

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/23/2024	
NAME OF PROVIDER OR SUPPLIER GRAND BROOK MEMORY CARE OF GREENWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 2444 SOUTH STATE ROAD 135, GREENWOOD, , 46143					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE			
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: January 22 and 23, 2024 Facility number: 014426 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 24, 2024.	R 0000					
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	<u>Deficiency ID: R - 0092 Plan of Correction</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: When ED started in August 2023, corrective action was taken immediately with fire drills and fire department participation. Since ED	01/24/2024			

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alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were held monthly for 7 of 12 months reviewed. Findings include: On 1/22/24 at 12:15 P.M., the Executive Director provided the fire drills reports for 2023. A review of the reports indicated fire drills were performed for August, September, October, November, and December of 2023. There was no documentation of fire drills being performed for January, February, March, April, May,	and new leadership team started in August, 2023, all drills have been done according to ISDH standards. ED continues to validate fire drills are being done monthly as stated in ISDH regulations. ED/designee signs off each month that fire drills are completed. By what date the systemic changes will be completed: 01/24/24	
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June, or July of 2023.

During an interview on 1/23/24 at 2:50 P.M., the Executive Director indicated there was no documentation indicating fire drills were performed for January, February, March, April, May, June, or July of 2023.

On 1/23/24 at 4:10 P.M., the Director of Health Services provided the facility Fire Procedure, undated, and indicated this was the procedure currently utilized by the facility. A review of the procedure indicated, "...fire drills must be done once every month and at least once per quarter on every shift...".

Based on record review and interview, the facility failed to ensure fire drills were held monthly for 7 of 12 months reviewed.

Findings include:

On 1/22/24 at 12:15 P.M., the Executive Director provided the fire drills reports for 2023. A review of the reports indicated fire drills were performed for August, September, October, November, and December of 2023. There was no documentation of fire drills being performed for January, February, March, April, May, June, or July of 2023.

During an interview on 1/23/24

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	at 2:50 P.M., the Executive Director indicated there was no documentation indicating fire drills were performed for January, February, March, April, May, June, or July of 2023. On 1/23/24 at 4:10 P.M., the Director of Health Services provided the facility Fire Procedure, undated, and indicated this was the procedure currently utilized by the facility. A review of the procedure indicated, "...fire drills must be done once every month and at least once per quarter on every shift...".			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one	R 0117	<u>Deficiency ID: R - 0117 Plan of Correction</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: An audit of all employee files has been completed. All residents have been identified as potentially being affected. All certificates have been uploaded into Alis, spreadsheet has been created, and a monthly report will be run for upcoming expiration dates in order to ensure community is in compliance by Executive Director/designee. The Executive Director or designee will conduct an audit on employee file to ensure certification are valid weekly x4 weeks, then	01/25/2024

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hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure a First Aid certified staff member was on site 24 hours a day for 7 of 7 days reviewed.

Findings include:

On 1/24/24 at 11:00 a.m., a review of the schedule, dated 1/16/24 to 1/22/24, indicated the following:

- On 1/16/24, the second shift did not have a certified First Aid staff member working.
- On 1/17/24, the third shift did not have a certified First Aid staff member working.
- On 1/18/24, the second and third shifts did not have a certified First Aid staff member working.
- On 1/19/24, the second and third shifts did not have a certified First Aid staff member working.

monthly thereafter.
Results of the audits will be brought to QA Committee meeting for review/recommendations.
By what date the systemic changes will be completed:
01/25/24

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- On 1/20/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/21/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/22/24, the second shift did not have a certified First Aid staff member working.

On 1/23/24 at 3:44 p.m., the Executive Director (ED) provided the facility policy, "Policy: Staffing (A-580)," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... 8. A staff member trained and certified in first aid/CPR will be onsite at all times." At that time, the ED indicated she would attempted to contact the agency staffing company to obtain first aid certification cards because they required all of their staff to be CPR and first aid certified.

Based on interview and record review, the facility failed to ensure a First Aid certified staff member was on site 24 hours a day for 7 of 7 days reviewed.

Findings include:

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On 1/24/24 at 11:00 a.m., a review of the schedule, dated 1/16/24 to 1/22/24, indicated the following:

- On 1/16/24, the second shift did not have a certified First Aid staff member working.

- On 1/17/24, the third shift did not have a certified First Aid staff member working.

- On 1/18/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/19/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/20/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/21/24, the second and third shifts did not have a certified First Aid staff member working.

- On 1/22/24, the second shift did not have a certified First Aid staff member working.

On 1/23/24 at 3:44 p.m., the Executive Director (ED) provided the facility policy, "Policy: Staffing (A-580)," undated, and indicated it was the policy currently being used by the facility. A review of the

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	policy indicated, "... 8. A staff member trained and certified in first aid/CPR will be onsite at all times." At that time, the ED indicated she would attempted to contact the agency staffing company to obtain first aid certification cards because they required all of their staff to be CPR and first aid certified.			
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R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4) (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure mechanical rooms were secured for 3 of 3 observations. (Cabin Unit Mechanical Room, Lakeside Unit Mechanical Room) Findings include: On the 1/22/24 at 11:05 A.M., 12:20 P.M., and 1:45 P.M., the	R 0148	<u>Deficiency ID: R - 0148 Plan of Correction</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All staff were in-serviced on keeping all work room doors closed at all times even if an outside vendor is working in one of them. Education was completed to make sure all staff knows to keep doors closed completely (latched) before walking away. These two handles identified have been replaced to make sure all is working properly, and any others checked and working properly.. The Executive Director/Maintenance Director or designee will conduct a walk-through of the building checking the doors x4 weeks, then monthly thereafter. Results of the walk-through will be brought to QA Committee meeting for review/recommendations. All residents have been identified as potentially being affected. By what date the systemic changes will be completed: 01/25/24	01/25/2024
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Cabin Unit Mechanical Room was observed to be unlocked. Inside the mechanical room was a hot water heater and hot water pipes. The water heater and pipes were hot to the touch.

On 1/22/24 at 11:15 A.M., 12:30 P.M., and 1:53 P.M., the Lakeside Unit Mechanical Room was observed to be unlocked. Inside the mechanical room was a hot water heater and hot water pipes. The hot water pipes were hot to the touch. The interior door handle was missing, requiring extensive manual manipulation of the door handle spindle (the steel rod meant to connect inner and outer door handles) in order to unlatch the door and make an exit from the room.

During an interview on 1/22/24 at 1:55 P.M., the Executive Director indicated the mechanical room doors were in need of attention in order to ensure cognitively impaired residents were not accidentally exposed to the hot water heaters and pipes and/become trapped in one of the mechanical rooms.

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Based on observation and interview, the facility failed to ensure mechanical rooms were secured for 3 of 3 observations. (Cabin Unit Mechanical Room, Lakeside Unit Mechanical Room)

Findings include:

On the 1/22/24 at 11:05 A.M., 12:20 P.M., and 1:45 P.M., the Cabin Unit Mechanical Room was observed to be unlocked. Inside the mechanical room was a hot water heater and hot water pipes. The water heater and pipes were hot to the touch.

On 1/22/24 at 11:15 A.M., 12:30 P.M., and 1:53 P.M., the Lakeside Unit Mechanical Room was observed to be unlocked. Inside the mechanical room was a hot water heater and hot water pipes. The hot water pipes were hot to the touch. The interior door handle was missing, requiring extensive manual manipulation of the door handle spindle (the steel rod meant to connect inner and outer door handles) in order to unlatch the door and make an exit from the room.

During an interview on 1/22/24 at 1:55 P.M., the Executive Director indicated the mechanical room doors were in need of attention in order to ensure cognitively impaired residents were not accidentally

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	exposed to the hot water heaters and pipes and/become trapped in one of the mechanical rooms.			
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. 3. On 1/22/24 at 1:05 p.m., Resident 3's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 12/20/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission.	R 0216	<u>Deficiency ID: R - 0216 Plan of Correction</u> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The weight record for five (5) of our residents proved no weight was obtained upon admission. An audit of all residents admitted has been completed to identify any weights missing. No other weights have been omitted upon admissions. Care staff was re-educated on obtaining resident weight upon admission. The Executive Director/Health and Wellness Director/or designee will conduct an audit of new admissions weekly x4 weeks, then monthly x5 months and post admission thereafter. Results of audit will be brought to QA Committee meeting for review/recommendations. By what date the systemic changes will be completed: 01/24/24	01/24/2024

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The first documented weight for Resident 3 was 1/1/24.

4. On 1/23/24 at 10:00 a.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 11/10/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 4 was 12/1/23.

During an interview on 1/23/24 at 3:30 p.m., the Director of Health Services indicated she was sure the staff obtained a weight on all new residents but she was unsure where the staff documented the admission weights.

On 1/23/2024 at 3:37 p.m., the Executive Director provided the facility policy, "Weight Monitoring" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate obtaining an admission weight when a resident was first admitted to the facility.

Based on record review and interview, the facility failed to ensure a resident's weight was taken or documented upon admission to the facility for 4 of 7 residents reviewed for

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admission weights. (Resident 1, Resident 2, Resident 3, Resident 4)

Findings include:

1. On 1/22/24 at 1:00 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 1 was 6/1/23.

2. On 1/23/24 at 10:50 a.m., Resident 2's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 4/13/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 2 was 5/1/23.

3. On 1/22/24 at 1:05 p.m., Resident 3's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 12/20/23. The clinical record lacked documentation of the resident's weight having been taken or

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documented upon admission.
The first documented weight for Resident 3 was 1/1/24.

4. On 1/23/24 at 10:00 a.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 11/10/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 4 was 12/1/23.

During an interview on 1/23/24 at 3:30 p.m., the Director of Health Services indicated she was sure the staff obtained a weight on all new residents but she was unsure where the staff documented the admission weights.

On 1/23/2024 at 3:37 p.m., the Executive Director provided the facility policy, "Weight Monitoring" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate obtaining an admission weight when a resident was first admitted to the facility.

Based on record review and interview, the facility failed to ensure a resident's weight was taken or documented upon admission to the facility for 4 of

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7 residents reviewed for admission weights. (Resident 1, Resident 2, Resident 3, Resident 4)

Findings include:

1. On 1/22/24 at 1:00 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 1 was 6/1/23.

2. On 1/23/24 at 10:50 a.m., Resident 2's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 4/13/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 2 was 5/1/23.

3. On 1/22/24 at 1:05 p.m., Resident 3's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 12/20/23. The clinical record lacked documentation of the resident's

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weight having been taken or documented upon admission. The first documented weight for Resident 3 was 1/1/24.

4. On 1/23/24 at 10:00 a.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 11/10/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 4 was 12/1/23.

During an interview on 1/23/24 at 3:30 p.m., the Director of Health Services indicated she was sure the staff obtained a weight on all new residents but she was unsure where the staff documented the admission weights.

On 1/23/2024 at 3:37 p.m., the Executive Director provided the facility policy, "Weight Monitoring" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate obtaining an admission weight when a resident was first admitted to the facility.

Based on record review and interview, the facility failed to ensure a resident's weight was taken or documented upon

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admission to the facility for 4 of 7 residents reviewed for admission weights. (Resident 1, Resident 2, Resident 3, Resident 4)

Findings include:

1. On 1/22/24 at 1:00 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 1 was 6/1/23.

2. On 1/23/24 at 10:50 a.m., Resident 2's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 4/13/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 2 was 5/1/23.

3. On 1/22/24 at 1:05 p.m., Resident 3's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 12/20/23. The clinical record lacked

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documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 3 was 1/1/24.

4. On 1/23/24 at 10:00 a.m., Resident 4's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 11/10/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 4 was 12/1/23.

During an interview on 1/23/24 at 3:30 p.m., the Director of Health Services indicated she was sure the staff obtained a weight on all new residents but she was unsure where the staff documented the admission weights.

On 1/23/2024 at 3:37 p.m., the Executive Director provided the facility policy, "Weight Monitoring" undated, and indicated it was the policy currently being used by the facility. A review of the policy did not indicate obtaining an admission weight when a resident was first admitted to the facility.

Based on record review and interview, the facility failed to ensure a resident's weight was

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	taken or documented upon admission to the facility for 4 of 7 residents reviewed for admission weights. (Resident 1, Resident 2, Resident 3, Resident 4) Findings include: 1. On 1/22/24 at 1:00 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 1 was 6/1/23. 2. On 1/23/24 at 10:50 a.m., Resident 2's clinical record was reviewed. The diagnosis included, but was not limited to, dementia. The resident's admission date was 4/13/23. The clinical record lacked documentation of the resident's weight having been taken or documented upon admission. The first documented weight for Resident 2 was 5/1/23.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin	R 0410	<u>Deficiency ID: R - 0410 Plan of Correction</u>	01/30/2024

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OMB NO. 0938-0391

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 ensure a first step tuberculin skin test was completed prior to or upon admission or a second step tuberculin skin test was completed within one to three weeks after the first step tuberculin skin test for 1 of 7 residents reviewed for tuberculin skin test. (Resident 1)

Finding includes:

On 1/22/24 at 1:00 p.m., Resident 1's clinical record was

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

New admissions have the potential to be affected. An audit was completed for 1st and 2nd test step PPD for residents. Licensed nurses will be re-educated on Tuberculosis Skin Testing and Follow Up Regulations. The Executive Director/Health and Wellness or designee will conduct an audit of new admissions to ensure completion of TB testing weekly x4 weeks, then monthly thereafter. Results of the audits will be brought to QA Committee meeting for review/recommendations.
By what date the systemic changes will be completed:
01/30/24

reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's first step tuberculin skin test having been completed or documented upon admission or the second step tuberculin skin test having been completed or documented within one to three weeks after the first step tuberculin skin test. The first documented tuberculin skin test was 5/22/23.

During an interview on 1/23/24 at 3:00 p.m., the Director of Health Services (DHS) indicated Resident 1's first step tuberculin skin test was done late and there had not been a second step done.

During an interview on 1/23/24 at 3:37 p.m., the DHS indicated the facility did not have a policy related to first and second step tuberculin skin test.

Based on interview and record review, the facility failed to ensure a first step tuberculin skin test was completed prior to or upon admission or a second step tuberculin skin test was completed within one to three weeks after the first step tuberculin skin test for 1 of 7 residents reviewed for tuberculin skin test. (Resident 1)

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OMB NO. 0938-0391

Finding includes:

On 1/22/24 at 1:00 p.m., Resident 1's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and anxiety. The resident's admission date was 5/16/23. The clinical record lacked documentation of the resident's first step tuberculin skin test having been completed or documented upon admission or the second step tuberculin skin test having been completed or documented within one to three weeks after the first step tuberculin skin test. The first documented tuberculin skin test was 5/22/23.

During an interview on 1/23/24 at 3:00 p.m., the Director of Health Services (DHS) indicated Resident 1's first step tuberculin skin test was done late and there had not been a second step done.

During an interview on 1/23/24 at 3:37 p.m., the DHS indicated the facility did not have a policy related to first and second step tuberculin skin test.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE