STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLANA SENIOR LIVING, LLC	7721 BATTERY POINTE WAY INDIANAPOLIS, IN 46240

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R 0000 Bldg. 00	This visit was for the State Residential Licensure Survey. Survey dates: July 13 & 14, 2015 Facility number: 013164 Provider number: 013164 AIM number: N/A Census bed type: Residential: 38 Total: 38 Sample : 7 These State findings are cited in accordance with 410 IAC 16.2-5	R 0000	R000 Initial Comments This plan of correction is neither an agreementof wrong doing by this facility or its staff members. Rather it is submitted for compliancepurposes. This facility alleges substantialcompliance with this plan of correction as of Friday July 31, 2015 and request paper compliance on this issue.	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate resident needs as resident's experienced changes of condition for 2 of 5 resident's reviewed for evaluation of needs. (Resident #13 and #36) Findings include: 1. On 7/14/15 at at 10:30 a.m., the record review for Resident #36 was completed. Diagnoses included, but were not limited to, Alzheimer's, depression and history of urinary tract infections. The resident's weights were as follows: 4/1/15: 118 pounds 5/1/15: 116. 6/4/15: 115 7/5/15: 112 The physician's progress notes dated 4/29/15 indicated the Nurse Practitioner (NP) was informed by family of difficulty swallowing. The plan was to follow up in a month for swallowing and start OT (Occupational Therapy) The Registered Dietician (RD) completed an assessment dated 4/29/15 which indicated the weight loss was not desirable and indicated the resident	R 0214	R214 Evaluation ***What corrective actions will be accomplished for those resident foundto have been affected by the finding:*** Resident #36 nursing staff did not note any swallowing difficulties. On 7/15/15 Nurse Practitioner saw resident. See Attachment A. Resident #13 weight loss was expected see Attachment C from Hospice provider. Resident #13 has had a private caregiver since April 2015. A new evaluation was completed on 7/29/15 for Resident #13. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** All residents residing at Traditions At Solana, an assisted living community, are expected to feed self. Weights for all residents have been evaluated to ensure no trending on significant weight loss. Audit completed 7/29/15. Any resident having a fall in the last 3 months will be re-evaluated to ensure each service plan is current with the residents needs. Re-evaluation willbe completed by Nurse Consultant or designee by 7/31/15. See on-going action plan #1. ***What measures will be put in place ore what systemic changes thefacility will make to ensure that the finding does not recur:*** Nurse Practitioner will	08/14/2015

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	should receive a multivitamin and start a nutritional supplement. The RD note dated 5/28/15 indicated she suggested to try Ensure Plus or Boost Plus daily and to consider a speech evaluation for swallowing ability as the NP had noted swallowing issues. The Occupational Therapy and Physical Therapy notes were reviewed. There was no documentation of evaluation of swallowing issues found. ON 7/14/15 at 4:15 p.m. the Regional Nurse Consultant indicated she had no documentation to provide regarding evaluation of the resident's swallowing concerns. 2. Resident #13's record was reviewed on 7/14/15 at 12:25 p.m. Diagnoses included, but were not limited to, dementia, Pulmonary Fibrosis, Congestive Heart Failure, and anemia. a. The resident's weights for the last 180 days were as follows: 1/6/15--105 2/3/15--103 3/6/15--102 4/8/15--100 5/1/15--105 6/4/15--94 7/2/15--92		meet with the charge nurse on residents she has seen and report any orders that have been changed or added. All nurses in-service (attachment D) on the updated evaluation form to ensure completeness (not to leave sections blank) and the new areas to address falls and hospice services, see attachment E. ***How will corrective action(s) be monitored to ensure the finding willnot recur:*** Clinical Director or designee will monitor after Physician/NP visits 1 x week x 1 month, bi-weekly x 1 month and 1 x month x 10months. See attachment B. See action plan #2 & #3. ***By what date the systemic changes will be completed:*** August 14, 2015	

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	The resident had greater than a 10% weight loss in 180 days. The resident had a 7.5% weight loss in 90 days. b. The resident had falls on the following dates: 2/3/15, 2/15/15, 2/19/15, 3/2/15, 3/4/15, 3/6/15, and 5/30/15 The resident's "Select Your Care" form dated 3/19/15, did not have an area to score points for the residents eating ability. The form did not have a score in the area "Transports and Transfers." The resident's "Select Your Care" form dated 3/19/15, did not have an area to evaluate the residents nutritional status after a significant change of status. The resident's "Select Your Care" lacked updated evaluations for weight loss and falls. During an interview on 7/14/15 at 3:08 p.m., the Director of Nursing (DON) indicated the resident's "Select Your Care" form did not have an area to assess the resident's ability to feed herself nor was her "Transports and Transfers" evaluated. She indicated this resident's			

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	"Select Your Care" form should have included an evaluation for her eating to evaluate her weight loss, "Transports and Transfers" and falls. During an interview on 7/14/15 at 3:08 p.m., the DON indicated the "Select Your Care" was the facilities Service Plan of Care and Evaluation forms used to plan the resident's care, so staff knew how to care for the resident's.			
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on interview and record review, the facility failed to ensure a pre-admission evaluation was completed for 1 of 5 residents being reviewed for completion of pre-admission evaluations before admission to the facility. (Residents #43) Findings include: Resident #43's record was reviewed on	R 0215	R215 Evaluation ***What corrective actions will be accomplished for those resident foundto have been affected by the finding:*** For Resident #43 no negative outcome was discovered from the pre-admission evaluation being dated 3/3/15. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** General Manager or	08/14/2015

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	7/14/15 at 2:45 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus type II, Alzheimer's disease, osteoporosis and falls. Resident #43's record lacked a pre-admission evaluation. A "Select Your Care" assessment was dated 3/3/15. The resident's admission date was 3/3/15. During an interview on 7/14/15 at 3:56 p.m., the Director of Nursing indicated she was not here at the time of the resident's admission, so she could only indicate the current "Select Your Care" assessment was dated 3/3/15. During an interview on 7/14/15 at 5:25 p.m., the Administrator indicated there was no pre-admission evaluation found in this resident's record.		designee will monitor all new admits for pre-assessment completion with every lease signing for the next 12 months. ***What measures will be put in place ore what systemic changes thefacility will make to ensure that the finding does not recur:*** All nurses were re-in-serviced on 7/29/15 on the importance of accurate documentation see attachment D. ***How will corrective action(s) be monitored to ensure the finding willnot recur:*** General Manager or designee will monitor all new admits for pre-assessment completion with every lease signing for the next 12 months. See attachment F. See action plan #4. ***By what date the systemic changes will be completed:*** August 14, 2015	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference;			

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	of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on interview and record review, the facility failed to update service plans for services to be provided for significant changes for 4 of 5 residents being reviewed for service plans. (Residents #13, #43, #86 and #36) Findings include: 1. Resident #13's record was reviewed on 7/14/15 at 12:25 p.m. Diagnoses included, but were not limited to, dementia, Pulmonary Fibrosis, Congestive Heart Failure, and anemia. a. The resident's weights for the last 180 days were as follows: 1/6/15--105 2/3/15--103	R 0217	R217 Evaluation ***What corrective actions will be accomplished for those resident foundto have been affected by the finding:*** Re-evaluations will be completed on all affected Residents. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** All residents residing at Traditions At Solana, an assisted living community, are expected to feed self. Weights for all residents have been evaluated to ensure no trending on significant weight loss. Audit completed 7/29/15. Any resident having a fall in the last 3 months will be reassessed to ensure each service plan is current with the residents needs.	08/14/2015

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	3/6/15--102 4/8/15--100 5/1/15--105 6/4/15--94 7/2/15--92 The resident had greater than a 10% weight loss in 180 days. The resident had a 7.5% weight loss in 90 days. b. The resident had falls on the following dates: 2/3/15, 2/15/15, 2/19/15, 3/2/15, 3/4/15, 3/6/15, and 5/30/15 The resident's "Select Your Care" form dated 3/19/15, did not have an area to score points for the residents eating ability. The form did not have a score in the area "Transports and Transfers." The resident's "Select Your Care" form dated 3/19/15, lacked updated information to the service plan to indicate the resident had lost 13 pounds in 62 days or she had 7 falls in less than 4 months and what services the facility would provide to the resident to intervene for these significant changes. During an interview on 7/14/15 at 5:15 p.m., the Regional Nurse Consultant		Re-evaluations will be completedby Nurse Consultant or designee by 7/31/15. See on-going action plan #1. ***What measures will be put in place ore what systemic changes thefacility will make to ensure that the finding does not recur:*** All nurses re-in-serviced attachment D on the assessment form to ensure completeness (not to leave sections blank) and the new areas to address falls and hospice services, see attachment E. ***How will corrective action(s) be monitored to ensure the finding willnot recur:*** All nurses were re-in-serviced on 7/29/15 on the importance of accurate documentation see attachment D. See on-going action plans #1, #2, #3. ***By what date the systemic changes will be completed:*** August 14, 2015	

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	indicated the "Select Your Care" form was not updated for this resident for weight loss and falls. 2. Resident #43's record was reviewed on 7/14/15 at 2:45 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus type II, Alzheimer's disease, osteoporosis and falls. The resident had falls on the following dates: 3/7/15, 3/19/15, 5/18/15 and 5/18/15. The resident's "Select Your Care" form dated 3/3/15, did not have a score in the area "Transports and Transfers." This form lacked updated information to the service plan to indicate the resident had 4 falls in 2 months and what services the facility would provide to the resident to intervene to prevent further falls. During an interview on 7/14/15 at 3:56 p.m., the Director of Nursing (DON)indicated this resident's "Select Your Care" form was not updated for falls. 3. Resident #86's record was reviewed on 7/14/15 at 9:30 a.m. Diagnoses included, but were not limited to, fracture of proximal humerus right arm, Alzheimer's dementia, seizures, falls and			

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	weakness. The resident had falls on the following dates: 5/11/15, 5/12/15, 5/12/15, 5/17/15, 5/19/15, 5/22/15, 5/23/15. The resident's "Select Your Care" form dated 5/11/15, (admission) indicated she was assessed as a 3 (escort needed to and from all meals). This Service Plan lacked updated information to indicate the resident had fallen 7 times since she was admitted and what services the facility would provide for the resident to intervene to prevent further falls. During an interview on 7/14/15, at 11:50 a.m., the Regional Nurse Consultant indicated the resident's "Select Your Care" form was not updated for falls. During an interview on 7/14/15 at 3:08 p.m., the DON indicated the "Select Your Care" was the facilities Service Plan of Care and Evaluation form they used to plan the resident's care, so staff knew how to care for the resident's. 4. On 7/14/15 at at 10:30 a.m., the record review for Resident #36 was completed. Diagnoses included, but were not limited to, Alzheimer's, depression and history of urinary tract infections.			

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	The nurses notes indicated the resident had falls on the following dates: 4/4, 4/29, and 5/10. The most recent Service Plan dated 6/26/15 indicated the resident was exceeding the facilities 'Select Care Costs' which were indicators of how many services the facility would provide for the resident. The categories of the services were listed and indicated things like dressing, transfer, and toileting, however no specific information was provided. There was no way to know if the resident was a 1 or 2 person transfer or if the resident had falls. On 7/14/15 at 3:05 p.m., the Director of Nursing indicated there was no fall information on the Service Plan.			
R 0273 Bldg. 00	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. Based on observation, interview and record review, the facility failed to ensure cooking appliances and kitchen equipment were maintained in sanitary	R 0273	R273 Food and Nutritional Services ***What corrective actions will be accomplished for those residents foundto have been affected by the***	08/14/2015

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	conditions and failed to ensure food being served from the kitchen was stored in sanitary conditions for 1 of 1 kitchens reviewed for safe food handling practices. This deficient practice had the potential to affect 83 of 83 residents being served from the kitchen. Findings include: The kitchen tour began on 7/13/15 at 1:17 p.m., with the Food Service Director (FSD) in attendance and on 7/13/15 at 1:30 p.m., the Executive Chef (EC) joined the tour. 1. The following cooking appliances were not maintained in a sanitary condition: The broiler grill had brown debris burnt onto the sides of the grill. The FSD indicated at that time, the broiler grill was deep cleaned weekly. The stove top grates and between the stove top grates had black debris burnt on on them and between them. The FSD indicated at that time, the stove top was deep cleaned weekly. The Flat top grill had black and brown debris burnt on the top of the grill and each of the sides, back and front edge of the grill. The FSD indicated at that time,		***finding:*** Effective immediately all food preparation and serving areas will be maintained in accordance with state and local sanitation and safe food handling standards. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** Facility will prevent potential residents being affected by ensuring all food preparation and serving areas will be maintained in accordance with state and local sanitation and safe food handling standards. New Food Service Managerstarted employment on 7/13/15. Deep cleaning of all kitchen equipment was completed by 7/28/15. Audit of current food inventory was completed on 7/13/15. ***What measures will be put in place or what systemic changes thefacility will make to ensure that the finding does not recur:*** All food service employees will be in-serviced on labeling, dating and storage of food items, cleaning and deep cleaning schedules, dented canned items and drying dishes. Food Service Manager and General Manager will facilitate in-services on 7/29/15,7/30/15 and 7/31/15. General Manager or designee will conduct unannounced bi-weekly sanitation audits on-going. Dietician will conduct monthly audits of kitchen. See Attachments J, K, L &M. ***How***	

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	this grill was cleaned daily. The deep fryer basket was not covered and the grease was a dark brown color. The deep fryer had brown burnt debris around the edge of the fryer. The FSD indicated the deep fryer was deep cleaned weekly and the grease was strained with a strainer two to three times weekly. He indicated at that time, this was his first day as the FSD. 2. One-half loaf of bread and a package of buns were observed opened sitting on the counter by the toaster. The FSD indicated at that time, the packages should have been closed after the bread products were finished being used after lunch. 3. The following foods were observed and identified by the FSD in the Walk-in freezer on 7/13/15 at 1:24 p.m. 1--5 lbs (pounds) container Ricotta cheese unopened with a use by date 5/11/15. 1--5 lbs container plain lowfat yogurt opened with 2.5 lbs remaining with a use by date 5/28/15. 4--5 lbs containers plain lowfat yogurt unopened with a use by date 7/3/15. 1--1/2 gallon carton Buttermilk opened with 1 cup remaining with a use by date 7/8/15.		***will corrective action(s) be monitored to ensure the finding willnot recur:*** An audit will be done to ensure that label, dating and storage of food items, cleaning and deep cleaning schedules, dented cans and drying of dishes are maintained in accordance with state and local sanitation and safe food handling standards. The Food Service Manager or designee will audit above mentioned items 3 X day x 4weeks, 2 x day x 4 weeks, 1 x day x 4 weeks. If no issues are identified, a monthly audit thereafter. Employees who do not comply will be counseled. See Attachments N, O, P &Q. ***By what date the systemic changes will be completed:*** August 14, 1015	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2--1/2 gallon cartons Buttermilk unopened with a use by date 7/8/15. The FSD indicated at that time, those food items were expired and should have been thrown out. 4. The following foods were observed and identified by the EC without an opened date and a label in the Walk-in Cooler on 7/13/15 at 1:30 p.m. 1--1/4 Chocolate Peanut Butter Silk Pie was opened, but did not have an open date. 1--1/4 Cookies and Creme Pie was opened, but did not have an open date. 1--1/2 bag frozen sliced potato chips opened, but did not have an open date. 1--1/2 bag frozen waffle fries opened, but did not have an open date. 18 hot dogs opened, but did not have a label or open date. 1--1/2 bag frozen hush puppies opened, but did not have an open date. 1--Whole bag non-dairy whipped topping , but did not have an open date. The EC indicated at that time, those food items should have been wrapped securely in plastic wrap, label and date them with an open date. 5. The dry storage area was observed to have dented cans on 7/13/15 at 1:36 p.m. 1--6 lb 8 oz (ounce) can Spaghetti Sauce			

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	with tomato bits 2--110 oz cans Great Northern Beans The EC indicated at that time, the staff sat dented cans aside and he sent them back to his distributor for credit. 6. A long flat rectangular metal pan sitting on the shelf with dry dishes, had beads of clear liquid on 7/13/15 at 1:50 p.m. The EC indicated at that time, the beads of liquid was water on top of the pan and there should not be any water on or between the pans. The EC indicated the kitchen staff dried the dishes before they put them away and someone must not have gotten that pan dried thoroughly before placing it on the shelf. He indicated the staff dried the dishes because there was not enough room in the dish area to air dry the dishes. He indicated he was not aware the staff were not allowed to towel dry dishes. 7. On 7/13/15 at 2:10 p.m., the Passthrough refrigerator had two refrigerators, which had the following food items observed without a label or date when the item was placed in the refrigerator: The first metal tray had a small plastic tray with 25 bacon dressings in a small plastic containers with lids on them.			

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	The second metal tray had two smaller brown trays. The first small brown tray in front had 3 Caesar and 15 French dressings in small plastic containers with lids on them. The second small brown tray in back had 20 Ranch dressings in small plastic containers with lids on them. The third metal tray had a small plastic tray on it with 12 Blue cheese dressings in small plastic containers with lids on them. The EC indicated at that time, these food items did not have a label or date on them. The FSD indicated the food items should have been labeled and had a date on them. The EC indicated he did not know the trays or food items needed a label or date on them when placed in the refrigerator. On 7/13/15 at 2:30 p.m., the following policies were requested from the Administrator: food storage, dented cans, dating and labeling of foods, sanitizing surfaces and cleaning of equipment. On 7/14/15 at 12:12 p.m., the FSD, provided the current undated, "A.M. Cook Cleaning List" and the "P.M. Cook Cleaning List," which indicated the "Weekly" tasks included, "Sweep walk			

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	in, mop walk in, sweep store room, mop store room, Delime streamer, Delime steam table, Clean fryer, Clean oven." The last date on the a.m., list was 30 and the last date on the p.m., list was marked July 1. There was no cleaning schedule dated July 2015, provided. There was no deep cleaning lists for the following items on the above cleaning lists: Boiler and Flat top grill Stove top As of the end of the exit conference on 7/14/15 at 5:45 p.m., there was no policies provided regarding the kitchen concerns.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care;			

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	(C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review the facility failed to have a transfer form for for 1 of 2 closed records reviewed. (Resident #84) Findings include: On 7/14/15 at 11:15 a.m., the record review for Resident #84 was completed. Diagnoses included, but were not limited to stroke and heart failure. The nurses notes indicated the resident had been transferred to the hospital on 4/16/15. The family had requested the resident be taken to the Emergency Room. On 7/14/15 at 5:10 p.m., the Regional Nurse Consultant indicated there was no transfer documentation from 4/16/15 found.	R 0354	R354 Clinical Records ***What corrective actions will be accomplished for those residents foundto have been affected by the finding:*** Resident # 84 was sent to a hospital familiar with his medical history no negative outcome experienced from potential lack of transfer form. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** Facility will prevent potential residents being affected by educating nursing staff on transfer paperwork, see attachment D. Education completed on 7/29/15. ***What measures will be put in place or what systemic changes thefacility will make to ensure that the finding does not recur:*** Nursing staff provided education on transfer paperwork, see attachment D. Education completed on 7/29/15. Clinical Director or designee will audit all transfer resident charts for 12 months. See Attachment H. See action plan #5. ***How will corrective action(s) be monitored to ensure the finding willnot recur:*** Clinical Director or designee will audit all	08/14/2015

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			transfer resident charts for 12 months. ***By what date the systemic changes will be completed:*** August 14, 2015	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to 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. (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. (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. Based on interview and record review, the facility failed to perform a second step Tuberculin (TB) skin test for 1 of 5 residents reviewed for TB testing. (Resident #36) Findings include: On 7/14/15 at at 10:30 a.m., the record review for Resident #36 was completed. Diagnoses included, but were not limited	R 0410	R410 Infection Control ***What corrective actions will be accomplished for those residents foundto have been affected by the finding:*** See attachment G, Resident #36 had received necessary Mantoux skin test. ***How will the facility identify other residents having the potential tobe affected by the same finding and what corrective action will be taken:*** All current resident medical	08/14/2015

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	to, Alzheimer's, depression and history of urinary tract infections. The resident was admitted on 4/1/15 from the hospital. The physician had written orders for a PPD (Purified Protein Derivative) to be placed on 4/14/15 and to be read on 4/17/15. Resident #36's MAR (Medication Administration Record) for April 2015 indicated a 2nd step PPD was to be given on 4/14/15 and to be read on 4/17/5. The MAR had boxes marked off for the nurses to document their initials in the box when completed. The boxes on the 14th and 17th of April were both blank. The Vaccination Flow Sheet indicated the resident had not received the PPD testing on 4/14/15. On 7/14/15 at 2:35 p.m., Regional Nurse consultant indicated they could not find any documentation, which indicated the 2nd step PPD test had been done for Resident #36.		records will be audited to ensure compliance with the Mantoux skin test process. See Attachment I. ***What measures will be put in place or what systemic changes thefacility will make to ensure that the finding does not recur:*** Nursing staff provided education on Mantoux skin test, see attachment D. ***How will corrective action(s) be monitored to ensure the finding willnot recur:*** Clinical Director or designee will audit all new resident medical records within 3 weeks of admission for the next 12 months. See Attachment I. See action plan #6. ***By what date the systemic changes will be completed:*** August 14, 2015	