectiveness, Side effect monitoring results...Complete a progress note...reviewed identified issues and initiated/updated the Care Plan as necessary."</p> <p>This Federal tag relates to Complaint IN00170430.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>			

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F 441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program			

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	<p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to ensure a newly admitted resident had a chest x-ray performed or tuberculosis skin tests prior to admission, for 1 of 5 residents reviewed for admission chest x-rays and tuberculosis skin tests, in a sample of 7. Resident D</p>	F 441	<p>F 441</p> <p>1. Resident D has a chest xray on 4/12/15 and PPD given 4/10/15. Both with negative results.</p> <p>2. Other center residents were reviewed and their TB skin tests are current.</p> <p>3. Licensed Nurses and the admission coordinator have been re-inserviced on the center policy for infection control related to chest x-rays and ppd tests. The DON or</p>	05/06/2015

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	<p>Findings include:</p> <p>The clinical record of Resident D was reviewed on 4/10/15 at 9:15 A.M. The resident was admitted to the facility from home on 3/20/15.</p> <p>A chest x-ray report, dated 4/15/13, was found in the clinical record. There was no more recent chest x-ray.</p> <p>The resident's Medication Administration Record (MAR) was reviewed at that time. There was no documentation of a PPD (tuberculosis skin test) given.</p> <p>On 4/13/15 at 10:00 A.M., during an interview with the Administrator, she indicated the lack of a chest x-ray and PPD test may have happened due to the facility having a new admissions coordinator. The Corporate Nurse Consultant indicated at that time that she did an audit of other residents in the building, to determine if any other residents "had been missed."</p> <p>On 4/13/15 at 10:30 A.M., the Administrator provided the current facility policy, "Tuberculosis Screening - Residents," revised November 2013. The policy included: "[The corporation] will administer the two-step Mantoux Purified</p>		<p>designee will verify that chest x-rays and ppd's are present on all new admissions going forward. A tracking system has been implemented to ensure that the annual ppd's are administered timely on all residents. Monthly audit will be completed by the DON or designee. Staff with identified non-compliance will result in 1:1 re-education up to and including termination</p> <p>4. The DON or designee will report findings to the center's monthly QAPI meeting times 6 months and quarterly times 2 quarters for recommendations.</p>	

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	<p>Protein Derivative [PPD] Test to all new residents as required by State Regulations on admission...If the resident tested positive in the past, they must have had a chest x-ray within 90 days preceding admission or 7 days after admission, or according to State/Federal Regulation...."</p> <p>This Federal tag relates to Complaint IN00170430.</p> <p>3.1-18(a) 3.1-18(c) 3.1-18(e)</p>			

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

PRINTED: 05/04/2015
FORM APPROVED
OMB NO. 0938-0391

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