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	10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARENDALE OF SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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: October 29 and 30, 2019 Facility number: 013825 Residential Census: 72 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/4/19.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to promptly notify the Physician of an urinary tract infection which required the use of antibiotic therapy for 1 of 7 residents reviewed. (Resident 5) Finding includes: The record for Resident 5 was reviewed on 10/29/19 at 1:18 p.m. Diagnoses included, but were not limited to, prostate cancer, subdural	R 0036	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.Resident #5, physician notified of lab orders, resident orders have been implemented and physician orders to start antibiotic for UTI has been administered. Clinical staff have received in-service documenting	12/02/2019

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

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	hematoma, diabetes, high blood pressure, stroke, and atrial fibrillation. An Advanced Practice Nurse's Order, dated 6/28/19, indicated to obtain an Urinalysis (UA) with culture and sensitivity. A Nurses' Note, dated 7/1/19 at 6:49 p.m., indicated "labs drawn this morning. Home Health will obtain urine on Wednesday." The lab results, dated 7/3/19, for the Urinalysis indicated the urine was clear yellow and there were few bacteria. A Nurses' Note, dated 7/5/19 at 2:45 p.m., indicated "spoke with Physician's office regarding the lab and UA results. Physician was out of the office until Monday and he will review the results then and call back with any new orders." A Nurses' Note, dated 7/8/19 at 2:43 p.m., indicated "left message with Physician's office related to labs and UA results. The office confirmed receiving the results and the Physician would review and get back to the facility with any new orders." A Nurses' Note, dated 7/9/19 at 2:54 p.m., indicated the lab results were faxed to the Physician. The urine culture and sensitivity, dated 7/8/19, indicated there was (greater than) >100,000 Kleb. pneumonia organisms in the urine, indicating an urinary tract infection. The organism was sensitive to the antibiotic of Tetracycline. A Nurses' Note, dated 7/12/19 at 1:06 p.m., indicated the writer spoke with the Physician's		communication to physician regarding notification of labs and ensuring resident (s) receive physician orders to prevent delay in resident treatment of care. 2.How the facility will identify other resident (s) having the potential to be affecte4d by the same deficient practice and what corrective action will be taken: 1.Director of Health Services and or assigned designee, will provide on going clinical education to ensure physician notification has been completed regarding resident (s) lab orders. Director of Health Service and or designee, will review all resident medical records to ensure all lab orders are communicated and documented in resident records of physician notification and documentation has been completed by assigned clinical staff. Director of Health Services and or designee will audit labs orders daily for three months, if no deficiencies noted after three month then Director of Health Services and or designee will audit up 3x weekly to ensure physician notification of labs and orders to be followed, are in compliance for the continuous. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.Director of Health Services	

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	office related to the labs faxed on 7/9/19. We were informed by the office the Physician would review and call back with any new orders. A Nurses' Note, dated 7/16/19 at 1:46 p.m., indicated the writer spoke with the Physician's office to follow up on the lab results faxed to him on 7/9/19. The office indicated the Physician still needed to review the results. A Nurses' Note, dated 7/20/19 at 10:42 a.m., indicated a new order was received from the Physician for the resident to start Doxycycline (an antibiotic) 100 milligrams twice a day for 60 days due to a wound infection. A Nurses' Note, dated 7/21/19 at 9:31 a.m., indicated the initial dose of Doxycycline was administered. Interview with the Director of Health Services on 10/30/19 at 8:50 a.m., indicated the nursing staff attempted to call the Physician's office regarding the lab results, however, he was either out of town or had not reviewed them yet. There were several days were the nursing staff did not attempt to call the Physician. The nurse who obtained the order indicated she did not document the antibiotic was for the urinary tract infection as well as the wound infection. The facility does not have a Medical Director.		and or designee, by compliance date will complete an 100 % audit of all resident (s) labs to ensure meeting compliance of physician notification of labs and orders. Monthly audits will be included in QAPI to track and trend clinical education regarding physician notification of labs and orders to be followed. If clinical staff is to be out of compliance with physician notification and lab orders, re-education regarding policy and procedure of physician notification and labs orders will be given along with written documentation of education. After three months of consecutive 100 % compliance up to 80% of physician notification and lab orders will be audited weekly to ensure continued compliance. Results will be discussed monthly during QAPI meetings. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: 1.Director of Health Services and or designee will complete 100% audit on resident (s) medical records to ensure physician notification and lab orders are being followed. After three months of consecutive 100% compliance will review all medical records for physician notification and lab orders 3x weekly. All findings will be reviewed at	

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			monthly QAPI meetings. 2.Compliance by 12/01/2019	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), 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 facility must assure the following: (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. The first tuberculin skin test must be read prior to the employee starting work. 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 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 of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of			

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	active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure every new employee had a health screen prior to working and a second step tuberculin skin test was performed for 2 of 5 employee records reviewed. (LPN 2 and CNA 1) Findings include: 1. The employee files were reviewed on 10/30/19 at 10:00 a.m. a. LPN 2, with a hire date of 9/23/19, did not have health screen prior to working. b. CNA 1, with a hire date of 9/17/19, did not have a health screen prior to working. A first step tuberculin skin test was read on 9/10/18. There was no second step tuberculin skin test available for review. Interview with the Business Office Manager on 10/30/19 at 10:40 a.m., indicated the above employees did not have a health screen prior to their start date or at the time of the start date. There was no second step tuberculin skin test for CNA 1.	R 0121	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.LPN 2, no longer employed with Clarendale, CNA 1, will removed from resident care until physical has been completed and TB 1st step have been completed. Compliance of 11/18/19 will be met for CNA 1, to have completed physical and 1st TB step. 2.How the facility will identify other resident (s) having the potential to be affected by the same deficient practice and what corrective action will be taken: 1.100% audit has been completed on new hire to ensure compliance for health screens and TB 1st and 2nd steps, compliance met 11/5/2019. Human Resources and or assigned designee will audit all new hire requirements to ensure compliance is being met. No staff will be permitted to work unless all prescreening requirements have been met. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.100% of new hire files will	11/18/2019

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			be reviewed weekly for three months to ensure compliance is being met. No new hire will be permitted to work in the community until prescreen requirements are met. After three months of consecutive of 100% compliance, 50% of new hire and 50% of yearly anniversary files will be audited to ensure compliance is met. If employee is to be found to be out of compliance, employee will be immediately removed from schedule shifts until compliance is met. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: 1.100% of new hire audits will be audited monthly, and if 100% consecutive audit compliance, 50% of new hire files will be audited monthly to ensure compliance of prescreen requirements are met. If any employee is found to out of compliance, the employee will be removed from schedule until all prescreen; health screens and TB 1st and 2nd steps are completed. 2.This will be part of our monthly QAPI meetings. 5.Compliance by 11/18/2019	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be			

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	as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review, and interview the facility failed to ensure an insulin flexpen was primed prior to use and sliding scale insulin was documented as being administered for 1 of 5 residents observed during medication pass and 1 of 7 residents reviewed for Physician's Orders. (Resident 1) Finding includes: On 10/29/19 at 11:50 a.m., during medication pass, LPN 1 was observed preparing an insulin injection for Resident 1. At that time, the LPN placed the needle on the Novolog Insulin Flexpen and dialed it to 20 units. The resident's 11:42 a.m. blood sugar was 205. She wiped the resident's abdomen with an alcohol pad and administered all 20 units via the flexpen. She did not prime the pen prior to use to ensure all the air was removed and the dose was accurate. The record for Resident 1 was reviewed on 10/29/19 at 2:14 p.m. Diagnoses included, but were not limited to, diabetes, heart disease, Alzheimer's, and depression. Physician's Orders, dated 9/7/19, indicated Novolog Flexpen, inject three times per day in the morning, lunch, and dinner per sliding scale parameters: 60-110=0 111-200=15 units 201-300=20 units	R 0241	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.Director of Health Services followed Resident 1, Levemir (insulin) instruction are in place. Clinical staff have been in-service to follow manufacture instruction of priming Flexpen prior to administering resident 1 insulin. 2.Resident 1, physician notification of blood sugar parameters is documented and sliding scale has been added to resident medical chart and daily Medication Administration Records. 1.How the facility will identify other resident (s) having the potential to be affected by the same deficient practice and what corrective action will be taken: 1.Director of Health Care Services and or assigned designee, audit resident (s) with blood sugar monitoring, all current sliding scales orders have been updated to reflect units given and to be signed when give. 2.Clinical staff have been in-service on following resident (s) physician orders for blood sugar parameters and documentation on	12/01/2019

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	301-350=25 units 351-400=30 units 401-450=35 units Blood sugar greater than 451=call Physician Interview with the Director of Health Services on 10/30/19 at 10:00 a.m., indicated she was unaware the insulin flexpen was supposed to be primed prior to use. The insert and instructions for use of the Novolog Flexpen, indicated "Prime your pen. Turn the dose selector to select 2 units. Press and hold the dose button. Make sure a drop appears. Turn the dose selector to select the number of units you need to inject." A Physician's Order, dated 9/7/19, indicated the resident was to receive Levemir (insulin) by the way of a flexpen one time per day between 8:00 p.m. and 10:00 p.m. based on the following sliding scale: 60-110=0 111-150=30 units 151-250=38 units 251-300=40 units 301-350=42 units 351-400=45 units 401-450=50 units Blood sugar greater than 451=call Physician The 10/2019 Medication Administration Record, indicated there was no documentation related to the amount of insulin administered on the following dates and times for both the Novolog and Levemir insulin: 10/1/19 AM (8:00 a.m. - 10:00 a.m.) blood sugar 196, no documentation of insulin given.		blood sugar parameters. 3.Director of Health Services and or designee, will educate clinical staff regarding insulin Flexpen requirements for directions and proper usage. Director of Health Service and or designee, will review resident (s) with blood sugar monitoring and insulin have parameters documented on the resident (s) Medication Administration Record. Director of Health Services and or designee will audit 100% resident (s) with blood sugars parameters orders daily for three months, if no deficiencies noted after three month then Director of Health Services and or designee will once monthly to ensure physician orders are followed and blood sugar parameters are being documented on resident (s) Medication Administration Records, 2.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.Director of Health Services and or designee, will complete an 100 % audit of all resident (s) who have Flexpen and sliding scale to ensure Flexpen instruction are being followed prior to administering resident (s) sliding scale orders. Director of Health Services and or designee will complete 100% audit on	

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	Lunch (11:00 a.m. - 1:00 p.m.) blood sugar 204, no documentation of insulin given. Dinner (5:00 p.m. - 7:00 p.m.) blood sugar 168, no documentation of insulin given. PM (8:00 p.m. - 10:00 p.m.) blood sugar 159, no documentation of insulin given. 10/2/19 AM blood sugar 238, no documentation of insulin given. Lunch blood sugar 238, no documentation of insulin given. Dinner blood sugar 168, no documentation of insulin given. PM blood sugar 197, no documentation of insulin given. 10/3/19 AM blood sugar 294, no documentation of insulin given. Lunch blood sugar 265, no documentation of insulin given. Dinner blood sugar 137, no documentation of insulin given. PM blood sugar 199, no documentation of insulin given. 10/4/19 AM blood sugar 148, no documentation of insulin given. Lunch blood sugar 188, no documentation of insulin given. Dinner blood sugar 163, no documentation of insulin given. PM blood sugar 157, no documentation of insulin given. 10/5/19 AM blood sugar 126, no documentation of insulin given. Lunch blood sugar 214, no documentation of insulin given. Dinner blood sugar 139, no documentation of insulin given.		resident(s) Medication Administration Record documentation of sugar parameters to ensure resident (s) safety of medication administration. 2.Monthly audits will be included in QAPI to track and trend clinical education regarding compliance of usage Flexpen directions, proper usage, and documentation of blood sugar parameters. After three months of consecutive 100 % compliance, once monthly up to 90% resident (s) with blood sugars will reviewed to ensure compliance. Director of Health Services and or designee, will complete monthly education with clinical team to ensure Flexpen instructions are being followed for three months, then will audit once month to ensure Flexpen instruction are being followed prior to administering resident (s) sliding scale orders. Results will be discussed monthly during QAPI meetings. 3.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: 1.Director of Health Services and or designee will complete 100% audit on resident (s) medical records to ensure blood sugar parameters documented and are being followed. After three months of consecutive 100%	

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	PM blood sugar 283, no documentation of insulin given. 10/6/19 AM blood sugar 138, no documentation of insulin given. Dinner blood sugar 215, no documentation of insulin given. PM blood sugar 277, no documentation of insulin given. 10/7/19 AM blood sugar 130, no documentation of insulin given. Lunch blood sugar 153, no documentation of insulin given. PM blood sugar 180, no documentation of insulin given. 10/8/19 AM blood sugar 245, no documentation of insulin given. Lunch blood sugar 210, no documentation of insulin given. Dinner blood sugar 139, no documentation of insulin given. PM blood sugar 340, no documentation of insulin given. 10/9/19 AM blood sugar 250, no documentation of insulin given. Lunch blood sugar 117, no documentation of insulin given. Dinner blood sugar 150, no documentation of insulin given. PM blood sugar 308, no documentation of insulin given. The resident should have received insulin coverage for the rest of the month except on the following dates: 10/11/19 Lunch blood sugar 98		compliance will review once monthly resident (s) with blood sugar orders, to ensure parameters are documented on the resident (s) Medication Administration Records and review clinical staff Flexpen medication pass. All findings will be reviewed at monthly QAPI meetings. 4.Compliance by 12/01/2019	

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	10/15/19 AM blood sugar 107 10/17/19 PM blood sugar 103 10/20/19 Dinner blood sugar 71 10/21/19 Dinner blood sugar 83 10/24/19 Dinner blood sugar 100 10/28/19 Dinner blood sugar 100 Interview with the Director of Health Services on 10/30/19 at 10:25 a.m., indicated the amount of insulin given should have been documented.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to an accumulation of grease on the combi-oven, fryer, stove/oven, grill, and flat top for 1 of 1 kitchens. (The Main Kitchen) Finding includes: On 10/29/19 at 8:44 a.m., during the Brief Kitchen Tour with the Culinary Director, the following was observed: a. An accumulation of grease on the sides and front of the combi-oven. b. An accumulation of grease on the sides and back of the fryer. c. An accumulation of grease on stove top and backsplash. d. An accumulation of grease on the front of the	R 0273	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.Culinary staff immediately cleaned all ovens, stove-tops, and backsplash equipment to ensure all accumulation of grease was removed. Culinary Director immediately in-serviced all culinary staff regarding infection control policy and procedure to ensure kitchen equipment sanitized before and after each use of the equipment. 2.How the facility will identify other resident (s) having the potential to be affected by the same deficient practice and what corrective action will be taken: 1.100% of culinary cooks and chefs have been in-serviced	11/18/2019

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	oven and debris inside the oven. e. An accumulation of grease on the grill top and backsplash. f. An accumulation of grease on the flat top. Interview with the Culinary Director, on 10/29/19 at 3:08 p.m., indicated the appliances needed to be cleaned more often than monthly to decrease grease build up.		on infection control of sanitizing kitchen ovens, stove tops, and backsplash. Culinary Director and or assignee designee will audit daily for three months to ensure infection control of sanitization of kitchen oven, stove tops, backsplash are in compliance. When 100% consecutive audits are met, Culinary Director and or assignee designee will audit three times a week to ensure infection control sanitization compliance is met. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.Culinary Director and or assignee designee will complete daily checklist audit to ensure infection control policies and procedure are being followed to reduce grease build up on ovens, stove tops, and backsplash. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: 1.Infection control and sanitization procedure will be part of our monthly QAPI meetings. 5.Compliance by 11/18/2019	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following:			

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		A. BUILDING 00 B. WING	10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CLARENDALE OF SCHERERVILLE	7770 BURR STREET SCHERERVILLE, IN 46375

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	(A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over-the-counter medications were labeled with the name of the resident's Physician for 1 of 5 residents observed during medication administration. (Resident 1) Finding includes: On 10/29/19 at 11:42 a.m., LPN 1 was observed preparing medications for Resident 1. A bottle of Cystex Urinary Health and a bottle of Alive Multivitamin were removed from the medication cart. The bottles were not labeled with the name of the resident's Physician. Interview with the Director of Health Services on 10/30/19 at 11:24 a.m., indicated the facility did not have a policy related to medication labeling, but the over-the-counter bottles of medication should have been labeled with the name of the resident's Physician.	R 0302	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.Director of Health Care Services and or assigned designee will notify resident (s), primary care physician that are OTC will need order with pharmacy label to be in compliance. 2.Director of Health Care Services and or assigned designee, in-serviced clinical staff to review resident (s) OTC to ensure we are meeting compliance. 3.All resident (s) residing in Assisted Living and Memory Care and families will be notified of the OTC primary physician notification and pharmacy labeling. 2.How the facility will identify other resident (s) having the potential to be affected by the same deficient practice and what corrective action will be taken: 1.Director of Health Care Services and or assigned designee will do an 100% chart audit of resident (s) medication to ensure OTC have labels. 2.Director of Health Care Services, and or assigned designee will work with resident	12/01/2019

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			(s) and families to educate on the compliance requirements for OTC. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.Director of Health Care Services and or assigned designee, will complete 100% resident (s) audit of OTC medications to ensure primary physician has been notified and pharmacy labeling, when 100% consecutive audit has been met, than up to 90% of resident (s) OTC will be audited for compliance. 2.All new resident (s) will be notified by admitting clinical staff of the OTC requirements to ensure we are meeting compliance. 3.Director of Health Care Services and or assigned designee will do quarterly clinical in-servicing to ensure they are following policy and compliance requirements. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place: 1.OTC labeling will become part of our QAPI until we have ensure policy and compliance are met, once met, Director of Health Services and or assigned designee will report quarterly to QAPI teem to ensure compliance	

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			is being met. 5.Compliance by 12/01/2019	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure an annual health statement was obtained which indicated the residents showed no evidence of tuberculosis in an infectious stage for 2 of 7 records reviewed. (Residents 3 and 5) Findings include: 1. The record for Resident 3 was reviewed on 10/29/19 at 11:08 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, mood disorder, anxiety disorder, depression, and psychotic disorder. The resident was admitted on 5/21/18. There was no annual health statement in the record indicating the resident was free from tuberculosis in an infectious stage. Interview with the Director of Health Services on 10/30/19 at 12:30 p.m., indicated the annual health statement would be added to the Physician's Order Summary. 2. The record for Resident 5 was reviewed on 10/29/19 at 1:18 p.m. Diagnoses included, but were not limited to, prostate cancer, subdural hematoma, diabetes, high blood pressure, stroke, and atrial fibrillation.	R 0409	1.What corrective action will be accomplished for those resident (s) found to have been affected by the deficient practice: 1.Director of Health Care Services and or assigned designee will complete and 100% audit of resident (s) charts to ensure annual tuberculin skin test are completed, all resident will be compliance by 12/01/2019. 2.Moving forward Director of Health Care Services and or assigned designee, in-serviced clinical staff to review resident (s) annual TB test are completed and documented of completion date. 3.All resident (s) residing in Assisted Living and Memory Care primary care physicians order for an annual screen needs to be completed. 2.How the facility will identify other resident (s) having the potential to be affected by the same deficient practice and what corrective action will be taken: 1.Director of Health Care	12/01/2019

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	The resident was admitted to the facility on 4/3/18. The 2019 health statement, indicating the resident was free from tuberculosis in an infectious stage was not available for review. The last documented health statement was on 4/2/18. Interview with the Director of Health Services on 10/29/19 at 2:00 p.m., indicated she was unaware a health statement was required every year.		Services and or assigned designee will do an 100% chart audit of resident (s) admission dates to ensure we are in compliance with annual TB screen, semi-annually TB screen will be completed and annual screening documentation by resident (s) primary care physician. 2.Director of Health Care Services, and or assigned designee will work with resident (s) and families to educate on the compliance requirements of annual TB screen that need to be completed to ensure infection control and resident shows no evidence of TB. Compliance will be met by 12/01/2019. 3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: 1.Director of Health Care Services and or assigned designee, will semi-annually send letters to resident (s), families of primary care physician TB screen that will be completed. 2.All new resident (s) will be notified by admitting clinical staff of the annual TB screen requirements. ts to ensure we are meeting compliance. 4.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program	

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			will be put into place: 1.Annual TB screen will become part of our QAPI until we have ensure policy and compliance are met, once met, Director of Health Services and or assigned designee will report quarterly to QAPI teem to ensure compliance is being met. 5.Compliance by 12/01/2019	