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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155267 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/09/2014 |
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| NAME OF PROVIDER OR SUPPLIER SCOTT VILLA NURSING AND REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 545 W MOONGLO RD SCOTTSBURG, IN 47170 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 2, 3, 4, 5, 6, and 9, 2014</p> <p>Facility number: 000168 Provider number: 155267 AIM number: 100267020</p> <p>Survey team: Gloria J. Reisert MSW - TC Gwen Pumphrey, RN (June 2, 3, 4, 5, and 9, 2014) Chris Greeney (June 2, 3, 4, 5, and 6, 2014)</p> <p>Census bed type: SNF/NF: 63 Total: 63</p> <p>Census payor type: Medicare: 13 Medicaid: 48 Other: 02 Total: 63</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on June 16,</p> | F000000 | <p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request that your office accept this plan as our facility's compliance and that you consider a desk review. Please review our attachments with the plan of correction. The attachments include audit and re-education tools. If you have any questions, please contact Megan Lengerich or Kimberly Smith at 812-752-3499. Thank You in advance for your consideration.</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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| F000309 SS=D | <p>2014, by Brenda Meredith, R.N.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to implement the care plan interventions related to fluid restriction education. This deficient practice affected 1 of 1 dialysis residents reviewed for fluid restrictions. (Resident #40)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #40 on 6/3/14 at 1:30 p.m., indicated the resident had diagnoses which included, but were not limited to renal failure with dialysis and diabetes mellitus.</p> <p>On 5/30/13, the physician gave an order for the resident to be on daily Fluid Restrictions - 1800 ml/day (milliliters/day) for renal failure with the following breakdown:</p> | F000309 | Resident #40 remains at the center. Resident has been assessed by interdisciplinary team (IDT). Care plans have been updated to reflect current status. A one time audit of current resident population of residents on a fluid restriction has been completed. Review of resident chart for documentation of education to resident and family if resident is noted to be non-compliant with fluid restriction. Staff have been re-educated on ensuring documentation is present in medical record when education is given to resident and family when there is non-compliance with fluid restriction. It is the responsibility of the IDT to ensure education is provided when appropriate and there is documentation of the education in the medical record. DON/designee will audit current population of residents under a fluid restriction for | 07/07/2014 |

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| | <p>- dietary = 1200 ml - nursing = 600 ml (6 a.m. - 6 p.m. = 300 ml; 6 p.m. to 6 a.m. = 300 ml)</p> <p>On 1/16/14, the resident's "Nutrition Risk Care Plan" had been re-written by dietary, with review dates of 1/29/14, 2/10/14, 3/7/14, 3/13/14, 3/24/14, 4/23/14, 5/13/14 and 6/2/14 in order to add new interventions.</p> <p>The Care Plan problem included "At nutritional risk r/t [related to] Resident is non-compliant with fluid restriction & diet." Approaches included, but were not limited to: "Family brings in food & beverage" and "Nutrition education as needed."</p> <p>A 10/16/13 Registered Dietitian (RD) note; a 10/30/13 RD note, a 1/8/14 Dietary Manager (DM) note; a 3/25/14 DM and 3/26/14 RD note reference the resident continuing to be non-compliant with fluid restrictions and that family will bring in snacks and drinks for resident. Documentation was lacking in which the resident and the family were educated on the importance of sticking to the fluid and food restrictions.</p> <p>During an interview with the resident on 6/5/14 at 10:30 p.m., he indicated that his family brought him in snacks and he</p> | | <p>compliance or non-compliance. Review will address presence of documentation of education to resident and family in the case of non-compliance with fluid restriction. This audit will be completed weekly for 12 weeks, monthly for 3 months, then quarterly for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> | |

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| F000329 SS=G | <p>loved Diet Pepsi and that if his sister brought it in, he would drink it.</p> <p>A 4/6/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident had a BIMS (Brief Interview Mental Status) score of 12 out of 15 - some cognitive problems but able to adequately make decisions.</p> <p>On 6/5/15 at 2:20 p.m., the Dietary Manager indicated "We did care plan that he was non-compliant with his fluids and diet but have not provided the education - we talk with him about his diet and fluid limits but he tells us he likes his extras that family brings."</p> <p>3.1-37(a)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that</p> | | | |

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| | <p>residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor residents receiving diuretic therapy. This resulted in a hospitalization for one resident for low potassium. This deficient practice affected 1 of 2 residents reviewed for hospitalization. (Resident #67).</p> <p>Finding includes:</p> <p>Resident #67's clinical record was reviewed on 6/5/14 at 9:27 a.m. He was admitted to the facility on 4/18/14 after an inpatient hospital stay. He had diagnoses including but not limited to, cellulitis, diabetes, and high blood pressure. Resident #67 was scheduled for surgery on 5/16/14.</p> <p>The residents admission Medication Administration Record (MAR) indicated Lasix (a diuretic medication) 20 milligrams every day.</p> <p>A physicians order dated 4/18/14 and</p> | F000329 | Resident #67 remains at the center. Resident has been assessed by the interdisciplinary team (IDT). Care plans have been updated to reflect current status. A one time audit of current resident population of residents receiving diuretic therapy has been completed. The audit included review of resident charts for documentation of MD notification and of any labs ordered for monitoring of diuretic therapy and review that MD lab orders were followed. Licensed nurses have been re-educated on ensuring there is MD notification of lab results related to monitoring of patients receiving diuretic therapy. Licensed nurses have been re-educated on ensuring MD lab orders are followed. It is the responsibility of the licensed nurse to ensure MD is notified of lab results ordered for monitoring of patients receiving diuretic therapy. It is the responsibility of the licensed nurse to ensure MD lab orders are followed. DON/designee will audit 15% of current population of residents receiving | 07/07/2014 |

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| | <p>untimed, indicated Bumex (a diuretic medication) 2 milligrams twice a day.</p> <p>A physicians order dated 4/26/14 and untimed, indicated Zaroxalyn (a diuretic medication) 2.5 milligrams every day.</p> <p>A physicians order, dated 4/18/14 and untimed, indicated Basic Metabolic Panel (a blood lab test that includes potassium levels) every four days.</p> <p>The Basic Metabolic Panel [BMP] results were reviewed for April 2014 and May 2014. The normal value for potassium is 3.5-5.1 mmol/L (milimoles/liter). The potassium levels for Resident #67 were:</p> <ul style="list-style-type: none"> -On 4/18/14, the potassium level was 3.7 mmol/L. -On 4/22/14, the potassium level was 3.2 mmol/L -On 4/26/14, the potassium level was 3.1 mmol/L. -On 5/14/14, the potassium level was 2.2 mmol/L. -On 5/15/14, the potassium level was 2.9 mmol/L. -On 5/17/14, the potassium level was 3.0 mmol/L. -On 5/18/14, the potassium level was 2.9 mmol/L. <p>The physician was notified of each lab result. Documentation was lacking of</p> | | <p>diuretics. Review will address notification to MD of lab results related to monitoring of residents receiving diuretics. This audit will be completed weekly for 12 weeks, monthly for 3 months, then quarterly for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> | |

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| | <p>any labs between 4/26/14 and 5/14/14. Documentation was lacking that the physician was notified that no labs had been drawn or that the physicians order had changed between 4/26/14 and 5/14/14.</p> <p>Nurses notes, dated 5/15/15 at 11:00 p.m., indicated..."cancel split skin graft surgery for am [morning] and reschedule for 5/19 or 5/20 if possible...."</p> <p>A physicians order, dated 5/15/15 and untimed, indicated to send resident to (named) hospital as direct admit related to hypokalemia (low potassium levels).</p> <p>The History and Physical (H&P) from (named) hospital, dated 5/18/14 at 11:31 p.m., was reviewed. The admitting diagnoses was severe hypokalemia not able to correct by p.o. (by mouth) potassium. The H&P indicated the resident had low potassium levels for four days prior to admission. The note also indicated the resident could not have his scheduled surgery because of severe hypokalemia.</p> <p>The Discharge Summary from (named) hospital, dated 5/22/14 at 11:27 p.m., was reviewed. The note indicated the resident received potassium intravenously.</p> | | | | | | |

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| F000356 SS=B | <p>On 6/4/14 at 1:45 p.m., RN #2 indicated the resident's surgery was postponed due to low potassium levels. She indicated the date for surgery had not been scheduled.</p> <p>On 6/5/15 at 10:11 a.m. the Director of Nursing indicated the BMP should have continued to be drawn unless the physician changed or discontinued the order. She was unable to provide documentation that the order had been changed or discontinued.</p> <p>A copy of the policy titled, " Physician's Orders," was provided by the administrator on 6/9/14 at 12:35 p.m. The policy indicated,"ensure appropriate departments are aware of applicable orders... confirm accuracy of orders when the new monthly orders arrive from the pharmacy...."</p> <p>3.1-48(a)(6)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.</p> | | | | |

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| | <p>o The current date.</p> <p>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview, the facility failed to ensure the daily staff posting of the number of Nurses and Certified Nursing Assistants (CNAs) per shift was current 4 out of 6 survey days. (June 4, 5, 6, and 9, 2014)</p> <p>Finding includes:</p> <p>1. On 6/4/14 at 9:10 a.m., observation of</p> | F000356 | No resident cited. Daily nurse staffing postings were updated on 6/9/14 and have remained current. A staff member has been assigned responsibility to update nurse staffing posting on a daily basis at the beginning of each shift. The assignment includes a plan for holiday and days off. Staff have been re-educated on ensuring daily nurse staffing information is posted. It is the responsibility of the DON/ADON | 07/07/2014 |

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| F000364 SS=E | <p>the posted staffing on the wall in the front lobby indicated the posted date was 6/3/14. At 2:30 p.m., same posting dated 6/3/14 was still observed on the wall.</p> <p>2. On 6/5/14 at 1:20 p.m., the 6/3/14 daily staffing remained posted on wall in the front lobby.</p> <p>3. On 6/6/14 at 8:50 a.m., the 6/5/14 daily staffing remained posted on wall in the front lobby.</p> <p>4. On 6/9/14 at 10:35 a.m., the 6/6/14 daily staffing was posted on the wall in the front lobby.</p> <p>On 6/9/14 at 10:41 a.m., the Administrator indicated that the Director of Nursing or Assistant Director of Nursing were responsible to post the daily staffing every day. She also indicated that it should have been changed out already.</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and</p> | | <p>to ensure daily nurse staffing information is posted.HFA/designee will complete daily review to ensure current nurse staffing hours are posted. This audit will be completed daily (Monday thru Friday) for 4 weeks, weekly for 2 months, monthly for 3 months, then quarterly for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> | |

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| | <p>appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interview, for 30 residents who eat in the main dining area, the facility failed to follow its policy to ensure milk was offered to residents at an appropriate temperature during a lunch meal.</p> <p>Finding includes:</p> <p>During observation of the noon meal, on 6/2/14, milk was observed to be served to residents from a pitcher that was stored on the top shelf of a rolling cart. The pitcher was a glass pitcher and was not stored in ice or had any other visible method of refrigeration. Residents that chose milk during this observation included, but were not limited to, residents #33, #70 and 78. These residents were seated by 11:40 A.M. and had milk served from the above mentioned pitcher at 11:45 A.M. The poured glasses sat unrefrigerated on the table, in front of Residents #33, #70 and #78 until their food arrived at their tables beginning at 12:38 P.M.</p> <p>During observation, on 6/5/14 of meal preparation in the kitchen from 11:20 A.M. until 12:15 P.M., milk was poured into a similar glass pitcher at 11:25 A.M. and sat on a kitchen counter while other</p> | F000364 | Residents 33, 70, 78 have no concerns related to milk temperature/palability. Milk will be served in individual glasses to maintain serving temperature at or below 41 degrees. Staff have been re-educated on pouring individual glasses of milk and placing them in refrigeration prior to service. Staff have been re-educated on palatable temperature of milk at service. Staff have been re-educated to ensure ice tube is filled with ice and placed in milk pitcher for service. It is the responsibility of the dietary staff to ensure individual glasses of milk are poured and refrigerated prior to service. It is the responsibility of the dietary staff to ensure the ice tube is filled with ice and placed in the milk pitcher for service. It is the responsibility of dietary staff to ensure palatable temperature of milk at service (at or below 41 degrees). NSM/designee will review for presence of ice tube in milk service pitchers and review that individual glasses are poured and placed in refrigeration until service. Review will monitor service temperatures of milk to ensure compliance. This audit will be completed at each mealtime when milk is served from a pitcher or individual glass for 12 weeks. Then the review will be conducted for at least 4 meals per week monthly for 3 months. | 07/07/2014 |

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| | <p>meal preparation tasks were being completed. The pitcher was not put into any type of refrigeration. At 11:40 A.M. the pitcher was placed onto a rolling cart without refrigeration and transported to the main dining room where service of drinks started for residents who came early for the noon meal. Resident #46 was offered milk, which she refused. After the resident had been offered the milk, the food services manager (FSM) came to the cart, retrieved the pitcher of milk and returned it to the kitchen.</p> <p>At 11:42 A.M. the FSM instructed a dietary aide to place an ice tube in the pitcher and take it back out to the dining room. Prior to placing the ice tube into the pitcher, the surveyor requested the temperature be taken of the milk that had been offered for service. The FSM measured the temperature and indicated the temperature was measured at 48.8 degrees Fahrenheit. The FSM then chose to discard the milk. Interview with the FSM at 11:45 A.M. indicated it was facility procedure to use ice tubes in milk pitchers in order to maintain temperature. The FSM indicated the staff preparing the milk pitchers on 6/1/14 and 6/5/14 noon meals had forgotten to use the ice tubes.</p> <p>Review of an excerpt of the facility's "Nutrition Services Practice Manual,"</p> | | Then 2 meals per week for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee. | |

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| F000431 SS=E | <p>revised July 2011, provided 6/6/14 at 10:30 A.M., indicated the facility will "Serve hot foods above 135 degrees [Fahrenheit] and cold foods at or below 41 degrees [Fahrenheit] for service."</p> <p>3.1-21(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in</p> | | | |

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| | <p>Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review, and interview the facility failed to ensure medications were properly stored in the refrigerator before use. This deficient practice affected 2 of 3 medications observed.</p> <p>Findings include:</p> <p>On 6/5/14 at 11:45 a.m. the medication cart on the Arbor Unit was observed to have two vials of unopened insulin (a medication used to treat diabetes). These vials were prescribed to Resident # 17 and Resident #36.</p> <p>On 6/5/14 at 11:49 a.m., LPN #1 indicated, "They [the insulin] are supposed to be stored in the fridge. They [insulin] were delivered last night and the nurse stuck them in the drawer." LPN #1 then removed the vials from the medication cart.</p> <p>On 6/9/14 at 10:20 a.m. the clinical record for Resident #17 was reviewed. The Medication Administration Record [MAR] indicated the insulin should be</p> | F000431 | <p>No residents identified. A one time review was conducted to ensure unopened vials of insulin and nasal sprays requiring refrigeration are stored in refrigeration. The receiving nurse will ensure medications requiring refrigeration storage are placed in refrigeration upon arrival. Licensed nurses have been re-educated on storage of unopened insulin and nasal sprays requiring refrigeration. It is the responsibility of licensed nurses to ensure insulin and nasal spray requiring refrigeration are stored in refrigeration prior to opening. DON/designee will review that unopened insulin vials are stored in refrigeration. This audit will be completed weekly for 12 weeks, then monthly for 3 months, then quarterly for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> | 07/07/2014 |

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| | <p>refrigerated before opening.</p> <p>On 6/9/14 at 10:25 a.m., the clinical record for Resident #36 was reviewed. The MAR indicated the insulin should be refrigerated before opening.</p> <p>On 6/5/14 at 1:20 p.m., the medication cart on the Meadows Unit was observed to have an unopened bottle of calcitonin-salmon nasal spray (a medication used to treat osteoporosis). The medication was prescribed to Resident #49.</p> <p>On 6/5/14 at 1:22 p.m., RN #1 indicated, "This should be in the refrigerator." RN#1 then removed the medication from the cart.</p> <p>On 6/9/14 at 10:17 p.m., Resident #49's clinical record was reviewed. The MAR indicated the medication should be refrigerated before opening.</p> <p>On 6/9/14 at 12:39 p.m., a copy of the policy, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" was provided by the administrator. The policy indicated, "...Facility should ensure that medications and biologicals are stored at their appropriate temperatures...."</p> | | | |

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| F000464 SS=D | <p>3.1-25(m)</p> <p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to ensure there was sufficient dining space to accommodate all residents the ability to eat without being disturbed in order to move a resident out who was finished eating or when passing between residents seated at opposite tables. This deficient practice affected 2 of 30 residents in the Main Dining Room. (Resident #53 and #6)</p> <p>Finding includes:</p> <p>During the observation of the lunch meal, on 6/2/14 between 12:15 p.m. and 1:00 p.m., the following was observed: - A CNA brought Resident #53 to the Main Dining Room [MDR] and was put at the tableside in the aisle way. Less than 1 foot of space was observed between Resident #53 and Resident #6 seated at the opposite table behind Resident #53. Either resident would have to be moved</p> | F000464 | Resident #53 remains at the center. Resident was reviewed by interdisciplinary team. Care plans have been updated appropriately to reflect the current status of the resident. A one time review of dining room capacity, seating preferences and table positioning was conducted. Seating arrangement was modified to accomodate residents. Staff have been re-educated on ensuring residents are seated in the dining room so as not to interupt dining of one resident in order to move another resident in our out of the dining room. It is the responsibility of the staff to ensure residents are able to dine without interruption. It is the responsibility of the dining room manager to oversee the dining room seatin arrangement is acceptable. HFA/designee will review that residents are seated appropriately in the dining room weekly for 12 weeks, then monthly for 3 months, then quarterly for 2 quarters. Any | 07/07/2014 |

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| F009999 | <p>in order for Resident #53's tablemate to her right and 4 residents at the next table over to be able to leave the dining room.</p> <p>- Staff were observed to have to turn their bodies to the side in order to carefully slide through without bumping both residents too much. Staff were also observed to have to go around the other side of the tables due to such small space between the 2 tables.</p> <p>- At 12:54 p.m. - observed Resident #53 having to be moved out of the way in the middle of the Speech Therapist feeding the resident in order for staff to move another resident at the other table out as she was finished.</p> <p>During an interview with the Administrator on 6/9/14 at 1:15 p.m., she indicated that Resident #53 was new and did not have a specific seat yet and was just placed there. She indicated that staff were looking at re-arranging the dining to accommodate enough room for everyone, especially in emergencies.</p> <p>3.1-19(v) 3.1-19(w)(4)(b)</p> <p>STATE RULE: 3.1-14 PERSONNEL</p> | F009999 | <p>issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> <p>No resident identified.A one time</p> | 07/07/2014 | | | |

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| | <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 recorded 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 at 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 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>audit was completed to review for presence of 2-step Tb skin testing for current employees. Employee file checklist was modified to ensure review for presence of 2-step Tb skin test. Staff have been re-educated on ensuring the 2-step Tb skin test is completed for new employees unless otherwise indicated. It is the responsibility of the Infection Control Nurse (ADON) to ensure new employees receive the 2-step Tb skin test unless otherwise indicated. Infection Control Nurse (ADON)/designee will review current employee population to ensure 2-step Tb skin test is completed unless otherwise indicated. This audit will be completed weekly for 12 weeks, then monthly for 3 months, then quarterly for 2 quarters. Any issues or concerns identified will be immediately addressed; either by 1:1 re-education, and/or disciplinary action. Results of the review will be forwarded to the Quality Performance Improvement Committee for review. Any additional actions will be as determined by the QAPI committee.</p> | | | | |

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| | <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employee First and Second PPD [Tuberculin Tests] were administered and read in a timely manner. This affected 9 of 9 employee files reviewed for Tuberculin Testing. (RN #3, RN #4, RN #5, CNA #6, CNA #7, Cook #8, and Culinary Assistant #9)</p> <p>Findings included:</p> <p>Review of the Employee Personnel Files on 6/9/14 at 10:45 a.m. indicated the following files had missing first and/or second step PPDs or were read after the employee started work:</p> <p>1. RN#3 (Registered Nurse) was hired into the Assistant Director of Nursing position on 11/25/13. Review of the file indicated the employee never received a First step PPD until 6/5/14 - 6 months after hire.</p> <p>2. RN #4 was hired into the nursing department on 2/10/14. A First step PPD was administered on 2/3/14 and read on 2/5/14. The Second step PPD was not administered until 6/3/14.</p> | | | |
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| | <p>3. RN #5 was hired into the nursing department on 2/4/14. A First step PPD was administered on 1/16/14 and read on 1/18/14. Documentation was lacking of the employee having been given a Second Step PPD.</p> <p>4. CNA (Certified Nursing Assistant) #4 was hired into the nursing department on 4/9/14. Review of the file indicated the employee received a First step PPD on 4/1/14. Documentation was lacking of the PPD having been read. On 6/5/14, the employee received another PPD.</p> <p>5. CNA #5 was hired into the nursing department on 1/15/14. Review of the file indicated the employee received the First step PPD on 1/14/14 which was read on 1/16/14 - one day after the employee had started work. Documentation was lacking of the employee having received a Second step PPD.</p> <p>6. CNA #6 was hired into the nursing department on 2/4/14. Review of the file indicated the employee received the First step PPD on 2/3/14 which was read on 2/5/14 - one day after the employee had started work. A Second step PPD was not administered until 6/3/14.</p> <p>7. CNA #7 was hired into the nursing</p> | | | | | | |

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| | <p>department on 3/12/14. Review of the file indicated the employee received the First step PPD on 3/10/14 which was read on 3/12/14. The next PPD was not administered until 6/3/14.</p> <p>8. Cook #8 was hired into the dietary department on 4/9/14. Review of the file indicated the employee received a First step PPD on 3/31/14 which was read on 4/2/14. The next PPD was not administered until 6/3/14.</p> <p>9. Culinary Assistant #9 was hired into the dietary department on 4/9/14. Review of the file indicated the employee received a First step PPD on 4/7/14 which was read on 4/9/14. Documentation was lacking of the employee having received a Second Step PPD.</p> <p>Review of the "Employee File Guide" checklist in the front of each of the employees' files indicated "Note: Employee cannot start until PPD is read."</p> <p>During an interview with the Administrator on 6/9/14 at 1:00 p.m., she indicated that upon review of the employee files last week on 6/3/14, problems were noted with some employees not receiving Second Step PPDs. She indicated that the Director and</p> | | | |

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| | <p>Assistant Director of Nursing, Business Office Assistant and herself reviewed the Company's Infection Control Policy and Procedure and that they were in the process of starting the PPD process over with the employees who had not received the proper testing.</p> <p>During this interview, the Administrator also presented a copy of the facility's current policy on "Tuberculosis Screening - Employee: Policy: Administer a two-step tuberculin Skin Test (TST) to all new employees and individual volunteers that do not have documented proof of a negative TST which includes documented millimeters (mm) of induration...Procedures: 1. Perform a two-step TST on all new employees/individual volunteers unless otherwise indicated. a. Complete and read the first step prior to resident contact. b. Administer second step no less than one week and no more than three weeks after a negative result from the first step or according to State/Federal Regulation..."</p> <p>3.1-14(t) 3.1-14(t)(1)</p> | | | |