

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2016
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NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: March 2, 3 and 4, 2016</p> <p>Facility number: 013327 Provider number: 013327 AIM number: N/A</p> <p>Residential Census: 26</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 14454 on March 10, 2016.</p>	R 0000		
R 0116  Bldg. 00	<p>410 IAC 16.2-5-1.4(a) Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on record review and interview, the facility failed to ensure the policy regarding criminal history inquiries was followed for 2 of 6 employees reviewed. (Employee #4 and #10)</p> <p>Finding includes:</p> <p>Personnel files were reviewed on 03/03/15 at 11:15 A.M. and the following was noted:</p> <p>Employee #4, the Activity Director, was hired on 06/23/15. Her criminal history report was not obtained until 02/05/16.</p> <p>Employee #10, a dietary employee, was hired on 07/06/15. Her criminal history report was not obtained until 02/06/16.</p> <p>During an interview on 03/04/16 at 11:30 A.M., the Administrator indicated the facility had 21 days after an employee was hired to obtain a criminal history report. He indicated the forms to request the criminal history reports had been completed timely when Employee #4 and #10 were hired, but no reports were obtained. He indicated the new business office manager had obtained reports in February 2016 after an audit discovered the missing reports.</p> <p>On 3/4/16 at 11:30 A.M., the</p>	R 0116	<p><b>R116 The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. 1) Immediate actions taken for those residents identified:</i> Employees #4 and #10 have current criminal history back ground checks in their employee file. <b>2) How the facility identified other resident:</b> All current personnel files were reviewed and obtain completed criminal history background checks. <b>3) Measures put into place/systems changes:</b> The facility is in the process of obtaining authorization for the business office to perform in house back ground checks. Until authorization approved the facility will obtain back ground checks from a sister facility. <b>4) How the corrective actions will be monitored:</b> The administrator will review new employee files to ensure a criminal back ground check has been submitted and or obtained weekly. The audit tool findings will be submitted in Quality Assurance monthly until</p>	03/21/2016			

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	Administrator provided the facility policy and procedure, titled "Assisted Living Compliance Plan Employee/Contractor Screening Policy," updated September 2015, and indicated this was the policy and procedure currently used by the facility. The policy and procedure included the following: "1....The background check will be initiated within 3 days of the employee providing care to residents, and results will be completed within 21 days of hire date...."		100% compliance x3 consecutive months. <b>5) Date of compliance: 3/21/2016</b> R116 Audit Tool  New Employee Name  Background Check Application Submitted Y/N  Background Check Application Returned Y/N				



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	<p>induration with the date given, date read, and by whom administered. 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. The first tuberculin skin test must be read prior to the employee starting work. 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>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interviews, the facility failed to ensure a health screen was completed timely for 1 of 6 employees reviewed. (Employee #7) In addition, the facility failed to ensure a tuberculin (TB) skin test was read prior to Employees working around residents</p>	R 0121	<p><b>R121</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	03/21/2016			

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	<p>for 3 of 6 employees reviewed. (Employee #4, #7 and #12)</p> <p>Findings include:</p> <p>1. The personnel file for Employee #7 was reviewed on 03/03/16 at 10:30 A.M. Employee #7 started working at the facility on 01/21/16. Her pre-employment physical form was not signed by the physician until 02/28/16.</p> <p>During an interview on 03/03/16 at 2:00 P.M., the Office Manager, Employee #8, indicated Employee #7 did not start orienting with residents until 01/27/16. She indicated the Director of Nursing had completed the health screen but failed to sign the form and the physician had then reviewed them at a later date and signed the form.</p> <p>2. Review of the personnel files for Employees #4, #7 and #12 was conducted on 03/03/16 at 10:00 A.M., and indicated the following:</p> <p>*Employee #4, with a start work date of 06/23/15, was not administered a Mantoux Tuberculin skin test until 06/24/15.</p> <p>*Employee #7, with a start work date of 01/21/16, was not administered a Mantoux Tuberculin skin test until</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Employee #7 there has been no negative outcome with the health screen and TB test. Employee #4 and #10 no negative outcome related to TB test.</p> <p><b>2) How the facility identified other resident:</b></p> <p>All personnel files were reviewed for current health screening and TB tests</p> <p><b>3) Measures put into place/systems changes:</b></p> <p>New employee PPD will be placed and first step PPD results read prior to contact with residents.</p> <p>The business office manager will</p>				

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	<p>01/26/16. *Employee #12, with a start work dated of 12/23/15, was not administered a Mantoux Tuberculin skin test until 12/29/15.</p> <p>During an interview on 03/03/16 at 2:00 P.M. the Office Manager, Employee #8, indicated the employees were still being oriented and were not allowed to work independently until their Mantoux tests were read.</p> <p>During the final exit to the survey, conducted on 03/04/16 at 12:30 P.M., the Corporate Nurse Consultant, Employee #17, confirmed the facility policy was to allow new employees to orient to their jobs, including working "upstairs" around residents, prior to their first step Mantoux skin test was read.</p> <p>The current facility policy and procedure, undated, titled "Policy for Tuberculosis Testing of Healthcare Workers" and provided by the Administrator on 03/04/16 at 11:00 A.M., indicated the following: "It is the policy of this facility that all healthcare workers be tested for tuberculosis (TB) upon hire and yearly thereafter. Initial testing will be a two-step procedure, with the first dose given as soon as possible and the second "booster dose" given 1 to 3 weeks after</p>		<p>utilize a new employee check list to ensure all steps of hiring process are followed and she will give to the administrator to review.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The administrator will review new employee check list and place findings on an audit tool.</p> <p>The audit tool findings will be submitted in Quality Assurance monthly until 100% compliance x3 consecutive months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/21/2016</b> R121 Audit Tool</p> <p>New Employee Name</p>				

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	<p>the first, if the first dose is negative...."</p> <p>The policy did not provide a specific time frame to ensure new employees were free of tuberculosis prior to working around residents.</p>		<p>New Hire Checklist Reviewed Y/N</p> <p>PPD results read prior to working with residents Y/N</p> <p>Employee Physical Signed by Nurse Y/N</p> <p>Employee Physical Signed</p>	



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	<p>Based on record review and interviews, the facility failed to ensure admission weights were obtained and documented for 2 of 7 resident records reviewed. (Resident #2 and #4)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #2 was reviewed on 03/03/16 at 2:00 P.M. Resident #2 was admitted to the facility on 01/16/15. There was no admission weight documented.</p> <p>2. The clinical record for Resident #4 was reviewed on 03/03/16 at 11:00 A.M. Resident #4 was admitted to the facility on 03/06/15 and there was no admission weight documented.</p> <p>During an interview on 03/04/16 at 11:45 A.M., the Administrator indicated there were no admission weights obtained for Resident #2 or #4. He indicated the facility "needed to do better."</p>	R 0216	<p><b>R216</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #2 and resident #4 have current weights in medical record at this time.</p> <p><b>2) How the facility identified other resident:</b></p> <p>All current resident records have been audited to ensure a weight is on file.</p>	03/21/2016			

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			<p><b>3) Measures put into place/systems changes:</b></p> <p>An inservice was held for all nursing personnel on the policy for obtaining weights upon admission and biannually.</p> <p>All new admissions will be audited to ensure weight was obtained upon admission.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The director of nursing will review new admissions for weights obtained and will review the resident weight book weekly to ensure bi-annual weights are completed timely and findings will be placed on an audit tool. The results of these audits will be reviewed in quality assurance meeting monthly until 100 percent compliance is achieved times 3 consecutive months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/21/2016</b></p> <p>R216 Audit Tool</p>	

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			<p>New Admit</p> <p>Weight obtained on Admission</p> <p>Bi-Annual Weight Due (month) and Resident added to Weight book Y/N</p>	



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Bldg. 00	<p>Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room.</p> <p>Based on observation, record review and interviews, the facility failed to address reasonable resident requests for a hot breakfast. This affected 2 of 3 residents interviewed and potentially affected all 26 residents who consumed food in the facility.</p> <p>Finding includes:</p> <p>1. During an interview with Resident #3, conducted on 03/04/16 at 8:45 A.M., he indicated he had complained about the lack of a hot breakfast meal since April 2015 when he was admitted. He indicated he was president of the Resident Council and the Resident Council had also complained about the lack of a hot breakfast meal.</p> <p>Observation of the dining room, on 03/04/16 at 8:30 A.M., indicated there were 2 residents seated at a dining table, the nursing staff were not in the dining room. There was a table with prepackaged muffins and fruit on the table and there were cups, glasses and</p>	R 0270	<p><b>R270</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p>	03/21/2016			

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	<p>beverage dispensers available.</p> <p>During the kitchen sanitation tour, conducted on 03/02/16 at 10:55 A.M., the Food Service Supervisor, Employee #5, indicated the facility only had "menus" for lunch and supper as dietary staff did not cook the breakfast meal. She indicated residents were offered "continental" breakfast.</p> <p>During an interview on 03/04/16 at 9:00 A.M., Resident #2 indicated her only main concern with the facility was the quality of the food at times and the lack of a hot breakfast. Resident #2 indicated she cooked herself a hot meal in her apartment but she would definitely eat a hot meal at breakfast if it was offered. She indicated she had complained about the food more than once in the "office downstairs."</p> <p>During an interview on 03/04/16 at 10:30 A.M., the Administrator indicated he was aware of the issue regarding the lack of a hot breakfast offering. He indicated the Resident Council President had proposed cooking a meal for residents himself but the Administrator had not allowed the plan to move forward because the Resident Council President was going to charge other residents for the meal. When asked for documentation from</p>		<p>1. Resident # 2 &amp; 3 have been appraised of a new menu schedule that will include hot breakfasts daily.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents have been notified that a new menu system, including hot breakfast, on 3/18/16</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>A revised and new menu system will be instituted on 4/15/16.</p> <p>A complaint log for all resident suggestions and or proposals will be kept in detail and reacted to timely and monitored through the QAPI committee as required.</p>				

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	<p>residents and/or the Resident Council regarding desiring a hot cooked breakfast, the Food Service Supervisor, Activity Director and Corporate Administrative Employee #15, all indicated they were aware some of the residents had desired a hot meal but there was no documentation regarding the complaints and/or concerns. Employee #15 indicated residents were informed of the continental breakfast policy when they were admitted to the facility. Employee #15 and the Food Service Supervisor both indicated there were plans to start offering a hot meal for breakfast when the next menu cycle was initiated.</p>		<p><b>4) How the corrective actions will be monitored:</b></p> <p>The Administrator will review the menus 5 days a week and present finding on an audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/21/2016</b></p> <p><b>R270 Audit Tool</b></p> <p><b>Date</b></p>	
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R 0273  Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation and interviews, the facility failed to ensure food was stored and prepared under sanitary conditions. This deficiency had the potential to affect 26 of 26 residents receiving meals from 1 of 1 kitchens.</p> <p>Findings include:</p> <p>1. During the kitchen sanitation tour, conducted on 03/02/15 at 10:35 A.M. to 10:50 A.M., with the Food Service Supervisor (FSS), the following was observed:</p> <p>There was a plastic container labeled "Broccoli/Cauliflower Salad," dated 02/25/16, and a plastic bag with a chunk of ham, dated 02/15/16, noted in the reach in refrigerator. The FSS indicated food should be discarded 3 days after it was dated.</p>	R 0273	<p><b>Signature of Auditor:</b> _____ _____ <b>D</b> <b>ate:</b> _____</p> <p><b>R273</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	03/21/2016

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NAME OF PROVIDER OR SUPPLIER  APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
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	<p>The bottom of the reach in refrigerator was peeling where the finish was scraped away.</p> <p>There was an opened, undated bag of vanilla pudding mix with the open top folded over loosely. There was also an opened, undated bag of gelatin mix with the open top folded over loosely. There was also an open bag of rice crispy cereal not dated and open to the air.</p> <p>There was a stand up mixer with two types of blades stored in the open metal bowl that was dusty and had dried food splatters on the area where the blades attached to the machine.</p> <p>There were several cutting boards on an open rack on top of a metal cabinet. There was a rolled up pair of used gloves shoved underneath the bottom edge of the boards touching the edges of three boards.</p> <p>There was a missing face plate off the bottom front edge of a stand up freezer.</p> <p>There were several chipped floor tiles around the stand up freezer beside the reach in refrigerator.</p> <p>There were gaps without tile around the pipes by the dishwasher.</p>		<p><b>1) Immediate actions taken for those residents identified:</b></p> <p>26 of 26 resident displayed no ill effects related to food storage and preparation. All outdated foods were discarded.</p> <p>The reach in refrigerator bottom portion was scraped and re-finished. All undated open foods were discarded.</p> <p>The standup mixer was thoroughly cleaned and covered with a plastic fitted bag.</p> <p>The cutting boards on the open rack on top of a metal cabinet was removed and the gloves were removed from the bottom of the three boards.</p> <p>The missing face plate on the stand up freezer was replaced.</p> <p>The chopped floor tiles around the stand-up freezer were replaced.</p> <p>The gaps without tile around the pipes of the dishwasher were repaired.</p> <p>Visible rust on the edge of a metal storage cabinet was repaired.</p>	

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	<p>There was a metal cabinet, utilized to store clean pans with visible rust on the sides of edges.</p> <p>There was a metal cabinet, utilized to store spices and boxed food products with visible rust on the shelves.</p> <p>There was a dark gray wheeled cart, utilized to cart hot food from the kitchen to the dining room. The cart was noted to be visibly dirty with dark orange colored food splatters. The cart was not cleaned and clean serving utensils were placed directly on dirty surface and transported to the dining room. The utensils were not covered and were utilized to serve lunch to the residents.</p>		<p>The dark grey wheeled cart used for transportation of hot foods was cleaned and sanitized.</p> <p>The utensils were placed in a clean area of the cart and covered for transportation.</p> <p><b>2) How the facility identified other residents:</b></p> <p>The Administrator and the Dietary Manager inspected the kitchen area for the potential for additional concerns.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>A policy for cleaning of carts and utensils has been reviewed and all dietary staff educated.</p> <p>A policy for labeling and dating food products has been reviewed and all dietary staff educated.</p> <p><b>4) How the corrective actions will be monitored:</b></p>				

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			<p>The dietary manager will observe the refrigerator for open, undated and expired foods 3 times a week and place findings on and audit tool.</p> <p>The dietary manager will observe food service for following policy on sanitary work station 3 times a week and place findings on and audit tool.</p> <p>The maintenance supervisor will continue to make rounds 5 days a week and document areas needing to be addressed on his maintenance log.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p> <p><b>5) Date of compliance:</b></p> <p>3/21/2016 R273 Audit Tool</p> <p>Day/Date</p> <p>Refrigerators free of</p>	

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			<p>open, undated and expired foods. Y/N</p> <p>Food Service observation: following policy on sanitary work stations Y/N</p> <p>COMMENTS: _____ _____ _____</p>		



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	<p>Finding includes:</p> <p>On 3/3/16 at 10:30 A.M., a review of the clinical record for Resident # 6 was conducted. The record indicated the resident was admitted to the facility on 7/1/15, and discharged on 1/18/16. The resident's diagnoses included, but were not limited to: dementia with behavioral disturbance, hypertension and rheumatoid arthritis.</p> <p>A chest x-ray was completed on 1/5/14, eighteen months prior to the resident being admitted to the facility.</p> <p>During an interview on 3/3/16 at 1:20 P.M., the Administrator indicated the only chest x-ray that could be found for Resident #6 was the one dated 1/5/14.</p> <p>On 3/4/16 at 12:25 P.M., the Administrator provided a policy titled "Tuberculosis Exposure Control Plan," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Resident Screening Standards:...a. Results of diagnostic chest x-n [sic] completed no more than six-(6) months prior to admission or at the time of admission shall be maintained in the resident's medical record...."</p>		<p><i>compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #6 no longer resides at this facility.</p> <p><b>2) How the facility identified other resident:</b></p> <p>All current resident records will be audited to ensure a valid chest x-ray is on file.</p> <p><b>3) Measures put into place/systems changes:</b></p> <p>Chest xray results will be reviewed as part of the preadmission evaluation to ensure they were obtained within 6 months of pending admission and are negative for signs of</p>				

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			<p>tuberculosis.</p> <p>All new admissions will be audited to ensure chest x-rays are obtained with date of x-ray confirmed to be within 6 months of admission for all new admissions.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The director of nursing will review all new admissions weekly and place findings on an audit tool.</p> <p>The audit tool findings will be submitted in Quality Assurance monthly until 100% compliance x3 consecutive months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/21/2016</b></p> <p>R408 Audit Tool</p> <p>New Admit</p>	

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			<p>Chest Xray Negative Y/N</p> <p>Date Chest Xray Obtained</p>	



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	<p>admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure a first step Tuberculin (TB) skin test was read on admission for 1 of 6 residents reviewed. (Resident #5)</p> <p>Finding includes:</p> <p>The clinical record for Resident #5 was reviewed on 03/03/16 at 2:15 P.M. Resident #5 was admitted to the facility on 11/16/15. A first step tuberculin skin test, administered on 10/31/15 had no results documented on the form. The time, date and nurse's name were completed on 11/02/15, but there were no results documented.</p>	R 0410	<p><b>R410</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</i></p>	03/21/2016			

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	On 03/04/16 at 11:45 A.M., the Administrator provided the current "Policy for Tuberculosis Testing of Residents," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...it is the policy of this facility that all residents will be tested for tuberculosis upon admission and annually thereafter...."		<p><b>1) Immediate actions taken for those residents identified:</b></p> <p>For resident #5 a new first step PPD was administered and a second step PPD scheduled for 2 weeks following.</p> <p><b>2) How the facility identified other resident:</b></p> <p>All current resident records will be audited for completed PPD's.</p> <p><b>3) Measures put into place/systems changes:</b></p> <p>All licensed nurses were in-serviced on admission PPD's and documentation. All new admissions will be audited to ensure date PPD given, read and results recorded into medical record.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The director of nursing will review all new admissions weekly and place findings on an audit tool.</p> <p>The audit tool findings will</p>				

