

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER  AZALEA HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 LAFAYETTE PKWY FLOYDS KNOBS, IN 47119
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R000000	<p>This survey was for Annual Recertification and State Licensure Survey.</p> <p>Survey Dates: May 22 and 23, 2013</p> <p>Facility Number: 012161</p> <p>Survey Team: Gwen Pumphrey, RN-TC Gloria Reisert, MSW Debbie Peyton, RN Joan Loax, RN Nicole Wright, RN</p> <p>Cesus Bed Type: Residential: 58</p> <p>Census Payor Type: Medicaid: 19 Private: 39 Total: 58</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2. Quality Review completed by W. Christopher Greeney QIDP on 5/31/2013</p>	R000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law.. Please accept this plan of correction as our credible allegation of compliance.	

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

TITLE

(X6) DATE

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

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R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on record review the facility failed to provide documentation that residents were advised of resident rights upon admission. This deficient practice affected 1 of 7 sampled clinical records reviewed (Resident #2).</p> <p>Findings include:</p> <p>Resident #2's clinical record, reviewed on 5/23/13 at 10:00a.m. lacked documentation that the resident received a copy of the resident's rights.</p>	R000026	R026 Residents' Rights-noncompliancel. Signed acknowledgment of Resident Rights was obtained and placed on the medical record of Resident #2. II. The medical records of all residents were audited to ensure signed acknowledgment of receipt of Resident rights is present for all residents of the facility. III. As a means to ensure ongoing compliance, a copy of Resident Rights shall be available to Residents upon admission via the Resident Handbook and receipted demonstrated by a Resident Signature page in the initial admission process.	05/27/2013

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	<p>During interview on 5/23/13 at 11:00 a.m. the Administrator stated there was no signed copy of an acknowledgment of resident rights in the resident's chart and then indicated the documentation "must be somewhere".</p> <p>16.2-5-4(d)(6)</p>		<p>Additionally, Resident Rights shall be located in a binder on the front table of the main entrance. IV. As a means of quality assurance, the Administrator shall monitor to ensure that the Residents Rights are received and signed acknowledgment obtained and present via audit of the newly admitted resident record within 3 days of admission. Should non-compliance be noted, the Administrator will re-educate the responsible staff and disciplinary action shall be taken, if warranted.</p>	

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R000117	<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 (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 interview and record review, the facility failed to have staff persons with current first aid certificates on site for 9 of 14 days reviewed. This practice had the potential to affect 58 of 58 residents residing in the facility.</p> <p>Findings include:</p> <p>A review of worked schedules from 5/8/13 through 5/23/13, and staff</p>	R000117	R117 Personnel- Deficiency I. Staff identified to be lacking first aid training shall receive said training and the same shall be documented and placed in their respective employee file.II. All the personnel files are to be audited and any nursing personnel not trained in first aid shall have the training with the next 2 weeks in an effort to ensure there is at least one staff member on duty who is certified in CPR and first aid at all	06/10/2013			

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	<p>persons with current first aid certificates, presented on 5/23/13, at 2:50 p.m., by the DON (Director of Nursing), indicated the following days and shifts where no staff persons were on site with first aid certification:</p> <p>-5/10/13: 11 p.m. to 7 a.m. shift -5/11/13: 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift -5/12/13: 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift -5/14/13: 3 p.m. to 11 p.m. shift -5-17-13: 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift -5/18/13: 3 p.m. to 11 p.m. shift -5/19/13: 3 p.m. to 11 p.m. shift -5/20/13: 3 p.m. to 11 p.m. shift -5/21/13: 3 p.m. to 11 p.m. shift</p> <p>During an interview on 5/23/13, at 3:40 p.m., the Administrator indicated that there were no staff persons with first aid certification on site during the above mentioned dates and shifts.</p>		<p>times. III In an effort to ensure ongoing compliance, all newly hired personnel shall have CPR and First Aid training prior to their start date. IV. As a means of quality assurance, the Administrator and Business Office Manager will conduct an audit on each new hire's personnel file prior to filing as complete to ensure proper training is complete and record of said training is present. The Business Office Manager shall also track expiration/renewal dates in an effort to remind staff of impending expiration and need for renewal.</p>				

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R000151	<p>410 IAC 16.2-5-1.5(h) Sanitation &amp; Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations.</p> <p>Based on observation, record review, and interview the facility failed to ensure pets maintained current immunizations. This deficient practice affected 1 of 5 pets currently housed in the facility. (Resident #24)</p> <p>Findings include:</p> <p>During the initial tour of the facility on 5/22/13 at 2:30 p.m. Resident #24 was observed to have a pet.</p> <p>An interview with the Administrator on 5/23/13 at 1:30 p.m. indicated she was aware the pet's vaccinations were expired. She indicated she contacted Resident #24's family three weeks ago and they had an appointment scheduled on 5/23/13 at 3:30 p.m.. A copy of the pet's appointment from the animal clinic indicated the appointment was scheduled for 5/31/13.</p> <p>Review of the pets medical records on 5/23/13 at 1:55 p.m. indicated the pet's vaccine records expired on 4/20/13.</p>	R000151	<p>R151 Sanitation &amp; Safety Standards-Noncompliancel. The pet of resident #24 has received necessary vaccinations and record of the same is on file with the facilityII. All pets have been reviewed and audited to ensure records of current vaccinations are on file with the facility and placed on a schedule to be monitored by facility administrative staff. III. As a means to ensure ongoing compliance with ensuring vaccinations are timely for all pets housed within the facility, the Business Office Manager shall be responsible to maintain a calendar of said vaccinations and remind the resident/owner within one month prior to expiration. The manager shall follow up weekly until vaccinations are obtained and record of the same provided for facility records. Should a resident be non-compliant, the same shall be reported to the Administrator prior to the date of expiration. IV. As a means of quality assurance, the Administrator shall monitor to ensure that the pet audits are in compliance on a monthly basis Should concerns be noted, the Administrator shall inform the</p>	05/24/2013			

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	The copy of the pet policy was received on 5/23/13 at 1:55 p.m.. indicated the resident must provide the facility with current vaccination history.  16.5-5-1.5(h)		Resident and assist to schedule a veterinary exam for the applicable pet.	

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review the facility failed to assess the resident's weight on admission. This deficient practice affected 1 of 7 sampled medical records reviewed.(Resident #2).</p> <p>Findings include:</p> <p>An interview with the Administrator on 5/23/13 at 11:15 a.m. indicated all residents should have initial vital signs upon admission that includes a weight. The Administrator also indicated the admission packet includes a checklist for staff obtain the information needed.</p> <p>Review of the medical record on 5/23/13 at 2:30 p.m. indicated Resident #2 did not have an admission weight documented.</p>	R000216	<p>R216 Evaluation-Noncompliance I. Current weight was obtained and documented on the medical record of Resident #2.II. Medical records of all residents were audited to ensure an admission weight was recorded and weight taken and recorded semi-annually thereafter.III. Nursing staff were educated as to following the admission checklist which addresses upon admission to the facility, the Resident shall have their weight taken and documented. IV. As a means of quality assurance, the Administrator shall monitor all new admissions by doing an audit on the new admission chart with 72 hours (i.e., 3 days) of admission. Should non-compliance be noted with the obtaining and documenting of an</p>	05/24/2013			

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	16.2-52(c)(3)		admission weight, applicable staff will be re-educated and disciplinary action taken, as warranted.	

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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: (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 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 maintain a service plan. This deficient practice affected two of seven medical records reviewed. (Resident #7, Resident #2).</p> <p>Findings include:</p>	R000217	R217 Evaluation-Deficiency1. Service plans of Residents #2 and #7 have been reviewed and updated to ensure the plans remain current and accurately reflect needs and services provided each resident, as well as signed by the nurse completing the assessment, client, case manager, and	05/24/2013			

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	<p>1. Review of medical record on 5/22/13 at 3:30 p.m. indicated Resident #7 had a diagnosis including but not limited to memory loss, hypertension and osteoporosis. Resident #7 was admitted to the facility on 6/23/10. The medical record contained the initial service plan with the Resident #7's admission into the facility. The medical record lacked a service plan updated since the resident's admission to the facility.</p> <p>An interview with the Administrator on 5/23/13 at 11:15 a.m. indicated service plans are to be completed on admission to the facility and updated quarterly.</p> <p>A copy of the policy and procedure titled Evaluation of Individual Resident Needs was received from the Administrator on 5/23/13 at 11:15 a.m. indicated each resident should be assessed upon admission to the facility and will be updated quarterly.</p> <p>2. Review of medical record on 5/23/13 at 10:30 a.m. indicated Resident #2 had a diagnosis including but not limited to hypertension, depression, and emphysema. Resident #2 was admitted to the facility on 4/29/13. The medical record contained a</p>		<p>provider.II. The service plans of all residents of the facility shall be reviewed and updated, as warranted, to ensure the plans remain current and accurately reflect the needs and services provided each resident and are signed by the nurse completing the assessment, client, case manager and provider, as applicable.III. As a means to ensure ongoing compliance, nursing staff shall be educated in regard to accurately completing a service plan upon admission and reviewing quarterly, obtaining necessary signatures following review of said service plan. IV. As a means of quality assurance, the DON and Administrator shall review the service plan and sign off on the admission record within 72 hours after admission to the facility. Additionally, service plans shall be audited on a quarterly basis to confirm continued compliance. Should non-compliance be noted, re-education shall be provided and disciplinary action taken, as warranted.</p>				

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	<p>service plan dated 4/28/13 in which the area of cognitive assistance was not addressed. The service plan lacked signatures of the nurse completing the assessment, client, case manager, and provider.</p> <p>A copy of the policy and procedure titled Evaluation of Individual Resident Needs was received from the Administrator on 5/23/13 at 11:15a.m., indicated the assessment will address the resident's mental status and the service plan should be signed and dated by the resident.</p> <p>16.2-5-2(e)</p>			

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R000356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> <li>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</li> <li>(2) The resident ' s hospital preference.</li> <li>(3) The name and phone number of any legally authorized representative.</li> <li>(4) The name and phone number of the resident ' s physician of record.</li> <li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li> <li>(6) Information on any known allergies.</li> <li>(7) A photograph (for identification of the resident).</li> <li>(8) Copy of advance directives, if available.</li> </ol> <p>Based on interview and record review, the facility failed to keep a complete emergency information file on 1 of 7 residents in a sample of 7, and 19 of 19 residents in a supplemental sample of 19.</p> <p>Findings include:</p> <p>A review of the emergency information files, presented on 5/22/13, at 4:00 p.m., by the business office manager, indicated the following residents with incomplete emergency files:</p> <p>-For Resident #8: Admitted on</p>	R000356	R356 Clinical Records-noncompliancel. Necessary information was obtained and the emergency files of all residents listed have been updated to ensure that they are complete with all necessary information listed/addressed.II. The emergency files of all residents have been reviewed to ensure they are complete with all necessary information listed/addressedIII. As a means of ongoing compliance, nursing staff has been addressed as to the correct completion of all necessary information to be within the emergency file. IV. As a means of quality assurance, the BOM and Administrator shall	05/24/2013			

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	<p>5/21/12. Hospital preference is not listed.</p> <p>-For Resident #9: Admitted on 8/1/12. Hospital preference is not listed.</p> <p>-For Resident #10: Admitted on 11/2/9/12. Hospital preference is not listed.</p> <p>-For Resident #11: Admitted on 8/1/09. Physician's phone number is not listed.</p> <p>-For Resident #12: Admitted on 8/1/09. Physician's phone number is not listed.</p> <p>-For Resident #13: Admitted on 11/3/12. Hospital preference, and physician's phone number are not listed.</p> <p>-For Resident #14: Admitted on 2/9/13. Hospital preference is not listed.</p> <p>-For Resident #15: Admitted on 4/17/12. Hospital preference is not listed.</p> <p>-For Resident #16: Admitted on 2/18/13. Hospital preference is not listed.</p> <p>-For Resident #17: Admitted on 10/16/12. Information cover sheet is not in the folder.</p> <p>-For Resident #18: Admitted on 7/6/12. Physician's phone number is not listed.</p> <p>-For Resident #26: Admitted on 1/18/13. Emergency contact folder is</p>		<p>review each emergency file and sign off on the admission record of completion (including the correct completion of the emergency file) with 72 hours after admission to the facility. Should non-compliance be noted, staff shall be re-educated and disciplinary action taken, as warranted. Review of the emergency file for accuracy will again be conducted with each quarterly review of the service plan in an effort to provide ongoing audit of presence and accuracy.</p>				

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	<p>not in the file.</p> <p>-For Resident #4: Admitted on 6/2/12. Physician's phone number is not listed.</p> <p>-For Resident #19: Admitted on 8/8/12. Room number is not listed.</p> <p>-For Resident #20: Admitted on 3/9/13. A photograph of the resident is not in the folder.</p> <p>-For Resident #21: Admitted on 2/14/10. The wrong room number is listed on the outside of the folder.</p> <p>-For Resident #22: Admitted on 4/23/12. Hospital preference is not listed.</p> <p>-For Resident #23: Admitted on 4/12/12. Hospital preference and physician's phone number are not listed.</p> <p>-For Resident #24: Admitted on 12/12/12. Hospital preference is not listed.</p> <p>-For Resident #25: Admitted on 1/26/13. Date of Birth and hospital preference are not listed.</p> <p>During an interview on 5/23/13, at 1:15 p.m., the administrator indicated emergency information sheets should be completed within 24 hours of the resident's admission to the facility, and this information sheet is located in the admission packet. She also indicated there is not a policy regarding this issue.</p>						

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	During an interview on 5/23/13, at 1:30 p.m., the administrator indicated that a letter is sent to each resident's family or representative yearly to obtain updated emergency information.			

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R000379	<p>410 IAC 16.2-5-11.1(c) Mental Health Screening - Deficiency (c) If a person is a recipient of Medicaid or federal SSI and has a major mental illness as defined by the individual needs assessment, the person will be referred to the mental health service provider for a consultation on needed treatment services. All residents who participate in Medicaid or SSI admitted after April 1, 1997, shall have a completed individual needs assessment in their clinical record. All persons admitted after April 1, 1997, shall have the assessment completed prior to the admission, and, if a mental health center consultation is needed, the consultation shall be completed prior to the admission and a copy maintained in the clinical record.</p> <p>Based on record review and interview the facility failed to complete a mental health screening for a resident who is a recipient of medicaid with a major mental illness. This deficient practice affected 1 of 7 sampled clinical records reviewed. (Resident #2).</p> <p>Findings include:</p> <p>Review of clinical record on 5/23/13 at 10:00 a.m. indicated Resident #2 had diagnosis including but not limited to hypertension, depression, and emphysema. Resident #2 was admitted to the facility on 4/29/13 and is also a recipient of medicaid. The clinical record lacked documentation that a mental health screening was completed on admission.</p>	R000379	R379 Mental Health Screening – Deficiency I. Appropriate mental health screening was completed for Resident #2 and mental health clinician notified for follow up.II. The records of all applicable residents were reviewed for appropriate mental health screening and need for referral to a mental health center with necessary referrals made, if indicated.III. In an effort to ensure ongoing compliance with the completion of a mental health screening for applicable residents, the facility is utilizing a tool for screening which will be completed and placed on the medical record of the applicable resident. Nursing staff shall be addressed regarding the correct completion of the screening.IV. As a means of quality assurance the Business	06/10/2013

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	<p>A physician order dated on 5/8/13 instructed the psychaitrist evaluate Resident #2 to continue management of psychotropic medications. The medical record lacked documentation that the psychiatrist had been contacted to see the resident. The medical record lacked documentation that the resident was seen by the psychiatrist.</p> <p>An interview with the Administrator on 5/23/13 at 11:15a.m. indicated when a resident requires mental illness evaluations the facility is responsible for arranging the appointments.</p> <p>A copy of the policy and procedure titled Range of Services Offered received from the Administrator on 5/23/13 at 1:15 p.m. indicated the facility will work in concert with the resident's phsycian to arrange for provision of psychiatric services.</p> <p>16.2-5-11.1(c)</p>		Office Manager and Administrator shall audit the medical record of each newly admitted resident within 72 hours of admission to confirm said screening was conducted and is present on the medical record with referral initiated, if indicated. Should non-compliance be noted, applicable staff will be re-educated and disciplinary actions shall be taken, as warranted.	

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R000410	<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 record review and interview the facility failed to ensure residents received the tuberculin skin test within three months prior to admission or prior to admission. This deficient practice affected 1 of 7 sampled clinical records reviewed (Resident #4).</p> <p>Findings include:</p> <p>Review of the policy and procedure titled Resident Screening for Tuberculosis recieved on 5/23/13 at 1:15p.m. indicated a tuberculin skin</p>	R000410	R410 Infection Control – noncompliance I. Resident #4 was screened for Tuberculosis and skin testing performed and recorded.II. The medical records of all resident were audited to confirm timely skin testing performed and documented, or alternate means (chest x-ray and/or health screen) obtained if the resident is a known positive reactor. III. As a means to ensure ongoing compliance, nursing staff has been addressed as to resident skin testing as per policy/rule, both upon admission and annually thereafter. The DON	05/24/2013			

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	<p>test shall be completed within 3 months prior to admission or upon admission. The policy also indicated residents who have not had a documented negative tuberculin skin test result during the preceding 12 months should have a baseline tuberculin skin test using the two-step method.</p> <p>During a record review on 5/23/13 at 2:30 p.m. Resident #4 had diagnosis of hypertension and history of skin cancer. Documentation was lacking that Resident #4 had a tuberculin skin test on admission in 2012. Documentation indicated Resident #4's last skin test was administered at a different facility on July 28,2011. Documentation indicated Resident #4 had a chest x-ray on 4/25/12 related to a cough.</p> <p>During an interview with LPN #1 on 5/23/13 at 3:00 p.m. indicated Resident #4 should receive a tuberculin(TB) skin test yearly. LPN #1 indicated Resident #4 transferred from the another facility and should have received a TB skin test before admission. LPN#1 could not provide documentation that Resident #4 received a TB skin test before admission into the facility. When asked when Resident #4 was due for</p>		<p>shall be responsible to ensure said testing is completed and/or scheduled for each newly admitted resident and placed on a calendar for annual testing thereafter.IV. As a means of quality assurance, the Administrator shall monitor all new admissions by completing an audit of the new admission chart with 72 hours of admission. Should non-compliance be noted, applicable staff will be re-educated, and disciplinary action taken, as warranted. The DON shall maintain an ongoing calendar and review monthly those residents due for annual testing to ensure said testing is scheduled and completed.</p>				

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	<p>the annual TB skin test, LPN #1 checked the monthly log and Resident #4 was not listed on any months for 2013. LPN#1 indicated the monthly log is the method the facility uses to determine when residents are due for their annual TB skin test.</p> <p>The Administrator indicated, during an interview on 5/23/13 at 3:30 p.m., the medical record lacked documentation of an annual TB skin test. The administrator indicated the TB skin test was administered at a previous facility but was not able to provide documentation.</p> <p>16.2-5-12(e)(f)</p>			