

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

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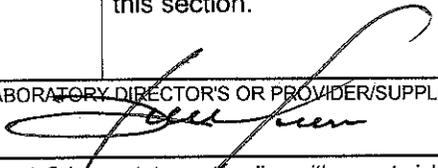
PRINTED: 05/12/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435112 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/01/2014 |
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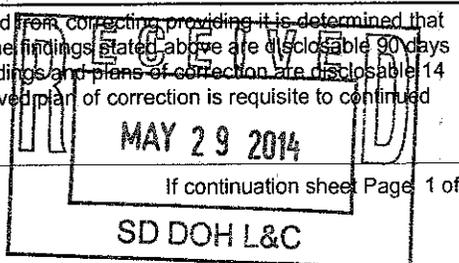
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| NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE 510 E 8TH ST POST OFFICE BOX 370 FREEMAN, SD 57029 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| F 000 | INITIAL COMMENTS Surveyor: 25107 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/29/14 through 5/1/14. Oakview Terrace was found not in compliance with the following requirements: F157, F371, and F514. | F 000 | <i>Addendums noted with an asterisk per 4/14/14 telephone to facility don. NS/SDDOH/ME</i> | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. | F 157 | A new policy entitled "Change in Condition" was drafted and approved by the DON on 4/30/14. Policy directs staff to refer to a physician any change in a resident's condition for appropriate follow-up and/or orders. Policy also directs staff to document the change in condition in progress notes. The policy entitled "Charting: Nursing Documentation" was revised by the DON on 4/30/14. Policy addresses that progress will be maintained for each resident from admission to discharge and that any changes in the resident's condition and/or resident responses to treatment will be recorded in the resident's medical record. Staff-specific education with nursing staff took place between 5/1/14 - 5/3/14. This was completed by the DON. Education consisted of individualized instruction regarding appropriate documentation of resident's condition and follow-up with resident's physician for care. Education of the entire nursing staff took place on 5/22/14. Education was completed by the DON. Education consisted of reviewing the "Change in Condition" and "Charting: Nursing Documentation" policies and instructing staff to refer to a physician any change in a resident's condition for appropriate follow-up/or orders. Staff were also educated on the requirement that progress notes be maintained for each resident from admission to discharge and that any (continued on Page 2 of 8) | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE CEO | (X6) DATE 5/27/14 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| F 157 | <p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure the physician was notified in a timely manner for a significant change in condition for 1 of 12 sampled residents (5). Findings include:</p> <p>1. Review of resident 5's 2/15/14 nurses' progress notes revealed he had been taken to the clinic following a fall. He had a cut on his right fifth finger that had required five stitches. Review of his nurses' notes following that clinic visit revealed: *2/17/14 at 4:45 p.m.: The fifth finger on his right hand was swollen and pink. He did not complain of pain at that time. *2/18/14 at 9:49 p.m.: There was a gaping area to the right fifth finger with only three and one half stitches noted. His finger was swollen, red, and puffy. It seemed warm to the touch and was bent. He would not straighten it out. It had appeared a stitch might have loosened or broken. There was a gap noted in the middle area of the laceration. *2/19/14 at 8:47 p.m.: The fifth finger was reddened, swollen, and gaping. No drainage had been noted. Only three and one half stitches were observed. The finger did not straighten, and he kept his finger bent. *2/20/14 at 2:24 a.m.: The right fifth finger remained red and swollen. It was bent with a gaping area noted. No drainage had been seen. *2/20/14 at 11:57 a.m.: He was seen by his doctor</p> | F 157 | <p>(continued From Page 1)</p> <p>changes in the resident's condition and/or resident response to treatment be recorded in the resident's medical record. Staff who were not in attendance at the 5/22/14 education session will meet individually with the DON by 5/27/14.</p> <p>QA audits to ensure that changes are being reported to a physician and that complete progress notes are being kept on the resident's condition and/or response to treatment will be done weekly for three months. If substantial compliance is achieved, QA audits will be conducted monthly for an additional six months. QA audits will be conducted by the Infection Control Director or their designee. The Infection Control Director will report audit findings to the QA committee monthly.</p> <p>5/27/14</p> <p><i>* Resident 5 has had no further concerns that required physician notification. If any concerns do result, the physician will be notified immediately. NS/DOH/mtf</i></p> |

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| F 157 | Continued From page 2 related to his right fifth finger redness, swelling, and stitches missing. He returned with orders for an antibiotic for seven days for wound infection. Interview on 4/30/14 at 11:10 a.m. with director of nursing A revealed it would have been her expectation the physician should have been notified when the first signs of infection were noted. She confirmed the documentation indicated primary signs of infection were first noted on 2/17/14 and again on 2/18/14. Review of the provider's newly revised 4/30/14 Changes in Condition policy revealed residents were to have been referred to the provider for any changes in condition. | F 157 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 25107 Based on observation, interview, and label review, the provider failed to prevent a hazardous chemical (sanitizer) from becoming a food additive for one of one ice scoop stored in a sanitizer solution prior to and between being used | F 371 | 1. A new policy entitled "Water Pass" was drafted by the DON on 5/6/14. Policy directs staff responsible for the water pass to obtain a clean container and a clean ice scoop from the kitchenette cupboard or kitchen prior to each water pass. Staff are to place the ice scoop in a dry, clean container between the filling of each mug. Ice scoop is not to be placed in a container containing sanitizer solution during water passes. Ice scoop and container are to be returned to the kitchen for cleaning after water pass is completed. The sanitizing solution previously used was removed from service by the DON on 5/5/14. Education of dietary staff responsible for taking clean containers and ice scoops to the kitchenette took place on 5/8/14. The delivery of clean containers and ice scoops is the responsibility of the morning cook position. Education was completed by (cont. on Page 4 of 8) | |

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| F 371 | <p>Continued From page 3 to dispense ice. Findings include:</p> <p>1. Observation and interview on 4/29/14 at 3:30 p.m. in the three hundred wing hallway with certified nurse assistant (CNA) C revealed: *She was passing water to the residents. *The ice scoop was stored in a sanitizer solution of 200 parts per million quaternary ammonia. *She would remove the ice scoop from the solution, scoop ice into resident water cups, return the scoop to the solution, fill the cup with water, and deliver the cup to the residents. *The scoop was not rinsed prior to scooping ice and never had a chance to air dry. *She had not considered that each time she used the ice scoop it was wet with the sanitizer, and small amounts of sanitizer were being added to the ice and water. *She had worked there for eight years and to her knowledge they had always carried the ice scoop in the sanitizer solution.</p> <p>Interview on 4/29/14 at 3:45 p.m. with director of nursing A revealed: *The scoop should have been stored in a sanitizer solution of 200 parts per million quaternary ammonia when not in use in the clean utility room. *When the staff started the water pass they should have removed the scoop from the sanitizer, rinsed it with water, and then taken just the scoop with them on the water pass. *She did not know when the practice of taking the sanitizer solution and keeping the scoop stored in the sanitizer solution on the snack cart while passing water began. *She agreed the scoop should have been rinsed or air dried prior to being used as an ice scoop to prevent the chemical from getting into the</p> | F 371 | <p>(Continued from page 4)</p> <p>the Dietary Manager. Education consisted of informing staff that they are to take clean containers and ice scoops to the kitchenette and to return to the kitchen any unused containers or ice scoops. Dietary staff also educated that the sanitizing solution has been removed from service and that a sanitizing solution should never be used.</p> <p>Education of nursing/CNA staff took place on 5/22/14. Staff educated on the Water Pass policy and that ice scoops never be kept in a container containing sanitizing solution during the water pass. Additionally, staff were educated that a clean ice scoop and container should be used for each water pass. Following the water pass, the ice scoop and container should be returned to the dietary department to be cleaned. Education was conducted by the DON on 5/22/14. Staff who were not in attendance at the 5/22/14 education session will meet individually with the DON by 5/27/14.</p> <p>QA audits to ensure that the ice scoop is no longer kept in a container containing sanitizing solution will be done weekly for three months. If substantial compliance is achieved, QA audits will be conducted monthly for an additional three months. QA audits will be conducted by the DON or their designee. The DON will report audit findings to the QA committee monthly.</p> | 5/27/14 |

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| F 371 | Continued From page 4 residents' water cups. Review of the instructions for J-512 Sanitizer for sanitizing mobile items revealed: *Immerse in a 200 ppm active quaternary solution for at least 60 seconds making sure to immerse completely. *Remove items, "drain the use solution from the surface, and air dry." | F 371 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation was maintained for | F 514 | | |

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| F 514 | <p>Continued From page 5</p> <p>1 of 12 sampled residents (5) with a significant change in condition. Findings include:</p> <p>1. Review of resident 5's 2/15/14 nurses' progress notes revealed he had been taken to the clinic following a fall. He had a cut on his right fifth finger that had required five stitches. Review of his nurses' notes following that clinic visit revealed:</p> <p>*2/17/14 at 4:45 p.m.: The fifth finger on his right hand was swollen and pink. He did not complain of pain at that time.</p> <p>*2/18/14 at 9:49 p.m.: There was a gaping area to the right fifth finger with only three and one half stitches noted. His finger was swollen, red, and puffy. It seemed warm to the touch and was bent. He would not straighten it out. It had appeared a stitch might have loosened or broken. There was a gap noted in the middle area of the laceration.</p> <p>*2/19/14 at 8:47 p.m.: The finger was reddened, swollen, and gaping. No drainage had been noted. Only three and one half stitches were observed. The finger did not straighten, and he kept his finger bent.</p> <p>*2/20/14 at 2:24 a.m.: The right fifth finger remained red and swollen. It was bent with a gaping area noted. No drainage had been seen.</p> <p>*2/20/14 at 11:57 a.m.: He was seen by his doctor related to his right fifth finger redness, swelling, and stitches missing. He returned with orders for an antibiotic for seven days for wound infection. No documentation had been found resident 5's laceration had been assessed during the day shift from 2/18/14 until he had been seen by the physician on 2/20/14. No documentation a daily wound monitoring sheet had been completed since the 2/15/14 laceration.</p> <p>*2/22/14: He had been seen by his physician again to have the stitches removed. He was to</p> | F 514 | <p>1. Education of the nursing staff on the policy entitled "Skin Documentation", and the forms entitled "Weekly Skin Healing Record" and "Daily Monitoring Sheet" took place on 5/22/14. This was completed by the DON. Staff were educated on the procedural elements of the policy "Skin Documentation" as well as the need to complete the "Weekly Skin Healing Record" and the "Daily Monitoring Sheet" to ensure skin treatments are implemented and continued until skin injuries/wounds are healed. Staff who were not in attendance at the 5/22/14 education session will meet individually with the DON by 5/27/14.</p> <p>QA audits to ensure the "Skin Documentation" policy is being followed and the forms "Weekly Skin Healing Record" and "Daily Monitoring Sheet" are being completed for each skin injury/wound will be done weekly for three months. If substantial compliance is achieved, QA audits will be conducted monthly for an additional six months. QA audits will be conducted by the DON or their designee. The DON will report audit findings to the QA Committee monthly.</p> <p><i>*Resident 5 has had no further concerns requiring daily monitoring of skin issues. If these should arise, the "Weekly Skin Healing Record" and "Skin Documentation" sheet will be implemented.</i> N/S/SD/MLM</p> | 5/27/14 |
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| F 514 | <p>Continued From page 6</p> <p>continue on his antibiotic. The bandage was to have been changed daily, and the area kept clean and dry. Any drainage was to have been noted.</p> <p>*2/24/14: He returned to the clinic to recheck his finger. If the finger became red, swollen, or had signs/symptoms of infection he was to have returned to the clinic.</p> <p>*2/25/14: He had fallen and had re-injured his right fifth finger. He was seen again at the clinic.</p> <p>*2/27/14: The open area on his right fifth finger remained covered with a Band-Aid.</p> <p>*2/28/14 to 3/3/14: There was no further documentation regarding his finger.</p> <p>*3/3/14. The wound appeared dry and healing.</p> <p>*3/4/14: He had been seen by his physician and was continued on the antibiotic for a wound infection.</p> <p>*3/6/14: There was slight redness noted in that finger.</p> <p>*3/7/14: The finger was pink, swollen, and tender to touch. He continued on the antibiotic.</p> <p>*3/11/14: His antibiotic was discontinued.</p> <p>There was no further documentation regarding his finger until 4/4/14 when the "every day treatment to his left 5th finger laceration" had been discontinued. No documentation on a skin monitoring sheet had been found from the time the wound occurred on 2/15/14 until the treatment had been discontinued on 4/4/14.</p> <p>Interview on 4/30/14 at 11:10 a.m. with director of nursing A revealed a skin assessment sheet should have been started as soon the wound was found. Daily monitoring should have been documented until the wound had healed. A weekly skin healing record should also have been started and completed. She confirmed that documentation had not been done. The daily monitoring sheet was a part of the electronic</p> | F 514 | | |

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| F 514 | <p>Continued From page 7</p> <p>medical record that had been started on 1/1/14.</p> <p>Review of the provider's 9/18/13 Skin Documentation policy revealed:</p> <ul style="list-style-type: none"> *The purpose was to ensure skin injuries and wounds were assessed and treated to promote healing and to prevent infection. *Skin treatments were to have been implemented and continued until healed for all skin injuries and wounds. *The skin assessment including time and date, cause, size, depth, length, signs of infection, drainage, color, odor, or other pertinent information was to have been documented in the nurses notes. *Any skin issue was to have been reported to the physician and treatment orders obtained. *A weekly skin healing record was to have been started at the time the skin issue had been noted. *Healing progress was to have been recorded on the skin healing record weekly. <p>Review of the provider's 1/1/14 Daily Monitoring Sheet revealed daily monitoring included:</p> <ol style="list-style-type: none"> 1. The status of the dressing. 2. Skin integrity. 3. Documentation of anything abnormal, signs of infection, notification of the physician, and addressing of the resident's pain. 4. Reporting of anything abnormal to the physician including signs of infection or deterioration to the area. | F 514 | | | |

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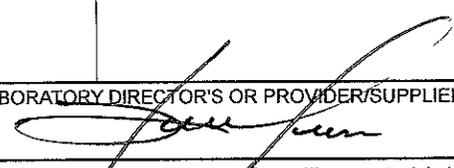
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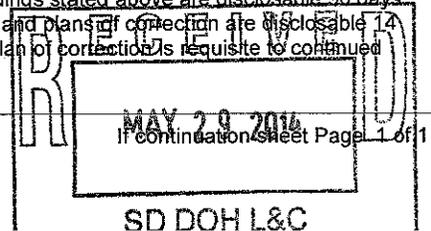
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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/30/14. Oakview Terrace was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE CEO | (X6) DATE 5/27/14 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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SOUTH DAKOTA DEPARTMENT OF HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0006 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 05/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER OAKVIEW TERRACE | STREET ADDRESS, CITY, STATE, ZIP CODE 510 EAST 8TH STREET, P.O. BOX 370 FREEMAN, SD 57029 |
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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) COMPLETE DATE |
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| S 000 | Initial Comments Surveyor: 25107 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/29/14 through 5/1/14. Oakview Terrace was found not in compliance with the following requirement: S236. | S 000 | | |
| S 236 | 44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Rule is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure a two-step tuberculin (TB) screening test or evaluation had been completed for 2 of 12 sampled residents (6 | S 236 | 1. Admission checklists have been revised to include section for the nurse to complete regarding date second TB was given and read. Form was revised by the DON on 5/5/14. Education of the nursing staff on the policy entitled "Tuberculosis Testing" and on the newly revised admission checklists took place on 5/22/14. This was completed by the DON. Staff were educated on the policy including the requirement that a two-step TB be completed within fourteen days of admission. Staff who were not in attendance at the 5/22/14 education session will meet individually with the DON by 5/27/14. QA audits to ensure a two-step TB is completed within fourteen days of admission will be done on all new admissions weekly for three months. If substantial compliance is achieved, QA audits will be conducted on all new admissions monthly for an additional six months. QA audits will be conducted by the Infection Control Director or designee. The Infection Control Director will report audit findings to the QA committee monthly. | 5/27/14 |

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

TITLE

(X6) DATE

CEO

STATE FORM

021199

JQ1311

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| R E C E I V E D | MAY 29 2014 |
| | SD DOH L&C |

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| S 236 | Continued From Page 1 and 11). Findings include: 1. Review of resident 6's TB screening form revealed she had been admitted on 4/3/14. Her first step TB screening had been administered on 4/3/14. The second step had been administered on 4/28/14 that was more than fourteen days after her admission. Interview on 4/30/14 at 2:55 p.m. with director of nursing B confirmed the second step had been overlooked. She confirmed it had not been completed in a timely manner. Review of the provider's 12/8/11 Tuberculosis Testing policy revealed all residents should have completed a two-step TB skin test within fourteen days of admission. Surveyor: 33265 2. Review of resident 11's entire medical record revealed: *She had been admitted on 9/18/12. *She had an allergy/sensitivity to the Mantoux skin test (used to detect history or presence of tuberculosis). *No documentation was found any TB skin testing had been done since her admission. *There was no record any physical assessment for signs and symptoms of TB had been completed since her admission. Interview on 4/30/14 at 4:00 p.m. with directors of nursing A and B revealed: *There had been no physical assessment for signs and symptoms of TB completed on resident 1 since her admission. *They both agreed there should have been an annual evaluation by a physician or nurse. | S 236 | 2. A new form entitled "Positive Mantoux Reactor Assesment" was drafted by the DON on 5/5/14. The Positive Mantoux Reactor Assessment form was completed for resident #11 and placed in the resident's medical record. This was completed by the DON on 4/30/14 . Education of the nursing staff on the new policy entitled "Positive Mantoux Reactor Assessment" took place on 5/22/14. This was completed by the DON. Staff were educated on the requirement that a yearly evaluation needs to be completed on those residents with an allergy to the tuberculin skin test. Staff were also educated on the use of the new form for those residents needing to be evaluated annually for exposure to TB and TB symptoms. Staff who were not in attendance at the 5/22/14 education session will meet individually with the DON by 5/27/14. (continued on Page 3 of 3) | |

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| S 236 | Continued From Page 2 Review of the provider's policy dated 6/4/13 titled tuberculosis control plan revealed a resident with an allergy to tuberculin skin test should have been evaluated yearly for exposure to TB and TB symptoms. | S 236 | Continued From Page 2 QA audits to ensure the yearly evaluation is being completed will be done monthly for twelve months. QA audits will be conducted by the Infection Control Director or designee. The Infection Control Director will report audit findings to the QA committee monthly. | 5/27/14 |