

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2012
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NAME OF PROVIDER OR SUPPLIER CHATEAU OF BATESVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 CHATEAU BLVD BATESVILLE, IN 47006
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R0000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: March 26, 27 and 28, 2012</p> <p>Facility number: 006489 Provider number: 006489 Aim number: NA</p> <p>Survey Team: Cheryl Fielden RN, TC Jill Ross, RN Janie Faulkner, RN</p> <p>Census bed type: Residential: 40 Total: 40</p> <p>Census payor type: Medicaid: 12 Other: 28 Total: 40</p> <p>Sample: 7</p> <p>These state residential finding are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed 4/1/12 Cathy Emswiller RN</p>	R0000	<p>This plan of correction is neither an agreement nor an admission of wrong doing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of April 11, 2012 and requests paper compliance for this survey.</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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R0006	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interview the facility failed to timely discharge a resident who became a danger to self and others. This affected 1 of 2 closed records in a sample of 7 residents reviewed. (Resident # 43)</p> <p>Findings included:</p> <p>During the closed record review for Resident # 43 on 3/28/2012 at 9:30 A.M., indicated the resident was admitted with, but not limited to hypothyroidism, diabetes mellitus, hypertension, arthritis,</p>	R0006	R006 Facility policy for admission/discharge is consistent and in accordance with IAC 410 16.2-5-0.5(f)(1-5). This same policy is included in the resident's admission packet. The timing of the discharge on this particular resident was complicated due to a family member being resistant to move the resident twice; that is, once to a comprehensive care facility in Indiana and then a second move to a facility in Florida. According to the family member (who lives in Florida), the resident had been on a waiting list at the Florida facility for quite some time at a facility that is near	04/11/2012			

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	<p>degenerative joint disease, and chronic transient ischemic attack.</p> <p>Review of an Incident/Accident Report dated 9/26/11 indicated, "[Resident's name] was verbally abusive to another resident. [Resident's name] rode in the back of vehicle during transportation from while other resident rode in the front seat. [Resident's name] became very angry over seating and stated that he had never hit a woman before, but he would like to hit her." "He told her this again after they arrived back to the facility."</p> <p>Review of Incident/Accident Report dated 10/21/11 at 11:00 P.M. indicated resident # 43 fell trying to get out of bed to go to the bathroom. Resident stated he was fine, cleaned up cut on right forearm with normal saline and applied bandage.</p> <p>Review of Incident/Accident Report dated 11/15/11 at 4:30 P.M. indicated Resident # 43 transferred from electric scooter to dining room chair. Dining room chair rolled and resident fell on his bottom. Staff assisted resident into chair with no complaints of pain. Notified doctor and resident's daughter.</p> <p>An Incident/Accident Report dated 12/3/11 at 3:30 P.M., indicated "Resident stated, I fell but don't know what</p>		<p>the family member's residence. As the resident's number of falls began to increase, the facility continued to emphasize to the family member the urgency of transferring the resident to a comprehensive care facility. Finally, and after the number of falls was unacceptable to our facility and a clear risk to the resident, the family member agreed to the transfer and then flew to Indiana to help transfer the resident to the comprehensive care facility. Therefore, this discharge ultimately resulted in a unique and isolated occurrence for our facility. We continue to abide by the facility policy which remains within the spirit of the licensure rules for all facility admissions and discharges. General Manager will continue to monitor.</p>				

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	<p>happened." "Denies hitting head" Res refused to have family notified, doctor notified."</p> <p>Review of Incident/Accident Report dated 12/5/11 at 3:35 A.M., indicated "Resident pushed pendant complained of being numb down arms and back, did not feel right requested 911. 911 called. Resident refused being transported."</p> <p>An Incident/Accident Report dated 12/11/11 at 1:00 P.M., indicated, "Resident was getting out of motorized wheelchair and he said, 'legs gave out' fell against the wall that separates the dining room kitchen from living room. Denies LOC [loss of consciousness] was getting up on his own when he called for help".</p> <p>Review of an Incident/Accident Report dated 12/13/11 at 7:50 P.M., indicated "Resident stated his legs gave out on him while attempting to get out of bed", 3" abrasion noted on his back, resident denies hitting his head." Notified daughter and doctor.</p> <p>An Incident/Accident Report dated 12/16/11 at 6:30 P.M., indicated "Resident lost balance while getting out of motorized scooter. Slid to floor."</p> <p>Review of an Incident/Accident Report</p>						

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	<p>dated 12/16/11 at 11:00 P.M., indicated "Resident was coming back to bed from restroom and lost balance, very unsteady gait recently, slightly confused or disoriented, had to reorient resident to time. Alert & oriented X 2, bandage to right elbow." "Instructed resident to call office(and provided number) if resident needs to get up or transfer."</p> <p>An Incident/Accident Report dated 12/18/11 at 10:45 A.M., indicated Resident # 43 was walking out of bathroom and he stated "it's my legs they just gave out on me!" Denies hitting his head. Notified the doctor and the resident's daughter.</p> <p>Review of an Incident/Accident Report dated 12/25/11 at 2:00 A.M., Resident stated, " my legs gave out", and he fell to the floor. "Assisted resident up, denied pain, 30 min. later Pt complains of leg, shoulder and back pain/spasms.""Resident refused to go to hospital to be treated." Notified Doctor and Resident's daughter.</p> <p>An Incident/Accident Report dated 12/30/11 at 3:30 P.M., indicated Resident was heard yelling for help, entered room & pt was in BR [bathroom] in the shower in sitting position. When asked what happened, resident replied, "I honestly</p>						

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	<p>don't know", denies hitting head. Doctor and daughter notified.</p> <p>Review of an Incident/Accident Report dated 1/2/12 at 3:30 P.M., indicated resident was heard calling out for help. Resident was on floor in the bedroom. States "I was going to go to the bathroom & I don't know what happened". Denies hitting head. Notified the daughter and the doctor.</p> <p>An Incident/Accident Report dated 1/12/12 at 8:45 P.M., indicated "Resident fell between bed & electric wheelchair, was yelling for help. Went to resident's room was yelling to get him up. So had to help get him up."</p> <p>Review of Incident/Accident Report dated 1/18/12 at 2:30 P.M. "found on bathroom floor by 1st floor laundry. Res. states knees just gave out. Denies hitting head and pain, no apparent injury noted".</p> <p>An Incident/Accident Report dated 1/20/12 at 10:30 P.M., indicated "Resident getting into bed, fell between wheelchair & bed. Ref[refused] med. [medical] treatment. c/o right side ribs hurting. Had to have CNA to help up off floor". Doctor and resident's daughter notified.</p>						

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	<p>Review of an Incident/Accident Report dated 1/24/12 at 2:00 A.M., indicated "Resident stated he slid off bed and fell trying to get back up. Denies hitting head and any injuries other than two skin tears on right upper arm and elbow, bandage applied to right arm and elbow." Notified doctor and resident's daughter.</p> <p>An Incident/Accident Report dated 1/30/12 at 8:40 P.M., indicated, Resident states "I guess my feet & legs quit working." Resident attempting to get into bed by standing up & turning all the way around, showed resident easier way to get into bed. Notified doctor and the resident's daughter.</p> <p>Review of Incident/Accident Report dated on 2/8/12 at 12:00 A.M., "Resident's neighbor calls CNA and reports Resident # 43 is calling for help" "CNA finds resident in WNL [within normal limits] for resident." "Resident confused/disoriented." "Advised resident to call for help before transferring and ambulating." Doctor notified.</p> <p>An Incident/Accident Report dated 2/8/12 at 1:00 A.M., indicated "Resident's neighbor calls CNA and reports Resident #43 is yelling for help...again" CNA finds resident WNL for resident confused/disoriented. "Advised resident</p>						

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	<p>to call for help before transferring and ambulating."</p> <p>"A physician order for physical therapy on 12/19/11 due to frequent falls." A nurse's note dated, 2/2/12 at 3:00 P.M., "Lg [large] purple bruise noted on R [right] hip, slightly swollen. Res states he did not fall but unable to tell me how he got the bruise. Res is also c/o R rib pain. Called Dr.'s name's office N.O. [new order] OK to send to [Name of Hospital] for x-ray of R hip & R ribs". X-ray report dated 2/2/2012 indicated acute to subacute fractures of the posterior right seventh and eighth ribs, no fracture or dislocation involving right hip.</p> <p>"A nurse's note dated 2/9/12 at 3:30 PM, Call placed to Res daughter [name of daughter] by the Administrator, to discuss res. recent decline, daughter agreed to LTC placement at this time. writer informed via Administrator." Signed by Director of Health Services.</p> <p>On 2/14/12 at 2000 [8:00 P.M.], nursing note indicated, "Res conts [continues] to require asst [assistance] from staff for all transfers. Res was lying in bed c [with] pants et [and] pull - ups pulled halfway down, filled c urine. Assisted res up cleaned et dressed res. Bed stripped et new sheets put on." States, "I just want to</p>						

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	<p>die" B/P 124/62 P 74 R 20 T 97.8."</p> <p>A nurse's note dated 2/17/12 at 10 AM, "T 97.2, P 71, R 24, B/P 147/89, Res showered, Meds[medications] pulled, incont [incontinent] of BM [bowel movement] X 2 thus far, D/C'd to local long-term care facility @ 0930 via their transport, daughter @ side."</p> <p>Review of the facility "Admission and Discharge Criteria Policy" provided by the Director of Health Services on 3/28/2012 at 12:40 P.M., indicated as their current policy and procedure. Policy: "It is the policy of this facility to ensure residents meet regulatory rules in regards to discharge from residential facility.</p> <p>The resident must be discharged if the resident:</p> <ul style="list-style-type: none"> * Is a danger to the resident or others * Requires twenty-four (24) hour per day comprehensive nursing care * Requires twenty-four (24) hour per day comprehensive nursing oversight or rehabilitative therapies and has not entered into a contract with a licensed provider * Is not medically stable * Meets at least two of the following criteria unless the resident is medically 						

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	<p>stable and the health facility can meet the residents needs.</p> <ul style="list-style-type: none"> o Requires total assistance with eating o Requires total assistance with toileting o Requires total assistance with transferring <p>During an interview with the Executive Director on 3/28/2012 at 11.30 P.M., he stated "Facility felt that transfer for Resident [name] # 43 was voluntary and he had been in contact with the daughter in Florida and she said she had him on a waiting list for facility in Florida." "Then it got so bad we had to call her and she got on a plane and came up."</p> <p>Interview with Director of Health Services on 3/28/2012 at 12:45 P.M. regarding length of time Resident # 43 was kept in facility after his verbal disrespect to another resident and she stated, "I was not the Director of Health Services at that time, I've been in my position about three weeks." "Yes, I see that we should have transferred him sooner, but the daughter kept telling us he was on a waiting list for a facility in Florida." "When she finally agreed to transfer to long term care, refused to take him due to care issues." "On 2/14/12 resident's daughter, called and said</p>						

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	someone will be here this afternoon to assess for LTC placement per her request. "A local long-term care facility accepted him and he was transferred on 2/17/12."				

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R0273	<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 interview, record review and observation the facility failed to provide sanitary conditions during food preparation and meal service in that hairnets were not worn and gloves were used inappropriately. This affected 38 out of 40 residents who received meals from the facility.</p> <p>Findings include:</p> <p>A. During observation in the kitchen on 3/26/12 at 9:40 a.m., the staff were observed to be wearing baseball caps and no hairnets. Cook #1 had a ponytail hanging out the back of the cap. When she moved her head around the equipment the hair would rub against the equipment.</p> <p>In interview on 3/26/12 at 9:45 a.m., Cook #1 indicated that according to their rules the caps were sufficient.</p> <p>On 3/26/12 at 10:20 a.m. it was observed that all dietary staff were wearing hairnets and the caps.</p>	R0273	R273 Facility policy regarding food and nutritional services is in accordance with 410 IAC 16.2-5-5.1 and in accordance with 410 IAC 7-24. Hairnets and/or hats are worn in order to cover all exposed hair. In addition, dietary employees have been in-serviced regarding the proper timing and proper use of gloves within the dietary department as well as a review of hand washing. Dietary Manager and General Manager will continue to monitor.	04/11/2012			

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	<p>In interview with the Dietary Manager on 3/27/12 at 10:30 a.m., she indicated she had no policy and procedure regarding hair covering for dietary.</p> <p>In interview on 3/27/12 at 12:50 p.m. the Dietary Manager indicated that as far as the regulations went she thought that the caps were sufficient hair covering for all staff in the kitchen.</p> <p>On 3/28/12 at 8:15 a.m. the Dietary Manager presented a copy of a portion of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENTS" with an effective date of November 13, 2004. In section "410 IAC 7-24-138 Effectiveness of hair restraint Sec. 138. (a) Except as provided in subsection (b), food employees shall wear hair restraints, such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting: (1) exposed food; (2) clean equipment, utensils, and linens;..." The Dietary Manager indicated that this is what she goes by as her guidelines for hair covering.</p> <p>B. During observation of food service on 3/26/12 at 11:20 a.m., Cook #1 used gloves to serve food, go to the refrigerator, open the door, remove butter</p>						

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	<p>and go back to serving food with the same gloves. Also observed during this same time was Dietary Aide #1 wearing the same gloves to serve multiple residents their food, open the refrigerator, get out milk, get glass and pour the milk, go back to serving food to other residents. No gloves were changed and no handwashing was done.</p> <p>In interview with the Dietary Manager on 3/27/12 at 10:30 a.m., she indicated she had no policy and procedure for wearing gloves/glove use in the dietary department.</p> <p>On 3/27/12 at 1:45 p.m., an inservice information paper for handwashing was brought in by the Dietary Manager. In review of this inservice with a date of March 2012 and titled, "Why wash?" under the titled area of "When to Wash" it indicates:..."After touching unclean equipment or work surfaces...Gloves- Gloves need to be changed after each client contact..." This was the only information the facility indicated they could find regarding a policy and procedure for glove use.</p>						

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R0304	<p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation and interview the facility failed to ensure that residents medications were kept behind locked closed door when authorized staff is not present.</p> <p>Findings included:</p> <p>"During the initial tour of facility with the Director of Health Services on 3/26/2012 at 10:45 A.M., she indicated all resident charts are kept in her locked office when she is not in her office."</p> <p>On 3/27/12 at 1:35 P.M., the DON's office was found with door open. Medications for residents were in milk size crate filled front to back, top to bottom with individual blister packets of medications from the new pharmacy on the floor just inside door. CNA came out of room across the hall and went to get the DON. This room was observed to be unattended by any staff member for 5 minutes. Just a few feet away was a</p>	R0304	R304 Facility policy is to have all medicine cabinets/rooms locked at all times unless authorized personnel are present. This event was an isolated occurrence and was simply an employee error which had no negative outcome with regard to any resident. This event was corrected immediately and nursing staff was inserviced regarding this issue. Director of Nursing will continue to monitor.	04/11/2012			

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	<p>resident sitting on a couch. In the main lobby there was an activity (singer) with 12 residents present."</p> <p>During an interview with the Director of Health Services on 3/27/12 at 2:45 P.M., she indicated the medications in the crate in her office had been delivered by their new pharmacy for all residents and her office door should have been shut and securely locked to ensure no unauthorized person has access to residents medications.</p>			

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R0354	<p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on record review and interview the facility failed to provide information to a long term care facility receiving their resident. This affected 1 of 1 residents reviewed for transfer from facility in a sample of 7. (Resident # 43)</p> <p>Findings included:</p> <p>During the record review for Resident # 43, on 3/28/2012 at 9:30 A.M., nurse's note dated "2/17/12 at 10:00 A.M. indicated, T [temperature] 97.2, P [pulse] 71, R [respirations] 24, B/P [blood pressure] 147/89, Res [resident] showered, meds [medications] pulled, incont [incontinent] of BM [bowel</p>	R0354	R 354 The facility policy is to provide the facility that the resident is being transferred to with a form containing the data described in accordance with 410 IAC 16.2-5-8.1(g)(1-7). We have obtained a new form from the Indiana State Health Department (form 49669) and this form, along with another form entitled "Discharge Instructions for Care" is now being sent with every discharge. We began using these forms immediately and implemented this new policy prior to the surveyor's exit conference. Director of Nursing will monitor.	04/11/2012			

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	<p>movement] X 2 thus far, D/C'd [discharged] to Name of other Facility @ 0930 via Name of other Facility transport, daughter @ side" signed by the Director of Health Services.</p> <p>In an interview with the Director of Health Services at 10:10 A.M. on 3/28/2012, discussed information provided to Name of other Facility when Resident # 43 was transferred from their facility. Director of Health Services stated, "I did not have transfer forms at that time, but I have ordered some to have for the next time." "I sent all of his medications with him to Name of other Facility, so they would have medications." "I gave them to his daughter along with all of his belongings."</p>						

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R0356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>A. Based on interview and record review the facility failed to ensure the resident emergency files were accurate and complete, in that 31 of 40 resident files in a sample of 40 did not include a gender (male, female). (Residents # 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 29, 31, 32, 33, 34, 36, 38, 39, 40)</p> <p>B. Based on interview and record review the facility failed to ensure the resident emergency files were accurate and complete, in that 5 of 40 residents in a sample of 40 did not have an emergency</p>	R0356	R 356 Facility policy was to have the resident's picture along with their name on the resident face sheet within the emergency file. The facility has since added the resident's gender to the face sheet form. This change was implemented immediately to all of the emergency files and was completed prior to the surveyor's exit conference. Director of Nursing will continue to monitor.	04/11/2012			

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	<p>file. (Residents # 12, 14, 26, 30 and 37)</p> <p>Findings include:</p> <p>A. Review of the emergency files provided by the DON on 3/28/12 at 10:30 a.m. included but was not limited to the gender (male-female) of residents. No gender was indicated in 31 residents files, residents # 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 29, 31, 32, 33, 34, 36, 38, 39, 40.</p> <p>Interview with the DON on 3/28/2012 at 11:00 a.m. indicated that 31 of 40 residents did not have their gender (male, female) identified in the emergency file.</p> <p>B. Review of the emergency files provided by the DON on 3/28/2012 at 10:30 a.m. indicated residents # 12, 14, 26, 30 and 37 did not have an emergency file.</p> <p>Interview with the DON on 3/28/2012 at 11:00 a.m. indicated that residents # 12, 14, 26, 30 and 37, did not have an emergency file.</p>						

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R0410	<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 a tuberculosis mantoux test was given in a timely manner. This affected 1 of 7 in a sample of 7 residents reviewed for tuberculosis mantoux test. (Resident # 28)</p> <p>Findings included:</p> <p>During the record review for Resident # 28 on 3/26/2012 at 3:00 P.M., indicated the resident was admitted with, but not limited to the following diagnoses:</p>	R0410	R 410 Facility policy is in accordance with 410 IAC 16.2-5-12(e-g) in that, for new residents, a tuberculin skin test shall be completed within three months prior to admission or upon admission. This facility policy continues to remain in effect and this particular incident was an isolated occurrence (a nursing oversight) that had no negative impact on any resident. The General Manager has in-serviced the current Director of Nursing regarding the timeliness of tuberculin skin testing in relationship to new resident admissions. General Manager	04/11/2012			

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	<p>pneumonia, chronic airway obstruction, diastolic heart failure, coronary artery atherosclerosis, restless leg syndrome, Bipolar I -depressed, lumbar disc disorder, and sleep apnea. Resident # 28 was admitted to the facility on 11/5/2011.</p> <p>Review of the facility Vaccination Flow Sheet for Resident # 28, indicated the resident received her first step mantoux test on 11/19/11 and was read on 11/22/11. This resident received her first tuberculosis mantoux test 14 days late. The second tuberculosis mantoux test was given on 12/3/11 and read on 12/6/11. During an interview with Resident # 28 on 3/28/2012 at 9:45 A.M., she stated, "I never lived in any kind of facility until now, no I never had TB test until after I came here."</p>		will continue to monitor.				