

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155819	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/12/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 SOUTH DIXON ROAD KOKOMO, IN 46902
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00197413 and IN00198501.</p> <p>Complaint IN00197413 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00198501 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 4, 5, 6, 9, 10, 11, & 12, 2016</p> <p>Facility number: 013153 Provider number: 155819 AIM number: 201254360</p> <p>Census bed type: SNF/NF: 6 SNF: 48 Residential: 30 Total: 84</p> <p>Census payor type: Medicare: 31 Medicaid: 6 Other: 17 Total: 54</p> <p>These deficiencies reflect State findings</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00197413) Survey on May 12, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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F 0279 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on May 18, 2016.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to provide a comprehensive plan of care for 1 of 3 residents for dental services, and 2 of 5 residents reviewed for unnecessary</p>	F 0279	F 279 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #20 - Care plan developed for dental concerns. Resident #38 care	06/11/2016

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	<p>medications. (Resident #38, #20, and #102)</p> <p>Findings include :</p> <p>1. The record for Resident #38 was reviewed on 5/9/16 at 2:05 p.m. Diagnoses included, but were not limited to, pneumonia, chronic obstructive pulmonary disease (COPD), depression, anxiety, and hypertension (HTN).</p> <p>A Physician order dated 6/26/15 indicated Bayer Chewable Aspirin 81 milligrams (mg) by mouth daily.</p> <p>No care plan related to Resident #38's anticoagulant use were noted.</p> <p>During an interview on 5/10/16 at 1:45 p.m., with the Minimum Data Set (MDS) #1, she indicated a care plan specific for anticoagulant therapy should have been entered for Resident #38, when the physicians order was written for anticoagulant therapy.</p> <p>2. The record for Resident #20 was reviewed on 5/6/ 2016 at 2:50 p.m.</p> <p>During an observation, on 5/04/16 at 3:26 p.m., Resident #20 was noted to have missing top teeth and zero bottom teeth.</p> <p>During an interview, on 5/04/16 3:36</p>		<p>plan developed for anticoagulant medication use. Resident #102- has been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with dental concerns, anticoagulant and antipsychotic medication use to ensure a care plan is in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: Care Plans. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review residents with dental concerns, anticoagulant and antipsychotic medication use to ensure a comprehensive plan of care has been developed. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>p.m., Resident #20 indicated he had bottom dentures however the dentures did not fit well and he could not eat with them.</p> <p>A Nutritional assessment, dated 5/17/15, indicated the resident stated he needed dentures but could not eat with his current dentures.</p> <p>No care plan related to Resident #20's dental concerns was noted.</p> <p>During an interview with the MDS coordinator, on 5/11/16 at 9:53 a.m., she indicated Resident #20 should have had a care plan addressing his dental concerns.</p> <p>3. The record for Resident #102 was reviewed on 5/6/16 at 9:02 a.m. Diagnoses included, but were not limited to, pneumonia, congestive heart failure, anemia, anxiety, insomnia, hypertension, COPD, type 2 diabetes, hypoglycemia, dehydration, hyperkalemia, and depression.</p> <p>The current physician orders indicated orders for: Celexa (an antidepressant) 10 mg (milligrams) every day, Xanax (an antianxiety) 1 mg three times a day, and Zyprexa (an antipsychotic) 2.5 mg at bedtime.</p>			

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	<p>No care plan related to Resident #102's antipsychotic medication was noted.</p> <p>During an interview with the Director of Health Services, on 5/11/16 at 2:16 p.m., she indicated resident #102 should have had a care plan related to antipsychotic medication use.</p> <p>The facility policy titled "Interdisciplinary Team Care Plan Guideline" dated 6/15, received from the Executive Director on 5/11/16 at 2:05 p.m., indicated "Purpose: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. Procedure: ... c. A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment (MDS 3.0) i. Problems areas should identify the relative concerns. ii. Goals should be measurable and attainable. iii. Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths...."</p> <p>3.1-35(a)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to assess bruising for 3 of 3 residents reviewed for skin issues. (Residents #67, #38 and #102).</p> <p>Findings include:</p> <p>1. During an observation of Resident #67 on 5/05/16 at 9:32 a.m., the resident was observed to have small bruises on the top of both hands.</p> <p>The record for Resident #67 was reviewed on 5/10/16 at 3:50 p.m. Diagnoses included but were not limited to, fracture of neck of left femur, and dementia.</p> <p>The current physician orders indicated an order for Lovenox (an anticoagulant) 40 milligrams (mg) once a day.</p>	F 0309	<p>F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #38 - skin assessed. Will initiate assessment for any bruising noted. Residents #67 and #102 have been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents skin condition will be observed to ensure an assessment has been completed for any bruising noted.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guideline How the</p>	06/11/2016

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	<p>A plan of care dated 4/08/16 indicated potential for abnormal bleeding tendencies related to anticoagulant therapy. Approaches to the plan of care included, but were not limited to, observe for unexplained bruising.</p> <p>A weekly skin assessment completed on 5/04/16 during the 7 a.m., to 3 p.m., shift did not indicate bruising.</p> <p>A nursing progress note dated 5/11/16 at 10:56 a.m., indicated skin assessment complete, existing pressure area to heel and no other skin areas noted.</p> <p>During an interview on 5/11/16 at 10:42 a.m., with the Director of Nursing, she indicated Resident #67 was due for his next weekly skin assessment on 5/11/16 and she also indicated the skin assessment completed on 5/04/16 did not have documentation of bruising on the resident's hands.</p> <p>During an interview on 5/11/16 at 2:20 p.m., with LPN #8 she indicated the weekly skin assessment is a head to toe assessment and bruising would be documented in a progress note.</p> <p>2. The record for Resident #38 was reviewed on 5/9/16 at 2:05 p.m. Diagnoses included, but were not limited to, pneumonia, chronic obstructive</p>		<p>corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents skin condition will be observed to ensure an assessment has been completed for any bruising noted. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>pulmonary disease (COPD), depression, anxiety, and hypertension (HTN).</p> <p>An admission assessment dated 6/26/15 at 10:01 p.m., indicated resident #38 had risk factors that predisposed her to skin breakdown and bruises located all over her body.</p> <p>During observations on 5/9/16 at 2:33 p.m., 5/10/16 at 2:20 p.m., and 5/11/2016 at 2:20 p.m., Resident #38 was noted to have bruising on both arms, which were greenish yellow in color, in the healing state.</p> <p>During an interview on 5/9/16 at 2:33 p.m., Resident #38 indicated she was on Aspirin medication which she took daily and it caused her to bruise.</p> <p>During an interview on 5/10/16 at 2:20 p.m., and 5/11/2016 at 2:24 p.m., Resident #38 indicated she had no new bruising and her bruises were getting better.</p> <p>During an interview on 5/9/16 at 3:10 p.m., with Registered Nurse (RN) #4, she indicated resident #38 had no new bruising and her old bruises were healing.</p> <p>During an interview on 5/11/16 at 9:36 a.m., with the Minimum Data Set</p>			

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	<p>Assistant #1, she indicated that the only assessment of bruising for Resident #38 was on 6/26/15 during the admission assessment.</p> <p>3. The record for Resident #102 was reviewed on 5/6/16 at 9:02 a.m. Diagnoses included, but were not limited to, pneumonia, congestive heart failure, anemia, anxiety, insomnia, hypertension, COPD, type 2 diabetes, hypoglycemia, dehydration, hyperkalemia, and depression.</p> <p>During an observation on 5/4/16 at 12:00 p.m., Resident #102 was noted to have bruising on the back of both hands.</p> <p>A care plan, dated 4/28/16, indicated potential for abnormal bleeding tendencies related to anticoagulant therapy. Approaches to the plan of care included, but were not limited to, observe for unexplained bruising.</p> <p>Resident #102's record did not indicate bruising to her hands.</p> <p>During an interview with Resident #102's daughter, on 5/10/16 at 10:39 a.m., she indicated her mother bruises easy and the bruises were a result of bumping the back of her hands on things and/or from blood draws.</p>			

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F 0371 SS=F Bldg. 00	<p>During an interview with the MDS (Minimum Data Set) assistant on 5/11/16 at 9:41 a.m., she indicated the facility could not locate any skin assessments or progress notes related to the resident's bruises.</p> <p>The facility policy titled, "Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines" dated 2/25/16, received from the Executive Director on 5/11/16 at 2:05 p.m., indicated "Purpose: Utilized to describe and monitor Bruises, Rashes, Lesions, Skin Tears, and Lacerations. Procedure: Bruise 1. May complete Bruise event in EHR (electronic health record) by an RN/LPN if the bruise warrants documentation due to extent and or location...3. One weekly follow-up assessment may be completed to ensure bruises are in the process of healing...."</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>			

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to ensure food items were dated when opened and frozen foods were not placed over other foods to thaw. This deficient practice had potential to affect 53 of 54 residents who receive food from the main kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 5/4/16 at 9:00 a.m., the following were observed:</p> <p>a. a bottle of canola oil was opened with no date</p> <p>b. a carton of buttermilk was in the refrigerator opened with no date</p> <p>c. observed in the refrigerator, a carton of frozen eggs were placed to thaw on top of a container of leftover gravy, the top was observed to be covered with thick dripping liquid.</p> <p>During an interview with the Dietary Manager on 5/11/16 at 4 p.m., he indicated all foods should be dated when opened and the thawing should be done differently.</p>	F 0371	<p>F 371</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit / observation of kitchen to ensure frozen foods are not placed over other foods to thaw. 2). Audit / observation of storage areas to ensure food items have been dated when opened</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food Production - Sanitation and Safety 2). Food Labeling How the corrective measures will be monitored to ensure the alleged deficient practice does</p>	06/11/2016			

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R 0000 Bldg. 00	<p>A policy titled "Food Labeling Guideline", dated 4/2013, received from Dietary Manager on 5/11/16 at 4:00 p.m., indicated "... Date marking must be done when food is: time and temperature, ready to eat, refrigerated, and held more than 24 hour..."</p> <p>3.1-21(i)(2)</p> <p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00197413.</p> <p>Complaint IN00197413 - Unsubstantiated due to lack of evidence.</p> <p>Residential Census: 30</p> <p>Sample: 7</p>	R 0000	<p>not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit / observation of kitchen to ensure frozen foods are not placed over other foods to thaw. 2). Audit / observation of storage areas to ensure food items have been dated when opened</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a</p>		

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R 0246 Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC16.2-5.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure a QMA (Qualified Medication Aide) obtained authorization from a licensed nurse prior to administering PRN (as needed) medications for 1 of 7 residents reviewed for QMA prior authorization of PRN medications. (Resident #168).</p> <p>Findings include:</p> <p>The record review for Resident #168 was completed on 5/10/16 at 10:30 a.m., PRN</p>	R 0246	<p>Recertification and State Licensure Survey in conjunction with Complaint (IN00197413) Survey on May 12, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> <p>R 246 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #168 PRN medication tracking record reviewed to ensure a QMA is obtaining authorization from a licensed nurse prior to administering PRN (as needed) medications. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: ALL residents PRN medication</p>	06/11/2016

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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 SOUTH DIXON ROAD KOKOMO, IN 46902		
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	<p>Medication Tracking record indicated Resident #168 received Hydrocodone-APAP 5/325 mg (milligrams) (a narcotic pain medication) orally. PRN Medication Tracking record indicated medication was given by QMA #6 and QMA #7 on the following dates:</p> <p>QMA#6 administered (Hydrocodone/APAP 5/325 mg) on 3/28/16 at 9:45 p.m. 3/31/16, no time listed</p> <p>QMA#7 administered (Hydrocodone/APAP 5/325 mg) on 10/13/15 at 9:45 p.m. 3/29/16 at 9:45 p.m.</p> <p>PRN Medication Tracking Sheet had no cosignature of licensed nurse on the above dates.</p> <p>During an interview with LPN #9 on 5/10/16 at 11:15 a.m., she indicated a QMA must have a licensed nurse co-sign PRN medications and this should be documented on PRN Medication Tracking Sheet in the clinical record.</p> <p>During an interview with QMA #6 on 5/10/16 at 11:25 a.m., she indicated during her training, she was instructed when giving a PRN medication, she must get a licensed nurse to give permission</p>		<p>tracking record reviewed to ensure a QMA is obtaining authorization from a licensed nurse prior to administering PRN (as needed) medications</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the campus staff on the following: Assisted Living Guidelines, Medication Administration How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of 5 resident PRN medication tracking record will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: residents PRN medication tracking record reviewed to ensure a QMA is obtaining authorization from a licensed nurse prior to administering PRN (as needed) medications The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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R 0273 Bldg. 00	<p>and must co-sign the PRN log.</p> <p>A review of the policy titled "Assisted Living Guidelines, Medication Administration" dated 12/10, received from Regional Clinical Coordinator on 5/10/16 at 3:15 p.m., and deemed as current indicated "... Purpose: To provide a mechanism for residents to receive their ordered medications. Procedure: ...g. PRN medications may be administered by a qualified medication side (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food items were dated when opened and frozen foods were not placed over other foods to thaw. This deficient practice had potential to affect 30 of 30 residents who received food from the main kitchen.</p> <p>Findings include:</p>	R 0273	<p>R 273</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit / observation of kitchen to ensure frozen foods are not placed over other foods to thaw. 2). Audit / observation of storage areas to ensure food items have been dated when</p>	06/11/2016

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	<p>During the initial tour of the kitchen on 5/4/16 at 9:00 a.m., the following were observed:</p> <p>a. a bottle of canola oil was opened with no date</p> <p>b. a carton of buttermilk was in the refrigerator opened with no date</p> <p>c. observed in the refrigerator, a carton of frozen eggs placed to thaw on top of container of leftover gravy, the top was observed to be covered with thick dripping liquid.</p> <p>During an interview with Dietary Manager on 5/11/16 at 4 p.m., he indicated all foods should be dated when opened and the thawing should be done differently.</p> <p>A policy titled "Food Labeling Guideline", dated 4/2013, received from Dietary Manager on 5/11/16 at 4:00 p.m., indicated "... Date marking must be done when food is: time and temperature, ready to eat, refrigerated, and held more than 24 hour..."</p>		<p>opened</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: 1). Food Production - Sanitation and Safety 2). Food Labeling How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit / observation of kitchen to ensure frozen foods are not placed over other foods to thaw. 2). Audit / observation of storage areas to ensure food items have been dated when opened</p> <p>The results of the audit observations will be reported,</p>		

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R 0410 Bldg. 00	<p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p> <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>(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 record review and interview, the facility failed to ensure a resident received a second step Tuberculin (TB) skin test on admission to the facility for 1 of 5 resident's reviewed to TB testing. (Resident #118)</p>	R 0410	<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>R 410 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #118 has been discharged from the campus. Identification of other residents having the potential to be affected by the same</p>	06/11/2016

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	<p>Findings include:</p> <p>The record of Resident #118 was reviewed on 5/10/16 at 1:00 p.m.</p> <p>Resident #118 received the first step TB skin test on 11/10/15. No record of the second step TB skin test was in the record.</p> <p>During an interview with the Unit Manager, on 5/10/16 at 3:05 p.m., she indicated a second step TB skin test was not done.</p> <p>A review of the policy titled " Assisted Living Guidelines, Chest X-ray and Mantoux Testing" dated 10/12, received from Regional Clinical Coordinator on 5/10/16 at 3:15 p.m., indicated "...Purpose: To ensure residents are free of tuberculosis prior to admission. Procedure: 1. Residents should have a Mantoux PPD(purified protein derivative) test: ...b. Indiana- within 3 months of admission if proof of previous testing or upon admission...2. Mantoux testing should be a two step process unless there has been continuous annual testing following the two step process. a. First step shall be read between 48-72 hours after administration b. Second step shall be administered between 1-3 weeks after the first test and read within 48-72</p>		<p>alleged deficient practice and corrective actions taken: DHS or designee review all residents to ensure a current tuberculin skin test is documented, unless clinically contraindicated.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Assisted Living Guideline Chest X-Ray and Mantoux Testing How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 new admission residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admission residents to ensure a tuberculin skin test was completed and documented on/or prior to admission, unless clinically contraindicated. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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

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	after administration...."				