

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2015
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177428.</p> <p>Complaint IN00177428 - Substantiated. Federal/state deficiencies related to allegation are cited at F157, F282, F312 and F9999 .</p> <p>Survey dates: July 13 and 14, 2015</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 4 Medicaid: 34 Other: 6 Total: 44</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when there was a change in condition for 1 of 3 residents reviewed</p>	F 0157	<p>F157 1.Resident C's physician was notifiedof the concerns of the skins condition, with no new orders. LPN #1 wasre-educated concerning the policy of Physician</p>	08/13/2015

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	<p>for physician notification. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 7/13/15 at 9:40 a.m. Diagnoses for Resident C included, but were not limited to, total left hip replacement, depression, Parkinson's Disease, pain, anemia and hypertension.</p> <p>A nursing note, dated 7/4/15 at 7:00 p.m., indicated Resident C's surgical incision was assessed. The nurse indicated "resident resting in bed c/o [complaints of] pain L [left] hip dsg [dressing] intact sm [small] amt [amount] of drng [drainage] noted area red & swollen warm to touch...." The next nursing note was dated 7/5/15 at 3:50 a.m.</p> <p>Review of the discharge instructions, dated 6/30/15, indicated post surgery instructions, as follows: "observe affected area or extremity for change in color, increased pain, numbness, tingling, foul odor, swelling, excessive bleeding or redness. *REPORT THESE SIGNS TO THE PHYSICIAN*."</p> <p>Review of a current care plan, dated 7/14/15, indicated Resident C had a problem related to impaired skin from a surgical incision. The interventions</p>		<p>notification.</p> <p>2.A chart review was conducted for allother residents with skin conditions to assure physician notification of anyconcerns, no concerns were identified. Nursing staff were re-educated on the policy for physician notificationspecifically with concerns upon assessment with skin conditions.</p> <p>3.As a means to ensure compliance withproper notification of physician for convers upon assessment with skinconditions, licensed nursing staff were re-educated on the policy and procedurefor skin assessments and notification of Physician for any concerns noted. The DON and/or designee will review allresident records which have skin conditions to assure proper notification ofPhysician for concerns noted, 5x/week on scheduled work days x 1 month, 2x/weekx 1 month, then weekly thereafter, should concerns be noted, corrective actionshall be taken.</p> <p>4.As a means of quality assurance, theDON and/or designee will report the findings of the above reviews and anycorrective actions taken to the QA committee monthly x 3 months and quarterlythereafter, and revisions made to the plan, if warranted.</p> <p>5.8-13-15</p>				

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	<p>included, but were not limited to, "keep dressing in place until follow-up with doctor and notify physician and family of any concerns."</p> <p>During an interview on 7/14/15 at 2:20 p.m., LPN #1 indicated she was the nurse who took care of Resident C on 7/4/15. She indicated she did not notify the physician of her assessment of the surgical area. She indicated she did not think to call the physician.</p> <p>Review of a current facility policy, dated 10/14, titled "NOTIFICATION OF CHANGE", which was provided by the Corporate Nurse on 7/14/15 at 4:05 p.m., indicated the following:</p> <p>"Purpose: To keep resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affect the care and welfare of the resident.</p> <p>Policy: Facility personnel shall immediately inform resident, consult with resident's physician; and, if known, notify the resident's legal representative or an interested family member when there is: *an accident... *a significant change in the resident's</p>			

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F 0282 SS=D Bldg. 00	<p>physical, mental, or psychosocial status, (i.e., a deterioration in health, mental, or psychosocial status, life-threatening condition or clinical complication);</p> <p>*a need to alter treatment...</p> <p>*a decision to transfer or discharge....</p> <p>PROCEDURE: ...1. All notifications shall be made per telephone, via fax, or in person and documented in the clinical record...."</p> <p>This federal tag relates to Complaint IN00177428.</p> <p>3.1-5(a)(2)</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure physician orders were accurately transcribed for 2 of 6 residents reviewed for physician orders. (Residents C and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was</p>	F 0282	<p>F282</p> <p>1.Resident C's physician was notifiedof the inaccurate order for the ice pack to the incision site with new ordersto make this order PRN. Resident D nolonger resides at the facility.</p> <p>2.A chart review was conducted for allresidents with orders for skin care/treatments and orders for oxygen withparameter to maintain oxygen saturations, to</p>	08/13/2015			

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	<p>reviewed on 7/13/15 at 9:40 a.m. Diagnoses for Resident C included, but were not limited to, total left hip replacement, depression, Parkinson's Disease, pain, anemia and hypertension.</p> <p>Review of the discharge instructions, dated 6/30/15, indicated post surgery instructions to "Leave dressing in place until further notice from Dr. [name of doctor]. Notify office if dressing becomes saturated. Do not apply any lotions or ointments around incision site." The discharge instructions also included the following: "Ice To: INCISION ADDITIONAL DIRECTIONS: REPLACE EVERY 2 HOURS AND PRN [as needed] *HIP/FEMUR..."</p> <p>During skin observation on 7/13/15 at 2:00 p.m., Resident C was standing at his bedside for RN #2 to assess his surgical site. RN #2 washed her hands and donned gloves. Resident C lowered his pants and exposed his left hip incision. The incision was covered with gauze dressing and a tegaderm was placed over the site. RN #2 then lifted the tegaderm from the bottom and peeled up to expose the incision. The incision was covered with steri-strips.</p> <p>During an interview on 7/13/15 at 2:38 p.m., RN #2 stated she had looked under</p>		<p>assure proper monitoring oftreatments of skin, and proper monitoring of oxygen saturation levels at aspecific percentage. Licensed nursingstaff were re-educated on proper transcription of new admissions/readmissions.(two nurses to check transcription of orders, as well as DON and/or designee) 3.As a means to ensure compliance withproper transcription of admission/re-admission orders including but not limitedto skin care/treatments and oxygen orders with parameters to maintain oxygensaturations at a specific percentage, licensed nursing staff were re-educatedon proper transcription of orders for residents with skin care/treatments andoxygen orders with parameters to maintain oxygen saturations at a certainpercentage. The nurses were instructedto assure a double check system of proper transcription of newadmissions/re-admissions. (two nurses tocheck transcription of orders, as well as DON and/or designee) The DON and/or designee will review allrecords of residents with orders for skin care/treatments and oxygen orders tomaintain oxygen saturations at specific oxygen saturation, as well as all newadmission/re-admission orders to assure proper</p>	

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	<p>the tegaderm before, but had not ever changed the dressing. She was not sure if other nurses were checking under the dressing or if the dressing had been re-enforced. RN #2 indicated she had not applied any ice to the surgical site today.</p> <p>On 7/14/15 at 8:55 a.m., the Director of Nursing (DON) was notified the hospital discharge instructions related to the application of ice and assessment of the post surgical site were not accurately reflected on the facilities medication record.</p> <p>During an interview on 7/14/15 at 3:40 p.m., LPN #3 indicated she had not put ice to the surgical site today or observed the site. LPN #3 indicated she was finishing her charting for the day, but was just about to go assess his site.</p> <p>During an interview on 7/14/15 at 3:45 p.m., LPN #4 indicated she was unaware the ice was a scheduled order. She indicated Resident C had refused ice in the past, but it was not charted.</p> <p>Review of the facilities medication record, dated June, 2015, indicated the following: "leave tegaderm in place till f/u [follow-up] appt in approx 2 weeks." The record also included the following: "Ice to incision *replace q [every] 2 hrs</p>		<p>transcription of orders 5x/ week on scheduled work days. Should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report the findings of the above reviews and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted.</p> <p>5.8-13-15</p>	

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	<p>and prn [as needed]."</p> <p>Review of the Medication Administration Record (MAR) for June, no staff person documented ice had been applied or refused to the incision since Resident C was admitted.</p> <p>Review of a current care plan, dated 7/14/15, indicated Resident C had a problem related to impaired skin from a surgical incision. The interventions included, but were not limited to, "keep dressing in place until follow-up with doctor and notify physician and family of any concerns."</p> <p>Review of the initial assessment of non-pressure related skin conditions sheet dated 7/3/15, the assessment indicated measurements were not obtainable related to dressing over the wound. The sheet indicated "Dressing not to be removed."</p> <p>2. The clinical record for Resident D was reviewed on 7/13/2015 at 1:30 p.m. Diagnoses for Resident D included, but were not limited to, diabetes type II, congestive heart failure, hypertension, angina, coronary artery disease status post coronary artery bypass surgery . Resident D was admitted to the facility on 6/13/15 and expired 6/18/2015.</p>				

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	<p>Review, on 7/13/2015 at 1:30 p.m., of the discharge orders from the hospital, dated 6/13/15, for transfer to the facility indicated Resident D was to have continuous oxygen per nasal cannula at 2 liters/minute to maintain an oxygen saturation of greater than 92%.</p> <p>Review of the transcribed orders, dated 6/13/2015, indicated Resident D was to have continuous oxygen at 2 liters/minute via nasal cannula. The order was also transcribed as a "for your information" order and no oxygen saturation monitoring times were listed. Another order indicated "May titrate O2 level to maintain sats greater than 92% as needed" The Medication Administration and Treatment Record indicated no routine monitoring of Resident D's oxygen saturation had occurred. The Director of Nursing indicated it would be checked it if he showed any signs of distress.</p> <p>Review of the Respiratory Assessment, dated 6/15/2015, indicated Resident D had an oxygen saturation of 98% on room air. No further oxygen saturations were documented.</p> <p>During an interview on 7/14/15 at 12:47 p.m., COTA #9 indicated Resident D did</p>			

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	<p>not wear oxygen while in therapy.</p> <p>During an interview on 7/14/15 at 9:51 a.m., CNA #8 indicated he didn't not remember Resident D ever being on oxygen.</p> <p>During in interview on 7/14/15 at 9:30 a.m., RN #6 indicated she could not recall ever seeing Resident D wearing oxygen.</p> <p>During an interview on 7/14/15 at 2:50 p.m., the Director of Nursing indicated she was responsible for checking to make sure admission orders were transcribed correctly. She indicated the oxygen order was not transcribed correctly and the physician should have been called for order clarification. She further indicated the oxygen saturations for Resident D should have been monitored.</p> <p>Review of a current facility policy, dated 10/14, titled "PHYSICIAN ORDERS", which was provided by the Corporate Nurse on 7/14/15 at 4:05 p.m., indicated the following: "PURPOSE: Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe.</p>			

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F 0312 SS=D Bldg. 00	<p>POLICY: Facility nursing personnel will ensure clear, accurate and complete physician's orders.</p> <p>...5. Transcribe new order onto MAR or TAR, as indicated. Ensure any follow through is completed."</p> <p>This federal tag relates to Complaint IN00177428.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident who was dependent on staff for grooming, nail care and personal hygiene received those services for 1 of 4 residents reviewed for personal hygiene. (Resident F)</p> <p>Findings Include:</p> <p>The clinical record of Resident F was reviewed on 7/14/15 at 10:10 a.m. The record indicated the resident's diagnoses included, but were not limited to, diabetes mellitus, chronic obstructive</p>	F 0312	<p>F312</p> <p>1.A podiatry referral was made forresident F. Resident F had a shower, andwas interviewed by SSD to identify his bathing preferences. Care plan and C.N.A assignment sheet updatedas to preferences.</p> <p>2.All residents in need of assistancewith bathing were identified and interviewed by SSD and/or designee as tobathing preferences, C.N.A. assignment sheets updated accordingly asspecialized services such as podiatry, were referred as necessary. Nursing staff re-educated on the policy forbathing and showers, including</p>	08/13/2015

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	<p>pulmonary disease, tracheostomy, congestive heart failure, depression and anxiety.</p> <p>During the initial tour on 7/13/15 at 9:00 a.m., Resident D was laying in bed, asleep. His door was open and his feet were uncovered. From the hallway, Resident F's toenails were noted to be very long.</p> <p>During an interview on 7/13/15 at 10:53 a.m., CNA #7 indicated staff could not take as much time as they wanted with the residents since they were short staffed. CNA #7 indicated if they were short on time, a resident would get a bed bath instead of a shower.</p> <p>On 7/13/15 at 11:15 a.m., CNA #8 indicated staff could not answer call lights as quickly as they would like because there were sometimes only 2 CNA's on the back hall.</p> <p>During an observation with the Director of Nursing (DON) on 7/14/15 at 10:00 a.m., Resident F was observed lying in bed. He had long, greasy hair. The DON asked if she could remove his socks. His toenails were all very long, thick and yellow. Several of his toenails had noted dried blood around the base. Resident F stated to the DON he tried to pull them</p>		<p>but not limited to resident preferences and following the resident shower schedules. Licenses nursing staff re-educated on resident assessment including butnot limited to assessment of residents fee and nails and the procedure forreferral to podiatry services as necessary.</p> <p>3.As a means to ensure compliance withassuring residents bathing preferences are following, and referrals to specializedservices such as podiatry were made, all residents in need of assistance withbathing were identified and interviewed by SSD and/or designee as to bathingpreferences, C.N.A. assignment sheets updated accordingly as to preferences. Resident assessments were completed to assureany resident in need of specialized services such as podiatry, were referred asnecessary. Nursing staff re-educated onthe policy for bathing and showers, including but not limited to residentpreferences and following the resident shower schedules. Licenses nursing staff re-educated onresident assessment including but not limited to assessment of residents feeand nails and procedure for referral to podiatry services as necessary. The DON and/or designee will monitor residentsrecords 5x/week on scheduled work days, 2x/week x</p>		

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	<p>off and he would appreciate if he could be seen by a podiatrist. He stated "it makes my socks fit better if nothing else."</p> <p>Review of the July resident care record for Resident F, indicated a partial bath had been given on 7/8, 7/9, 7/10, 7/11, 7/12, 7/13 and 7/14/15. Nail care was documented as having been done with the partial bath. Resident F was on the shower schedule for Mondays and Thursdays.</p> <p>During an interview on 7/14/15 at 10:15 a.m., Social Service Director (SSD) #5 indicated the podiatrist came to the facility approximately every 60 days, unless they had a resident who needed to be seen. She indicated she had a couple new admissions that she needed to check to see if they needed to be put on the list for the podiatrist to see. She indicated the nursing staff informed her who needed to be seen. She indicated she had not been informed by any nurse Resident F needed to be seen by the podiatrist.</p> <p>At 11:00 a.m., SSD #5 indicated consent had not been found on the chart for Resident F, but she had since obtained consent from the resident to see the podiatrist. She indicated the person who normally got the consent on admission</p>		<p>1 month then weekly thereafter, to assure shower schedules are being followed, and assessments complete to assure proper referral to specialized services such as podiatry are made. Should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report findings of above reviews and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter, and revisions made to the plan if warranted.</p> <p>5.8-13-15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2015
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>was on vacation.</p> <p>In the social service admission note, dated 7/8/15, SSD #5 indicated Resident F appeared "unkempt." The assessment indicated Resident F was alert and oriented.</p> <p>During an interview on 7/14/15 at 11:10 a.m., the DON indicated the resident should be seen by the podiatrist because his toenails were "gnarly."</p> <p>On 7/14/15 at 1:50 p.m., RN #6 indicated she was the nurse for Resident F for the past couple of days. She indicated she noticed his long toenails. She indicated the resident was diabetic, but she had not yet trimmed his fingernails. She indicated she also noticed his greasy hair, but the resident had refused a shower earlier in the day. She indicated she had not yet gone back to attempt to get the resident to take a shower. She indicated since the resident was diabetic, nurses had to cut his fingernails. She indicated the nurses could not cut the toenails if they were long and thick.</p> <p>During an interview on 7/15/15 at 2:10 p.m., Resident F indicated he had not been offered a shower since he had been admitted. Resident F was admitted on 7/8/15.</p>			

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F 9999 Bldg. 00	<p>During review of the admission/re-admission resident assessment, dated 7/8/15, LPN #1 indicated on the assessment "toe nails long."</p> <p>During an interview on 7/14/15 at 2:20 p.m., LPN #1 indicated she admitted Resident F to the facility. She indicated she noticed his long toenails and told a "doctor or someone that he needed his feet cut." She indicated staff normally inform the social worker when a resident needs to be seen by the podiatrist. No additional documentation was provided related to who was informed of Resident F's long toenails.</p> <p>This federal tag relates to Complaint IN00177428.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(E)</p> <p>State Findings: "3.1-18 INFECTION CONTROL</p>	F 9999	State finding 3.1-18 1.Resident D no longer resides in the facility. 2.Residents' records were reviewed to ensure the administration of a tuberculin skin	08/13/2015

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	<p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the administration of a tuberculin skin test upon admission for 1 of 7 residents reviewed for infection control. (Resident D).</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 7/13/2015 at 1:30 p.m. Diagnoses for Resident D included, but were not limited to, diabetes type II, congestive heart failure, hypertension, angina, coronary artery disease status post coronary artery bypass surgery . Resident D was admitted to the facility on 6/13/15.</p> <p>Review of the Medication Administration Record for June 2015 indicated Resident D received a tuberculin skin test on 6/16/15 at 2:00 p.m. The tuberculin skin</p>		<p>test upon admission completedand timely. Licensed nursing staff werere-educated on policy for administration of tuberculin skin test uponadmission.</p> <p>3.As a means to ensure compliance withassuring tuberculin skin test upon admission, residents" records were reviewedto ensure the administration of a tuberculin skin test upon admission completedand timely. Licensed nursing staff werere-educated on policy for administration of tuberculin skin test uponadmission. The DON and/or designee willmonitor all new admissions to assure timely administration of tuberculin skintesting 5x/week x 1 month, 3x/week x 1 month and weekly thereafter, shouldconvers be noted, corrective action shall be taken.</p> <p>4.As a means of quality assurance, theDON and/or designee will report the findings of the above reviews and anycorrective actions taken to the QA committee monthly x 3 months and quarterlythereafter, and revisions made to the plan if warranted.</p> <p>5.8-13-15</p>				

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	<p>test was not administered until three days after Resident D was admitted to the facility.</p> <p>During an interview on 7/14/15 at 3:00 p.m., LPN # 1 indicated all residents were to have tuberculin skin test placed upon admission unless the physician ordered otherwise or medically contraindicated.</p> <p>During an interview on 7/14/15 at 10:22 a.m., the Director of Nursing indicated the skin tuberculin test for Resident D had been administered late. No further information was provided.</p> <p>Review of Admission Checklist provided by the Nurse Consultant on 7/14/15 at 10:22 a.m. indicated the following: "... Mantoux All residents must have a mantoux on admission or prior to admission, but not more than 3 months prior..."</p> <p>This Federal tag relates to Complaint IN00177428.</p>			