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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155026 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/09/2015 |
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| NAME OF PROVIDER OR SUPPLIER GREENWOOD VILLAGE SOUTH | STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN 46143 |
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| F 000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 30, 31, April 1, 2, 3, 6, 7, 8, and 9, 2015</p> <p>Facility number: 000010 Provider number: 155026 AIM number: 100453660</p> <p>Census bed type: SNF: 32 SNF/NF: 65 Residential: 38 Total: 135</p> <p>Census payor source: Medicare: 18 Medicaid: 40 Other: 39 Total: 97</p> <p>Residential sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> | F 000 | <p>Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. IN fact, Greenwood Village south reserves the right to challenge in legal proceedings all deficiencies, statements, finding, facts, and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.</p> | |
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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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| F 279 SS=D Bldg. 00 | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 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, interview and record review, the facility failed to develop comprehensive care plans for 1 of 5 residents reviewed for unnecessary medication use (Resident #41) and for 1 of 3 residents reviewed for accidents (Resident #104) and failed to revise comprehensive care plans for 1 of 1 resident reviewed for dental health (Resident #104) and 1 of 3 residents reviewed for incontinence (Resident #40).</p> | F 279 | <p>None of the residents identified experienced any harm. All identified residents care plans were reviewed and updated. It is the policy of GVS to complete Comprehensive Care plans. Res #41 care plan was updated on 4-7-15 and 4-13-15. Res #104 care plan was updated on 4-16-15 and 4-22-15. Res #40 care plan was updated on 4-22-15. All residents had the potential to be affected. No other residents experienced any harm. All resident's care plans will be reviewed developed and revised based on the</p> | 05/09/2015 |

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| | <p>Findings include:</p> <p>1. The clinical record for Resident #41 was reviewed on 4/01/2015 at 3:09 p.m. Diagnoses included, but were not limited to depression, anxiety and atrial fibrillation.</p> <p>Admission physician orders dated 3/8/2015, included duloxetine hydrochloride 60 mg (milligrams) capsule (antidepressant medication), 1 capsule by mouth daily for depression and diazepam 5 mg (antianxiety medication) 1 tablet by mouth three times a day as needed for anxiety. Per pharmacy recommendation 3/9/2015, physician decreased diazepam to a 4 mg tablet by mouth three times a day as needed for anxiety.</p> <p>Minimum Data Set (MDS) admission comprehensive assessment, reference date 3/15/2015, indicated a care plan would be developed for psychoactive medications with the date of completion being 3/19/2015. The Care Area Assessment (CAA) dated 3/16/2015, addressed use of the antidepressant medication, but not the antianxiety medication. The analysis of findings included diagnosis of depression, monitoring of side effects and statement that there was no need to decrease</p> | | <p>resident's comprehensive Assessment. MDS, Clinical Leaders, SS, AT, DT were in-serviced on Comprehensive Care Plan Development and Revision on 4-22-15 DON or Designee will monitor care plans for accuracy through our QA program with audits completed on 5 resident's per week for 90 days, then 5 residents biweekly for 90 days, and then 5 residents quarterly thereafter for one year. Completion date 05/09/2015</p> | |

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| | <p>medication at this time. CAA lacked further analysis of use of the psychoactive medications, including, but not limited to, cause and contributing factors and risk factors related to psychoactive medication use, did not identify behaviors associated with medication use and did not address possible non-drug interventions prior to the use of the anti-anxiety medication.</p> <p>As of 3/26/2015, a comprehensive care plan relative to psychoactive medications had not been completed for Resident #41.</p> <p>During interview 04/01/2015 at 4:30 p.m., MDS Coordinator #2 indicated Social Service staff were responsible for the completion of care plans for psychoactive medications. MDS Coordinator #2 indicated a comprehensive care plan relative to psychoactive medications had not been completed for Resident #41 by 3/26/2015, as defined by MDS regulation and facility policy.</p> <p>During interview 04/02/2015 at 12:01 p.m., Social Service Director indicated Social Service staff were responsible for the completion of care plans for psychoactive medications. Social Service Director verified a comprehensive care plan relative to psychoactive medications</p> | | | |

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| | <p>had not been completed for Resident #41 by 3/26/2015.</p> <p>On 4/2/2015 at 10:40 a.m., the Director of Nursing presented the policy on Comprehensive Care Plans, not dated, and indicated the policy was the current one being used. Policy indicated that the resident's comprehensive care plan was to be developed within 7 days of the completion of the resident's comprehensive assessment.</p> <p>2. The clinical record for Resident #104 was reviewed 4/2/2015 at 2:29 p.m. Diagnoses included, but were not limited to, anxiety, depression, irritable bowel syndrome and chronic back pain.</p> <p>Minimum Data Set (MDS) Comprehensive assessment, reference date 10/12/2014, and MDS Quarterly assessment, reference date 1/23/2015, indicated the cognition of Resident #104 was intact and resident required extensive assistance with 1 person physical support for majority of activities of daily living.</p> <p>Review of fall incidents for Resident #104 from September 2014 through March 2015, indicated the resident deliberately placed herself on floor in her room on 9/15/2014, 10/4/2014, and 2/24/2015. Fall incident on 9/15/2015,</p> | | | |

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| | <p>indicated cause of incident was attention seeking and occurred when resident felt like she did not get enough attention from staff. Nurse progress notes dated 10/4/2014, indicated the resident gave a reason why she continued to place self on floor as being that she wanted to slide to floor, because there was nothing better to do. Resident told nurse that maybe her daughter would come if staff called her and told daughter resident was on the floor.</p> <p>During an interview on 04/02/2015 at 3:40:07 p.m., RN #4 indicated resident deliberately puts herself on floor and tells staff she does it on purpose as she knows staff will come.</p> <p>Psychotherapy progress notes 2/4/2015, 2/18/2015, and 3/18/2015, identified that a stressor of Resident #104 was worrying about others. Notes identified resident's coping skills included distraction techniques, prayer, resting and visiting. Psychotherapy progress note 2/26/2015, indicated resident seemed to enjoy manipulating staff to do tasks that resident was capable of accomplishing herself.</p> <p>As of 4/6/2015 a comprehensive care plan had not been developed to address the specific behavior of Resident #104</p> | | | |

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| | <p>routinely placing self on floor. Only an intervention on the fall care plan of educating resident on risks and benefits of placing self on floor and potential injury addressed resident's behavior. Frequency and impact of behavior on resident or others had not been analyzed to assist in development of a care plan. An in-depth evaluation relative to resident's need for attention and manipulative behavior, as well as stress factors and coping skills, had not been completed to address in care plan.</p> <p>During interview on 4/6/2015 at 2:00 p.m., Social Service Director and RN #4 indicated a comprehensive care plan had not been developed for Resident #104 specific to the behavior of deliberately placing self on floor.</p> <p>3. The clinical record for Resident #104 was reviewed 4/2/2015 at 2:29 p.m. Diagnoses included, but were not limited to, anxiety, depression, irritable bowel syndrome and chronic back pain.</p> <p>Quarterly Minimum Data Set (MDS) assessment with reference date 1/23/2015, indicated resident's cognition was intact, received a mechanically altered diet and had no dental issues.</p> <p>On 04/01/2015 at 10:49 a.m., lower teeth</p> | | | |

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| | <p>of Resident #104 were observed to be either missing and/or broken with fragments. Teeth were discolored dark yellow/brown with the appearance of decay. In interview 04/01/2015 at 10:51 a.m., resident indicated her bottom teeth were always sensitive and she knew they were decayed. Resident indicated she thought her daughter was going to take her to the dentist, but did not know if or when the appointment was scheduled.</p> <p>Clinical record indicated Resident #104 had a dental exam 6/3/2014, with recommendation that a tooth be extracted due to caries. Extraction was performed 6/9/2014. Dental oral assessment on 6/3/2014, identified plaque, calculus, stains, inflammation, recession, bleeding and gingivitis of resident's lower teeth.</p> <p>Care plan for Resident #104 with effective date 11/3/2013, identified problem of resident having upper dentures and her own lower teeth. Problem included a note "6/9/14 tooth pulled." Goal was that resident would maintain adequate intake of nutrients over the next 90 days. One intervention was to schedule dental evaluation and arrange for follow-up care as indicated. Another intervention included the instructions for care post tooth extraction with status of intervention being active</p> | | | |

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| | <p>and current.</p> <p>Care plan problem had not been updated to address issues of sensitive, broken, and discolored teeth that appeared decayed, nor was the periodontal disease identified in dental exam 6/3/2014, addressed in care plan. Care plan did not identify potential risks, nor impact periodontal disease would have on resident's overall health, nor address goals of prevention of systemic disease or other complications related to poor oral health.</p> <p>In interview 4/2/2015 at 2:00 p.m., MDS Coordinator #3 indicated the care plan had not been updated to reflect the current dental status of resident.</p> <p>4. The clinical record for Resident #40 was reviewed on 4/6/2015 at 9:13 a.m. Diagnoses included, but were not limited to, chronic kidney disease, atrial fibrillation, neuropathy, depression and anxiety.</p> <p>Admission care plan, effective date 8/7/2014, identified problem of resident having episodes of bladder incontinence. Goal was for resident to have no more than three incontinent episodes in a 24 hour period. Interventions included assist to commode upon rising in the am, after meals, at bedtime, upon request and prn</p> | | | |
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| | <p>(as needed); apply moisture barriers; provide hygiene after voiding and bowel movements to prevent skin breakdown; check for incontinence and change if wet/soiled; clean skin with mild soap and water; apply moisture barrier; implement safety measures and select clothing that is easily removed for toileting. Upon readmission from an acute care hospital on 10/20/2015, voiding diary and elimination summary dated 10/20-10/23/2014, indicated a goal of continent 100% of time.</p> <p>Care plan problem did not include any factors that may have predisposed resident to having urinary incontinence, had not identified the possible cause of incontinence or classified the type of incontinence. Care plan goal did not reflect the current goal on the voiding diary and elimination summary. Interventions remained unchanged.</p> <p>In interview 4/6/2015 at 4:49 p.m., Minimum Data Set Coordinator #2 indicated the care plan had not been updated for incontinence of Resident #104.</p> <p>3.1-35 (a) 3.1-35 (c)(1) 3.1-35 (d)(2)(B)</p> | | | |

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| F 323 SS=E Bldg. 00 | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure knives used on a secured dementia unit were secured in a locked drawer. This had the potential to affect 12 of 24 residents residing on the unit. (Residents #3, #83, #65, #50, #86, #60, #34, #92, #143, #138, #1, and #127)</p> <p>Findings include:</p> <p>During a tour of the secured dementia unit on 3/30/15 at 9:45 a.m., 2 knives were found in an unlocked drawer in an open, centralized kitchen area on the unit, which could be easily assessed by a resident. The blade of 1 knife was approximately 10 inches long with a sharp, serrated edge. The blade of the other knife was approximately 10 inches long with a sharp, smooth edge. The drawer was located on the left side of the stove.</p> | F 323 | <p>No residents were found to be affected. All knives were immediately removed from the unit. All drawer locks were repaired.</p> <p>All ambulatory residents in the Sycamore Neighborhood had the potential to be affected. Dietary staff will no longer take sharp knives onto the Sycamore Neighborhood. All foods prepared for the Sycamore Neighborhood will be cut prior to leaving the Dietary Department.</p> <p>All Dietary staff has been in-serviced on the new procedures.</p> <p>Food and Beverage Director or designee will audit drawers and cabinets for the presence of knives and properly functioning locks daily for 30 days; then weekly for 60 days, then quarterly thereafter for one year. Results will be monitored through the QA program.</p> <p>Completion date 05/09/15</p> | 05/09/2015 |

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| | <p>An annual Minimum Data Set assessment (MDS), dated 1/6/15, indicated Resident #65 was severely impaired in her ability to make decisions.</p> <p>An admission MDS assessment, dated 2/21/15, indicated Resident #3 was moderately impaired in his ability to make decisions.</p> <p>A quarterly MDS assessment, dated 3/3/15, indicated Resident #83 was moderately impaired in her ability to make decisions.</p> <p>A quarterly MDS assessment, dated 2/17/15, indicated Resident #50 was severely impaired in her ability to make decisions.</p> <p>A quarterly MDS assessment, dated 1/6/15, indicated Resident #86 was severely impaired in his ability to make decisions.</p> <p>A quarterly MDS assessment, dated 1/6/14, indicated Resident #60 was severely impaired in his ability to make decisions.</p> <p>A quarterly MDS assessment, dated 1/6/15, indicated Resident #34 was severely impaired in her ability to make decisions.</p> | | | |

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| | <p>A significant change MDS assessment, dated 1/30/15, indicated Resident #92 was severely impaired in her ability to make decisions.</p> <p>An admission MDS assessment, dated 1/22/15, indicated Resident #143 was severely impaired in her ability to make decisions.</p> <p>A quarterly MDS assessment, dated 1/2/15, indicated Resident #138 was severely impaired in her ability to make decisions.</p> <p>A significant change MDS assessment, dated 1/17/15, indicated Resident #1 was severely impaired in her ability to make decisions.</p> <p>A quarterly MDS assessment, dated 2/5/15, indicated Resident #127 was moderately impaired in her ability to make decisions.</p> <p>On 4/1/15 at 11:20 a.m., the Unit Manager of the secured dementia unit provided a list of residents who were independently mobile (either ambulatory or in a wheel chair). The list included Residents #65, #3, #83, #50, #86, #60, #34, #92, #143, #138, #1, and #127.</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER GREENWOOD VILLAGE SOUTH | STREET ADDRESS, CITY, STATE, ZIP CODE 295 VILLAGE LANE GREENWOOD, IN 46143 |
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| R 000 Bldg. 00 | <p>On 3/10/15 at 10:09 a.m., Dining Service Staff #9 indicated she was not aware the drawer was unlocked. She indicated the knives were kept in the drawer to be used everyday for lunch preparation.</p> <p>On 3/10/15 at 10:10, the Unit Manager indicated the drawer had a lock on it, but it wasn't catching.</p> <p>3.1-45(a)(1)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> | R 000 | <p>Preparation and execution of this Plan of Correction in no way constitutes an admission or agreement by Greenwood Village South of the truth of the facts alleged in this statement of deficiencies and Plan of Correction. IN fact, Greenwood Village south reserves the right to challenge in legal proceedings all deficiencies, statements, finding, facts, and conclusions that form the basis of the deficiency. This Plan of Correction serves as our credible allegation of compliance.</p> | |

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| R 117 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 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 observation, interview, and record review, the facility failed to ensure all shifts were covered with staff who had a current CPR (Cardiopulmonary Resuscitation) certification and failed to ensure properly trained agency or contract staff person provided care to a resident in the facility. (Resident #400)</p> <p>Findings include:</p> | R 117 | <p>No residents were harmed by this practice. All shifts will be covered with staff that has a current CPR (Cardiopulmonary Resuscitation) certification. Resident #400 has been properly fitted for a wheelchair and is now utilizing it. Both Community and agency staff have been educated on proper use and safety of a rolling walker. Agency staff has been given a facility orientation, safety training and guidance on resident care. All residents have</p> | 05/09/2015 |

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| | <p>During a review of the as worked Nursing Schedule on 4/8/15 at 10:00 a.m., for March 29, 2015 through April 3, 2015, the facility did not have a staff person with a current CPR certification on site for Sunday 3/29/15, night shift and again on Friday 4/3/15, night shift (10:45 p.m.- 6:45 a.m.).</p> <p>On 3/10/15, at 10:10 a.m., the Director of Residential Health Services (DRHS) indicated there was no staff person with a current CPR certification on site for Sunday 3/29/15, night shift or on Friday 4/3/15, night shift (10:45 p.m.- 6:45 a.m.). The DRHS indicated the facility did not have a current policy to ensure 1 staff person was on site at all times with a current CPR certification.</p> <p>2. The clinical record review, completed 4/8/15 at 3:45 p.m., indicated Resident #400 had diagnoses including, but not limited to, severe memory loss and weakness.</p> <p>The resident had a Mini Mental Status Exam completed on 2/7/15. The resident was assessed as scoring 7 out of 30, indicating severe cognitive impairment.</p> <p>During a random observation of Resident #400 on 4/8/15 at 11:30 a.m., the resident was observed sitting on the seat of a rolling walker while being propelled</p> | | <p>the potential to be harmed by this practice. No residents were harmed by this practice. The Director of Residential Health Service/designee will ensure CPR certification upon hire, prior to providing resident care and annually thereafter. Present employees will be required to maintain current certification. The Director of Residential Health Service/designee will audit certification monthly for 3 months and quarterly thereafter for one year. The Director of Residential Health Service/designee will ensure agency staff is given a facility orientation, safety training and guidance on resident care prior to providing resident care. The Director of Residential Health Service/designee will audit agency staff orientation monthly for 3 months and quarterly thereafter for one year. Completion date 05/09/2015</p> | |

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| | <p>down the hallway and into the spa room. Certified Nursing Assistant (CNA) #5 (agency staff person) was observed pushing the resident on the walker.</p> <p>During a random observation of Resident #400 on 4/8/15 at 12:40 p.m., the resident was observed sitting on the seat of a rolling walker while CNA #5 was pushing the walker into the dining room and up to a table. The resident stood up from the walker and sat in a chair at the table.</p> <p>During an interview with CNA #5 at 12:45 p.m. on 4/8/15, CNA #5 indicated the resident had walked part of the way to the dining room, but then complained of being tired and had requested to be pushed on the walker. CNA #5 indicated the resident did not have a wheelchair in her room and CNA #5 was not sure where a wheelchair was located in the facility. CNA #5 indicated this visit was the first time for the CNA to be in the facility and to provide care for the resident, and the facility had not provided guidance prior to the CNA providing care.</p> <p>During an interview with the Director of Residential Health Services (DRHS) and Executive Director (ED) on 4/9/15 11:30 a.m., the ED indicated the facility</p> | | | |

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| R 408 Bldg. 00 | <p>verbally provided information to agency or contract staff when a new staff person was sent to provide care for a resident in the facility, but the facility did not have a formal orientation or checklist of items and information provided to the staff. When asked about transporting a resident on a rolling walker, the DRHS indicated the staff of the facility had been instructed not to transport residents a resident while the resident was seated on a rolling walker.</p> <p>During an observation of the rolling walker belonging to Resident #400 on 4/9/15 at 11:45 a.m., the walker had a manufacturer label affixed to the bar below the seat of the walker. The label indicated, "WARNING: This seat is not intended for transport. While in motion, do not attempt to sit on the seat or transport objects on the seat. Failure to comply may lead to serious injury."</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure a resident had a diagnostic chest x-ray completed within 6 months of admission to the facility for</p> | R 408 | No residents were harmed by this practice. Resident #400 received a chest x-ray 04/23/15. Results were negative. | 05/09/2015 |

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| | <p>1 of 8 residents reviewed for tuberculosis screening. (Resident #400)</p> <p>Findings include:</p> <p>The clinical record review, completed on 4/8/15 at 3:45 p.m., indicated Resident #400 had diagnoses including, but not limited to, severe memory loss.</p> <p>The resident was admitted to the facility on 2/7/15, and had a history of a positive reaction to tuberculin skin testing (a screening skin test for tuberculosis).</p> <p>Chest x-ray results in the clinical record indicated the resident had a chest x-ray completed on 7/9/13.</p> <p>During an interview with the Director of Resident Health Services (DRHS) on 4/9/15 at 3:00 p.m., the DRHS indicated the resident had a chest x-ray completed prior to admission to the independent living area, but did not have a chest x-ray completed prior to admission to the assisted living facility on 2/7/15.</p> | | <p>All residents have the potential to be harmed by this practice. No residents were harmed by this practice. All residents will be audited to ensure a diagnostic chest x-ray has been completed within six (6) months of admission. Any residents without a chest x-ray will have an order for chest x-ray obtained.</p> <p>The Director of Residential Health Service/designee will ensure admission paperwork prior to admission for the presence of a negative diagnostic chest x-ray. The Director of Residential Health Service/designee will audit admission paperwork monthly for 3 months and quarterly thereafter for one year.</p> <p>Completion date 05/09/2015</p> | |