

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 301 W ESSEX ST LEBANON, IN 46052
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 31 and September 1, 2, 3, 4, and 8, 2015.</p> <p>Facility number: 000291 Provider number: 155404 AIM number: 100286710</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 1 Medicaid: 25 Other: 3 Total: 29</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 09/09/2015 by 29479.</p>	F 0000		
F 0159 SS=E Bldg. 00	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the</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>resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other</p>			

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	<p>nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on observation, interview, and record review, the facility failed to ensure residents funds were accessible on the weekends for 3 of 15 residents reviewed for personal funds (Residents #13, #15, #9).</p> <p>Findings include:</p> <p>During an interview on 8/31/2015 at 11:59 a.m., Resident #13 indicated he could not access his money from his personal funds account on the weekends.</p> <p>During an interview on 9/1/2015 at 10:35 a.m., Resident #15 indicated he could not access his money from his personal funds account on the weekends.</p> <p>During an interview on 9/1/2015 at 10:41 a.m., Resident #9 indicated he was unaware if the facility had provided him access to his personal funds account on the weekends.</p> <p>During an observation on 9/3/2015 at 10:24 a.m., a sign posted outside of the business office indicated the open hours for banking were Monday through Friday from 8:30 a.m. to 3:45 p.m.</p>	F 0159	<p>A All residents in this facility have to potential to be affected by this alleged deficient practice.</p> <p>B Banking hours for residents to access money from personal funds accounts has been reposted to include week-end hours from 10A-2P on Sat/Sun. This will ensure regulatory compliance with Resident Access to Personal Funds 7 days per week.</p> <p>C All Management staff have been re-educated re: policy for access to personal funds for all residents. All staff have been re-educated on new banking hours, to include weekend days. Business Office Manager (BOM)/Administrator will ensure that residents have access to personal funds during weekdays (M-F) and Manager on Duty (MOD) will have access to cash on weekends (Sa-Su) for resident needs.</p> <p>D Random interviews with a minimum of 3 residents will be done on Mon/Tues weekly x one month by the BOM/Administrator/designee to ensure compliance. A log of resident trust transactions will be available for review by HFA wkly. Ongoing resident interviews to continue bi-weekly x one month, then monthly x one month.</p>	10/08/2015

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F 0280 SS=D Bldg. 00	<p>During an interview on 9/3/2015 at 10:24 a.m., the Business Office Manager indicated residents did not have access to personal funds every weekend.</p> <p>During an interview on 9/8/2015 at 9:19 a.m., the Administrator indicated the facility did not have a system to provide money to residents from their personal funds accounts on the weekends.</p> <p>A policy titled "Standards and Guidelines: Resident Funds" dated June 2006, and identified as current by the Director of Nursing (DON) on 9/8/2015 at 2:47 p.m., indicated, "It will be the practice of this facility to establish a process on how resident funds are dispersed...the agreed upon funds will be withdrawn by the Business Officer Manager or their assistant...."</p> <p>3.1-6(f)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be</p>		<p>Compliance to be monitored at monthly QA meeting x 3 months, then quarterly QA meeting.</p> <p>Date of Compliance: October 8, 2015</p>	

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	<p>developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure care plan meetings were conducted and included resident participation for 2 of 15 residents reviewed for participation in care planning (Resident #9 and #27).</p> <p>Findings include:</p> <p>1. During an interview on 9/1/15 at 10:37 a.m., Resident #9 indicated the facility did not include him in decisions about his care.</p> <p>Resident #9's record was reviewed on 9/2/15 at 10:51 a.m. A Minimum Data Set (MDS) assessment, dated 5/13/15, indicated Resident #9 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 out of 15 and it was very important for him to be involved in discussion about his care.</p> <p>The record did not indicate a care plan</p>	F 0280	<p>Essex Nursing and Rehabilitation recognized and upholds the Residents Rights to participate in Planning Care and treatment and or changes in care or treatments.</p> <p>A Residents 9 and 27 care plans were updated and reviewed with each resident on September 24, 15. Communications with residents were documented in each resident's clinical record.</p> <p>B All residents have the potential to be affected. All care plans will be reviewed by the Interdisciplinary Team and updated as needed. A listing of all residents responsible parties addresses were reviewed to identify those who will be notified of future care plan meetings.</p> <p>C The interdisciplinary Team Policy was reviewed and approved for continued use through the QA Committee. MDS, Social Services, Care Plan Coordinator, Dietary and</p>	10/08/2015

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	<p>meeting that included Resident #9 had been conducted since 1/29/15.</p> <p>During an interview on 9/3/15 at 10:15 a.m., the MDS/Careplan Nurse indicated she revised and updated residents' plans of care without input from residents and families unless concerns were voiced. She further indicated a care plan meeting had not been held for Resident #9 since January 29, 2015.</p> <p>During an interview on 9/8/15 at 9:02 a.m., Resident #9 indicated he wanted to participate in decisions about his care and had not been informed of care plan meetings.</p> <p>2. During an interview on 8/31/15 at 12:10 p.m., Resident #27 indicated she was not included in decision about her care.</p> <p>Resident #27's record was reviewed on 9/2/15 at 1:00 p.m. A Minimum Data Set (MDS) assessment, dated 4/16/15, indicated Resident #27 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 12 out of 15 and it was very important for her to be involved in discussion about her care.</p> <p>The record lacked indication Resident #27 had been involved in discussions</p>		<p>Licensed Nurses will be reeducated on the Policy.</p> <p>D The Director of Nursing or designee will review 2 charts weekly using a tool created to assure documentation is present in each residents clinical record that resident and or responsible party has been invited to the scheduled care plan conference. The Director of Nursing or designee will randomly complete the tool weekly x 3, monthly x3 and quarterly x3. Any identified issues will be immediately addressed. The tool will be reviewed by the Quality Assurance Committee and the regularly scheduled meeting with additional recommendations as needed based on the outcome of the audit.</p>	

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F 0312 SS=D Bldg. 00	<p>regarding her care since the last care plan meeting on 4/21/15.</p> <p>During an interview on 9/3/15 at 10:15 a.m., the MDS/Careplan Nurse indicated Resident #27's care plan had been updated/revised since the 4/21/15 care plan meeting and Resident #27 had not participated.</p> <p>During an interview on 9/08/2015 at 9:08 a.m., Resident #27 indicated she was not routinely invited to meetings regarding her care and she would like to participate in decisions regarding her care.</p> <p>During an interview on 9/3/15 at 10:50 a.m., the Director of Nursing indicated the facility did not have a policy regarding resident/family participation in decisions about care. She indicated the facility should have conducted quarterly interdisciplinary care plan meetings.</p> <p>3.1-35d(2)(B)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral</p>			

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	<p>hygiene.</p> <p>Based on interview and record review, the facility failed to ensure showers were provided for 1 of 1 resident reviewed for care with activities of daily of living (Resident #23).</p> <p>Findings include:</p> <p>During an interview on 8/31/2015 at 1:48 p.m., Resident #23 indicated she had not received her scheduled showers.</p> <p>Resident #23's record was reviewed on 9/4/2015 at 10:00 a.m. A Minimum Data Set assessment (MDS), dated 8/5/2015, indicated Resident #23 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, and required physical help with the assistance of one person while bathing.</p> <p>An Activities of Daily Living care plan, dated 4/3/2015, indicated Resident #23 required extensive assistance with bathing or showering and scheduled for 2 showers a week.</p> <p>A monthly shower sheet, dated August 2015, indicated Resident #23 had 4 shower refusals documented on 8/5/2015, 8/12/2015, 8/16/2015, and 8/29/2015. No other shower attempts or completed showers had been documented for the</p>	F 0312	<p>Essex Nursing and Rehabilitation recognized and upholds the Residents Rights to have care provided for dependent residents as needed.</p> <p>A Residents 23 has discharged to home.</p> <p>B All residents requiring assistance were identified through the MDS review. All residents Shower Preference Sheets were updated and reviewed.</p> <p>C CNA Assignment sheets were updated using the most current preference audit. All CNA's will be provided with a copy of the updated Assignment Sheet and be educated on the updates.</p> <p>D The Director of Nursing or designee will audit showers randomly for 2 residents and complete the audit tool weekly x3, monthly x3 and quarterly x3. Any identified issues will be addressed immediately. The results of the audits will be reported to the QA Committee at the regularly scheduled meeting, additional recommendations as needed based on the outcome of the audit.</p>	10/08/2015

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F 0329 SS=D Bldg. 00	<p>month.</p> <p>During an interview on 9/4/2015 at 1:15 p.m., Certified Nursing Assistant (CNA) #2 indicated all weekly showers should have been documented on the monthly shower sheets.</p> <p>During an interview on 9/4/2015 at 3:12 p.m., the Director of Nursing (DON) indicated she expected staff to provide assigned showers to all residents and document each shower attempt or completion of showers on the monthly shower sheets.</p> <p>During an interview on 9/8/2015 at 2:47 p.m., the DON indicated the facility could not provide a policy for activities of daily living regarding showers.</p> <p>3.1-38(b)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure behaviors were monitored to determine necessity, lowest possible dose, and duration of antipsychotic medications for 1 of 5 residents reviewed for unnecessary medication (Resident #13).</p> <p>Findings include:</p> <p>Resident #13's record was reviewed on 9/3/2015 at 1:30 p.m. The record indicated Resident #13 had diagnoses which included, but were not limited to, bipolar and schizophrenia.</p> <p>The August 2015, physician's recapitulation orders indicated quetiapine (antipsychotic medication) 300 milligram (mg) administered daily. for schizophrenia and olanzapine (antipsychotic medication) 20 mg administered daily for schizophrenia.</p>	F 0329	<p>Essex Nursing and Rehabilitation recognized and upholds the Residents Rights to be free from unnecessary drugs.</p> <p>A Residents 13 was reassessed and the Medical Director was contacted to attempt a gradual reduction as suggested by the pharmacist.</p> <p>B All residents receiving psychoactive medications were identified through a review of physician orders. Care Plans and behavior tracking sheets for all identified residents were reviewed and updated to reflect each resident's current needs.</p> <p>C The Psychotropic Medication Policy was reviewed through the Quality Assurance Committee and approved to continue. Licensed Nursing, MDS/ Care Plan Coordinator, Social Service Designee will be reeducated on the</p>	10/08/2015

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	<p>This document indicated both medications were originally ordered July 28, 2014.</p> <p>Admission orders, dated 2/29/12, indicated Resident #13 was admitted with orders for quetiapine 300 mg daily and olanzapine 20 mg daily. The record did not indicate Resident #13 displayed behaviors and did not indicate target behaviors for monitoring to determine efficacy of quetiapine and olanzapine. The record did not indicated a gradual dose reduction was contraindicated or had been attempted.</p> <p>The record indicated Resident #13 had been evaluated by a psychiatrist on 10/24/14, 2/2/15, and 6/12/15. The psychiatrist's consultation notes indicated Resident #13 had not exhibited psychotic behaviors, no psychopharmacotherapy changes, and lacked indication a gradual dose reduction was contraindicated.</p> <p>During an interview on 9/03/2015 at 1:56 p.m., the Director of Nursing (DON) indicated Resident #13 had behavior monitoring records but the records lacked indication of target behavioral symptoms. She indicated Resident #13 did not exhibit behaviors.</p> <p>During an interview on 9/03/2015 at</p>		<p>policy. All nursing staff and social service will be educate on provisions of psychoactive medications, appropriate use, behavior tracking qualitative and quantitative documentation for gradual dose reduction.</p> <p>D Social Service Designee will conduct an audit for all psychoactive medications to identify diagnosis for use, date of most recent gradual dose reduction, medical symptoms, behaviors, mood, behavior tracking in place and care plan reflective of resident's needs.</p> <p>Initially and then monthly through the Behavior Management Meeting the DON or designee will monitor Pharmacy recommendation to assure gradual dose reduction is reviewed.</p> <p>The Director of Nursing or designee will audit this process monthly for 6 months then quarterly after. The results of the audits will be reported to the QA Committee at the regularly scheduled meeting, additional recommendations as needed based on the outcome of the audit.</p>	

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	<p>3:05, the Social Service Director indicated Resident #13 was admitted to the facility on the anti-psychotropic medication for schizophrenia and bi-polar, had not had a failed gradual dose reduction, and was not aware of what behaviors the medication was supposed to be treating.</p> <p>During a telephone interview on 9/8/15 at 10:57 a.m., the facility's pharmacy consultant indicated Resident #13's medications were reviewed on 6/10/15 and a recommendation was made to consider a gradual dose reduction of antipsychotic medications since the resident did not have behaviors. She indicated the recommendation was provided to the facility via email.</p> <p>During an interview on 9/08/2015 at 10:45 a.m., the DON indicated since she took the position as DON in August 2015, pharmacy recommendations were printed and placed in the physician's communication folder for review. She indicated she did not have an explanation regarding pharmacy recommendations made prior to her employment.</p> <p>A pharmacy recommendation, dated June 10, 2015, indicated recommendations for the physicians to review Resident #13's medication orders for quetiapine and</p>			

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	<p>olanzapine for possible gradual dose reduction. The pharmacy recommendation lacked indication the physician had acknowledged the recommendation.</p> <p>A policy titled "Psychotropic Medication Policy" identified as current by the Social Service Director on 9/8/15 at 1:22 p.m., indicated, "1. To assure each Resident receives the appropriate assessment and intervention regarding the use of psychotropic medications in order to attain and/or maintain his/her highest practicable level of function. 2. To assure each Resident receiving psychotropic medication is monitored, evaluated and assessed for reduction opportunities on an ongoing basis... Behavior Tracking: For those residents receiving medications to treat behavioral symptoms, qualitative and quantitative monitoring shall be completed and documented... Daily behavior tracking shall be completed for those residents receiving psychoactive medication...Possible gradual dose reductions will be assessed by IDT (Interdisciplinary team) ...and care plan process. Interpretive guidance for dose reductions are as follows: Antipsychotic Medication: GDR should be attempted within the first year in which a resident is admitted on medication(s) or after</p>			

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F 0333 SS=D Bldg. 00	<p>medications initiated. A second GDR should be attempted in a separate quarter at least one month following initial GDR then annually thereafter unless clinically contraindicated... Clinical contraindication for GDR of antipsychotic medication used to treat behavior: The resident's target symptoms return or worsen after most recent GDR attempt and the physician has documented the clinical rationale for why any additional attempts at GDR would be likely to impair resident's functioning increase distressed behavior... The physician has documented the clinical rationale for why any attempts at GDR would be likely to impair resident's function or cause psychiatric instability...."</p> <p>3.1-48(b)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free of a significant medication error for 1 of 3 residents reviewed for Coumadin (anticoagulant) administration (Resident #20).</p>	F 0333	<p>Essex Nursing and Rehabilitation recognized and upholds the Residents Rights to be free from Medication Errors.</p> <p>A Resident # 20 no longer</p>	10/08/2015

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	<p>Findings include:</p> <p>Resident #20's closed record was reviewed on 9/1/2015 at 1:42 p.m. The record indicated Resident #20 had diagnoses which included, but were not limited to, exacerbation of congestive heart failure (CHF) and chronic ischemic heart disease. Resident #20 received Coumadin (anticoagulant therapy).</p> <p>A hospital assessment, dated 7/16/2015, indicated Resident #20 had chronic CHF, with an International Normalized Ratio (INR) goal between 2.5- 3.5 on anticoagulant therapy.</p> <p>A Protime-INR lab (blood test to determine clotting time), dated 7/20/2015 at 8:27 a.m., indicated an INR value of 1.2 and indicated an order to increase Coumadin dose to 2 milligrams (mg) for 5 days of the week and Coumadin 1 mg for 2 days of the week and to recheck the INR lab in one week.</p> <p>An Anticoagulant Therapy Flow Sheet, dated 7/20/2015, indicated a new order for Coumadin 2 mg for 5 days of the week and Coumadin 1 mg for 2 days of the week.</p> <p>A physician's telephone order, dated</p>		<p>resides at the facility.</p> <p>B All residents who receive medications or treatments have the potential to be affected by this finding.</p> <p>C All nursing staff will be reeducated on transcribing medications, labs and treatment orders according to Physicians current orders. A change of condition tool will be initiated that will randomly review 3 residents to assure that medication and treatment orders are transcribed accurately.</p> <p>D The DON or designee will randomly complete the audit tool weekly x3, monthly x3 and quarterly x3. Any identified issues will be addressed immediately. Results of the audit will be forwarded the QA Committee at the regularly scheduled meeting, additional recommendations as needed based on the outcome of the audit.</p>		

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	<p>7/20/2015, indicated an order to increase Coumadin to 5 mg for 5 days of the week and 1 mg for 2 days of the week. Then recheck the Prottime-INR lab.</p> <p>The Medication Administration Record (MAR), dated July 2015, indicated an order for Coumadin 5 mg to be administered on 7/20/2015 through 7/24/2015 and an order for Coumadin 2 mg to be administered on 7/25/2015 and 7/26/2015.</p> <p>A Prottime-INR lab, dated 7/27/2015, indicated a high Prothrombin (PT) time of 119.6 seconds (normal range is 9.5-11.8 seconds) and a critically high INR of 9.1 (normal range is 2.5- 3.5).</p> <p>A physician's progress note, dated 8/1/2015 indicated Resident #20's assessment included CHF with a Coumadin overdose. Resident's current INR lab had decreased to 4.0.</p> <p>During an interview on 9/2/2015 at 3:22 p.m., Licensed Practical Nurse (LPN) #3 indicated PT and INR lab values received are called into the physician's office and the physician's order is written on the lab sheet. The order is then written on a telephone order, the Anticoagulant Therapy Flow Sheet, and the MAR. She indicated Resident #20's 7/20/2015 had</p>			

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F 9999 Bldg. 00	<p>been incorrectly transcribed on both the physician's telephone order and the MAR, causing a significant medication error that resulted in a high PT and critically high INR level for the resident on 7/27/2015.</p> <p>During an interview on 9/8/2015 at 2:47 p.m., the Director of Nursing (DON) indicated the facility could not provide a policy regarding medication errors. She indicated the facility should ensure residents are free from medication errors that jeopardize their health.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p> <p>3.1-14 PERSONNEL</p> <p>(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p>	F 9999	<p>A All residents of the facility have the potential to be affected by these alleged deficient practices: 1) failure to ensure references check are completed on all prospective employees; and 2) tuberculin skin test not performed per policy/regulation on newly hired employees.</p> <p>B 1) Employment reference checks</p>	10/08/2015

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure reference verification for 1 of 5 recently hired employees. This deficiency had the potential to affect 29 of 29 residents residing in the facility.</p> <p>Finding includes:</p> <p>Employee records were reviewed on 9/8/15 at 8:30 a.m. The record did not indicate an employee reference was obtained prior to hiring the Administrator. The record indicated the Administrator began employment on 1/29/15.</p> <p>During an interview on 9/08/2015 at 2:13 p.m., the Business Office Manager indicated she was not able to locate documentation of references being verified prior to the Administrator beginning employment on 1/29/15.</p> <p>A policy titled "Human Resources Policies and Procedures Manual" identified as current by the Director of Nursing on 9/8/15 at 2:44 p.m., indicated, "...The Human Resources Department must ensure that all applicants for</p>		<p>have been completed on the Administrator.</p> <p>2) 100% audit of all employees has been completed to ensure compliance with tuberculin skin test (2 step) on all employees. Any deficiencies noted have been corrected. All employees are in compliance. Compliance Log available for review.</p> <p>C 1) Human Resources/Administrator will validate all reference checks have been completed on prospective employees prior to offer of employment with each new hire.</p> <p>2) Human Resources (HR) and Director of Nursing (DON) will be responsible to monitor all newly hired employees for compliance with 2 step tuberculin skin tests, and current employees for annual TB screening/testing weekly. Employees who fail to comply with policy will not be permitted to work until in compliance. Administrator will review monthly to ensure compliance. TB Monitoring log available for review.</p> <p>D Monitoring for compliance with proposed changes will be completed weekly indefinitely by HR and DON, with oversight by Administrator. Wkly audit logs will be reviewed in monthly QA meetings x 3 months, then quarterly QA meeting to ensure</p>	

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	<p>employment are properly interviewed and will ensure that appropriate background checks on all applicants are completed. Appropriate reference and/or background checks can consist of: former employer references...."</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a</p>		<p>on-going compliance with reference checks and tuberculin skin testing on all employees.</p>	

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	<p>documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 2 out of 5 newly hired employees had a base line tuberculin skin test which employed the two-step method. This deficiency had the potential to effect 29 out of 29 residents residing at the facility.</p> <p>Findings include:</p> <p>On 9/9/15 at 9:15 a.m., five employee records were reviewed for proof of tuberculosis (TB) screening upon hire. Two employee records failed to show documentation of a second step TB screening.</p> <p>State form 5440, "Employee Records," provided on 9/9/15. by the Administrator, indicated Certified Nurse Aide (CNA) # 9 began employment on 4/13/15.</p>			

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	<p>A human resources record indicated CNA #9 had a negative result to the first of the two step testing process on 4/10/15. The record lacked indication the second step test was administered.</p> <p>State form 5440, "Employee Records," provided on 9/9/15 by the Administrator, indicated Registered Nurse (RN) #8 started employment on 5/26/15.</p> <p>A human resources record indicated RN #9 had a negative result to the first of the two step testing process on 5/12/15. The record lacked indication the second step test was administered.</p> <p>During an interview on 9/08/2015 at 2:13 p.m., the Business Office Manager indicated CNA #8 and RN #9 did not have the second step tuberculin test required.</p> <p>A policy titled "Tuberculosis, Screening Employees" identified as current by the Director of Nursing on 9/8/14 at 2:44 p.m., indicated, "...Each employee will be screened for tuberculosis (TB) infection and disease... A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the</p>			

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	<p>Mantoux method ...For employees who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months the two-step method...."</p> <p>During an interview on 5/27/15 at 2:35 p.m., the Human Resources (HR) Director indicated she did not have record of RN Supervisor #10's TB screening prior to employment or since hire. She indicated CNA #8 and CNA #9 had the first TB test on 5/26/15 and were scheduled to have the second TB test the next week.</p> <p>During an interview on 5/27/15 at 2:42 p.m., the HR Director indicated she overlooked the TB screening upon hire for RN Supervisor #10 and CNA #9. She indicated she had been informed CNA #8 had a TB test with her previous employer. She indicated CNA #8 had failed to provide documentation of her recent TB screening and the HR Director had recently addressed the lack of TB documentation on 5/26/15.</p> <p>During an interview on 5/27/15 at 3:03 p.m., the Director of Nursing (DON) indicated employees were to have TB screening upon hire and annually per the state regulations. She indicated the facility did not have documentation of</p>			

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	<p>TB screening for CNA #8, CNA #9, and RN Supervisor #10.</p> <p>On 5/27/15 at 3:08 p.m., the DON provided the current employee health policy, dated 6/1/02. The policy indicated the facility was to comply with state and federal regulations regarding employee health and ensuring employees were free of communicable diseases.</p> <p>3.1-14(t)(1)</p>				