STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	11/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN HEALTH ALTERNACARE	1104 E GRACE ST RENSSELAER, IN 47978

(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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: November 27 and 28, 2017. Facility number: 004199 Residential Census: 13 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/30/17.	R 0000		
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.			

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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	(2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure an emergency file was complete and accurate related to a resident's advanced directive information for 1 of 5 residents reviewed. (Resident 4) Finding includes: On 11/27/17 at 9:45 a.m., the emergency file was reviewed for Resident 4. The file lacked any documentation of the resident's advanced directive information. Interview with the Director of Nursing (DON) on 11/27/17 at 11:00 a.m., indicated the emergency file did not have the resident's advanced directive information and she would update the emergency file for the resident immediately.	R 0356	Missing Advanced Directives (POST Form) The emergency file listed was immediately fixed (11/27), upon notification of missing document (Advanced Directive). POST form was copied from chart and placed into emergency file. Education has been provided to all the licensed nursing staff to ensure compliance going forward. This education occurred on 12/12/17. A review of all resident emergency files, was completed on 12/11/17, to ensure that all components of the Emergency Record are present, including the Advanced Directives/POST Forms. A QA form was created and will be attached to all new POST forms. The QA form is attached. This will ensure compliance going forward. The completed QA form will be signed and turned into the	12/12/2017

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			Alternacare Nurse Manager. The Alternacare Nurse Manager/designee will audit new admissions within 24 hours of admission for compliance, for presence of Advanced Directives. The Alternacare Nurse Manager is responsible for ensuring compliance and auditing of this process.	
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 record review and interview, the facility failed to ensure residents received a tuberculin (TB) test on or prior to admission for 2 of 7 residents reviewed for TB testing. (Residents 4 &	R 0410	Infection Control: All new admissions will have a TB screening test (or CXR, if positive converter). The admission nurse will enter the appropriate order	12/12/2017

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	5) Findings include: 1. Record review for Resident 4 was completed on 10/27/17 at 9:45 a.m. Diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus. The resident was admitted to the facility on 9/27/17 and received a TB test on 10/6/17. The record lacked any documentation the resident had received a TB test on admission or within 3 months prior. Interview with the Director of Nursing (DON) on 11/27/17 at 2:45 p.m., indicated the resident had received a TB test in February 2017 while in another facility. The resident did not get a TB test on admission or within 3 months prior to admission to the facility. The TB test was not competed until 10/6/17. 2. Record review for Resident 5 was completed on 10/27/17 at 10:12 a.m. Diagnoses included, but were not limited to, Parkinson's disease, high blood pressure and anemia (low iron level). The resident was admitted on 3/3/17 and received a first step TB test on 3/17/17 and a second step on 3/24/17. The record		into the computer and call lab to ensure they received the order. This will be documented on the Admission Checklist for Alternacare. Education has been provided to all the licensed nursing staff to ensure compliance going forward. This occurred on 12/12/17. A review of the remaining 11 resident files verified that admission TB regulations for admission are in compliance. The QA form (see attachment) is on the Admission Checklist for Alternacare and will be reviewed by the Alternacare Nurse Manager or designee, on day of admission for adherence to regulation. The Alternacare Nurse Manager is responsible for ensuring compliance and auditing of this process.	

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	lacked documentation the resident had received a TB test on admission or within 3 months prior. Interview with the DON on 11/27/17 at 3:15 p.m., indicated the resident should have received the first step TB test on the day of admission and it was not completed until 3/17/17. A current Tuberculosis Testing Procedure policy, dated 2/20/17 and provided by the DON on 11/28/17 at 10:02 a.m., indicated "...Policy: Verification that the resident is free of communicable disease including Tuberculosis in an infective state shall be by PPD test, either within 3 months prior or upon admission...."			