

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00153526.</p> <p>Complaint IN00153526. Unsubstantiated due to lack of evidence.</p> <p>Survey dates: Sept. 8, 9, 10, 11, 12, 15, 16 & 17, 2014</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100287520</p> <p>Survey team: Leslie Parrett RN TC Diana Sidell RN Penny Marlatt RN</p> <p>Census bed type: SNF/NF: 126 Total: 126</p> <p>Census payor type: Medicare: 14 Medicaid: 96 Other: 16 Total: 126</p> <p>These deficiencies reflect state findings</p>	F000000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.	

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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F000323 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 23, 2014 by Cheryl Fielden, RN.</p> <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, interview and record review, the facility failed to ensure the safety of a resident being transferred from toilet to wheelchair with the use of a gaitbelt and locking of the wheelchair wheels, for a resident with a recent femur fracture with no weight bearing to the affected leg for 1 of 4 residents reviewed for accidents. (Resident #68)</p> <p>Findings include:</p> <p>Resident #68's clinical record was reviewed on 9-12-14 at 10:19 a.m. His diagnoses included, but were not limited to a proximal fracture of the right femur on 9-8-14. Review of his most recent Minimum Data Set assessment, dated 7-4-14, indicated he was cognitively intact. The clinical record indicated the resident returned to the facility on</p>	F000323	F323 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: CNA #1 and CNA #3 9/12/14 were in-serviced immediately on proper use of gait belts. CNA #1 and CNA #3 were also in-serviced on proper transfer techniques with return demonstration by Therapy Dept. Res # 68 had his own personal wheelchair, maintenance immediately tightened his brakes for a more secure lock. Gait belt was assigned to res #68. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Mandatory in-service was done to ensure all nursing staff were adhering to the gait belt policy. All staff signed acknowledgement papers of proper use of gait belts. All staffed	10/03/2014

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	<p>9-11-14.</p> <p>A care observation was conducted on 9-15-14 at 11:10 a.m. with Resident #68, CNA #1, CNA #3 and RN #1. The resident was not observed to have a gait belt placed on him prior to or during the transfer and the wheelchair's wheels were not locked during the transfer from the toilet to the wheelchair. CNA #1 and CNA #2 provided extensive assistance to the resident during the transfer and RN #1 was located behind the wheelchair. During the care observation, staff members indicated to the resident to stand and pivot on his "good leg" [left leg] and not bear weight on his "weak leg" [right leg].</p> <p>Once the resident was seated in his wheelchair, he was observed to be transported to his room. CNA #1 was observed to obtain a gait belt while CNA #3 transported the resident to his room. The same staff were observed to assist Resident #68 from his wheelchair to his bed. The resident was observed to have a gait belt applied prior to arising from the wheelchair. The resident's wheelchair was not observed to have the wheels locked prior to the resident arising from the wheelchair.</p> <p>In an interview with CNA #3 on 9-15-14</p>		<p>performed return demon-strations of transfer techniquesincluding use of gait belt. In-service also addressed informing maintenance of any non workingequipment immediately. All roomswere supplied with a coat hook andgait belts for each bed for conven-ience. Completed 9/23/14 & 9/28/14 The measures put into place and the systemic changes made to ensure that this deficient practice does notrecur are as follows: Mandatory in-service was done toensure all nursing staff were ad-hering to the gait belt policy. Allstaff signed acknowledgementpapers of proper use of gait belts.All staffed performed return demon-strations of transfer techniquesincluding use of gait belt. In-service also addressed informing maintenance of any non workingequipment immediately. All roomswere supplied with a coat hook andgait belts for each bed for conven-ience. Completed 9/23/14 & 9/28/14 All new nursing staff will sign acknow-ledge-ment of gait belt policy upon hire. Deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months.Non compliance to gait belt policywill result in following facilitydiscipline process and re-education.DNS/ADNS or designee will do randomchecks on transfers ensuring gait belts</p>				

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F000334 SS=D	<p>at 11:32 a.m., she indicated she did not use the gait belt for the resident while in the bathroom because there were 3 staff present and the resident was able to use the safety rails. She indicated with the second transfer, she remembered to get the gaitbelt. She indicated the resident's wheelchair locks do not lock correctly, so that was why they were not locked. She indicated she had not notified the Maintenance Department yet to repair the wheelchair.</p> <p>On 9-16-14 at 3:10 p.m., the Director of Nursing provided a copy of a procedure, entitled, "Gait Belts," which she indicated to be the current procedure utilized by the facility. This procedure indicated, "The following individuals may have responsibility for gait belts specific to state professional licensing requirements. [It listed] RN, LPN/LVN, CNA." It indicated the purpose as, "Gait belts provide increased security for the resident and staff, and prevent injury during movement of a resident."</p> <p>3.1-45 (a)(1) 3.1-45 (a)(2)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and</p>		are utilized 5x week x 4 weeks, then 3x week x 4 weeks then weeklyx 4 weeks and monthly x 3 months toinclude CNA #1 & CNA #2.	

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	<p>procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes</p>			

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	<p>documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to ensure a newly admitted resident had received education on the influenza vaccine, as well as failed to ensure this same resident had documentation which included the acceptance or declination of the same vaccine upon admission in January, 2014. This practice has the potential to adversely affect 1 of 5 residents reviewed for influenza and pneumococcal immunizations. (Resident 143)</p> <p>Findings include:</p> <p>Resident #143's clinical record was reviewed on 9-15-14 at 1:30 p.m., Her "Record of T.B. [tuberculosis] Tests & Immunization Record." indicated the</p>	F000334	F 334 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: 9/15/14 DNS immediately called sister facility where resident had transferred from and obtained documentation of influenza and pneumococcal vaccines, signed consents for vaccines and given to surveyor team. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: 9/15/14 Immediately all clinical records were audited by DNS/ADNS/Unit RN Spvr to ensure all were in compliance with no deficiencies found. Charts were audited for vaccine consent forms, dates of influenza	10/03/2014	

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	<p>most recent influenza immunization was administered in another facility in October, 2012.</p> <p>In interview with RN #1 on 9-15-14 at 1:45 p.m., she indicated she could not locate in the resident's clinical record the document in which the resident had been offered the influenza vaccine upon admission in January 2014. She indicated the resident had transferred to this facility from a sister facility.</p> <p>In an interview on 9-15-14 at 3:30 p.m., with the Director of Nursing (DON), she indicated she had just looked up the immunization status for Resident #143 via a corporate computer program for when Resident #143 was at the sister facility. She indicated the corporate computer program indicated Resident #143 had received an influenza immunization on 10-1-13.</p> <p>In an interview on 9-15-14 at 4:40 p.m., with the DON, she indicated the previous facility had just faxed over Resident #143's immunization record as well as a consent form for the influenza vaccine that was dated 6-18-13. She indicated, "I have no explanation for why we did not catch that [the lack of consent for the influenza immunization and the October, 2012 date for the last documented</p>		<p>and pneumococcal vaccine administrations and PPD current. 9/22/14 All annual PPD orders were put into PCC system to ensure they are given in 365 days from the date of administration by DNS/ADNS. DNS/ADNS or designee will audit every chart upon admission for compliance to influenza and pneumococcal policy. All new admission PPD orders will be put into PCC system to be administered every 365 days by DNS/ADNS or designee. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DNS/ADNS or designee will audit every chart upon admission for compliance to influenza and pneumococcal policy. All new admission PPD orders will be put into PCC system to be administered every 365 days by DNS/ADNS or designee. This will be on-going. Deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months. Any deficiency to the plan of correction will be addressed immediately during audits.</p>				

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	<p>influenza immunization] when she came in. The...Flu shot and Pneumococcal shot are all part of our [clinical record] audits on a regular basis."</p> <p>On 9-12-14 at 10:01 a.m., the Executive Director provided a policy entitled, "Influenza/Pneumococcal Immunization Guideline." This policy was identified as the current policy utilized by the facility. This policy indicated, "Center will offer and encourage that each resident receive immunization against Influenza annually...The immunization will be administered unless it is medically contraindicated, the resident has already been immunized or the resident and/or responsible party refuses the immunization...Upon admission to the center the resident and/or responsible party will be given education of the risks and benefits of receiving the Influenza and Pneumococcal immunization vaccine. (Centers for Disease Control Vaccine Information Sheets)...The resident and/or responsible party will be required to sign the Immunization Consent or Declination Form. The Resident Annual Consent or Declination Form will be signed each year as proof that education of risk/benefits was provided on the Influenza vaccine...The original copy of the Immunization Consent or Declination Form will be</p>			

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F000371 SS=E	<p>maintained on each resident's current medical record in the same section as the Immunization log [sic]...The center will administer the Influenza vaccine each fall when the vaccine is available to the living center and will continue to be administered throughout the influenza season (October 1 through March 31)..."</p> <p>3.1-13(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions A. Based on observation, interview, and record review, the facility failed to ensure the high temperature dishwasher reached a rinse cycle temperature of at least 180 degrees for 3 of 3 attempts and 1 of 1 observation. This had the potential to affect 126 of 127 residents currently residing in the facility. B. Based on observation and interview the facility failed to provide a safe and sanitary dining environment for 1 of 7 residents' observed for dining in the Center hall assisted dining room and 1 of 12 residents' observed for dining in the</p>	F000371	F371 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: 9/8/14 Maintenance was called immediately. Problem was fixed fuse was blown. Temp tested reading of 187 and recorded. Dishes washed in correct temp. 9/8/14 CNA #1 and CNA #2 were immediately counseled on proper handling of food while feeding a resident by DNS. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: 9/9/14 Those employees found to	10/03/2014			

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	<p>Acute Alzheimer's Care Unit (Resident # 119 & Resident # 128).</p> <p>Findings include:</p> <p>A. The initial dietary tour was done on 9/8/14 at 9:02 a.m., with the Director of Dining Services. The Director of Dining Services indicated they have a dishwasher that uses heat sanitation. When the temperature was checked on the dishwasher, the gauge went up to 170, so the Director of Dining Services used a temperature test strip to check the temperature. The temperature test strip did not turn black, which would have indicated the dishwasher had reached the proper temperature. The Director of Dining Services then used a thermometer to check the dishwasher and the thermometer registered 160 degrees Fahrenheit.</p> <p>On 9/8/14 at 9:35 a.m., the maintenance department was notified and Maintenance Staff #6 checked the dishwasher and indicated a breaker was blown, and went to reset it. At that time, the Director of Dining Services indicated she had the staff stop washing dishes and will have them run all the dishes back through after the fuse was changed.</p> <p>On 9/8/14, at 9:42 a.m., Maintenance</p>		<p>have not followed policy were in-serviced immediately. 9/25/14 all dietary staff had completed mandatory in-service on policy for maintaining proper water temperature and monitoring. DSM/ADSM or designee will check temperature of dish-washer prior to cycle 3 times daily to ensure proper temp. Dietary will notify maintenance of any discrepancies. Wash cycle and rinse cycle temperatures will be maintained at manufacturers guidelines. 9/8/14 CNA#1 and CNA #2 were immediately counseled on proper handling of food while feeding a resident. 9/8/14 in-service began for all nursing staff who feed residents on how to properly handle food DNS/ADNS. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: DSM/ADSM or designee will check temperature of dish-washer prior to cycle 3 times daily to ensure proper temp. Dietary will notify maintenance of any discrepancies. Wash cycle and rinse cycle temperatures will be maintained at manufacturers guidelines this will be on going. 9/8/14 in-service for all nursing staff who feed residents on how to properly handle food by DNS/ADNS. Deficient practice was addressed during monthly QAPI meeting and will be</p>		

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	<p>Staff #6 indicated there was a loose wire and was working on it.</p> <p>On 9/8/14 at 9:56, the Director of Dining Services indicated the dishwasher was repaired. The rinse cycle temperature was checked at 10:00 a.m., with the Director of Dining Services, and was 187 degrees.</p> <p>Review of the "Dish Machine Temperature Log", on 9/8/114 at 9:30 a.m., indicated the dish machine temperature log lacked documentation that the wash and rinse temperatures had been logged for the dinner meal on 9/7/14, and the rinse temperature had been documented as 178 degrees for the breakfast meal on 9/8/14. The instructions for the "Dish Machine Temperature Long" indicated: "Please log wash and rinse temperatures when washing dishes after each meal, to insure that the wash and rinse temperatures are properly monitored and controlled. The log should be filled in and signed by those who are directly involved in the dishwashing process...."</p> <p>A policy and procedure for "Dish Machine Use and Care" was provided by the Director of Dining Services, on 9/8/14 at 10:30 a.m. The policy included, but was not limited to, "...Machine Type:</p>		<p>monitored monthly x 6 months. Any non compliance to safe handling of food will be addressed immediately by following facility discipline process and staff re-educated to policy. DNS/ADNS or designee will monitor resident meal times randomly to ensure proper hand washing and food handling are being used while feeding or assisting residents with their meals daily x 4 weeks, 3x week x 8 weeks, weekly x 3 months. Any staff found to be non compliant will be addressed immediately.</p>				

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	<p>High-temperature machine...Rinse: Temperature must be maintained at a minimum of 180 [degrees] F (Fahrenheit) per gauge, 170 [degrees] F per non-mercury thermometer or 160 [degrees] F at point of contact on plates and utensils using a temperature test strip...Completing the Dish Machine Temperature Log: Use the following guidelines to complete the Dish Machine Temperature Log...The dish machine operator should document the temperatures on the Dish Machine Temperature Log. Run two or three empty racks through the dish machine to raise water temperature. Make entries for each meal prior to running dishes. Observe and record actual wash and rinse temperatures and/or chemical concentration in ppm before the dishwashing period. Cease dishwashing if temperatures or ppm are below the required levels. Report temperatures and ppm that are below the required levels to the director of dining immediately....</p> <p>B. On 9/8/14 at 12:20 p.m., observation of the assisted dining room on Center hall indicated 7 residents' being assisted with eating the lunch meal. Resident # 119 was being fed french fries by CNA # 1. CNA # 1 held the french fry up to Resident # 119's mouth for him to take a bite, using her bare hands, no gloves were observed being used. No observation of</p>			
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	<p>hand washing or sanitizing hands prior to feeding Resident # 119.</p> <p>Interview with CNA # 1 indicated she did not know she was not to touch the Resident's food with her bare hands.</p> <p>Observation on 9/8/14 at 12:35 p.m., of the lunch meal on the Acute Alzheimer's Care Unit indicated 12 residents' in the dining room being assisted with their meal. Resident # 128 was in the dining room and CNA # 2 was using a fork and a knife to cut Resident # 128's hamburger in half. CNA # 2 picked up half of the hamburger with her bare hand and handed it to Resident # 128. No observation of handwashing, sanitizing of hands or gloves in use prior to touching the food.</p> <p>Interview with CNA # 2 indicated she was not aware that she was not to touch the Resident's food with her bare hands.</p> <p>On 9/16/14 at 2:50 p.m., Director of Nursing provided a document titled "Hand Washing" and indicated the document was used for CNA training. Review of the document titled "Hand Washing" indicated Responsibility: The following individuals may have responsibility for hand washing specific to state professional licensing requirements RN, LPN/LVN, CNA. Purpose: The purpose of hand washing is</p>			

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F000372 SS=E	<p>to: control infection through medical asepsis, reduce transmission of organisms from resident to resident, reduce transmission of organisms from nursing staff to resident, reduce transmission of organisms from resident to nursing staff. General instructions: Hands should be thoroughly washed before and after providing resident care. Proper hand-washing techniques must be followed at all times. Infection control: Associates will observe universal precautions at all times. Particular questions regarding universal precautions can be found in the Infection Control Manual...</p> <p>3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p> <p>Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly, in that trash and larger items were strewn around the dumpster for 1 of 1 observations. This had the potential to affect 127 out of 127 residents.</p> <p>Findings include:</p>	F000372	F 0372The corrective actions accomplishedfor those residents found to havebeen affected by the deficient practice are as follows:Maintenance immediately removed the pipe and picked up any debris in the area. The dumpster was replaced during the survey.Other residents having the potentialto be affected by the same deficientpractice will be identified and thecorrective actions taken are as follows:Maintenance will follow	10/03/2014

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	<p>During an observation, on 9/16/14 at 2:18 p.m., with the Director of Dining Services, the area around the dumpster was observed to have plastic straws, a piece of insulation approximately one foot by 8 inches that was wet and stuck to the ground, a rusty pipe approximately 18 inches long and 5 inches wide with part of the rounded area of the pipe rusted away and the pipe was laying on a piece of board about 2 feet by 2 feet square. The Director of Dining Services indicated the rusty pipe had been dug up from the kitchen floor back in May.</p> <p>Also observed on the ground around the dumpster were small, half pint milk cartons, plastic bottle lids, plastic straws, plastic lids, a folded towel stuck to the ground. The Director of Dining Services indicated the maintenance department cleans the area and the trash in the dumpster is picked up three times a week.</p> <p>During an interview, on 9/17/14 at 9:50 a.m., the Executive Director indicated the outside areas are inspected quarterly, and provided an "Environmental Safety Inspection Survey Checklist". The checklist indicated, under "General Safety", included the question: "15C: Is all trash and waste in containers; does it need to be picked up more often?" The 3rd quarter box, dated 7/17/14, was</p>		<p>Building Engines Policy and programs that requires weekly inspection of the entire grounds and is recorded as when completed in the program. The Maintenance Supervisor will review this record weekly. Any uncompleted required maintenance past 30 days is escalated to the ED's attention for action, ED will ensure action is followed upon. Any debris will be disposed of properly and areas around dumpsters will remain free of clutter and discarded items. Maintenance Supervisor will ensure by observation that these rounds are being made. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Maintenance will follow Building Engines Policy and programs that requires weekly inspection of the entire grounds. Any debris will be disposed of properly and areas around dumpsters will remain free of clutter and discarded items. Maintenance Supervisor will ensure by observation that these rounds are being made for 6 months he will record if any non-compliance issues are identified. Dietary staff will be instructed to report any concerns to maintenance by utilizing the Building Engines System. Deficient practice was addressed during monthly QAPI meeting and will be monitored</p>	

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F000441 SS=D	<p>checked Yes, and had no notes under "Corrective Action Needed/Taken".</p> <p>A document titled "Preventative Maintenance" indicated a task for daily exterior inspection, that included, but was not limited to, "...4. Keep area around garbage cans clean...."</p> <p>3.1-21(i)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin</p>		monthly for the next six months.	

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	<p>lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on interview and record review, the facility failed to ensure annual tuberculin testing or assessment, which indicated no active state of tuberculosis existed, was conducted for 1 of 5 residents reviewed for current tuberculin testing/assessment. (Resident #143)</p> <p>Findings include:</p> <p>Resident #143's clinical record was reviewed on 9-15-14 at 1:30 p.m. Her "Record of T.B. [tuberculosis] Tests & Immunization Record." indicated the most recent tuberculin skin test was administered on 7-10-13. The clinical record did not indicate a tuberculin risk assessment had been conducted since 7-10-13.</p> <p>In interview with RN #1 on 9-15-14 at 1:45 p.m., she indicated the documentation for the tuberculin testing</p>	F000441	F441 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: 9/15/14 Resident # 143 was given PPD by RN spvr. followed by 2nd step. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: 9/15/14 Immediately all clinical records were audited by DNS/ADNS/Unit RN Spvr to ensure all were in compliance with no deficiencies found. Charts were audited for vaccine consent forms, dates of influenza and pneumococcal vaccine administrations and PPD current. 9/22/14 All annual PPD orders were put into PCC system to ensure they are given in 365 days from the date of administration by DNS/ADNS DNS/ADNS or designee will audit every chart upon admission for compliance to influenza and pneumococcal policy. All new admission PPD orders will	10/03/2014

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	<p>information should be either in the progress notes or with the Immunization Record. She indicated she could not find any of this information in either place for the 2014 year.</p> <p>In an interview on 9-15-14 at 4:40 p.m. with the Director of Nursing, she indicated, "I have no explanation for why we did not catch that [the date when the next tuberculin test would be due] when she came in [was admitted to the facility]." She indicated checking for the tuberculin testing is a part of the facility's routine audits of residents's clinical records.</p> <p>On 9-16-14 at 12:25 p.m., the Director of Nursing provided a policy statement, entitled, "Tuberculosis, Screening Residents for [sic]." This policy was indicated to be the current policy utilized by the facility regarding tuberculin testing for residents. This policy indicated, "This facility shall screen all residents for tuberculosis infection and disease (TB)...The facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of, TB and will check results of recent (within 12 months) tuberculin skin tests...The facility will conduct an annual risk assessment to determine TB risk classification..."</p>		<p>beinputted into PCC system to be admin-istered every 365 days by DNS/ADNS or designee. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: All new admission PPD orders will beinputted into PCC system to be admin-istered every 365 days by DNS/ADNS or designee. This will be monitored by doing new admission chart audits within 24hrs of admission by DNS/ADNS or designee. Deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 mo.</p>	

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F009999	<p>3.1-18(d)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be documented in millimeters of induration with the date given, date read,, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the</p>	F009999	F9999DCE/designee and personnel clerk and disciplines involved in hiring practices will be trained via inservice to ensure PPDs will be completed prior to start of employment in adherence to State guidelines. The Director of Education/Administrative Nurse Designee will ensure by review that documentation is present that confirms that health and TB screenings are present before any newly hired staff are scheduled to work. The Business Office Manager or the Executive Director will review new associate employment files by reviewing the file completion check list and verifying that files for new hires no less than monthly for six months for compliance to TB screening regulations. The check list will be initialed off after the audit by the Executive Director or thier designee. Any non-compliance will result in further review and training for the DCE and the Payroll/Benefits Clerk. Non-compliance with the requirements will be reported to the QAA Committee and any trend of non-compliance will require the QAA Committee to design and implement an action plan of correction. This will be monitored for six months through	10/03/2014			

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	<p>baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure new employees receiving a two-step tuberculin skin test had the second step tuberculin skin test performed one to three weeks, or 7 to 21 days, after the first step tuberculin skin test for 2 of 11 employees reviewed for tuberculin skin tests. (CNA #4 and LPN #1)</p> <p>Findings include:</p> <p>1. 9-16-14 at 11:00 a.m., the employee record for CNA #4 was reviewed. It indicated she began employment on 7-1-14 with the facility. It indicated the first step of the tuberculin skin test was administered on 6-24-14 and the second step of the tuberculin skin test was administered on 7-29-14. This indicated a lapse of 35 days between the first and second steps of the tuberculin skin test.</p>		the QAPI process.				

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	<p>2. 9-16-14 at 11:00 a.m., the employee record for LPN #1 was reviewed. It indicated she began employment on 6-19-14 with the facility. It indicated the first step of the tuberculin skin test was administered on 6-10-14 and the second step of the tuberculin skin test was administered on 8-4-14. This indicated a lapse of 55 days between the first and second steps of the tuberculin skin test.</p> <p>On 9-17-14 at 1:36 p.m., the Executive Director provided a policy entitled, "Infectious Diseases in the Workplace." This policy was indicated to be the policy currently utilized by the facility. This policy indicated, "The Company shall observe applicable federal, state, and local health standards and guidelines, as they develop, concerning employees with infectious diseases...All employees who have direct contact with nursing home residents will complete a baseline TB [tuberculosis] screening test, after they have accepted an offer of employment and prior to beginning work..."</p> <p>3.1-14(t)(1)</p>				