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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155783 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/16/2015 |
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| NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514 |
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| F 0000 Bldg. 00 | <p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: December 9, 10, 11, 14, 15 & 16, 2015</p> <p>Facility number: 002661 Provider number: 155783 AIM number: 201056540</p> <p>Census bed type: SNF: 25 NF: 15 SNF/NF: 10 Residential: 43 Total: 93</p> <p>Census payor type: Medicare: 25 Medicaid: 10 Other: 15 Total: 50</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on</p> | F 0000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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| F 0279 SS=D Bldg. 00 | <p>December 23, 2015.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure care plans were developed related to diabetes and dialysis for 3 of 19 residents reviewed for care plans. (Resident #9, Resident #77, and Resident #93)</p> <p>Findings include:</p> | F 0279 | <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Residents #9, #77, and #93 had their plan of care reviewed and</p> | 01/15/2016 |
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| | <p>1. On 12-14-15 at 2:40 P.M., a clinical record review was conducted for Resident #77. Resident #77 was readmitted to the facility on 03/17/15, with diagnoses including, but were not limited, to type 2 diabetes mellitus with other skin ulcer. The MAR (Medication Administration Record) indicated " ...Humalog kwikpen [insulin pen injection device] [sliding scale] AC [before meals] and HS [bedtime] ... Humalog kwikpen 4 units SQ [subcutaneous] at every breakfast plus sliding scale... Humalog kwikpen 4 units SQ at every lunch plus sliding scale...Humalog kwikpen 4 units SQ at every dinner plus sliding scale... Lantus Solostar [insulin injection pen] 14 units SQ every morning...."</p> <p>The care plans for Resident #77 indicated that a care plan was not developed for the diagnosis of diabetes or for the use of insulin.</p> <p>2. On 12-15-15 at 10:00 A.M., a clinical record review was conducted for Resident #9. The resident was admitted to the facility on 11/24/15 with diagnoses including, but were not limited to, type 2 diabetes mellitus with diabetic neuropathy. MAR indicated "...Humalog insulin SS [Sliding Scale], AC, and HS ... Lantus 15 units HS, QD [every day]...."</p> | | <p>updated to reflect current status of diabetes diagnosis and hemodialysis.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Current residents with diabetes and hemodialysis have had their plan of are reviewed and updated to reflect their current status.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>MDS co-ordinator has been re-educated on plan of care for residents to reflect current status including diagnosis of diabetes and hemodialysis.</p> | | | | |

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| | <p>The care plans for Resident #9 indicated that a care plan was not developed for the diagnosis of diabetes or for the use of insulin.</p> <p>3. On 12-15-15 at 11:06 A.M., a clinical record review was conducted for Resident #93. The resident was readmitted to the facility on 10/31/15, with diagnoses, including but were not limited, to type 2 diabetes mellitus with diabetic chronic kidney disease, chronic kidney disease stage 3 (moderate) and dependence on renal dialysis.</p> <p>The care plans for Resident #93 indicated that a care plan was not developed for the diagnosis of renal dialysis, fistula care or fistula monitoring.</p> <p>During an interview on 12-15-15 at 1:08 P.M., MDS (Minimum Data Set) Coordinator #13 indicated " ... no diabetes care plan had been created for Resident #9 or Resident #77 and no dialysis care plan had not been created for Resident #93... yes they should have care plans...."</p> <p>During an interview on 12-15-15 at 1:41 P.M., the DON (Director of Nursing) indicated "... residents are assessed ...nursing assessment is completed ... the</p> | | <p>Admissions/readmissions will be reviewed Monday thru Friday during Clinical care meeting to ensure careplans are completed and reflect resident status.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>DHS/designee will audit 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of MDS Co-ordinator as needed.</p> | |

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| F 0309 SS=D Bldg. 00 | <p>MDS is completed ...MDS person should creates the care plans ... everything going on with that resident should have a care plan...."</p> <p>On 12-15-15 at 2:00 P.M., the DON provided the undated policy titled " Resident First Meeting Guidelines" and indicated the policy was the one currently used by the facility. The policy indicated "... 5. Compare the care plan to the MDS...make sure it all matches...."</p> <p>3.1-35(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p> | | | |

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| | <p>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 interview and record review, the facility failed to monitor a dialysis site daily for bruit, thrill and signs and symptoms of infection, for 1 of 1 residents reviewed for hemodialysis. (Resident #93)</p> <p>Finding includes:</p> <p>On 12-15-15 at 11:06 A.M., a clinical record review for Resident #93 was conducted. The diagnoses included, but were not limited to, chronic kidney disease stage 3 (moderate) and dependence on renal dialysis. The MAR (Medication Administration Record) or TAR (Treatment Administration Record) had no order for assessment of Resident #93 fistula site. The Nurse's notes indicated no daily charting for assessment of fistula.</p> <p>During an interview on 12-15-15 at 1:55 P.M., the ADON (Assistant Director of Nursing) indicated " ...the facilities policy is to assess the site everyday ... document in the nursing notes...."</p> <p>On 12-15-15 at 2:15 P.M., the DON</p> | F 0309 | <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Resident #93 discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Current hemodialysis residents had their sites assessed for bruit and thrill along with any signs or symptoms of infection.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> | 01/15/2016 |

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| | <p>(Director of Nursing) provided the policy titled " Guidelines for Monitoring Shunt : Hemodialysis Arteriovascular Access [Fistula, Graft, or Central Venous Catheter]" revised 6/2015, and indicated the policy was the one currently being used by the facility. The policy indicated " ...2. Monitor the AV shunt daily for thrill and bruit ...6. Document assessment findings in resident medical record nursing notes and or in designated area on TAR"</p> <p>During an interview on 12-15-15 at 2:25 P.M., the DON indicated " ...we don't have documentation of assessment of Resident #93 fistula..."</p> <p>3.1-37(a)</p> | | <p>Licensed nursing staff were re-educated regarding assessment of bruit, thrill and any signs or symptoms of infection.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>DHS/designee will audit 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.</p> | | |

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| F 0371 SS=F Bldg. 00 | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>Based on observation, interview and record review, the facility failed to store and serve food under sanitary conditions in 1 of 1 kitchens and 1 of 1 dining rooms. This included undated food, expired food, food storage and hand washing.</p> <p>Findings include:</p> <p>1. On 12-9-15 between 11:00 A.M., and 11:45 A.M., an initial kitchen tour was conducted with the DM (Dietary Manager). The following was observed:</p> <p>In the walk in cooler: An open, undated, container of fruit. The DM indicated "... yes this should have a date...."</p> <p>In the walk in freezer: An open, undated, bag of french fries.</p> <p>In the dry storage room:</p> | F 0371 | <p>(1) The items identified not labeled, covered or dented cans were thrown away. Employee #3,4,5, 8 &9. Were inserviced on appropriate handwashing.</p> <p>(2) All resident had the potential to be effective by not labeling or dented cans. The associates were inserviced on handwashing.</p> <p>(3) Dietary employee will be re-inserviced on labeling, covering and dented cans. Dietary employee will be re-inserviced on handwashing by the Director of Food Services (DFS) or designee. DFS or designee will audit employee 3 times per week to ensure labeling, covering and dented cans are being stored correctly. The DFS or designee will monitored for handwashing 3 times per week to include all 3 meals. Audits will be done 3 times per week. DFS or designee will report findings monthly to QA&A.</p> | 01/15/2016 |

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| | <p>2 dented cans of tapioca pudding. The DM indicated "...those should be sent back...."</p> <p>1 can of cream of mushroom soup with a use by date of October 15, 2015.</p> <p>In a reach in cooler:</p> <p>1 gallon of 2% milk, open, dated 11-28-15. The DM indicated "...we keep milk for 9 days after opening...."</p> <p>1 container of nectar thick applesauce, dated 11-29-15, and 1 container of honey thick applesauce dated 11-27-15. The DM indicated "...we keep those for 10 days after opening...."</p> <p>In the prep area: a bulk sugar container with a scoop in it. The DM indicated "...no it shouldn't be in there...."</p> <p>2. On 12-9-15 between 12:04 P.M., and 12:40 P.M., observation of the lunch meal was conducted in the main dining room. During this time the following were observed:</p> <p>At 12:07 P.M., Employee #4 was observed to wash her hands for 8 seconds.</p> | | (4) QA&A will monitor for any trends and make recommendations to the plan of correction as needed. QA&A will monitor monthly for 3 days or until 100% compliance is obtained. | | |

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| | <p>At 12:17 P.M., Employee #3 was observed to wash her hands for 10 seconds, then serve a lunch plate to a resident with her thumb on the inside edge of the plate.</p> <p>At 12:18 P.M., Employee #3 was observed serve a lunch plate to a resident with her thumb on the inside edge of the plate.</p> <p>12:19 P.M., Employee #8 was observe to wash her hands for 8 seconds, then serve a resident a lunch plate.</p> <p>12:20 P.M., Cook #9 was observed to pick up a piece of toast with a gloved hand and placed it on a plate, she then ladled chipped beef on the toast with the same gloved hand, then with the same gloved hand picked up another piece of toast and placed it on a plate.</p> <p>At 12:24 P.M., Employee #4 was observed to wash her hands for 14 seconds, then served a resident a lunch plate.</p> <p>At 12:25 P.M., Employee #5 was observed to wash her hands for 15 seconds, then serve a lunch plate to a resident.</p> <p>At 12:28 P.M., Employee #8 was</p> | | | |

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| | <p>observed to serve a lunch plate to a resident with her thumb on the inside edge.</p> <p>At 12:31 P.M., Employee #3 was observed to serve a resident a lunch plate with her thumb on the inside edge of the plate.</p> <p>At 12:33 P.M., Employee #3 washed her hands for 10 seconds, then served a resident a lunch plate with her thumb on the inside edge of the plate.</p> <p>At 12:36 P.M., Employee #4 was observed to adjust her clothes, pour a drink for a resident, then fed the resident lunch with out washing her hands.</p> <p>On 12-15-15 at 2:00 P.M., the DON (Director of Nursing) provided the policy titled "Guideline for Handwashing/Hand Hygiene," last revised 8/2014, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Healthcare workers shall wash hands at times such as...b. Before/after preparing serving meals, drinks...8. Wash well for 20 seconds...."</p> <p>On 12-15-15 at 2:00 P.M., the DON provided the policy titled "Storage Procedures, Leftover Food Storage, and Food labeling Guideline", last revised</p> | | | |

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| | <p>4/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...Dry Storage of Food...7. Dry bulk foods are stored in plastic containers...scoops are stored separately...Refrigerated Storage...5. Food is covered, dated...Storage of Damaged Containers...Do Not Use...4. Any can that is dented...Leftover Food Storage...2. Date all food and use or discard within three days...4. Ready to eat, potentially hazardous foods that are not consumed within 24 hours must be marked with a consume by date which is seven [7] days from date of preparation or opening of package...Marking of Food...Milk...the container must be date marked and used with in 7 days...."</p> <p>On 12-16-15 at 10:00 A.M., the DON provided the policy titled "Food Production Guidelines-Sanitation and Safety," revised 2009, and indicated this was the policy currently used by the facility. The policy indicated "...22. Plates...are handled so hands do not touch the areas where the food or mouth will be placed...."</p> <p>During an interview on 12-16-15 at 10:48 A.M., the DM indicated "...plates should be handled from underneath...hands should be washed after every 3 plates served or touching anything that caused a</p> | | | |

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| F 0441 SS=D Bldg. 00 | <p>sanitation issue...hands should be washed for 20 seconds...if picking up food tongs should be used not hands...bread shouldn't be picked up with gloved hand then touch ladles then touch bread again...."</p> <p>3.1-21(i)(2)</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</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER GREENLEAF HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 1201 E BEARDSLEY ELKHART, IN 46514 |
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| | <p>a communicable disease or infected skin 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 administer a TB (Tuberculosis) test upon admission in a timely manner for 1 of 5 residents reviewed for TB testing upon admission. (Resident #20)</p> <p>Finding includes:</p> <p>On 12-16-2015 at 10:00 A.M., a record review for Resident #20 was conducted. Resident #20 had an admission date of 6-15-2015. An Immunization Record for Resident #20 indicated a first step TB test was conducted on 6-19-2015. Resident #20 had a readmission date of 9-9-2015. An Immunization Record for Resident #20 for this second admission indicated a first step TB test was conducted on 9-13-2015.</p> <p>During an interview on 12-1-2015 at</p> | F 0441 | <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Resident #20 was assessed using the TB risk assessment and no negative outcomes were noted from late</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>Current resident charts were audited to ensure TB test was</p> | 01/15/2016 |

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| | <p>10:52 A.M., the DHS (Director of Health Services) indicated, "...a first step [TB test] should be given in the first 24 hours after admission...4 days is too long...."</p> <p>On 12-15-2015 at 2:15 P.M., a policy entitled, "Guidelines for TB Results Summary Documentation: Residents" received from the DHS at this time as the current guidelines, indicated, "...Procedures...1. Upon admission each resident shall receive a Two Step Mantoux PPD [Purified Protein Derivative] test to ensure they are free of tuberculosis...7. An order should be written upon admission to re-test annually to ensure each resident is re-tested on their admission anniversary date with a one-step Mantoux...."</p> <p>3.1-18(e)</p> | | <p>administered either prior to admission and/or received TB test upon admission.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Licensed nursing staff were re-educated regarding TB test to be given upon admission unless resident received TB test prior to admission then follow up of reading the TB test within 48-72 hours and documentation of procedure.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>DHS/designee will audit admission/re-admission charts to ensure TB test was</p> | |

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| R 0000 Bldg. 00 | <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 43</p> <p>Sample: 7</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> | R 0000 | <p>administered either prior to admission or upon admission during Clinical Care Meeting Monday thru Fri 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.</p> | |
| R 0354 Bldg. 00 | <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the</p> | | | |

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| | <p>following:</p> <p>(1) Identification data.</p> <p>(2) Name of the transferring institution.</p> <p>(3) Name of the receiving institution and date of transfer.</p> <p>(4) Resident ' s personal property when transferred to an acute care facility.</p> <p>(5) Nurses ' notes relating to the resident ' s:</p> <p>(A) functional abilities and physical limitations;</p> <p>(B) nursing care;</p> <p>(C) medications;</p> <p>(D) treatment; and</p> <p>(E) current diet and condition on transfer.</p> <p>(6) Diagnosis.</p> <p>(7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to obtain a diet order for 1 of 7 records reviewed for diet orders. (Resident #136)</p> <p>Finding includes:</p> <p>On 12-15-2015 at 11:15 A.M., a record review for Resident #136 was conducted. Resident #136 was admitted on 10-3-2015. No diet order in the physician orders was available for review.</p> <p>On 12-15-2015 at 1:00 P.M., during an interview, the DHS (Director of Health Services) indicated, "She [Resident #136] does not have a current diet order, we should have obtained one upon admission."</p> | R 0354 | <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Resident 136 had diet order clarified.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> | 01/15/2016 | | | |

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| | On 12-15-2015 at 3:00 P.M., a policy entitled "Procedure for Ordering Individual Diets," received from the DHS at this time as the current policy, indicated, "...Procedure:...1. The individual's diet is ordered by the physician upon admission...." | | <p>Current Assisted Living resident charts were audited to ensure diet orders are noted.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Licensed nursing staff were re-educated to obtain diet order on admission/readmission.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>DHS/designee will audit admission/re-admission charts to ensure diet orders are obtained on admission/readmission during Clinical Care Meeting Monday thru Fri 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in</p> | |

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| R 0409 Bldg. 00 | <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interview and record review, the facility failed to conduct TB (Tuberculosis) testing upon admission for 2 of 7 records reviewed for TB testing. (Resident #136 and #137) The facility failed to test for TB on the annual date for 1 of 7 records reviewed for annual testing. (Resident #135)</p> <p>Findings include:</p> <p>1. On 12-14-2015 at 2:10 P.M., a record review for Resident #135 was conducted. Resident #135's Immunization Record indicated an annual TB test on 10-1-2014. An annual TB test due by 10-1-2015 was not found in the record.</p> <p>2. On 12-15-2015 at 11:15 A.M., a record</p> | R 0409 | <p>Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.</p> <p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Resident #136, #137 and #135 were assessed using the TB risk assessment and no negative outcomes were noted from late administration of TB test.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and</p> | 01/15/2016 |

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| | <p>review for Resident #136 was conducted. Resident #136 was admitted on 10-3-2015. The Immunization Record indicated a TB test was done on 11-19-2015.</p> <p>3. On 12-15-2015 at 11:40 A.M., a record review for Resident #137 was conducted. Resident #137 was admitted on 5-25-2015. The Immunization Record indicated a TB test was done on 8-4-2015.</p> <p>On 12-16-2015 at 10:45 A.M., during an interview, the DHS (Director of Health Services) indicated, "She [Resident #135] should have had an annual TB test done by 10-1-2015. They [Residents #136 and #137] should have had a first step TB test upon admission. It is the expectation to administer the test within the first 24 hours after admission."</p> <p>On 12-15-2015 at 2:15 P.M., a policy entitled, "Guidelines for TB Results Summary Documentation: Residents" received from the DHS at this time as the current guidelines, indicated, "...Procedures...1. Upon admission each resident shall receive a Two Step Mantoux PPD [Purified Protein Derivative] test to ensure they are free of tuberculosis...7. An order should be written upon admission to re-test</p> | | <p>corrective actions taken:</p> <p>Current resident charts were audited to ensure TB test were administered prior to admission and/or received TB test upon admission and/or annually.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p> <p>Licensed nursing staff were re-educated regarding TB test to be given either annually or upon admission unless resident received TB test prior to admission then follow up of reading the TB test within 48-72 hours and documentation of procedure.</p> <p>How the corrective measures will be monitored to ensure the</p> | |

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| | annually to ensure each resident is re-tested on their admission anniversary date with a one-step Mantoux...." | | <p>alleged deficient practice does not recur:</p> <p>DHS/designee will audit admission/re-admission charts to ensure TB test was administered annually and/or prior to admission or upon admission during Clinical Care Meeting Monday thru Fri 5 residents weekly times 4 weeks then 3 residents weekly times 4 weeks then 1 resident weekly times 4 weeks. Audits will be reviewed in Quality Assurance meeting monthly for 3 months and if findings are 100% compliance then consider system working and if not then re-education of Licensed nurses as needed.</p> | |