| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155741 | A. BUILDING 00<br>B. WING | 07/24/2023 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: July 18, 19, 20, 21, and 24, 2023<br><br>Facility number: 004700<br>Provider number: 155741<br>AIM number: 100266630<br><br>Census Bed Type:<br>SNF/NF: 44<br>Total: 44<br><br>Census Payor Type:<br>Medicare: 1<br>Medicaid: 42<br>Other: 1<br>Total: 44<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed July 31, 2023. | F 0000 | Please, accept this as our plan of correction for the most recent annual survey and recertification of July 2023<br>We will like to request for a desk review or paper compliance for this deficiencies and we have attached the education and supporting documents for this plan of correction. | |
| F 0578<br>SS=D<br>Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v)<br>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical | | | |

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

Patrick Ngene | HFA | 08/11/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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| | treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br><br>Based on interview and record review, the facility failed to ensure a resident's code status preference was documented accurately in the clinical record for 1 of 16 residents reviewed for advanced directives (code status). (Resident 18) | F 0578 | **F tag**: **578 – Advance Directives**<br>The code status for resident 18 was confirmed with the responsible party, MD order obtained, and care plan updated to reflect code status per resident's responsible party. Resident 18 | 08/18/2023 |

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| | Finding includes:<br><br>On 7/19/23 at 1:51 p.m., the clinical record for Resident 18 was reviewed. The diagnoses included, but were not limited to, dementia, acquired absence of left leg above the knee, and adult failure to thrive.<br><br>Resident 18's face sheet indicated the resident was a full code (meaning a desire for all life sustaining measures to be implemented) and had an Emergency Contact person responsible for making health care decisions on behalf of the resident.<br><br>The Quarterly MDS (Minimum Data Set) assessment, dated 6/20/23, indicated Resident 18 was severely cognitively impaired.<br><br>Resident 18's care plan, initiated on 7/25/19 and current through 9/29/23, indicated "Resident/legal representative prefers a full code status...code status will be honored...review advanced directives [code status] with resident/legal representative during care conferences and as needed ..."<br><br>Physician Orders, dated 5/4/22, indicated Resident 18 was a full code, effective 5/4/22, with no end date noted.<br><br>On 7/21/23 at 8:15 a.m., the Director of Nursing Services (DNS) provided a copy of Resident 18's State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order, dated 6/5/20. A review of the document indicated Resident 18's code status was "Do not attempt resuscitation [DNR]." Resident 18's Emergency Contact person provided verbal consent via phone on 6/5/20. The | | continues to reside in the facility without any negative outcome.<br><br>**All residents have the potential to be impacted by this deficient practice.** Code status for all residents will be reviewed for accurate documentation of preference.<br>**Inservice will be provided to licensed staff by DNS/and or designee regarding process for obtaining and documenting accurate code status preference on or before August 18, 2023. The IDT will review resident documents received from the hospital upon admission and/or readmission to identify any information regarding the resident's code status preference and will confirm with the resident and/or resident's responsible party the code status.**<br><br>To ensure compliance, the DNS/Designee is responsible for the completion of the Advance Directive CQI tool weekly times 4 weeks, monthly times 5. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | document was signed by two witnesses and the physician on 6/5/20. No other advanced directive code status documents were provided.<br><br>On 7/24/23 at 10:40 a.m., the DNS provided copies of the following progress notes and corresponding care plan meeting results as it related to Resident 18's code status:<br><br>- Progress notes, dated 9/14/20 at 5:00 p.m., indicated "...[Resident] continues with full code status..."<br><br>- Progress notes, dated 9/16/20 at 11:10 a.m., indicated "...Resident...moderate cognitively impaired...[Emergency Contact] remains the same...wishes to remain a full code..."<br><br>- Progress notes, dated 1/11/22 at 12:20 p.m., indicated "...Resident is full code status and prefers to remain so at this time...[Resident is] moderate cognitively impaired...resident and family invited to care plan [meeting]." The Care Plan Summary, dated 1/20/22, indicated neither the resident or Emergency Contact person attended the meeting.<br><br>- Progress notes, dated 5/11/22 at 12:21 p.m., indicated "...resident on this day able to participate in MDS assessment...[moderately cognitively impaired]...resident is a full code status..." The clinical record lacked a response from the Emergency Contact person regarding the planned care plan meeting.<br><br>- Progress notes, dated 11/14/22 at 1:53 p.m., indicated "...attempted to contact [Emergency Contact] to schedule quarterly care plan [meeting]..." The clinical record lacked a response from the Emergency Contact person. | | | |

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| | - Progress notes, dated 4/3/23 at 2:30 p.m., indicated "...attempted to contact [Emergency Contact] to invite to quarterly care plan [meeting]..." The clinical record lacked a response from the Emergency Contact person.<br><br>- Progress notes, dated 7/13/23 at 10:44 a.m., indicated "...attempted to call [Emergency Contact] to set quarterly care plan [meeting]..." The clinical record lacked a response from the Emergency Contact person.<br><br>- Progress notes, dated 7/20/23 at 9:58 a.m., indicated "...attempted to contact [Emergency Contact] to schedule quarterly care plan [meeting]..." The clinical record lacked a response from the Emergency Contact person.<br><br>- Progress notes, dated 7/24/23 at 9:58 a.m., indicated "...attempted to call [Emergency Contact] to discuss resident's code status. No reply or answer..." The clinical record lacked a response from the Emergency Contact person.<br><br>On 7/24/23 at 10:40 a.m., the DNS provided copies of the following Observation - Care Plan Summaries related to Resident 18's code status. A review of the documents indicated:<br><br>- Summary dated: 6/25/20 at 9:57 a.m. indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status.<br><br>- Summary dated: 12/15/20 at 12:15 p.m., indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status. | | | |

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| | - Summary dated: 2/3/21 at 12:54 p.m. indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status.<br><br>- Summary dated: 7/27/21 at 11:28 a.m. indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status.<br><br>- Summary dated: 10/28/21 at 2:38 p.m. indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status.<br><br>- Summary dated: 6/30/23 at 2:41 p.m. indicated neither Resident 18 nor the Emergency Contact person participated in the meeting and had not provided feedback regarding the code status.<br><br>During an interview on 7/20/23 at 11:00 a.m., the DNS indicated Resident 18's code status was considered a full code.<br><br>During an interview on 7/20/23 at 2:38 p.m., Resident 18's Emergency Contact person indicated, the Out of Hospital DNR document was completed on 6/5/20. The document indicated Resident 18 was a DNR and that decision had not changed.<br><br>During an interview on 7/24/23 at 11:29 a.m., the DNS indicated the only advanced directive document for Resident 18 was the 6/5/20 Out of Hospital DNR document.<br><br>On 7/21/23 at 8:15 a.m., the DNS provided a copy of Resident Rights policy, dated November 2016, and indicated it was the current policy in use by the facility. A review of the policy indicated, | | | |

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| | "...this document informs each resident/responsible party of his/her rights and responsibilities regarding medical care while a resident at the facility...all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care..."<br><br>On 7/21/23 at 8:15 a.m., the DNS provided a copy of Advanced Directives policy, dated February 2023, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...the facility's care will reflect the resident's wishes as expressed in the Directive..."<br><br>3.1-4(f)(4)(A)(ii) | | | |
| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>Based on observation, interview, and record review, the facility failed to prevent accident and hazards for 2 of 2 residents reviewed for accidents. A thin liquid treatment was left at a resident's bedside. (Resident 12, Resident 39)<br><br>Finding includes:<br><br>During an observation on 7/20/23 at 10:30 a.m., Licensed Practical Nurse (LPN) 4 was observed at | F 0689 | **F tag: 689 – Accidents/Hazards**<br><br>Resident 12 and resident 39 did not access the liquid topical medication left at bedside. No other instances have occurred and there were no negative outcomes.<br><br>**All residents have the potential to be negatively** affected. | 08/18/2023 |

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| | the treatment cart, located next to the nurse's station. LPN 4 retrieved Resident 12's physician's prescribed betadine solution from the treatment cart. LPN 4 poured the betadine solution into a small medication (med) cup and then carried the un-covered med cup to Resident 12's room, located at the far end of the hall.<br><br>The following was observed on 7/20/23 from 10:32 a.m. to 10:40 a.m.:<br><br>- Resident 12 was resting on his bed in the supine position upon entry into the room. Resident 12 was then observed to independently reposition self into a sitting position on the side of the bed. Resident 12's bed and chair were observed to be within 8 inches from each other and were approximately 8 feet from the small table where the betadine med cup was placed.<br><br>- Resident 12's roommate, Resident 39, was observed sitting in his chair, next to his bed. Resident 39 was approximately 10 feet from the small table where the betadine med cup was placed.<br><br>- LPN 4 placed the betadine med cup on the small table next to the restroom door.<br><br>- LPN 4 entered the adjoining restroom for approximately 10 seconds before exiting.<br><br>- LPN 4 exited Resident 12's room, entered a resident's room across the hall, and then was observed walking down the hall toward the nurse's station. During that time, the med cup containing the betadine was observed on the small table.<br><br>- LPN 4 returned to Resident 12's room. LPN 4 | | **Education will be provided by the DNS/designee to licensed nursing staff regarding proper medication procedure on or before August 18, 2023.**<br>**Nurse managers will observe for medication left at bedside during daily rounding. Follow up education and/or disciplinary action will be provided when non-compliance is** noted.<br>To ensure compliance, the DNS/Designee is responsible for the completion of the Medication Pass Procedure audit tool will be completed daily for 2 weeks, 3x/week for 2 weeks and then monthly for five months by DNS/Designee . Results of the skills validation will be reviewed by the CQI committee overseen by the ED. If 95% compliance is not achieved an action plan will be developed to ensure compliance. | |

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| | moved the betadine med cup from the small table and placed it on Resident 12's chair, located next to the bed on where Resident 12 was sitting. LPN 4 spilled a small amount of the betadine solution onto the chair. At that time, LPN 4 indicated she needed to get something to clean up the spill. The betadine med cup was left on the chair and LPN exited the room.<br><br>- LPN 4 returned to Resident 12's room, cleaned up the spill, and then applied the remaining betadine to Resident 12's scabbed areas on the left hand.<br><br>No facility staff were observed in the resident's room or in the immediate area during the time periods that LPN 4 had left the betadine med cup unattended in the resident occupied room.<br><br>1. On 7/19/23 at 1:48 p.m., the clinical record for Resident 12 was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease and dementia.<br><br>Physician orders, included, but were not limited to, "...apply betadine [a thin liquefied antiseptic non-sterile topical solution that works on a broad range of germs and used on minor wounds] to scabbed skin tears on left hand each shift...start date 7/19/23 with no end date noted..."<br><br>The Annual Minimum Data Set (MDS) assessment, dated 5/10/23, indicated Resident 12 was severely cognitively impaired and required set up assistance with ambulation.<br><br>2. On 7/21/23 at 9:57 a.m., the clinical record for Resident 39 was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and dysphagia (difficulty swallowing foods or liquids). | | | |

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| | Physician orders included, but were not limited to, "regular diet with nectar thick/mildly thick liquids...start date 3/28/23 with no end date noted..."<br><br>The Significant Change Minimum Data Set (MDS) assessment, dated 6/9/23, indicated Resident 39 was severely cognitively impaired and required set up assistance with ambulation.<br><br>On 7/21/23 at 11:00 a.m., a review of a betadine solution label indicated "...keep out of reach..."<br><br>During an interview on 7/20/23 at 3:08 p.m., the Director of Nursing Services (DNS) indicated the betadine solution medication should not have been left unattended in the resident's room. The DNS indicated Resident 12 and Resident 39 were severely cognitively impaired and were able to ambulate independently.<br><br>During an interview on 7/21/23 at 2:23 p.m., the Infection Preventionist (IP) indicated she was near the nurse's station on "7/20/23 around 10:35 a.m." LPN 4 was in the hall at that time and had requested the IP staff member to "monitor Resident 12's hall to ensure no residents entered Resident 12's room." The IP staff member indicated she remained at the nurse's station area during that time and indicated LPN 4 should not have left the betadine solution unattended in Resident 12's room.<br><br>During an interview on 7/24/23 at 9:25 a.m., LPN 4 indicated medications were not to be left unattended in a resident's room.<br><br>On 7/21/23 at 9:10 a.m., the DNS provided a copy of the Medication Pass Procedure Section: Skills | | | |

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| | Validation policy, dated December 2016, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...7. Medications-not left at bedside..."<br><br>3.1-45(a)(1) | | | |
| F 0732 SS=C Bldg. 00 | 483.35(g)(1)-(4)<br>Posted Nurse Staffing Information<br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not | | | |

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| | to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>Based on interview and record review, the facility failed to ensure the daily posted nurse staffing documents reflected the actual hours worked by staff from 6/14/23 through 7/17/23.<br><br>Finding includes:<br><br>On 7/18/23 at 2:00 p.m., the Director of Nursing Services (DNS) provided a copy of the daily Posted Nursing Staffing Data documents for 6/14/23 through 7/17/23. A review of the documents indicated, but were not limited to, the following:<br><br>- a column titled "Specific Shift" had dedicated space available for the actual work start times and end times per shift for each licensed staff.<br><br>- the documents lacked the actual hours worked by staff.<br><br>During an interview on 7/21/23 at 1:56 p.m., the DNS indicated the daily posted nurse staffing documents lacked the actual work start and end times for each shift.<br><br>On 7/21/23 at 8:15 a.m., the DNS provided a copy of the Posted Staffing Data and Retention Requirements policy, dated July 2019, and indicated it was the current policy in use by the facility. A review of the policy indicated, "...To allow public access to posted nursing staffing | F 0732 | **F tag: 732 – Posted Nurse Staffing Information**<br><br>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>- **No residents were affected.**<br><br>- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>- **All residents/staff have the potential to be negatively affected**<br>- **Education will be provided by the DNS on or before _Aug. 18, 2023_____ to the scheduler regarding completion of the form for nurse staffing to include specific starting an**<br><br>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not | 08/18/2023 |

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| | data per federal regulations...the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered nurses...licensed practical nurses...certified nurse aides...the total hours column should be all hours worked during each specific shift. Total hours should include the total actual hours worked on each shift including partial shifts. For example, a licensed nurse works...and your shifts are 2-10 p.m..." | | recur;<br>- **Education will be provided by the DNS on or before Aug. 18, 2023_____ to the scheduler regarding completion of the form for nurse staffing to include specific starting and ending shift times.**<br>- **DNS/designated manager will review posted nursing staff form for completion daily**<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br><br>- **To ensure compliance, the DNS/Designee is responsible for the completion of the Required Postings CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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| F 0921 SS=E Bldg. 00 | 483.90(i)<br>Safe/Functional/Sanitary/Comfortable Environ<br>§483.90(i) Other Environmental Conditions<br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>Based on observation, interview, and record review the facility failed to ensure paper towels were available for facility staff and residents for 11 of 24 rooms observed. (Room 103, Room 104, Room 105, Room 106, Room 107, Room 108, Room 203, Room 204, Room 206, Room 207, Room 215)<br><br>Findings include:<br><br>1. On 7/20/23 at 10:35 a.m., Room 103 and Room 104's shared bathroom was observed. The paper towel dispenser was not able to dispense paper towels.<br><br>2. On 7/20/23 at 10:36 a.m., Room 105 and Room 106's shared bathroom was observed. The paper towel dispenser was not able to dispense paper towels.<br><br>3. On 7/20/23 at 10:37 a.m., Room 107 and Room 108's shared bathroom was observed. The paper towel dispenser was not able to dispense paper towels.<br><br>4. On 7/20/23 at 10:38 a.m., Room 203 and Room 204's shared bathroom was observed. The paper towel dispenser was not able to dispense paper towels.<br><br>5. On 7/20/23 at 10:39 a.m., Room 207 and Room 206's shared bathroom was observed. The paper towel dispenser was not able to dispense paper towels. | F 0921 | **F tag: 921 Environment**<br><br>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>- **Paper towel dispensing was provided right away for residents in rooms 103, 104, 105, 106, 107, 108, 203, 204, 206, 207, 215 and there were no negative outcomes**<br><br>- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>- **All residents have the potential to be affected. All resident rooms were checked for paper towel dispensing and corrected as needed**<br><br>what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>- **Education will be provided to staff by the** | 08/18/2023 |

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| | 6. On 7/20/23 at 10:45 a.m., Room 215's bathroom was observed. The paper towel dispenser was not able to dispense paper towels.<br><br>During an interview on 7/20/23 at 10:30 a.m., Licensed Practical Nurse (LPN) 1, indicated the paper towel dispenser in Room 107 was "out of paper towels."<br><br>During an interview on 7/20/23 at 10:45 a.m., Housekeeper 3 indicated the available paper towels were too small for the automatic paper towel dispenser, and indicated most of the paper towel holders in the facility did not work. "They have not worked for awhile," and indicated she reported the issue to her supervisor.<br><br>During an interview on 7/20/23 at 11:00 a.m., Certified Nursing Assistant (CNA) 2 indicated the only working paper towel dispenser was located behind the nursing station.<br><br>During an interview on 7/20/23 at 10:35 a.m., the Director of Nursing indicated all the resident bathrooms should have paper towels available for proper hand hygiene.<br><br>During an interview on 7/20/23 at 12:55 p.m., the Administrator was unaware the paper towel dispensers were not dispensing paper towels properly. "The batteries were dead in some of the dispensers, but the dispensers all had paper towels in them."<br><br>During an interview on 7/21/23 at 9:00 a.m., Regional Corporate Support Director indicated the facility should always have paper towels available in all the residents rooms. | | **Executive Director/designee regarding replenishing paper towels for resident rooms on or before August 18, 2023.**<br>**- Housekeeping staff will check daily for paper towel dispensing in resident rooms and correct as needed. Managers will check paper towel dispensing during customer care rounds**<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br><br>**- To ensure compliance, the Housekeeping Supervisor is responsible for the completion of the Environmental CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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| | On 7/20/23 at 12:55 p.m., the Administrator provided a policy titled Hand Hygiene, dated February, 2010, and indicated it was the current policy being used by the facility. A review of the policy indicated, "1. check that sink areas are supplied with soap and paper towels. ...8. Use clean paper towel; dry hands and wrists. ...10. Use paper towel to turn off faucet."<br><br>3.1-19(f)(5) | | | |
| F 9999<br><br>Bldg. 00 | 3.1-14 PERSONNEL<br><br>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work.<br>The facility must assure the following:<br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the | F 9999 | F tag: 9999 Personnel<br><br>- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice<br>- **No residents were affected.**<br><br>- how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken<br>- **All residents and staff have the potential to be negatively affected**<br>- **Tb test documentation was reviewed for staff hired in the past 30 days.**<br><br>what measures will be put into place or what systemic | 08/18/2023 |

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| | 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 repeat testing will depend on the risk of infection with tuberculosis.<br><br>This State rule was not met as evidenced by:<br><br>Based on interview and record review, the facility failed to document the time tuberculin tests were administered and failed to document the time tuberculin tests were read, to ensure a minimum of 48 and a maximum of 72 hours between administration and reading of results, for 2 of 5 employees reviewed during the employee record review. (Cook 5, CNA 6)<br><br>Findings include:<br><br>1. On 7/21/23 at 9:55 a.m., the employee record of Cook 5 was reviewed. The employee immunization record indicated the following:<br>- Cook 5 had a hire date of 4/12/23.<br><br>- Cook 5 received a Step 1 Mantoux test (The Mantoux skin test or tuberculin skin test is used for detecting tuberculosis, a potentially serious infectious disease caused by bacteria that most often affects the lungs) on 4/11/23 in the left forearm and the test was read on 4/13/23. Both the time the test was administered and the time the test was read were not documented on the record.<br><br>- Cook 5 received a Step 2 Mantoux test on 4/25/23 in the right forearm and the test was read on 4/27/23. Both the time the test was administered and the time the test was read were not documented on the record.<br><br>- Cook 5's employee immunization record included | | changes will be made to ensure that the deficient practice does not recur;<br>- **Education will be provided by DNS/designee to licensed nursing staff on proper documentation of TB skin test administration and reading of TB skin test to include time administered and read on or by August 18, 202**<br><br>- how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;<br><br>**To ensure compliance, the DNS/Designee is responsible for the completion of the Employee File Audit CQI tool weekly times 4 weeks, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.** | |

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| | places to document the date/time given, the site, the lot number, the nurse's signature administering the test, the date/time read, the results in mm (millimeters), and the nurse's signature reading results.<br><br>2. On 7/21/23 at 10:20 a.m., the employee record of Certified Nursing Aide (CNA) 6 was reviewed. The employee immunization record indicated the following:<br><br>- CNA 6 had a hire date of 4/11/23.<br><br>- CNA 6 received a Step 1 Mantoux test on 3/22/23 in the right forearm and the test was read on 3/24/23. Both the time the test was administered and the time the test was read were not documented on the record.<br><br>- CNA 6 received a Step 2 Mantoux test on 4/4/23 in the right forearm and the test was read on 4/6/23. Both the time the test was administered and the time the test was read were each documented on the record.<br><br>- CNA 6's employee immunization record included places to document the date/time given, the site, the lot number, the nurse's signature administering the test, the date/time read, the results in mm (millimeters), and the nurse's signature reading results.<br><br>During an interview on 7/21/23 at 1:55 p.m., the Director of Nursing (DON) indicated that both the times of the skin test administrations and the times that the tests were read for each employee should have been documented on the employee immunization records.<br><br>On 7/24/23, the DON provided a nursing skills | | | |

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| | competency checklist titled, "Tuberculin Skin Test - Give and Read" dated for 3/2019, and indicated it was the competency skills checklist currently in use. The document indicated that the final step for both giving a tuberculin skin test and reading a tuberculin skin test was "Document pertinent information." Under the portion on reading a tuberculin skin test the document had a note indicating "skin test should be read between 48 to 72 hours after skin test has been administered." | | | |