

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 5, 8, & 9, 2015</p> <p>Facility number: 005722 Provider number: 005722 AIM number: N/A</p> <p>Census bed type: Residential: 101 Total: 101</p> <p>Sample: 9</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
R 0036 Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form</p>			

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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	<p>of treatment.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician was notified of a potential need to alter treatment in that the resident's mental status had declined and the resident exhibited aggressive behaviors towards others for 1 of 6 residents reviewed for notification of change in condition. (Resident #103)</p> <p>Findings include:</p> <p>The clinical record of Resident #103 was reviewed on 6/5/15 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, dementia, Alzheimer's disease, delusional disorder, and impulse control disorder.</p> <p>A recapitulated physician's order for June, 2015, with an original order date of 6/20/14, indicated Resident #103 was to receive citalopram 10 mg daily. Citalopram (Celexa) is a</p>	R 0036	<p>1. Resident #103's current MD was notified of psych eval recommendation on 6/5/2015 and a new order was received to discontinue Celexa.</p> <p>2. Wellness Directors have audited the medical records of each resident who is receiving mental health services in the community to ensure all recommendations have been reported to the physician.</p> <p>3. Per facility procedure, the 24 hour report and Daily Shift Transfer Communication form will be utilized to ensure physician notification has occurred. An in-service will be conducted by Wellness Director to licensed nurses on these procedures to ensure physician notification of potential needs to alter treatment for residents occurs.</p> <p>4. Wellness Directors/designee will audit 10% of the medical records for residents receiving services to ensure appropriate physician notification. Audits will be conducted two times/week x2 weeks; weekly x 4 weeks; monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>	07/09/2015			

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	<p>medication used to treat depression.</p> <p>A review of Nurses' Notes indicated the following:</p> <p>9/1/14, no time documented, "...res [resident] had behaviors hitting staff..."</p> <p>9/18/14 at 2:45 p.m., "Male res. [resident] squeezed her [Resident #103) hand & res. slapped him..."</p> <p>9/20/14, no time documented, "...difficult to re-direct today aggravating other residents, stole cake from 3 different people..."</p> <p>A physician's note, dated 9/24/14, indicated, "staff notes increased agitation [without] provocation tries to hit/shove staff. Has hit other residents...takes food from other res...Is physically aggressive at random times...can consider alternate placement if behaviors continue...Psych eval. [evaluation]."</p>			

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	<p>Review of a Psychological Evaluation, performed by the in-house psychologist, dated 9/26/14, indicated, "Staff and chart report frequent agitation, physical aggression, impulsivity, intrusive behavior, wandering, and exit-seeking. No signs/symptoms of depression are reported or observed...2. In view of agitation and aggressive behavior, lack of depression, and the tendency for SSRIs [selective serotonin re-uptake inhibitors, a group of medications used to treat depression] to cause agitation in some older adults with dementia, you may wish to consider the medical appropriateness of discontinuing Celexa [citalopram] for better control of agitation and aggression."</p> <p>Continued review of Nurses' notes indicated the following:</p> <p>9/30/14 at 9:00 p.m., "...Res hitting staff..."</p>			
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	<p>11/23/14, no time documented, "...combative today, swinging @ staff."</p> <p>11/30/14 at 7:40 a.m., "This res. was found in bed [with] another res. in other res.'s room et [and] CNA [Certified Nursing Assistant] witnessed this res. hit other res. in face..."</p> <p>11/30/14 at 6:10 p.m., "Was noted at meal time res. trying to reach over & take food from other res."</p> <p>12/30/14 at 6:00 p.m., "Resident involved in a resident to resident altercation. Resident was resting on shoulder of resident B [name of another resident on the unit] and resident was startled and woke up to smack resident B on the face repeatedly..."</p> <p>12/30/14 at 6:12 p.m., "Resident entered rm [room] of [room number on unit] and proceeded to scare resident and remove clothing</p>			

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	<p>from resident's closet..."</p> <p>1/3/15 at 3:00 p.m., "Resident walked up to another resident that was standing by her door and...started hitting her and smacking her for no reason..."</p> <p>1/3/15 at 7:00 p.m., "[name of resident #103] walked up to a resident that was sitting in her wheel chair and [name of Resident #103] just started smacking her in the back of her head and trying to push her out of her chair..."</p> <p>1/4/15, no time documented, "CNA was walking [Resident #103] to her chair for lunch and [Resident #103] started slapping and hitting the CNA..."</p> <p>1/5/15 at 5:40 a.m., "Assisted resident upon getting up. Was very aggressive, agitated and combative..."</p> <p>1/11/15 at 9:50 a.m., "...This res. approached another res. sitting on</p>			

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	<p>couch during activities and attempted to hold other res's hand. Other res. pinched this res's hand and this res. open handed hit res in..[illegible]...then pulled their hair..."</p> <p>1/27/15 at 11:15 (a.m. or p.m. not documented), "Res tried to hit writer..."</p> <p>2/7/15, no time documented, "This res was sitting next to another res in activity area and began hitting res in face and pulled ear..."</p> <p>2/8/15, no time documented, "...res has been trying to hit other res..."</p> <p>3/7/15 at 1:00 p.m., "Combative [with] staff today and spit food..."</p> <p>5/3/15 at 8:00 p.m., "Was reported to writer res came behind CNA & was aggressive trying to get in another res rm. [room] and was hitting CNA on back of head..."</p> <p>5/20/15 at 2:45 p.m., "[increased]</p>			

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	<p>agitation noted with residents. Resident in nursing office currently striking staff..."</p> <p>5/22/15 at 7:00 p.m., "Res up for supper and tried to reach for other res. food..."</p> <p>An Indiana/Tennessee Assisted Living Resident Evaluation and Service Plan for Resident #103, dated 9/9/14, indicated the resident got easily agitated with other residents and staff, was exit seeking, wandered and paced in the hallways, and was followed by the, "in-house psychologist."</p> <p>An Indiana/Tennessee Assisted Living Resident Evaluation and Service Plan for Resident #103, dated 11/27/14, indicated the resident could become easily agitated, was, at times, difficult to redirect, and was followed by in house psych.</p> <p>An Indiana/Tennessee Assisted Living Resident Evaluation and</p>			

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	<p>Service Plan, dated 2/16/15, indicated the resident could become agitated, was difficult to redirect at times and was followed by in-house psych. The service plan indicated the resident was resistive to care, easily irritable/agitated, and disturbances or emotional states created special plans for staff.</p> <p>An Indiana/Tennessee Assisted Living Resident Evaluation and Service Plan, dated 5/16/15, indicated the resident could become agitated, was difficult to redirect at times and was followed by in-house psych.</p> <p>On 6/5/15 at 4:00 p.m., the Keepsake Village Wellness Coordinator (KVWC) indicated the psychological evaluation, dated 9/26/14, had been faxed to the resident's physician on 10/10/14, but the physician had not addressed/responded to the consideration of discontinuing the resident's citalopram, and nothing</p>			

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R 0044 Bldg. 00	<p>further had been done with the psychologist's recommendation. The KVWC indicated the resident had a different in house physician now and the new physician would be consulted regarding the discontinuation of the citalopram.</p> <p>On 6/8/15 at 2:50 p.m., the KVWC indicated Resident #103's new physician gave orders on 6/5/15, to discontinue the citalopram, as recommended by the psychologist. The citalopram was discontinued on 6/5/15.</p> <p>410 IAC 16.2-5-1.2(r)(1-5) Residents' Right - Deficiency (r) The transfer and discharge rights of residents of a facility are as follows: (1) As used in this section, " interfacility transfer and discharge " means the movement of a resident to a bed outside of the licensed facility. (2) As used in this section, " intrafacility transfer " means the movement of a resident to a bed within the same licensed facility. (3) When a transfer or discharge of a resident is proposed, whether intrafacility or interfacility, provision for continuity of care shall be provided by the facility. (4) Health facilities must permit each</p>			

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	<p>resident to remain in the facility and not transfer or discharge the resident from the facility unless:</p> <p>(A) the transfer or discharge is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility;</p> <p>(B) the transfer or discharge is appropriate because the resident ' s health has improved sufficiently so that the resident no longer needs the services provided by the facility;</p> <p>(C) the safety of individuals in the facility is endangered;</p> <p>(D) the health of individuals in the facility would otherwise be endangered;</p> <p>(E) the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or</p> <p>(F) the facility ceases to operate.</p> <p>(5) When the facility proposes to transfer or discharge a resident under any of the circumstances specified in subdivision (4) (A), (4)(B), (4)(C), (4)(D), or (4)(E), the resident ' s clinical records must be documented. The documentation must be made by the following:</p> <p>(A) The resident ' s physician when transfer or discharge is necessary under subdivision (4)(A) or (4)(B).</p> <p>(B) Any physician when transfer or discharge is necessary under subdivision (4) (D).</p> <p>Based on record review and interview, the facility failed to ensure their policy regarding residency requirements was followed for a resident experiencing mental status changes and aggressive behaviors towards other residents and staff, which resulted in resident to resident physical altercations, for 1 of 8 residents reviewed for meeting residency</p>	R 0044	<p>1. Executive Director and Wellness Director reviewedresident #103's current status, current care plan and interventions with MD andfamily. All parties agreed for resident admission for inpatient GeriatricPsychiatric treatment. Resident remains hospitalizedat this time.</p> <p>2. All residents on Keepsake Village will be screened byWellness</p>	07/09/2015

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	<p>requirements. (Resident #103)</p> <p>Findings include:</p> <p>On 6/5/15 at 11:00 a.m., the Executive Director provided a policy titled, "Residency Requirements," dated 12/5/2012, and indicated it was the policy currently used by the facility. The policy indicated, "...resident...f. must not exhibit behavior problem(s) disturbing to other residents...g. must not be a safety risk to self or others...4. If...a current resident has difficulty with one or more of the above criteria, an assistance/service plan to meet his/her needs will be developed with resident, staff, family, and home health agency involvement. If the needs cannot be met with the services available, then the prospective resident would not qualify for residency nor the current resident for continued residency..."</p> <p>The clinical record of Resident #103 was reviewed on 6/5/15 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, dementia, Alzheimer's disease, delusional disorder, and impulse control disorder. The resident was admitted to the facility on 1/3/14, and readmitted from a hospital stay on 6/20/14.</p> <p>Resident #103 was receiving in-house</p>		<p>Director, Executive Director and Regional Operations Manager for appropriateness of continued residency per facility policy.</p> <p>3. Any aggressive behaviors by residents will be reviewed for appropriate continued residency per facility policy by interdisciplinary team. The team will review possible solutions including placement in another care facilities. Interdisciplinary team members include ED, Wellness Directors, Activities and Medical Director. An in-service will be conducted by the Regional Operations Manager and the Director of Clinical Services to the Executive Director and Wellness Director regarding the facility policy for residency requirements.</p> <p>4. Executive Director/Wellness Directors/designee will review all residents in the weekly Resident Rounding meeting to ensure that each resident continues to meet the facility's residency requirements. This meeting is an ongoing weekly meeting. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>psychological services since 9/9/14, and hospice services since 10/20/14.</p> <p>Resident #103's service plans, dated 9/9/14, 11/27/14, 2/16/15 and 5/16/15, indicated she required medication management, hands-on extensive assistance with hygiene and grooming, showers, assistance with mobility, meals, activities, toileting and daytime checks every hour while awake. The evaluations/service plans indicated she could become agitated and/or easily agitated at times, was difficult to redirect, was resistive to care, easily irritable/agitated.</p> <p>Review of nurses' notes indicated the following:</p> <p>9/1/14, no time documented, "...res [resident] had behaviors hitting staff..."</p> <p>9/18/14 at 2:45 p.m., "Male res. squeezed her [Resident #103) hand & res. slapped him..."</p> <p>9/20/14, no time documented, "...difficult to re-direct today aggravating other residents, stole cake from 3 different people..."</p> <p>A physician's note, dated 9/24/14, indicated, "staff notes increased agitation</p>			

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	<p>[without] provocation tries to hit/shove staff. Has hit other residents...takes food from other res...Is physically aggressive at random times...can consider alternate placement if behaviors continue...Psych eval [evaluation]."</p> <p>Continued review of Nurses' Notes indicated the following:</p> <p>9/30/14 at 9:00 p.m., "...Res hitting staff..."</p> <p>11/23/14, no time documented, "...combative today, swinging @ staff."</p> <p>11/30/14 at 7:40 a.m., "This res. was found in bed [with] another res. in other res.'s room et [and] CNA [Certified Nursing Assistant] witnessed this res. hit other res. in face..."</p> <p>11/30/14 at 6:10 p.m., "Was noted at meal time res. trying to reach over & take food from other res."</p> <p>12/30/14 at 6:00 p.m., "Resident involved in a resident to resident altercation. Resident was resting on shoulder of resident B [another resident on the unit] and resident was startled and woke up to smack resident B on the face repeatedly..."</p>			

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	<p>12/30/14 at 6:12 p.m., "Resident entered rm [room] of [room number on unit] and proceeded to scare resident and remove clothing from resident's closet..."</p> <p>1/3/15 at 3:00 p.m., "Resident walked up to another resident that was standing by her door and...started hitting her and smacking her for no reason..."</p> <p>1/3/15 at 7:00 p.m., "[name of resident #103] walked up to a resident that was sitting in her wheel chair and [name of Resident #103] just started smacking her in the back of her head and trying to push her out of her chair..."</p> <p>1/4/15, no time documented, "CNA was walking [Resident #103] to her chair for lunch and [Resident #103] started slapping and hitting the CNA..."</p> <p>1/5/15 at 5:40 a.m., "Assisted resident upon getting up. Was very aggressive, agitated and combative..."</p> <p>1/11/15 at 9:50 a.m., "...This res. approached another res. sitting on couch during activities and attempted to hold other res's hand. Other res. pinched this res's hand and this res. open handed hit res in..[illegible]...then pulled their hair..."</p>			

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	<p>1/27/15 at 11:15 (a.m. or p.m. not documented), "Res tried to hit writer..."</p> <p>2/7/15, no time documented, "This res was sitting next to another res in activity area and began hitting res in face and pulled ear..."</p> <p>2/8/15, no time documented, "...res has been trying to hit other res..."</p> <p>3/7/15 at 1:00 p.m., "Combative [with] staff today and spit food..."</p> <p>5/3/15 at 8:00 p.m., "Was reported to writer res came behind CNA & was aggressive trying to get in another res rm. [room] and was hitting CNA on back of head..."</p> <p>5/20/15 at 2:45 p.m., "[increased] agitation noted with residents. Resident in nursing office currently striking staff..."</p> <p>5/22/15 at 7:00 p.m., "Res up for supper and tried to reach for other res. food..."</p> <p>On 6/9/15 at 12:00 p.m., the Keepsake Village Wellness Director indicated Resident #103 wasn't always a safety risk to others, her aggressiveness was random. They try to keep her separated from the other residents. When they take her to</p>			

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R 0090 Bldg. 00	<p>meals they lead her away from other resident's food. They have tried changing her medications.</p> <p>On 6/9/15 at 2:00 p.m., the Executive Director indicated Resident #103's aggressive behavior towards other residents and staff was random, unpredictable.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal</p>			

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	<p>representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure resident to resident physical altercations in a secured dementia unit were reported to the Indiana State Department of Health for 6 of 7 altercations reviewed. (Resident #103)</p> <p>Findings include:</p> <p>The clinical record of Resident #103 was reviewed on 6/5/15 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, dementia, Alzheimer's disease, delusional disorder,</p>	R 0090	<p>1. Facility leadership has submitted the required report of Unusual Occurrence to the ISDH regarding items identified by surveyor pertaining to resident #103.</p> <p>2. All residents have the potential to be affected by this alleged deficient practice. The facility leadership reviewed all current resident incident reports. No additional concerns were identified and none were identified as needing to be reported to ISDH.</p> <p>3. The regional director of operations has reviewed the ISDH Unusual Occurrences policy and</p>	07/09/2015

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	<p>and impulse control disorder.</p> <p>Review of Nurses' Notes indicated the following:</p> <p>9/18/14 at 2:45 p.m., "Male res. [resident] squeezed her [Resident #103] hand & res. slapped him..."</p> <p>11/30/14 at 7:40 a.m., "This res. was found in bed [with] another res. in other res.'s room et [and] CNA [Certified Nursing Assistant] witnessed this res. hit other res. in face..."</p> <p>12/30/14 at 6:00 p.m., "Resident involved in a resident to resident altercation. Resident was resting on shoulder of resident B [name of another resident on the unit] and resident was startled and woke up to smack resident B on the face repeatedly..."</p> <p>1/3/15 at 3:00 p.m., "Resident walked up to another resident that was standing by her door and...started hitting her and smacking her for no reason..."</p> <p>1/3/15 at 7:00 p.m., "[name of resident #103] walked up to a resident that was sitting in her wheel chair and [name of Resident #103] just started smacking her in the back of her head and trying to push her out of her chair..."</p>		<p>facility procedures pertaining to this ISDH policy with the administrator, wellness directors and key department supervisors. The Executive Director will also review with facility staff the ISDH unusual occurrences reporting guidelines and their responsibility to report any possible concerns immediately to a supervisor or administrator.</p> <p>4. The administrator and/or designee will conduct a review of all grievance and incident reports to ensure proper reporting, as applicable. A review will be conducted weekly x 4 weeks, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>	

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	<p>1/11/15 at 9:50 a.m., "...This res. approached another res. sitting on couch during activities and attempted to hold other res's hand. Other res. pinched this res's hand and this res. open handed hit res in..[illegible]...then pulled their hair..."</p> <p>2/7/15, no time documented, "This res was sitting next to another res in activity area and began hitting res in face and pulled ear..."</p> <p>On 6/5/15 at 4:00 p.m., the Executive Director (ED) was asked to provide any incidents/unusual occurrences reported to the Indiana State Department of Health (ISDH) regarding Resident #103.</p> <p>On 6/8/15 at 9:00 a.m., the Executive Director provided an Incident Report Form sent to ISDH regarding the resident to resident altercation on 12/30/14. The ED indicated resident to resident altercations which threatened the safety of residents were unusual occurrences at the facility, but the above altercations involving Resident #103 had not been reported to ISDH, except for the one which occurred on 12/30/14.</p> <p>On 6/5/15 at 12:20 p.m., the Executive Director provided a policy titled, "Abuse</p>			

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R 0117 Bldg. 00	<p>Prevention," dated 1/8/14, and indicated it was the policy currently used by the facility. The policy indicated, "Employees will report all situations that may be considered abuse or neglect to a resident from any and all sources... Reports of suspected or confirmed abuse or neglect must be presented immediately to the Administrator. Confirmed abuse/neglect will be reported to the State Department of Health within 24 hours of the occurrence."</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred</p>			

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	<p>(100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure a minimum of 1 staff person, with current Cardiopulmonary Resuscitation (CPR) and first aid certificates was on staff at all times. This had the potential to affect all residents residing in the facility.</p> <p>Findings include:</p> <p>On 6/8/15 at 2:55 p.m., the Executive Director (ED) provided 14 Daily Staffing Assignment records, dated 5/22/15 through 6/4/15, and indicated the names on the assignment records were the staff who had actually worked each shift on those dates. The ED indicated the names highlighted in yellow were staff who had their CPR certification, and the staff highlighted in pink had their first aid certification.</p> <p>The 14 Daily Staffing Assignment records indicated the following regarding staff who held CPR and first aid certifications:</p>	R 0117	<ol style="list-style-type: none"> 1. No residents were affected by the alleged deficient practice. 2. The Business Office Manager audited nursing department personnel records to determine the status of their certification of CPR/First Aid. All nurses with expired certifications will be re-certified as soon as possible. 3. The Business Office Manager will maintain a tracking system to ensure ongoing compliance with current CPR & First Aid certifications. An inservice will be conducted by the Executive Director to the Business Office Manager, Wellness Directors and Wellness Administrative Assistant regarding this procedure. A notation will also be made on the daily staffing sheet to indicate which employee on each shift is CPR/First Aid certified. 4. Executive Director/designee will audit 10 employee files for current CPR/First Aid certifications and review the daily staffing sheets weekly x4 weeks and monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further 	07/09/2015

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	5/22/15: day shift - no first aid; night shift - no first aid.		recommendations accordingly.	
	5/23/15: day shift - no first aid; evening shift - no first aid; night shift - no first aid.			
	5/24/15: day shift - no first aid; evening shift - no first aid; night shift - no CPR, no first. aid.			
	5/25/15: day shift - no first aid; night shift - no first aid.			
	5/26/15: day shift - no first aid; evening shift - no CPR, no first aid; night shift - no first aid.			
	5/27/15: day shift - no first aid; evening shift - no CPR, no first aid; night shift - no first aid.			
	5/28/15: day shift - no first aid; night shift - no first aid.			
	5/29/15: day shift - no first aid; night shift - no first aid.			
	5/30/15: day shift - no first aid; night shift - no first aid.			
	5/31/15: day shift - no first aid; night shift - no first aid.			

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R 0121 Bldg. 00	<p>6/1/15: day shift - no first aid; evening shift: no first aid; night shift - no first aid.</p> <p>6/2/15: day shift - no first aid; night shift - no CPR, no first aid.</p> <p>6/3/15: day shift - no first aid; evening shift - no CPR, no first aid; night shift - no CPR, no first aid.</p> <p>6/4/15: day shift - no first aid; night shift - no first aid.</p> <p>On 6/8/15 at 3:00 p.m., the ED indicated, "We need to work on getting CPR and first aid coverage."</p> <p>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, and by whom administered. The facility must</p>						

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	<p>assure the following:</p> <p>(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.</p> <p>(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.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure a health screen was completed for new employees prior to resident contact, for 3 of 5 staff reviewed. (Qualified Medical Assistant #1, Server #2, and Certified Nursing Assistant #3).</p> <p>Findings include:</p>	R 0121	<p>1. No residents were affected by the alleged deficient practice.</p> <p>2. The Business Office Manager/designee will audit all current employee files to determine status of employee Health Screenings. Health screenings will be provided for any employees who have not received one.</p> <p>3. An inservice will be conducted by the Executive Director to the</p>	07/09/2015

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	<p>A review of Employee Records on 6/5/15 at 3:00 p.m. indicated the following:</p> <p>Qualified Medical Assistant #1 was hired on 5/7/15 and was currently working in the facility. A two-step tuberculin skin test had been performed, but there was no documentation in the record which indicated any other health screening had been done.</p> <p>Server #2 was hired on 5/28/15 and was currently working in the facility. A two-step tuberculin skin test had been performed, but there was no documentation in the record which indicated any other health screening had been done.</p> <p>Certified Nursing Assistant #3 was hired on 4/15/15 and was currently working in the facility. A two-step tuberculin skin test had been performed, but there was no documentation in the record which indicated any other health screening had been done.</p> <p>On 6/5/15 at 3:00 p.m., the Executive Director indicated the facility has had some difficulty getting new employee health screens done in a timely manner and was not able to provide any further information regarding the missing health</p>		<p>Business Office Manager on facility policy regarding pre-employment health screenings prior to resident contact. Arrangements have been made with Medical Director to conduct employee health screenings in conjunction with new employee hire process.</p> <p>4. Executive Director/designee will audit all new employee paperwork for appropriate health screening weekly x4 weeks and monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>	

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R 0217 Bldg. 00	<p>screens above.</p> <p>On 6/5/15 at 2:00 p.m., the Executive Director provided a policy titled, "Pre-Employment Physical," dated 4/30/15, and indicated it was the policy currently used by the facility. The policy indicated, "Each employee will have a physical completed by a physician prior to the first day of work but after the job offer has been made...A physical exam is required for employment..."</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations</p>			

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	<p>subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure service plans were signed by the resident or the resident's representative for 4 of 8 residents reviewed for having resident/representative signatures on their service plans. (Residents #122, #88, #62 and #40)</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident #122 was reviewed on 6/8/15 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, major depressive disorder and high blood pressure.</p> <p>Resident #122 was admitted to the facility on 2/3/15 and discharged 3/5/15. A review of an Indiana/Tennessee Assisted Living Resident Evaluation and Service Plan for the resident, dated 2/3/15, indicated the service plan had not been signed by the resident or the resident's representative.</p> <p>On 6/8/15 at 10:50 a.m., the Keepsake Village Wellness Director indicated</p>	R 0217	<p>1. Resident #88, #62, and #40 all have signed Service plans in the Medical Record. Resident #122 was included in the deficiency, but is no longer a resident at the community.</p> <p>2. An audit of all resident's medical records will be performed by the Wellness Directors/designee to determine if there are unsigned Resident Service Plans. Any unsigned Service Plans will be removed from the resident's medical record and signature will be obtained.</p> <p>3. Resident/representative signatures will be obtained for all initial service plans and any subsequent evaluations indicating a need for a change in services. For residents/families that choose to attend ongoing care plans, service plans will be signed at that time. For those who do not have care plan meetings, service plans will be reviewed with them by phone and then mailed to them for signature. A copy of service plan will remain in the chart noting the telephone consent until a signed copy is received back to the facility. Copy will be replaced when signed service plan is returned.</p> <p>4. Wellness Directors/designee</p>	07/09/2015

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	<p>Resident #122's service plan, dated 2/3/15, had not been signed by the resident or the resident's representative.</p> <p>2. The clinical record of Resident #88 was reviewed on 6/5/15 at 1:15 p.m. Diagnoses for the resident included, but were not limited to, dementia with aggressive behaviors and anxiety.</p> <p>Resident #88 was admitted to the facility on 11/7/14. A review of an Indiana/Tennessee Assisted Living Residential Evaluation and Service Plan for the resident, dated 11/7/14, indicated the service plan had not been signed by the resident or the resident's representative.</p> <p>On 6/5/15 at 4:50 p.m., the Keepsake Village Wellness Director indicated Resident #88's service plan, dated 11/7/14, had not been signed by the resident or the resident's representative.</p> <p>3. The clinical record of Resident #62 was reviewed on 6/5/15 at 3:05 p.m. Diagnoses for the resident included, but were not limited to, high blood pressure.</p> <p>A review of Resident #62's service plans, indicated none had been signed by the resident or the resident's representative.</p>		<p>will audit 10% of the medical records for residents receiving services to ensure appropriate service plan signatures two times/week for x2 weeks; weekly for 4 weeks and monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				

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	<p>On 6/5/15 at 4:15 p.m., the Senior Living Wellness Director indicated she was unable to find any service plans for Resident #62, which had been signed by the resident or the resident's representative.4. The clinical record for Resident #40 was reviewed on 06/08/2015 at 10:30 a.m. Diagnoses included, but were not limited to, depression.</p> <p>A review of the Indiana/Tennessee Assisted Living Resident Evaluation and Service Plan for Resident #40, dated 05/18/2015, indicated the document lacked a signature from the resident or the resident ' s Power of Attorney. During an interview on 06/08/2015 at 5:30 p.m., the Executive Director indicated the facility did not have a signed service plan for Resident #40. On 6/8/15 at 5:30 p.m., the Executive Director provided a policy titled, "Assistance/Service Plan," dated 9/27/11 and updated 1/8/14, and indicated it was the policy currently used by the facility. The policy indicated, "...4. All components of the assistance/service plan form must be completed..."</p>			

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R 0241 Bldg. 00	<p>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. Based on observation, interview, and record review, the facility failed to administer medication as ordered by the physician, in that a resident received 5 mg (milligrams) of warfarin, a blood thinner, when 2.5 mg was ordered. (Resident #68)</p> <p>Findings include:</p> <p>During an observation of medication administration on 6/5/15 at 5:05 p.m., Resident #68 was administered warfarin 5 mg by Qualified Medication Assistant (QMA) #1. During the preparation of the medications for administration, QMA #1 indicated the resident's dose was 2.5 mg of warfarin every day and 2.5 mg every day except Sunday. QMA #1 reviewed the Medication Administration Record (MAR) and indicated the 5 mg dose was correct.</p> <p>During the reconciliation of the Medication Administration on 6/5/15 at</p>	R 0241	<p>1. Resident #68 was assessed for any adverse effects, Vitalsigns were obtained, and MD and family were notified. Correct dose wasconfirmed with MD. 2. Wellness Director/designees completed a reconciliation ofcurrent medication orders on MAR/and current medication orders in medicalrecord to ensure all are in agreement for each resident. Any identifieddeficiencies were corrected at that time. Nurses, QMA's were in-serviced to educate on proper medicationadministration techniques, transcription and documentation, and need toreference Physicians Orders in the Medical Record anytime any uncertaintypresents itself in the MAR, for verification. Training was also included on new implementation of Coumadin flow sheetsdesigned to monitor and record current Coumadin dose, and all Coumadin dosechanges. 3. Monthly reconciliation of MAR's/Physicians orders willcontinue as currently performed, by a designated floor nurse. A</p>	07/09/2015			

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R 0349 Bldg. 00	<p>5:10 p.m., Resident #68's physician's order for warfarin dated 5/28/15, indicated the resident was prescribed 2.5 mg every day except Sunday and 3.75 mg on Sunday.</p> <p>During an interview with the Administrator and the Wellness Director on 6/5/15, the Wellness Director indicated the physician's order on 5/28/15, was the most recent warfarin order for the resident. During a review of the MAR for June 2015, for Resident #68, the Administrator and Wellness Director indicated the documentation indicated the resident was administered warfarin 5 mg on June 1, 2, 3, 4, and 5, 2015, when 2.5 mg was prescribed.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview,</p>	R 0349	<p>second check of reconciled MAR's/Physicians orders will be performed by Wellness Directors/designee to ensure accuracy of all MAR information. Each MAR checked will required to be initialed. An inservice will be conducted by our pharmacy provider and Wellness Directors to licensed nurses and QMA's regarding proper transcription of physician orders and verification procedures.</p> <p>4. Wellness Directors/designee will audit 10% of the medical records for residents receiving services to ensure proper transcription, complete orders and verification procedures two times/week x 2 weeks; weekly x 4 weeks; and monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>	07/09/2015		1. Families and MD's were notified	

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	<p>the facility failed to ensure clinical records were complete in that results of laboratory blood draws were not documented in the clinical record (Resident #68 and Resident # 103) and a resident's behaviors were not documented in the resident's records. (Residents #104)</p> <p>Findings include:</p> <p>1.a. The clinical record review, completed on 6/8/15 at 10:00 a.m., indicated Resident #68 had diagnoses including, but not limited to mitral valve replacement and a past history of a stroke.</p> <p>A physician's order dated 5/28/15, indicated the resident was prescribed warfarin 5 mg to be administered only on 5/28/15, and then was prescribed 2.5 mg every day but Sunday and 3.75 mg on Sunday. The order also indicated the resident was scheduled for a PT/INR (prothrombin time/international normalized ratio, a laboratory test to monitor the effectiveness of warfarin) on 6/4/15.</p> <p>During an interview with Licensed Practical Nurse (LPN) #5 and the Executive Director (ED) on 6/8/15 at 5:00 p.m., LPN #5 indicated the laboratory test was not completed on</p>		<p>of missed labs for resident#68 and# 103. Resident # 68 obtained lab on 6/5/15. Resident #103, orderreceived to discontinue lab.</p> <p>2. Wellness Directors/designees audited resident medicalrecords to reconcile physician ordered labs as compared to those on record withlab. Any labs missed will be clarified with MD.</p> <p>3. All lab orderswill be tracked for completion by licensed nurses for residents receiving services on the Daily Shift Transfer Communication Notes form. An inservice will be conducted by WellnessDirector to licensed nurses on this procedure to ensure lab completion asphysician ordered.</p> <p>4. Wellness Directors/designee will audit 10% ofthe medical records for residents receiving services to ensure lab completionas physician ordered two times/week for x2 weeks; weekly for 4 weeks and monthlythereafter. Results of these audits will be reviewed by the QA committee, whowill establish the threshold of compliance and make further recommendationsaccordingly.</p>	

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	<p>6/4/15, as ordered, and the resident was taken to the hospital laboratory on 6/5/15, to have the testing completed. The results of the test on 6/5/15, indicated the resident had an INR of 3.0. The normal range for the test was 2.0 - 3.0. The PT was not provided on the results. The ED indicated the physician had been notified of the administration of 5 mg of warfarin on 6/5/15, and no new orders were received.</p> <p>b. The clinical record of Resident #103 was reviewed on 6/5/15 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>A recapitulated physician's order for June, 2015, with an original date of 7/9/14, indicated Resident #103 was to have a CBC (complete blood count), a BMP (basic metabolic panel, which measures electrolytes in the body) and a TSH (thyroid stimulating hormone) laboratory blood tests every 3 months. No laboratory results for these blood tests were found in the resident's clinical record after 10/30/14.</p> <p>On 6/8/15 at 11:00 a.m., the Keepsake Wellness Director indicated he was not able to find any lab results for the resident after 10/30/14 or any orders which discontinued the lab tests.</p>			

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	<p>2. The clinical record review of Resident #104, completed 6/8/15 at 3:15 p.m., indicated the resident had diagnoses including, but not limited to, dementia and psychotic disorder.</p> <p>The Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 6/1/15, indicated hospice was assisting with preventing spitting and swelling for the resident. The report indicated the resident required assistance with skin care related to incontinence of bowels and bladder. The note indicated the resident was not spitting as much and continued to have a decline in condition.</p> <p>During a review of the nursing progress notes from 4/7/15 - 6/2/15, the progress notes lacked documentation of the resident having any behaviors including spitting. The notes lacked any documentation from 4/23/15 at 1:00 a.m., to 6/2/15 at 2:30 p.m.</p> <p>During an observation of Resident #104 on 6/9/15, from 11:25 a.m. to 12:05 p.m., the resident was noted to be in a high back wheelchair in the dining room area sitting at a table with a female resident. Resident #104 was initially yelling out in non-sensible noises. When approached, the resident answered to name. The resident was noted to have a clear</p>			

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	<p>drainage extending from the corner of the mouth down onto the shirt and clothing protector and some trembling of both hands.</p> <p>During an interview with Certified Nursing Assistant (CNA) #7 on 6/9/15 at 11:40 a.m., CNA #7 indicated the resident calls out most days, off and on throughout the day. When asked about the resident spitting, CNA #7 indicated the resident spits "all the time" and the staff has to be careful when around the resident because the resident frequently spit on the floor beside the chair. CNA #7 indicated the resident had spit on the floor while in the dining room. Resident observed eating food with fingers. Large white mucus looking area noted on the floor beside the wheelchair.</p> <p>At 11:55 a.m. on 6/9/15, the resident was observed coughing and having clear nasal drainage. The resident made no attempts to wipe the nose and the drainage was noted to extend from the nose onto the clothing protector and the shirt. The resident then started coughing, turned the head, and then spit onto the floor beside the chair. There were 2 CNAs in the dining area assisting other residents.</p> <p>At 12:05 p.m., on 6/9/15, the resident was again noted to have clear drainage</p>			

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R 0410 Bldg. 00	<p>from the nose onto the clothing protector. The Activity Director took the resident a tissue and the resident wiped at the drainage. Two large mucus looking areas were noted on the floor beside the resident.</p> <p>During an interview with the Unit Manager (UM) of the Keepsake Unit on 6/9/15 at 1:45 p.m., the Unit Manager indicated the staff was responsible for cleaning the floor with the mop and bucket filled with disinfectant whenever the resident spit onto the floor. The UM indicated the resident typically would spit on the floor 2-3 times a day. When asked about behavior tracking, the UM indicated the staff documented behaviors in the nursing progress notes. The UM was informed of the lack of documentation in the resident's chart from 4/23/15 - 6/2/15, and specifically the lack of documentation regarding behaviors and the monitoring of medications.</p> <p>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</p>			

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	<p>induration with the date given, date read, and by whom administered and read.</p> <p>(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.</p> <p>(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.</p> <p>Based on interview and record review, the facility failed to complete a tuberculin skin test prior to or upon admission for 1 of 8 residents reviewed for tuberculin skin tests (Resident #40).</p> <p>Findings include:</p> <p>A review of the clinical record for Resident #40 was completed on 06/08/2015 at 10:30 a.m. Diagnoses included, but were not limited to, depression.</p> <p>The clinical record indicated Resident #40 was admitted to the facility on 05/18/2015.</p> <p>A review of the Resident TB (tuberculin)/Immunization Record for</p>	R 0410	<p>1. A first and second step PPD has been completed for resident #40. 2. All residents have the potential to be affected by the deficient practice. Wellness Directors/designees conducted an audit of all resident medical records to ensure all residents have a current annual TB test completed. Any identified concerns were promptly resolved. 3. Admitting nurse will administer and record the 1st step PPD on the resident medication administration record (MAR). Admitting nurse will also schedule the reading of the 1st step and administration and reading of the 2nd step PPD on the MAR. An in-service will be conducted by the Wellness Director to licensed nurses about facility procedure to administer, record and schedule admission and 2-step PPD's. 4. Wellness</p>	07/09/2015

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	<p>Resident #40, indicated a tuberculin skin test was administered on 05/31/2015.</p> <p>During an interview on 06/08/2015 at 4:30 p.m., the Executive Director indicated there was no tuberculin skin test on file for Resident #40 prior to 05/31/2015. The Executive Director indicated a tuberculin skin test should have been administered the day the resident admitted to the facility.</p> <p>The policy titled "Tuberculosis Testing Policy for Residents" was provided by the Executive Director on 06/08/2015 at 5:35 p.m. The policy indicated, "... 3. In addition, a tuberculin skin test shall be completed within three months prior to admission or upon admission and read at forty-eight to seventy-two hours...."</p>		<p>Directors/designee will audit all new move-ins since last audit to ensure timely TB testing per facility policy two times/month x2 months and monthly thereafter. Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly.</p>				