

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 10/20/2015
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NAME OF PROVIDER OR SUPPLIER  OASIS AT 30TH	STREET ADDRESS, CITY, STATE, ZIP CODE 5651 E 30TH STREET INDIANAPOLIS, IN 46218
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R 0000  Bldg. 00	<p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey dates: October 19 &amp; 20, 2015</p> <p>Facility number: 013347 Provider number: N/A AIM number: N/A</p> <p>Census bed type: Residential: 12 Total: 12</p> <p>Census payor type: Medicaid: 12 Total: 12</p> <p>Sample: 6</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on October 26, 2015.</p>	R 0000		
R 0185  Bldg. 00	<p>410 IAC 16.2-5-1.6(i)(1-2)(A)(i-iii)(B-E Physical Plant Standards - Noncompliance</p> <p>(i) The facility shall house residents only in areas approved by the director for housing and given a fire clearance by the state fire</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>marshal. The facility shall:</p> <p>(1) Have a floor at or above grade level. A facility whose plans were approved before the effective date of this rule may use rooms below ground level for resident occupancy if the floors are not more than three (3) feet below ground level.</p> <p>(2) Provide each resident the following items upon request at the time of admission:</p> <p>(A) A bed:</p> <p>(i) of appropriate size and height for the resident;</p> <p>(ii) with a clean and comfortable mattress; and</p> <p>(iii) with comfortable bedding appropriate to the temperature of the facility.</p> <p>(B) A bedside cabinet or table with a hard surface and washable top.</p> <p>(C) A cushioned comfortable chair.</p> <p>(D) A bedside lamp.</p> <p>(E) If the resident is bedfast, an adjustable over-the-bed table or other suitable device.</p> <p>(3) Provide cubicle curtains or screens if requested by a resident in a shared room.</p> <p>(4) Provide a method by which each resident may summon a staff person at any time.</p> <p>(5) Equip each resident unit with a door that swings into the room and opens directly into the corridor or common living area.</p> <p>(6) Not house a resident in such a manner as to require passage through the room of another resident. Bedrooms shall not be used as a thoroughfare.</p> <p>(7) Individual closet space. For facilities and additions to facilities for which construction plans are submitted for approval after July 1, 1984, each resident room shall have clothing storage that includes a closet at least two (2) feet wide and two (2) feet deep, equipped with an easily opened door and a closet rod at least eighteen (18) inches long of adjustable height to provide access by</p>			
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	<p>residents in wheelchairs.</p> <p>Based on observation, interview, and record review, the facility failed to provide a method by which each resident may summon a staff person at any time for 2 of 2 residents reviewed for a method to summon a staff person. (Resident #1 and #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1 was reviewed on 10/20/15 at 11:30 a.m. The diagnoses for Resident #1 included, but were not limited to, thrombophlebitis (inflammation of the wall of a vein with associated thrombosis) of the lower limb.</p> <p>The 9/30/15 Level of Service Assessment/Evaluation for Resident #1 indicated her transferring ability as, "Transfers and changes position consistently, but needs direct assistance less than 3 times in a 7-day period. Episodes when client can't get up from sitting or reclining position without assistance. Client needs cueing for safety. Power Lift Chair."</p> <p>An interview was conducted with Resident #1 on 10/20/15 at 11:00 a.m. She indicated she fell in her closet in her bedroom the night of 10/17/15. She indicated she was on the floor for</p>	R 0185	<p>1. Pendants have been ordered for all residents. Until the pendants arrive, residents that have shown a history of falling will be placed on 15 minute checks by nursing staff to ensure that if a resident falls and is unable to reach the pull chord, they will be checked on frequently. 2. All residents will be given a "Fall Risk Assessment" upon admission. Residents identified as a "high risk" will be placed on 15 minute checks by nursing staff. This will prevent the resident having to wait for assistance if they fall in an area inaccessible from the pull chord until their pendants arrive. 3. A 15 minute sign off sheet will be placed in each residents' apartment that has been identified as a high fall risk for nursing staff to sign off when they do their checks. This sheet will be turned into the DON daily for monitoring purposes. All staff will be in-serviced regarding the High Fall Risk residents. This practice will continue until the pendants arrive.4. This procedure will be monitored by the Director of Nursing and the QA committee. Sign off sheets will be reviewed daily to ensure compliance by the Director of Nursing. The QA committee will review all falls/incidents during the quarterly QA meeting to ensure appropriate interventions are in place and response times are within</p>	11/09/2015			

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	<p>approximately 45 minutes before she was able to get to her cellular phone to call her home health aide. She indicated she was on the floor for another 20 to 30 minutes before the fire department helped her from the floor. She indicated the fire department reached her before facility staff reached her. She indicated she was not hurt, but was "stiff" and could not go to church the next day. She indicated she slid from her recliner the evening of 10/18/15, and was on the floor for approximately 2 hours before facility staff found her.</p> <p>An interview was conducted with Resident #1's home health aide (HHA #5) on 10/20/15 at 11:00 a.m. HHA #5 indicated after receiving Resident #1's phone call the night of 10/17/15 to inform her (HHA #5) she (Resident #1) was on the floor, she (HHA #5) called the facility, but no one answered, so she (HHA #5) called 911. HHA #5 indicated she went to the facility after calling 911, and the fire department was already there upon her arrival. She indicated she and facility staff entered Resident #1's room at the same time, after the fire department.</p> <p>The 10/17/15 CNA #6 written statement regarding Resident #1's 10/17/15 fall was provided by the Administrator on</p>		<p>satisfactory limits. Monitoring will be ongoing by both the QA committee and the Director of Nursing. Once the pendants arrive, the signoff sheets will be discontinued, as will the 15 minute checks. All residents will be in-serviced on the use of the pendants by the nursing staff. However, the QA committee will continue to review all falls/incidents to decrease/eliminate further incidents.5. Effective date for the above changes is November 9th, 2015.</p>				

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	<p>10/20/15 at 12:30 p.m. The statement indicated CNA #6 arrived to work at about 10:05 p.m., when the ambulance and fire truck pulled in also. The statement indicated CNA #6 called the number posted on the wall with no answer, rang the door buzzer with no answer, and called the on-call phone with no answer. The statement indicated CNA #6, along with the ambulance and fire department, stood outside until about 10:20 p.m., before a resident walked down the hall and let them in. The statement indicated the ambulance went to Resident #1's room, because Resident #1 told HHA #5 that she fell and needed help, so HHA #5 called 911. The statement indicated Resident #1 refused treatment, but her right leg was hurting.</p> <p>The 10/18/15, 6:00 p.m. nurse's note indicated Resident #1 was observed laying on her back in front of the television stand. Her recliner was at maximum height position. The note indicated, "Res (resident) feet slipped et (and) as she was falling, hit the right side of her head on the table that was placed on the right side of the recliner. No injury noted at this time. Res c/o (complains of) right side of face soreness. PRN (as needed) pain med (medication) administered. Res assisted from floor by two staff members..."</p>			

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	<p>An interview was conducted with the Administrator on 10/20/15 at 12:45 p.m. She indicated, if a resident was not within reach of their call light cord when assistance was needed, the resident did not have a way to summon a staff person. She indicated she questioned whether Resident #1 was on the floor for 2 hours after her 12/18/15 fall, but 5 minutes could seem like an hour if you've fallen on the floor.</p> <p>Observations of Resident #1's bathroom and bedroom call lights were made on 10/20/15 at 1:00 p.m. Both call lights were affixed to the wall with 4 feet cords, inaccessible from the living room area and bedroom closet area.</p> <p>An interview was conducted with the Resident Care Director (RCD) on 10/20/15 at 1:20 p.m. She indicated there was no facility policy regarding a method to summon a staff person.</p> <p>2) The clinical record was reviewed on 10/19/15 at 2:30 p.m. The record indicated Resident #2's admission date was on 9/30/15. Resident #2's medical diagnoses included but were not limited to, chronic respiratory failure, idiopathic chronic restricted lung disease, and pulmonary fibrosis.</p>			

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	<p>A progress noted on a pulmonary report dated, 5/18/15, indicated Resident #2 required 4 liters of oxygen with exertion and 3 liters of oxygen at rest.</p> <p>An observation was made of Resident #2's room. on 10/19/15 at 1:30 p.m. A call light was located in Resident #2's bedroom on the back wall where the bed was up against, and another call light was located in her bathroom on the wall by the toilet. There was no call lights located in living room or kitchen area.</p> <p>An interview and observation was conducted with Resident #2 on 10/19/15 at 1:30 p.m. She indicated she was concerned with the distance she had to go to reach her call lights in her room in case she needed immediate staff assistance. Resident #2 indicated she becomes out of breath very easy and just by talking long periods of time she gets out of breath. An observation was made at that time of Resident #2 who appeared to be out of breath just by having a conversation sitting in her wheelchair with oxygen assistance. She indicated she would feel more comfortable with an assisted alert device she could wear on her body to push if she needed staff assistance. The facility had not offered an assisted alert device to wear if she was unable to go into her bedroom or</p>			

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R 0240 Bldg. 00	<p>bathroom to reach her call lights.</p> <p>An interview was conducted with the Administrator on 10/20/15 at 11:20 a.m. She indicated the facility does not have safety alert devices available to offer to the residents.</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, interview and record review, the facility failed to provide a shower to 1 of 3 residents reviewed for activities of daily living. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record was reviewed on 10/19/15 at 2:30 p.m. The record indicated Resident #2's admission date was on 9/30/15. Resident #2's medical diagnoses included but were not limited to, chronic respiratory failure, idiopathic chronic restricted lung disease, and pulmonary fibrosis.</p> <p>A progress noted on a pulmonary report dated, 5/18/15, indicated Resident #2 required 4 liters of oxygen with exertion</p>			R 0240	<p>1. Resident is offered a shower two times per week. If the resident refuses a shower, staff will approach her at a later time and ask again. Any refusals are being documented by nursing staff, with two nursing staff signing off that the shower was refused. This is included in her service plan. 2. All residents are offered showers twice a week. This is in each resident's service plan. The above procedure will be followed for any resident refusing a shower. 3. All staff will be in-serviced regarding the shower procedure. The Director of Nursing will ensure that showers are being offered and documented appropriately when refused. 4. The Director of Nursing will be responsible for monitoring the shower schedule and compliance with that schedule. All shower sheets will be reviewed weekly by the</p>		11/08/2015

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	<p>and 3 liters of oxygen at rest.</p> <p>A "Level of Service Assessment/Evaluation," dated 9/30/15, was provided by the Resident Care Director on 10/20/15 at 11:00 a.m. It indicated Resident #2 was dependent on others to provide a complete bath, including shampoo and constant supervision for safety.</p> <p>An interview and observation was conducted with Resident #2 on 10/19/15 at 1:30 p.m. She indicated she had not received a shower since her admission to the facility and had only been able to wash herself up in the bathroom sink. Resident #2 indicated she needs assistance with bathing, because she becomes out of breath very easy. She indicated just by talking for long periods of time she becomes out of breath. During this time an observation was made of Resident #2, who appeared to be out of breath just by having a conversation sitting in her wheelchair with oxygen assistance. Resident #2 indicated she had discussed with staff about bathing. It was arranged for a shower to be given in the evening time before she goes to bed, but she had not received one as of yet.</p> <p>An interview was conducted with</p>		<p>Director of Nursing to ensure that all residents are being offered a shower according to their scheduled times. Shower sign off sheets are in place to ensure that if a resident refuses a shower, two staff persons must sign off indicating that the shower has been refused. Should the resident consistently refuse showers, the DON will meet with the resident to discuss alternate shower times or staff, to encourage regular showers. The QA committee will review any resident that consistently refuses showers during the quarterly meeting to discuss possible alternative approaches. Monitoring will be ongoing.5. Effective date for these changes is November 8th, 2015</p>				

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R 0246	<p>Resident Care Director (RCD) on 10/20/15 at 1:15 p.m. She indicated staff had been offering Resident #2 showers, but Resident #2 had been refusing. She indicated the staff had not been documenting the refusals.</p> <p>An interview was conducted with Resident #2 on 10/20/15 at 1:20 p.m. She indicated she had been offered a shower one time by the night staff since her admission, and she had refused. Resident #2 indicated she was not feeling well at that time, but had not been offered any other time by day or night staff to receive a shower.</p> <p>During an interview with the Administrator and RCD, on 10/20/15 at 1:30 p.m., the Administrator and RCD indicated all residents residing in the facility were interviewable, including Resident #2.</p> <p>A policy dated, 1/26/15, was provided by the the Administrator on 10/20/15 at 1:15 p.m. "Policy: 4. Arrangement for healthcare..4.1 Activities of Daily Living. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident..."</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency</p>			

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Bldg. 00	<p>(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 interview and record review, the facility failed to provide authorization by a licensed nurse or physician during administrations of as needed (PRN) medications for 1 of 5 residents record reviewed. (Resident #1)</p> <p>Findings include:</p> <p>The clinical record was reviewed on 10/19/15 at 12:00 p.m. The record indicated Resident #1's medical diagnoses included but were not limited to, diabetes mellitus II, and thrombophlebitis lower limb.</p> <p>A "Patient Medication List" dated, 9/24/15 was provided by the Resident Care Director on 10/20/15 at 1:20 p.m. It indicated Resident #1 had a physician order for tramadol 50 mg tablet. It indicated Resident #1 was to take 1 tablet by mouth 2 times a day as needed (PRN) for pain and not to take more than 2 tablets a day.</p>	R 0246	<p>1. All QMA's were in-serviced regarding proper procedure in administering PRN medications to residents.</p> <p>2. All PRN medications are being authorized by a nurse. Should a QMA administer a PRN medication, the nurse or Director of Nursing will first verbally authorize, and then will follow that authorization with a signature to the MAR. 3. The Director of Nursing will review the MAR weekly to ensure that this procedure is being followed by all QMA's administering PRN medications. All QMA's will be in-serviced regarding this practice.4. The Director of Nursing will be responsible for checking the MAR weekly to ensure that all PRN medications are approved and signed off on by an LPN when a QMA administers the PRN. The Executive Director will check the MARs monthly for compliance. The QA committee will discuss compliance in this</p>	11/01/2015			

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	<p>A Medication Administration Record, dated, October 2015, was reviewed on 10/20/15 at 11:45 a.m. with the Resident Care Director. It indicated Resident #1 was administered PRN tramadol 50 mg on the following days and times:</p> <p>10/8/15 at 6:30 p.m., 10/9/15 at 12:30 p.m., 10/10/15 at 5:30 p.m., 10/11/15 at 12:30 p.m., 10/16/15 at 5:30 p.m., 10/17/15 at 11:25 p.m., and 10/18/15 at 6:15 p.m.</p> <p>An interview was conducted with the Resident Care Director at this time. She indicated the PRN tramadol 50mg was administered to Resident #1 by Qualified Medical Assistants (QMAs). There was no additional signatures of authorization from a nurse or physician for the October administrations of the PRN tramadol. The Resident Care Director indicated Resident #1's pain was assessed prior to and after for effectiveness of her pain medication by QMA staff not by a nurse or physician. The Resident Care Director was unable to provide any documentation the QMA staff received authorization to administer PRN tramadol.</p> <p>A policy dated, 6/17/15, was provided by</p>		<p>area during the quarterly meeting. Should a staff be identified as being consistently non-compliant with this practice, appropriate discipline will be administered, up to and including termination. Monitoring will be ongoing. 5. Effective immediately.</p>	

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R 0408 Bldg. 00	<p>the Resident Care Director on 10/20/15 at 12:20 p.m. "Policy: 33. Medication Management...Medication Administration...4. PRN medications may be administered by a qualified medication aide 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 must be documented in the nursing notes indicating the time and date of the contact.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure a Resident had a diagnostic chest x-ray completed prior to admission to the facility for 1 of 5 residents reviewed for chest x-rays (Resident #2).</p> <p>Findings include:  The clinical record for Resident #2 was reviewed on 10/19/15 at 1:15 p.m. The diagnoses for Resident #2 included, but</p>	R 0408	<p>1. Chest X-rays were ordered for all existing residents that did not have on in place.2. Chest X-rays will be scheduled for the day of the lease signing prior to the resident admission, unless the resident can provide sufficient documentation indicated that they have had one within the time frame required.3. Chart audits will be completed by the DON on admission and on a monthly basis to ensure that all residents have appropriate documentation of Chest X-rays.4. In addition to the</p>	11/01/2015

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NAME OF PROVIDER OR SUPPLIER  OASIS AT 30TH	STREET ADDRESS, CITY, STATE, ZIP CODE 5651 E 30TH STREET INDIANAPOLIS, IN 46218
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R 0409 Bldg. 00	<p>were not limited to, diabetes mellitus, chronic kidney disease, and chronic restrictive lung disease according to Admission Physician's Orders. Resident #2 was admitted to the facility on 9/30/15.</p> <p>A chest x-ray for Resident #2 was not located in the clinical record.</p> <p>During an interview with the Resident Care Director (RCD), on 10/20/15 at 10:35 a.m., the RCD indicated Resident #2 had an appointment on 9/28/15 for a chest x-ray but never went to the appointment. The RCD further indicated the facility ordered a chest x-ray that day.</p> <p>A policy titled, Infection Control, dated 6/25/15, was received from the Administrator on 10/19/15 at 2:18 p.m. The policy indicated, "...Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission...."</p> <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly</p>		<p>chart audits completed by the DON on admission and monthly, the QA committee will pull a sample of charts (no less than 3 charts) of residents admitted in during the previous quarter and audit those charts to ensure compliance with chest x-rays. Monitoring will be on-going.5. Effective date for the above changes is immediately.</p>	

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	<p>thereafter.</p> <p>Based on interview and record review, the facility failed to ensure a resident had a health assessment that included a statement that the resident showed no evidence of tuberculosis in an infectious stage for 1 of 5 residents reviewed for annual health statements. (Resident #3)</p> <p>Findings include:</p> <p>The clinical record for Resident #3 was reviewed on 10/20/15 at 10:00 a.m. The diagnoses for Resident #3 included, but were not limited to: renal failure and diabetes. Resident #3 was admitted to the facility on 9/30/15.</p> <p>No statement that Resident #3 showed no evidence of tuberculosis in an infectious stage was found in the clinical record. No verification was found in the clinical record to indicate Resident #3 had a tuberculin skin test upon admission to the facility.</p> <p>An interview was conducted with the Resident Care Director (RCD) on 10/20/15 at 10:03 a.m. The RCD reviewed Resident #3's clinical record and indicated it should include a statement to indicate the resident showed no evidence of tuberculosis in an infectious stage, but didn't.</p>	R 0409	<p>1. All current residents have a completed assessment in their charts.2. All potential residents will receive an assessment prior to admission. The Director of Nursing will complete this and review with the administrator prior to admission. No resident will be permitted admission without the assessment being completed first.3. The Executive Director will complete chart audits on admission to ensure this practice is being followed.4. In addition to the Executive Director completing chart audits, the Executive Director will approve all assessments prior to admission. Following the completion of the assessment, the Director of Nursing will provide the assessment to Executive Director who will ensure that the resident meets admission criteria and the facility can meet the residents needs. The QA committee will review a sampling (no less than 3 charts) per quarter to ensure that a pre-admission assessment was completed on each resident. Monitoring will be ongoing. 5. Effective Date for the above change is immediately.</p>	11/01/2015			

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R 0410 Bldg. 00	<p>The Infection Control policy was provided by the Administrator on 10/19/15 at 2:18 p.m. It indicated, "Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter."</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 induration with the date given, date read, and by whom administered and read. (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. (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. Based on interview and record review, the facility failed to complete tuberculin</p>	R 0410	1. All current residents that were missing a Tuberculin skin test	10/26/2015			

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	<p>(TB) testing for Residents prior to admission or upon admission for 5 of 5 residents reviewed for TB testing. (Resident #'s 1, 2, 3, 5, 9)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed on 10/20/15 at 10:00 a.m. The diagnoses for Resident #3 included, but were not limited to: renal failure and diabetes. Resident #3 was admitted to the facility on 9/30/15.</p> <p>No information was found in the clinical record to indicate Resident #3 had a tuberculin skin test upon admission to the facility or thereafter. 2. The clinical record was reviewed on 10/19/15 at 12:00 p.m. Resident #1's admission date to the facility was on 9/30/15. Resident #1's medical diagnoses included but were not limited to, diabetes mellitus II, and thrombophlebitis lower limb.</p> <p>The clinical record did not indicate a tuberculin test was completed upon admission to the facility for Resident #1.</p> <p>3. The clinical record for Resident #2 was reviewed on 10/19/15 at 1:15 p.m. The diagnoses for Resident #2 included, but were not limited to, diabetes mellitus, chronic kidney disease, and chronic restrictive lung disease. Resident #2 was</p>		<p>were administered one by the Director of Nursing on October 26, 2015. The second step will be administered on November 9, 2015. 2. All prospective residents will either provide documentation of a TB test within the time frame specified, or one will be administered when the resident comes to complete their lease signing, prior to admission. For any resident that is not able to provide the above, a TB test will be completed on their admission date. 3. The Director of Nursing will complete a chart audit on admission and monthly to ensure all documentation is in place. 4. In addition to the chart audits completed by the DON on admission and monthly, the QA committee will pull a sample of charts (no less than 3 charts) of residents admitted in during the previous quarter and audit those charts to ensure compliance with TB tests. Monitoring will be on-going. 5. Effective Date for the above change is October 26, 2015.</p>	

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	<p>admitted to the facility on 9/30/15.</p> <p>Tuberculin testing was not located in the clinical record for Resident #2.</p> <p>4. The clinical record for Resident #5 was reviewed on 10/19/15 at 12:21 p.m. The diagnoses for Resident #5 included, but were not limited to, chronic pain, hyperlipidema, congestive heart failure, anxiety, and depression. Resident #5 was admitted to the facility on 10/1/15.</p> <p>Tuberculin testing was not located in the clinical record for Resident #5.</p> <p>5. The clinical record for Resident #9 was reviewed on 10/19/15 at 11:53 a.m. The diagnoses for Resident #9 included, but were not limited to, hypertension and osteoarthritis. Resident #9 was admitted to the facility on 10/3/15.</p> <p>Tuberculin testing was not located in the clinical record for Resident #9.</p> <p>During an interview with the Resident Care Director (RCD), at 10:35 a.m. on 10/20/15, the RCD indicated she was unable to locate any indication that TB testing was completed prior to or upon admission for Resident #'s 1, 2, 3, 5, &amp; 9.</p> <p>A policy titled, Infection Control, dated</p>			

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	<p>6/25/15, was received from the Administrator on 10/19/15 at 2:18 p.m. The policy indicated, "...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. 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...."</p> <p>A policy titled, Admission, dated 6/25/15, was received from the Administrator on 10/20/15 at 12:45 p.m. The policy indicated, "...Prior to admission the prospective resident must have proof of two negative tuberculin skin test results within twelve months. 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...."</p>			

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

PRINTED: 11/12/2015

FORM APPROVED

OMB NO. 0938-0391

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