

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/18/2016
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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 11, 12, 15, 16, 17, & 18, 2016</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census payor type: Medicare: 1 Medicaid: 27 Other: 12 Total: 40</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 8/22/16.</p>	F 0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiency or any violation of regulation. Provider desires that the 2567 Plan of Correction be considered the letter of credible compliance and respectfully requests that a desk review be completed in lieu of a revisit. Should additional information be necessary to confirm said compliance, feel free to contact me. Kind Regards, Daphne New,HFA</p>	
F 0224	483.13(c)			

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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SS=D Bldg. 00	<p>PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a resident was free from misappropriation of resident property, related to a resident's missing funds and a resident's missing narcotic pain medication for 2 of 2 residents reviewed for misappropriation of resident property out of the 3 residents reviewed for abuse. (Residents #34 and #11)</p> <p>Findings include:</p> <p>1. Record review for Resident #34 was completed on 8/15/16 at 1:31 p.m. The resident's diagnoses included, but were not limited to, diabetes, dementia, and hypertension.</p> <p>An Indiana State Department of Health reportable Incident, dated 8/2/16, indicated Resident #34's bank statement had suspicious withdrawals made from ATM's over the past month. The resident did not have possession of a bank card to his account.</p> <p>The reportable indicated an investigation</p>	F 0224	<p>The facility replaced the missing funds for Resident #34 and the employee has been terminated. The facility replaced the missing narcotic pain medication for Resident #11 and the contracted employee has been terminated. All residents have the potential to be affected. All resident funds have been reviewed and no other missing funds were found. All narcotics have been counted and checked with each individual's narcotic count sheet and no other missing narcotics were found. The facility's policy for abuse prohibition has been reviewed and no changes are indicated at this time. The staff have been re-educated on the abuse prohibition policy with a special focus on misappropriation of resident's property including funds and narcotics. An audit tool has been implemented. The Administrator or designee will be responsible for completing an audit tool to ensure the abuse prohibition, including misappropriation of funds, is being followed. The audit tool will be completed on scheduled work days as follows: Daily for two weeks, weekly for two weeks,</p>	09/02/2016			

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	<p>had been started. The resident was interviewed, and the family was notified and interviewed. The local police was contacted, the bank was notified, and the business office manager had been suspended pending the outcome of the investigation.</p> <p>A follow up to the investigation on 8/9/16, indicated the suspended employee admitted to the theft and was promptly terminated. After a thorough accounting audit of the resident's account, the facility deposited the missing funds back into the residents account.</p> <p>Interview with the Administrator and Director of Nursing (DON) on 8/15/16 at 3:16 p.m., indicated the business office manager had admitted to the theft and was terminated. The Administrator indicated the resident had gotten his mail delivered to him one weekend and he had gotten his bank statement. She indicated the resident did not usually get his bank statement and brought it to her attention that he had "a bunch of charges" to his account that he did not make. She indicated the business office manager had been using the residents debit card to purchase items for other residents and then pocketed the other residents' money. She further indicated the business office manager was also using the debit card to</p>		<p>then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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	<p>withdraw money from his bank account at ATM's. She further indicated the resident did not have a debit card so they are unsure of how the business office manager had gotten one.</p> <p>2. Record review for Resident #11 was completed on 8/15/16 at 2:17 p.m. The resident's diagnoses included, but were not limited to, unspecified pain and hypertension.</p> <p>Review of the August 2016 Physician Order Summary (POS) indicated the resident received Percocet (pain medication) 5-325 milligrams (mg) 1 tablet three times a day for pain and 1 tablet every 5 hours when necessary (prn) for pain. The order was started on 4/4/16.</p> <p>An Indiana State Department of Health reportable Incident, dated 7/21/16, indicated Resident #11 had 2 narcotic pain pills missing from the medication cart.</p> <p>The reportable indicated an investigation had been started. An immediate search for the missing medication was completed. All staff who were deemed to potentially have had access to the medication, were contacted and interviews were conducted. The</p>			

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	<p>employees with suspected involvement had been suspended pending investigation. The local law enforcement had been contacted.</p> <p>A follow up to the investigation on 8/1/16 indicated the resident had sufficient medication in supply and the facility replaced the 2 narcotic pain medications that were missing at the facility cost. The staff were interviewed and drug screened, with no findings.</p> <p>A written statement from RN #2 on 7/21/16 indicated at 10:00 p.m., she had checked the narcotic count and discovered a medication card was missing that had 2 Percocet remaining for Resident #11. She indicated she had given the resident pain medication at 8:00 p.m. She indicated the Hospice nurse was there and had obtained narcotic pain medication out of the medication cart for another resident.</p> <p>Interview with the Administrator and the DON on 8/15/16 at 3:12 p.m., indicated RN #2 had given the Hospice nurse her keys to the medication so the Hospice nurse could give another resident some pain medication. The DON indicated that is not the facility policy for nurses to give the Hospice nurses their medication cart keys. The Administrator indicated</p>			

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F 0279 SS=D Bldg. 00	<p>the Hospice nurse was contracted out and the Corporate office did the interview and investigation with the Hospice nurse and the Hospice nurse had been fired, but the Administrator was unaware of the reasons for the firing. She further indicated they had completed drug screens on their employees with negative findings. The DON indicated they were unable to locate the missing narcotic pain medication but she believed the Hospice nurse was responsible for taking the medication.</p> <p>A policy titled, "Narcotic Count/Disposal", was received as current from the Nurse Consultant on 8/18/16 at 2:02 p.m. The policy indicated, "...Procedure: 2. The medication nurse on duty maintains possession of the key or code to the medications...."</p> <p>3.1-28(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and</p>			

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	<p>mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident had a comprehensive care plan related to a resident's oral condition for 1 of 16 residents whose plan of care was reviewed. (Resident #16)</p> <p>Finding includes:</p> <p>On 8/12/16 at 11:18 a.m., Resident #16 was observed laying in bed. The resident was observed to not have any natural teeth or dentures.</p> <p>Record review for Resident #16 was completed on 8/17/16 at 11:22 a.m. The resident's diagnoses included, but were not limited to, hypertension, aphasia (communication disorder), dementia, and dysphagia (difficulty swallowing).</p> <p>Review of the Annual Minimum Data Set (MDS) assessment completed on</p>	F 0279	<p>The care plan for Resident #16 is comprehensive and now addresses the resident's oral condition. All residents have the potential to be affected. The care plans for each resident has been reviewed and revised if indicated, to ensure they are comprehensive. The facility's policy for care plan development has been reviewed and no changes are indicated at this time. The care plan team, including the MDS staff member, has been re-educated on the policy with a special focus on making sure the care plans are comprehensive. An audit tool has been implemented. The DON or designee will be responsible for completing the audit tool to ensure care plans are comprehensive. The audit tool will be completed on scheduled work days as follows: 5 residents careplans will be reviewed daily for two weeks, then weekly for two weeks, then monthly for two months, then quarterly thereafter.</p>	09/02/2016

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F 0309	<p>11/10/15, indicated the resident was severely cognitively impaired. The assessment indicated the resident did not have any natural teeth or tooth fragments. The MDS Care Area Assessment (CAAs) indicated the resident was edentulous (lacking teeth) and did not have or use dentures. The assessment indicated the resident had dysphagia and was NPO (no food or fluids by mouth). The assessment indicated the resident had both cognitive and communicative deficits and was totally dependent on others for oral care. The assessment further indicated a care plan would be completed for the resident to exhibit no problems related to oral condition.</p> <p>The record lacked any indication a care plan for the resident's oral condition was in place.</p> <p>Interview with the MDS Coordinator on 8/17/16 at 3:05 p.m., indicated a care plan for the residents oral condition should have been put into place, especially since the resident was NPO. She further indicated she was unable to find a care plan had been put into place.</p> <p>3.1-35(a)</p>		Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.		
F 0309	483.25				

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SS=D Bldg. 00	<p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to assessment of the dialysis access site for 1 of 1 residents reviewed for dialysis of the 1 resident who met the criteria for dialysis. (Resident #19)</p> <p>Finding includes:</p> <p>The record for Resident #19 was reviewed on 8/15/16 at 10:35 a.m. The resident's diagnoses included, but were not limited to, chronic renal disease stage IV and hypertension.</p> <p>Review of a Physician's Order, dated 7/22/16, indicated an order to "monitor dialysis cath (catheter) site for bleeding, warmth, redness and edema q (every) shift and monitor dressing to ensure dry and intact q shift."</p> <p>Review of the Post Dialysis Assessments for August 2016, indicated the resident's dialysis access site had only been</p>	F 0309	<p>Assessment of the dialysis access site for Resident #19 is currently being completed every shift. The MD's order to monitor the dialysis access site and dressing every shift has been placed on the Treatment Administration Record. All residents receiving dialysis have the potential to be affected. Their clinical records have been reviewed to ensure physician's orders to monitor the dialysis access site is being completed. The facility's policy for Dialysis Coordination/Facility Services has been reviewed and no changes are indicated at this time. The nurses have been re-educated on the policy with a special focus on monitoring the dialysis access site. An audit tool has been implemented. The DON or designee will be responsible for completing the audit tool to ensure the dialysis access site is being monitored every shift. The audit tool will be completed on scheduled work days as follows: daily for two weeks, weekly for two weeks, then monthly thereafter. Should a concern be noted, immediate corrective</p>	09/02/2016	

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	<p>monitored upon return from dialysis on Tuesdays, Thursdays, and Saturdays.</p> <p>Review of the August 2016 Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation the dialysis access site had been assessed every shift.</p> <p>Review of the Nurse's Notes for August 2016, lacked documentation the dialysis access site had been assessed every shift.</p> <p>Resident #19 had a care plan for end stage renal disease and hemodialysis. The nursing interventions included "...observe site for redness, drainage, or other signs of infection..."</p> <p>Interview with RN #1 on 8/17/16 at 3:46 p.m., indicated she normally checked the resident's vital signs, checked the dressing on the access site, and checked to make sure the clamps were closed on the resident's dialysis catheter when the resident returned from dialysis. She indicated she usually documented this on the Post Dialysis Assessment Form.</p> <p>Interview with the Director of Nursing (DON) on 8/17/16 at 3:11 p.m. indicated a clarification order to monitor the dialysis site and dressing every shift had been written on 7/22/16. She indicated</p>		<p>action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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F 0329 SS=D Bldg. 00	<p>7/22/16 was the same day the Pharmacy printed out the Physician Order Summary for August and the order was missed to be put on the August re-writes. She further indicated the dialysis access site should have been monitored every shift and documented on the TAR.</p> <p>A facility policy, titled Dialysis Coordination/Facility Services, dated 10/2014, and received as current on 8/11/16, indicated "...The following should be addressed on the Treatment Administration Record every shift of the resident on dialysis who has a central line in place: Dressing dry and intact, Clamps present/closed."</p> <p>3.1-37(a)</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> <p>Based on a comprehensive assessment of a</p>			

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	<p>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 observation, record review, and interview, the facility failed to ensure a resident was free from unnecessary medications, related to an increase of an antipsychotic medication without justification for 1 of 5 residents reviewed for unnecessary medications. (Resident #41)</p> <p>Finding includes:</p> <p>On 8/12/16 at 3:23 p.m., Resident #41 was observed sitting in a recliner in her room with her eyes closed. No behaviors were observed.</p> <p>On 8/17/16 at 2:29 p.m., Resident #41 was observed sitting in a recliner in her room with a blanket on. No behaviors were observed.</p> <p>Record review for Resident #41 was completed on 8/15/16 at 11:56 a.m. The resident's diagnoses included, but were not limited to, dementia with behaviors,</p>	F 0329	<p>Behavioral documentation to support the justification of the use of Seroquel for Resident #41 is currently being completed by the facility staff as behaviors occur. All other residents receiving psychotropic medications, including antipsychotics, have the potential to be affected. Behavioral documentation to support the justification of the use of the antipsychotic is being completed by the staff as behaviors occur. If found to not be experiencing behaviors, Vanguard has been contacted for orders in an effort to reduce the medication. The facility's policies for behavior management and antipsychotic drug use have been reviewed and no changes are indicated at this time. The staff have been re-educated on the policies with a special focus on behavioral documentation to support justification for psychotropic use, including antipsychotics. An audit tool has been implemented. The Social Service Director or designee will complete the audit tool to ensure</p>	09/02/2016			

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	<p>organic delusional disorder, depression, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 5/27/16 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 9, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident did not have any mood, behaviors, or indicators of psychosis observed. The assessment indicated the resident received an antipsychotic medication 7 times during the 7 day assessment period.</p> <p>Review of the August 2016 Physician Order Summary (POS) indicated the resident had an order for Seroquel (antipsychotic medication) 100 milligrams (mg). Give 1 and 1/2 tablet to equal 150 mg by mouth at bedtime for delusions. The order had been increased from 100 mg and started on 7/14/16.</p> <p>Review of a Physician Order on 7/14/16 indicated to discontinue Seroquel 100 mg at bedtime, and to start Seroquel 150 mg at bedtime.</p> <p>Review of Social Service notes indicated the resident had not had any documented behaviors since returning from a Psychiatric hospital stay in April 2016.</p>		<p>there is behavioral justification for antipsychotic use. This audit will be completed on scheduled work days as follows: Five residents who receive psychotropic medications will be reviewed daily for two weeks, weekly for two weeks, then monthly thereafter. Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>	

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	<p>Review of a Psychiatric Progress Note dated 7/7/16 indicated: Assessment and Treatment plan and Recommendations were the resident had a delusional disorder. Continue the Seroquel 100 mg every night. Continue to monitor for delusions and redirect when needed and to document accordingly. If problems develop, notify Vanguard (psychiatric medical group) immediately.</p> <p>The record lacked any indication of any documented behaviors or that the psychiatric medical group had been notified of any behaviors between the visit on 7/7/16 and the increase of the antipsychotic medication on 7/14/16.</p> <p>Interview with the Social Service Director on 8/17/16 at 2:20 p.m., indicated the resident had not exhibited any behaviors since April 2016 that she was aware of. She indicated she was unsure why the resident had an increase of the Seroquel on 7/14/16. She further indicated she would have to look into it.</p> <p>Interview with the Corporate Consult for Social Services on 8/17/16 at 3:19 p.m., indicated he could not find any indication of why the resident's Seroquel had been increased. He indicated he could not find</p>			

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F 0465 SS=E Bldg. 00	<p>any indication that would justify an increase of the medication. He further indicated the facility should have contacted the psychiatric services first, rather than the doctor who had increased the medication if the resident did have any behaviors.</p> <p>3.1-48(a)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain an environment that was clean and in a state of good repair, related to gouged walls, discolored pull cords, and missing phalange bowl caps for 2 of the 2 Units throughout the facility. (East Unit and South Unit)</p> <p>Findings include:</p> <p>During the Environmental Tour on 8/8/16 from 10:50 a.m. until 11:00 a.m. with the Maintenance Director, the following was observed:</p> <p>1. East Unit:</p> <p>a. In Room 38 the phalange bowl caps</p>	F 0465	<p>The phalange bowl caps have been replaced in the bathrooms in rooms 38, 39, 40, 18, 19, 20. The pull cord has been replaced in rooms 42, 18. Caulking has been replaced around the toilet in rooms 40, 18, 19, 20,21. The walls have been fixed in rooms 40, 16. The bathroom door has been fixed in room 21. The floor is no longer discolored in room 21. The button has been replaced on the call light box in room 21. All other environmental areas used by the residents have the potential to be affected. Rounding has been completed and any area found to be in disrepair has been corrected. The facility's preventative maintenance program has been reviewed and no changes are</p>	09/02/2016

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	<p>for the toilet were missing in the bathroom. Two residents shared this bathroom.</p> <p>b. In Room 39 the phalange bowl caps for the toilet were missing in the bathroom. Two residents shared this bathroom</p> <p>d. In Room 42 the bathroom pull cord was discolored. One resident resided in this room.</p> <p>2. South Unit:</p> <p>a. In Room 40 the caulking around the toilet in the bathroom was discolored, the phalange bowl caps for the toilet were missing, and the wall behind the resident's recliner was gouged. One resident resided in this room.</p> <p>b. In Room 18 the caulking around the toilet in the bathroom was discolored, the phalange bowl caps for the toilet were missing, and the bathroom pull cord was discolored. 3 residents shared this bathroom.</p> <p>c. In Room 19 the caulking around the toilet was peeling and discolored and the phalange bowl caps for the toilet were missing. Three residents shared this bathroom.</p>		<p>indicated at this time. The Maintenance Director has been re-educated on the program with a special focus on maintaining an environment in good repair. An audit tool has been implemented. The Maintenance Director or designee will be responsible for completing the audit tool to ensure the facility's environment remains in good repair. These audits will review five environmental areas utilized by the residents and will be completed on scheduled work days as follows: daily for two weeks, weekly for two weeks, then monthly thereafter. Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated</p>		

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F 9999 Bldg. 00	<p>d. In Room 20 the caulking around the toilet was peeling and discolored and the phalange bowl caps for the toilet were missing. Three residents shared this bathroom.</p> <p>e. In Room 16 the wall by the head of the resident's bed was gouged. One resident resided in this room.</p> <p>f. In Room 21 the inside bottom of the bathroom door was gouged, the floor around the toilet was discolored and missing caulk, and the call light box on the wall above the bed was missing a button cover. Two residents resided in this room and three residents shared this bathroom.</p> <p>Interview with the Maintenance Director at the time of the tour, indicated all of the above were in need of repair.</p> <p>3.1-19(f)</p>	F 9999	The mantoux test is now current for Cook #1, Maintenance Supervisor, and CNA #2. Inservices for Resident Rights and 3 hours of Dementia training	09/02/2016
	3.1-14 Personnel (q) Each facility shall maintain current and accurate personnel records for all			

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	<p>employees. The personnel records for all employees shall include the following:</p> <p>(6) Position in facility and job description</p> <p>(7) Documentation of orientation to the facility and to the specific job skills.</p> <p>(8) Signed acknowledgement of orientation to residents' rights.</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment...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 non paid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test 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>(3) The facility shall maintain a health record of each employee that includes:</p> <p>(A) a report of the preemployment physical examination;</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a</p>		<p>have been completed for Cook #1, Maintenance Supervisor, and CNA #1. Three hours of Dementia training has been completed for Housekeeper #1, RN #1, and CNA #2. A specific job description has been completed for Activities Assistant #1 and Host #1. A first and second step Mantoux has been completed for LPN #1. A physical has been completed for LPN #1. All employee files have been reviewed and if records were found to have missing items, the noted items have been completed. The Business Office Manager has been educated related to what needs to be completed and placed in employee files. An audit tool has been implemented. The Business Office Manager or designee will complete the audit tool to ensure employee files are complete. These audits will review five employee files on scheduled work days on a weekly basis. Should a concern be noted, immediate corrective action will occur. Results of these reviews will be discussed during the facility's monthly QA meetings on an ongoing basis for a minimum of 6 months and the plan adjusted if indicated.</p>		

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	<p>minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure personnel records were complete, related to Mantoux (tuberculosis testing) testing, job specific orientation, job descriptions, physical exam, and dementia training, for 9 of 12 employee files reviewed. (Cook #1, Housekeeper #1, Activities Assistant #1, LPN #1, Maintenance Supervisor, RN #1, CNA #1, Host #1, and CNA #2)</p> <p>Findings include:</p> <p>Employee files were reviewed on 8/17/16 at 2:00 p.m. and the following were not included in the Personnel File:</p> <p>Cook #1 (hired 7/20/1994): No current Mantoux test was available and yearly</p>			

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	<p>inservices on Resident Rights and three hours of dementia training were not completed.</p> <p>Housekeeper #1 (hired 6/10/2015): Three hours of yearly dementia training had not been completed.</p> <p>Activities Assistant #1 (hired 6/14/16): No specific job description had been completed.</p> <p>LPN #1 (hired 6/24/16): No first and second step Mantoux was available and no pre-employment physical had been completed.</p> <p>Maintenance Supervisor (hired 7/26/2013): No current Mantoux test was available and yearly inservices on Resident Rights, abuse, and three hours of dementia training had not been completed.</p> <p>RN #1 (hired 9/19/2006): Three hours of dementia training had not been completed.</p> <p>CNA #1 (hired 8/16/2003): Yearly inservices on Resident's Rights, abuse and three hours of dementia training were not complete.</p> <p>Host #1 (hired 7/5/2016): A job</p>			

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	<p>description had not been completed.</p> <p>CNA #2 (hired 5/22/2015): No current Mantoux test was available and three hours of yearly dementia training were not completed.</p> <p>During an interview with the Administrator on 8/18/16 at 1:30 p.m., she indicated the yearly Mantoux testing for CNA #2 was missed and should have been completed May 18 of this year.</p> <p>Interview with the Regional Director on 8//18/16 at 3:14 p.m., indicated the employees listed above were missing or had not completed the listed tasks.</p> <p>3.1-14(q)(6) 3.1-14(q)(7) 3.1-14(q)(8) 3.1-14(t)(1)</p>			