

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 04/27/2016
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NAME OF PROVIDER OR SUPPLIER  HEARTH AT TUDOR GARDENS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077
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R 0000  Bldg. 00	<p>This Visit was for a State Residential Licensure Survey.</p> <p>This visit included the Investigation on Complaint IN00196450.</p> <p>Complaint IN00196450 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: April 26 &amp; 27, 2016.</p> <p>Facility number: 012263 Provider number: 012263 AIM number: NA</p> <p>Residential Census: 98</p> <p>Sample: 8</p> <p>The following Residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 4/29/16 by 29479.</p>	R 0000		
R 0117  Bldg. 00	<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</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>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 ensure a minimum of one awake person, with cardiopulmonary resuscitation (CPR) and first aid certificates, was on site at all times. This deficient practice had the potential to affect 98 out of 98 Residents.</p> <p>Finding includes:</p> <p>Employee records and employee time sheets were reviewed on 4/27/16 at 12:00 p.m. The records lacked indication that a staff member with cardiopulmonary resuscitation (CPR) or first aide certification worked day shift on April 10, and 23, 2016. The records lacked</p>	R 0117	<p>1 No residents were affected by the alleged deficient practice 2 The Business Office Manager audited nursing department personnel records to determine the status of their certification of CPR/First Aid All nurses with expired certifications will be re-certified as soon as possible 3 The Business Office Manager will maintain a tracking system to ensure ongoing compliance with current CPR &amp; First Aid certifications An in-service will be conducted by the Executive Director to the Business Office Manager, Wellness Directors and Wellness Administrative Assistant regarding this procedure A notation will also be made on the daily staffing sheet to indicate</p>	05/27/2016

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	<p>indication that a staff member with first aid worked the evening shift on April 14, 15, 16, 17, 18, 19, 20, 21, and 23, 2016. The records lacked indication that a staff member certified in first aid worked night shift from April 10, 2016 to April 23, 2016. The records lacked indication that a staff member with cardiopulmonary resuscitation (CPR) certification worked night shift from April 10, 11, 16, 17, 18, 19, 20, 21, 22, and 23, 2016.</p> <p>During an interview, on 4/27/16 at 12:15 p.m., the Wellness Administrative Assistant (WAA) indicated she was the scheduler and she was aware there should at all times be a CPR and first aid certified person in the building during each shift. She indicated all first aid certifications and CPR certifications that were in the building had been provided for review.</p> <p>During an interview, on 4/27/16 at 3:06 p.m., the Director of Human Resources(DOHR) indicated all staff without CPR or first aide certifications had been called and requested to submit certifications but at this time there were no other certifications in the building. The DOHR indicated there was no policy for CPR or first aide. The DOHR indicated State guidelines were followed for their facility.</p>		<p>which employee on each shift is CPR/First Aid certified Modification to schedule will be made to ensure a CPR/First Aid employee is on all 3 shifts 4 Executive Director/designee will audit 10 employee files for current CPR/First Aid certifications and review the daily staffing sheets weekly x4 weeks and monthly thereafter Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly</p>				

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R 0152  Bldg. 00	<p>410 IAC 16.2-5-1.5(i) Sanitation and Safety Standards - Deficiency (i) The facility shall handle, store, process, and transport clean and soiled linen in a safe and sanitary manner that will prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure linen was transported using a sanitary technique for 1 of 3 observations of linen handling.</p> <p>Finding includes:</p> <p>On 4/26/16 at 10:23 a.m., Housekeeper #30 walked out of the laundry room on the 2nd floor with folded towels and washcloths in her arms. The stack of folded linens were resting against Housekeeper #30's upper body and Housekeeper #30 placed her chin on top of the stack of wash clothes as she walked down the hallway to Resident #15's room. Housekeeper #30 walked into Resident #15's room with the linens and exited the resident's room without the linens.</p> <p>During an interview on 4/27/16 at 3 p.m., Housekeeper #30 indicated residents' laundry should be transported away from her body.</p>	R 0152	<p>1 No residents were affected by the alleged deficient practice 2 Staff was immediately instructed to use baskets when transporting resident's laundry 3 In-services were held by the Environmental Service Director with housekeeping staff on 5/6/16 and 5/9/16 titled "Transporting Laundry" All residents had the potential to be affected by this deficient practice 4 Environmental Service Directors will observe one housekeeping staff monthly x3 months, then quarterly thereafter Results of these audits will be reviewed by the QA committee, who will establish the threshold of compliance and make further recommendations accordingly</p>	05/13/2016

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R 0216 Bldg. 00	<p>During an interview on 4/27/16 at 3:12 p.m., the Wellness Director #2 indicated staff should not transport laundry against their bodies.</p> <p>During an interview on 4/27/16 at 3:48 p.m., the Wellness Director #2 provided the current policy titled, "Personal Laundry." The policy lacked documentation related to the proper linen transportation procedure.</p> <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 and interview, the facility failed to evaluate residents' ability to self-administer medications for 1 of 2 residents reviewed for self-administering medications (Resident # 6); and the facility failed to obtain weights for 1 of 7 residents reviewed for</p>	R 0216	1 Resident #6 was assessed and passed her self-medication administration evaluation on 5/11/16 A physician order was received on 5/2/14 indicating resident can self administer her own meds Resident #6 weight was obtained and documented on	05/20/2016

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	<p>admission documentation (Resident #6).</p> <p>Findings include:</p> <p>1. Resident #6's record was reviewed on 4/27/16 at 11:12 a.m. A form titled "Resident Self Medication Evaluation," dated 6/14/15 indicated Resident #6 was evaluated for her ability to self administer medications.</p> <p>During an interview on 4/27/16 at 11:58 a.m., the Director of Nursing (DON) #1 indicated Resident #6 self-administered her own medications. She indicated she had not done an evaluation of self-administration of medications for Resident #6 during the time frame indicated on the policy.</p> <p>On 4/26/16 at 3:30 p.m., the DON provided the current policy titled, " Self Administration of Medication." The policy indicated, "...Staff members are responsible for evaluating residents who self-administer medication prior to admission and at least quarterly to ensure their continued compliance (CS-111)...."</p> <p>2. Resident #6's record was reviewed on 4/27/16 at 9:30 a.m. A resident information face sheet, indicated Resident #6 moved into the facility on 5/1/14. The record lacked documentation</p>		<p>5/11/16</p> <p>2 Residents who self-administer their own medications have the potential to be affected by this alleged deficient practice An audit of these residents will be completed to ensure an evaluation of each resident's ability to safely self-administer medications has been completed and a physician order has been obtained All residents who have admitted to the facility have the potential to be affected by this alleged deficient practice of weight being taken on admission and semiannually An audit of resident medical records will be completed to ensure residents have current weights</p> <p>3 Nurses will evaluate residents requesting to self-administer medications prior to admission and at least once quarterly thereafter For residents who pass the self medication evaluation, their physician will be notified to obtain an order Training will be conducted by the DON and Regional Director of Clinical Services for all nurses and QMA's on the facility policy for resident self medication during the week of 5/16/16 Training will be conducted by the DON for all nurses and QMA's on facility policy on obtaining admission weights and semiannual weights on all residents in regards of medical needs during the week of 5/16/16</p> <p>4 The DON and/or designee will</p>	

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R 0217  Bldg. 00	<p>of Resident #6's weight history.</p> <p>During an interview on 4/27/16 at 3:36 p.m., the Director of Nursing (DON) #1 indicated Resident #6 did not have a weight record because she was an independent resident.</p> <p>On 4/27/16 at 4:33 p.m., the DON #1 provided the current policy titled, "Health Promotion Services." The policy indicated, "The assisted living nurse will provide health promotion services. These wellness services will include, but not limited to...weight monitoring...."</p> <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: (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. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires</p>				<p>conduct a review of residents who self-administer medications to ensure compliance with facility policy monthly x3 months and quarterly thereafter The DON and/or designee will conduct a medical record review of 10% of current residents to ensure compliance with admission weights and semiannual weights monthly x3 months and quarterly thereafter Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly</p>		

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	<p>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 ensure a service plan was developed for 1 or 8 residents reviewed for service plans (Resident #3).</p> <p>Finding includes:</p> <p>Resident #3's record was reviewed on 4/26/16 at 3:00 p.m. A nursing progress note, dated 2/24/16, indicated Resident #3 moved into the facility on 2/24/16. The record lacked documentation a service plan had been developed.</p> <p>During an interview, on 4/27/16 at 12:15 p.m., Wellness Director 1 indicated a service plan had not been completed for Resident #3.</p> <p>On 4/26/16 at 3:47 p.m., Wellness Director 1 provided the current policy titled, "Assistance/Service Plan." The</p>	R 0217	<p>1 Resident #3 was not able to be assessed Discharged from the facility on 3/31/16</p> <p>2 All residents who have admitted to the facility have the potential to be affected by this alleged deficient practice An audit of resident medical records will be completed to ensure residents have current evaluations DON will complete an missing evaluations</p> <p>3 Training will be conducted by the Regional Director of Clinical Services for DON's on the facility policy for resident evaluations during the week of 5/16/2016</p> <p>4 The DON an/or designee will conduct an audit of new resident's records to ensure compliance with facility policy monthly x3 months and quarterly thereafter Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly</p>	05/27/2016

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R 0273  Bldg. 00	<p>policy indicated, "...a service plan will be completed by the Wellness Director prior to or upon admission to the facility...."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper storage of foods for 2 of 2 observations of food storage and failed to ensure the correct application of chemical products in food preparation area. These deficient practices had the potential to affect 38 of 38 residents who consumed food from the facility's kitchen.</p> <p>Findings include:</p> <p>1. On 4/26/16 from 10:09 a.m. to 11:05 a.m., kitchen observations were made with the Dietary Manager (DM). Opened undated cookies and peaches were in the freezer. Open and undated dry seasonings were stored above the food prep area including but not limited to: sage, garden seasoning, ground white pepper, rosemary, thyme, pickling spice, minced onion, select seasoning salt, old bay seasoning, Spanish paprika, Italian</p>	R 0273	<p>1 No residents were affected by the alleged deficient practice Thermometer was placed in refrigerator on Keepsake Village 4/26/16 by Food Service Director All thermometers and tongs were cleaned with proper technique 4/26/16 Undated food items were discarded on 4/26/16 2 All residents had the potential to be effected by the alleged deficiencies There were no reports from residents related to the deficiencies 3 In-services were completed 5/11/16 with food service personnel titled, "Sanitizer", "Dating Food and Storage", "Thermometers and Temperatures" The facility is following manufacturing guidelines for the cleaning of thermometers and tongs The Food Service Director and/or designee will conduct a review of staff sanitizing thermometers and tongs They will also review the refrigerator for thermometer Stored food items will be reviewed for correct dates. A</p>	05/27/2016

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	<p>seasoning, bay leaves, lemon pepper, whole basil leaves, granulated garlic, onion powder, ground lack pepper, parsley flakes. There were open and undated items in the reach in cooler located outside of the walk in refrigerator, including but not limited to: horseradish sauce, hoisin sauce, Worcestershire sauce. There were olives, dated 3/17/15, in the reach-in cooler.</p> <p>During an interview on 4/27/16 at 11:34 a.m., the DM indicated all items are to have two dates on them one when they are received and one when opened. There should be no food items retained after a year's time from open date.</p> <p>On 4/27/16 at 12:33 p.m., the Executive Director (ED) provided the current policy titled, "Food Receiving and Storage Policy." The policy indicated, "...Storage Frozen, Fresh and dry...#1. First-in, first-out rotation method shall be used for all received items. All received items shall be dated..."</p> <p>2. During an observation on 4/26/15 at 11:43 a.m., the Dietary Manager (DM) used a red bucket of liquid to clean the thermometer between each food item tested for temperature.</p> <p>During an observation on 4/26/16 at</p>		<p>review of sanitizer thermometers will be weekly at breakfast, lunch, and dinner x 3 months and quarterly thereafter. A review will be conducted of stored food items and thermometers in refrigerator monthly x3 months and quarterly thereafter Results of these reviews will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly</p>				

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	<p>11:45 a.m., Cook #1 was observed taking a pair of serving tongs and placing it in the red bucket to clean, then shaking them in the air, and then mixing the vegetable melody with the damp tongs.</p> <p>During a interview on 4/26/16 at 11:46 a.m., the Cook #1 indicated that the method that is used to clean the serving tongs is to either dip the tongs in the red bucket and then shake off the moisture in the air before using them with food.</p> <p>During an interview on 4/26/15 at 11:59 a.m., the DM indicated the liquid in the bucket was a mixture of water and Clean Quick Quaternary Sanitizer Concentrate. The DM indicated that the correct method of its use would be to use a single use drying cloth each time the solution was used to clean the thermometer but he had not used that method and continued to place the dampen thermometer straight from the bucket into the food items for testing.</p> <p>On 4/27/16 at 12:05 p.m., the DM provided the current Material Safety Data Sheet (MSDS) titled, "Procter &amp; Gamble Professional." The MSDS indicated, "...#2...Hazards Identification...Ingestion...Harmful if swallowed. Can burn mouth, throat, and stomach. Severe swelling of the larynx,</p>						

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	<p>skeletal muscle paralysis affecting the ability to breathe, circulatory shock ad convulsions...."</p> <p>On 4/27/16 at 1:00 p.m., the Executive Director (ED) provided the current policy titled, "Food Temperatures." The policy indicated,...a... Thermometer is cleaned, rinsed and sanitized before, after, and in between uses...After each meal, thermometers are sanitized according to manufactures directions...</p> <p>3. During an observation on 4/26/15 at 10:50 a.m., on the Keep Sake Village unit with the DM the thermometer in the refrigerator was not present. The contents of the refrigerator included but not limited to: milk, jelly, ketchup, and mustard.</p> <p>During an interview on 4/26/15 at 10:51 a.m., the DM indicated he was unaware there had been no thermometer present in the Keep Sake Village refrigerator.</p> <p>On 4/27/16 at 12:33 p.m., the Executive Director (ED) provided the current policy titled, "Storage of Food in Refrigeration." The policy indicated, "...All containers must be labeled with the contents and date food item was placed in storage...."</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0275 Bldg. 00	<p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p> <p>Based on record review and interview, the facility failed to ensure residents had a diet order signed by a physician or verbally verified by a physician for 1 of 8 residents reviewed for diet orders (Resident #4).</p> <p>Finding includes:</p> <p>Resident #4's record was reviewed on 4/27/16 at 11:00 a.m. A nursing progress note, dated 3/31/16, indicated Resident #4 moved into the facility on 3/31/16. The record lacked indication Resident #4 had a diet order signed by a physician or verbally verified by a physician.</p> <p>During an interview on 4/27/16 at 12:10 p.m., Wellness Director #1 indicated Resident #4 did not have a diet order. She indicated all residents should have diet orders signed by a physician or verbally verified by a physician.</p> <p>On 4/27/16 at 4:33 p.m., Wellness Director #1 indicated there was no policy</p>	R 0275	<p>1 Resident #4 diet order was obtained from the physician and placed in medical record on 5/12/16</p> <p>2 All residents have the potential to be affected by this alleged deficient practice An audit of resident medical records will be completed to ensure residents have diet orders DON and/or designee will obtain any missing diet orders</p> <p>3 Current diet orders will be obtained by nursing staff and documented in the clinical record for residents upon admission and as indicated thereafter Training will be conducted by the DON for all nurses on facility policies and procedures for obtaining diet orders during the week of 5/16/16</p> <p>4 The DON and/or designee will conduct an audit on new admissions resident records to ensure diet order is present Audits will be completed monthly x3 months and quarterly thereafter Results of these audits will be reviewed by the QA Committee who will establish the threshold of compliance and make further recommendations accordingly</p>	05/20/2016

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 04/27/2016
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R 0410 Bldg. 00	<p>for obtaining diet orders.</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.</p> <p>Based on record review and interview, the facility failed to ensure residents received tuberculosis screening within 3 months prior to or on admission to the facility for 2 of 8 residents reviewed for tuberculosis screening (Resident B, and</p>	R 0410	<p>1 A first step was administered to resident B and Resident D on 5/12/16 2nd step is scheduled for 5/23/16</p> <p>2 All residents have the potential to be affected by the deficient practice DON and/or designee will conduct an audit of all</p>	05/27/2016

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	<p>Resident D).</p> <p>Findings include:</p> <p>1. Resident B's record was reviewed on 4/27/16 at 11:00 a.m. A nursing progress note, dated 6/1/15, indicated Resident B moved into the facility on 6/1/15. The record lacked documentation Resident B had received her second step tuberculosis screening within one to three weeks after the first step.</p> <p>2. Resident D's record was reviewed on 4/26/16 at 12:50 p.m. A nursing progress note, dated 9/29/15, indicated Resident D moved into the facility on 9/29/15. The record lacked documentation Resident D had received a tuberculosis screening 3 months prior to or on admission to the facility.</p> <p>During an interview, on 4/26/16 at 3:11 p.m., the Director of Nursing (DON) indicated Resident D did not received a second step tuberculosis screening, and Residents B had not had a tuberculosis screening 3 months prior to or on admission.</p> <p>On 4/26/16 at 3:48 p.m., the DON provided the current policy titled, "Tuberculosis Testing for Residents." The policy indicated, "...a tuberculin skin</p>		<p>resident medical records to ensure all residents have a current annual TB test completed</p> <p>3 Admitting nurse will administer and record the 1st step PPD on the resident medication administration record (MAR) Admitting nurse will also schedule the reading of the 1st step and administration and reading of the 2nd step PPD on the MAR An in-service will be conducted the DON to licensed nurse in regards to facility procedure to administer, record and schedule admissions and 2 step PPD's</p> <p>4 DON and/or designee will audit all new move-ins to ensure timely TB testing per facility policy two times monthly 2 x3 months and quarterly thereafter Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly</p>				

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