

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/26/2021
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NAME OF PROVIDER OR SUPPLIER BELVEDERE SENIOR HOUSING	STREET ADDRESS, CITY, STATE, ZIP CODE 343 E 90TH DRIVE MERRILLVILLE, IN 46410
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: May 25 and 26, 2021</p> <p>Facility number: 014178</p> <p>Residential Census: 110</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 5/28/21.</p>	R 0000	<p>This POC constitutes our written allegation of compliance for the deficiency cited, however, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet established state and federal law.</p>	
R 0117 Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency</p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times.</p> <p>Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and</p>			

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

TITLE

(X6) DATE

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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	<p>on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure there was one staff member with a current CPR and first aid certificate scheduled for 3 of 21 shifts reviewed.</p> <p>Finding includes:</p> <p>Facility staffing schedules for 5/20/21 through 5/26/21/21 were reviewed on 5/26/21 at 9:36 a.m. The schedules indicated there were no staff members who were CPR or first aid certified on the following dates and shifts:</p> <p>Day shift on 5/20/21 Evening shift on 5/21/21 Midnight shift on 5/21/21</p> <p>Interview with the Business Office Manager on 5/26/21 at 2:21 p.m. indicated she had no additional staff CPR or first aid certifications to provide.</p>	R 0117	<p>Belvedere Senior Housing Provider # 014178 Survey Date: 05/26/2021 Plan of Correction R -117 Personnel –Deficiency</p> <ol style="list-style-type: none"> Personnel on the shifts identified without the required training and certification were immediately contacted to certify for the required CPR/First aid training and certification. All other staff identified during audit as needing training/certification has obtained the required training/recertification. No residents were affected by alleged deficiency. Nursing / QMA's and CNA's have been in-serviced on June 9, 2021 by the Administrator on keeping the CPR/First Aid Training and Recertification up to date to assure that at least 1 certified staff member per 50 residents are scheduled for each shift. An audit will be conducted monthly x 6 months by the BOM/designee to assure the alleged deficiency does not reoccur. Monthly audit will be reviewed at Quarterly QA meeting and make recommendations for 	06/26/2021

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R 0118 Bldg. 00	<p>410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide.</p> <p>Based on record review and interview, the facility failed to ensure all employees had an active license or certification. This had the potential to affect all 110 residents who resided in the facility.</p> <p>Finding includes:</p> <p>The employee licenses and certifications were reviewed on 5/26/21 at 9:36 a.m.</p> <p>CNA 3 was hired on 6/2/20. There was no active license or certification available for review.</p> <p>QMA 1's license had expired on 3/10/21.</p> <p>The staff schedule for May 2021 indicated QMA 1 had worked on 5/1/21, 5/2/21, 5/15/21, and 5/16/21.</p> <p>Interview with the Administrator on 5/26/21 at 2:25 p.m. indicated CNA 3 had completed the CNA training class but had never taken the certification test. She was unsure when she had</p>	R 0118	<p>continued auditing.</p> <p>Date of Completion: 06/26/2021</p> <p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -118 Personnel –Deficiency</p> <ol style="list-style-type: none"> CNA# 3 was immediately taken off the schedule and termed. QMA #1 immediately renewed her license that had expired on 3/10/2021. The Administrator/BOM conducted an audit of all employee files to determine whose license or certification was going to expire or had expired. All licensed/certified personnel have active licenses/certifications. No residents were noted to be affected by the alleged deficiency. Staff has been in-serviced on the necessity of keeping licenses and certifications in 	06/26/2021

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R 0120 Bldg. 00	<p>completed the class, but had been employed by the facility for almost a year and should have taken the test by now. She had spoken with QMA 1 and she indicated she had not renewed her license yet. She would be removed from the schedule immediately.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences,</p>		<p>compliance. 4. A QA audit will be conducted monthly x 6 by the BOM/Administrator and/or Designee to assure that all licensed and certified personnel have active licenses/certifications so the alleged deficiency does not reoccur. Quarterly QA committee will review monthly audits and make recommendations for need of further auditing. Date of Completion: 06/26/2021</p>	

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	<p>or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure annual inservices were completed for 1 of 5 employees reviewed. (CNA 2)</p> <p>Finding includes:</p> <p>The employee records and inservices were reviewed 5/26/21 at 9:36 a.m.</p> <p>CNA 2 was hired 10/2/18. She had not completed any resident rights inservice for 2020. She had completed only one hour of dementia training in 2020.</p> <p>Interview with the Business Office Manager on 5/26/21 at 2:21 p.m. indicated she had provided all the completed training and inservices she had on file for CNA 2.</p>	R 0120	<p>Belvedere Senior Housing Facility # 014178 Survey Date: 05/26/2021 Plan of Correction R -120 Personnel –Deficiency Corrective Action:</p> <ol style="list-style-type: none"> CNA# 2 was educated on resident rights and completed the dementia training required annually on 6/11/2021. An audit was conducted to assure that all staff has completed the necessary annual trainings. Any staff found to be deficient in training will complete training. No residents were noted to be affected by the alleged deficiency. Staff has been in-serviced on annual trainings for resident rights and dementia on June 9, 2021. The community will offer trainings annually for all staff and retain a copy of the trainings in their personnel file. A QA audit will be conducted monthly by the 	06/26/2021			

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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.		DON/Administrator and/or Designee x 6 months to assure that all staff receive the annual in-services/training for resident rights/dementia training. Audits will be reviewed at the Quarterly QA meeting, QA committee to make recommendations for need of on-going audits. Date of Completion: 06/26/2021				

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	<p>(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.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of 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.</p> <p>Based on record review and interview, the facility failed to ensure employees of the facility received an annual Mantoux test (test for tuberculosis) or screening for 3 of 5 employee files reviewed. (LPN 3, QMA 2, CNA 2)</p> <p>Finding includes:</p> <p>Employee files were reviewed on 5/26/21 at 9:36 a.m.</p> <p>LPN 3 was hired 10/15/19. She did not have any TB (tuberculosis) screening assessment or Mantoux test completed for 2020 or 2021.</p> <p>QMA 2 was hired 12/18/18. She did not have any TB (tuberculosis) screening assessment or Mantoux test completed for 2020 or 2021.</p> <p>CNA 2 was hired 10/2/18. She had a Mantoux test documented on 3/10/20. She did not have any TB (tuberculosis) screening assessment or Mantoux test completed for 2021.</p> <p>Interview with the Business Office Manager on 5/26/21 at 2:21 p.m. indicated she could not find</p>	R 0121	<p>Belvedere Senior Housing Facility # 041178 Survey Date: 05/26/2021 Plan of Correction R -121 Personnel –Deficiency It is the policy of this community to be in 100 % compliance with the regulations regarding staff obtaining annual TB screening/assessment or Mantoux test. Potential for all staff to be affected by the alleged deficiency. Corrective Action: 1. LPN 3 received her annual Mantoux test on 6/9/2021. QMA 2 received her annual Mantoux test on 5/13/2021. CNA 2 received her annual Mantoux test 6/9/2021. 2. A TB clinic for all personnel was conducted on June 9th and June 18, 2021. 3. The community will conduct annual TB clinics for screening and assessments upon hire and every June thereafter to assure</p>	06/26/2021

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R 0153 Bldg. 00	<p>any TB screening or testing for LPN 3, QMA 2 or CNA 2.</p> <p>410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen.</p> <p>Based on observation, record review and interview, the facility failed to ensure safety precautions were in place related to the storage of oxygen cylinders in a resident's room. (Resident 2)</p> <p>Finding includes:</p> <p>On 5/26/21 at 9:05 a.m., Resident 2 was observed in her room. There were several oxygen cylinders near the kitchen area. Nine of them were secured in crates, four of them were standing unsecured on the floor.</p> <p>The policy titled, "Oxygen Use and Storage</p>	R 0153	<p>compliance. The nurses were in-serviced on all staff receiving TB screening/assessment or Mantoux test upon hire and annually thereafter.</p> <p>4. A QA audit will be conducted at a minimum monthly or upon any new hires x 6 months by the DON or Designee to assure that all staff have received their TB testing and assessments conducted upon hire and annually. Audits will be reviewed by quarterly QA committee. Date of Completion: 06/26/2021</p> <p>Belvedere Senior Housing Facility# 014178 Date of Survey: 05/26/2021 Plan of Correction R -153 Sanitation and Safety -Deficiency It is the policy of this community to assure safety precautions are in place related to storage of oxygen cylinders in a resident's room.</p> <p>Corrective Action: 1. Resident 2 oxygen cylinders in the apartment have been secured into racks.</p>	06/26/2021

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R 0215 Bldg. 00	<p>Policy and Procedure", dated 2/21/21, was provided by the Administrator on 5/25/21 at 9:28 a.m. The policy indicated, "...D. The community staff will routinely observe rooms of oxygen user to ensure that oxygen cylinders are properly secured. The oxygen cylinders will be stored in the appropriate container to prevent accidental tipping/falling of cylinders...."</p> <p>Interview with the Administrator on 5/26/21 at 10:40 a.m., indicated she was not aware the cylinders were not properly stored.</p> <p>410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility.</p>		<p>2. The community conducted house rounds in resident rooms for residents with orders for oxygen to assure the proper storage is in place for the oxygen cylinder(s). The DME company was contacted to provide residents with appropriate oxygen storage containers to assure the oxygen cylinders are properly secured for safety.</p> <p>3. Nursing personnel were in-serviced on June 9, 2021 by Regional nurse on assuring that oxygen cylinders must have appropriate safe storage for oxygen cylinders in resident apartments.</p> <p>4. A QA audit will be conducted weekly for the 1st 4 weeks and then monthly thereafter to assure oxygen cylinders are appropriately stored in resident rooms. The DON or Designee will be responsible for this audit and compliance.</p> <p>Date of Completion: 06/26/2021</p>				

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R 0216 Bldg. 00	<p>Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 8 residents reviewed. (Resident 9)</p> <p>Finding includes:</p> <p>Resident 9's closed record was reviewed on 5/25/21 at 10:27 a.m. Diagnoses included, but were not limited to, heart failure and lymphedema. The resident was admitted to the facility on 7/28/20.</p> <p>There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility.</p> <p>Interview with the Administrator on 5/26/21 at 11:57 a.m. indicated she could not find any further documentation.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and</p>	R 0215	<p>Belvedere Senior Housing Facility # 014178 Survey Date: 05/26/2021</p> <p>Plan of Correction R -215 Evaluation –Deficiency 1. Resident 9 (closed chart) was noted to be affected by the alleged deficiency. 2. All potential residents have the potential to be affected by this deficiency. 3. Nursing personnel has been in-serviced on preadmission evaluations to be conducted prior to admission. File folder will be labeled with resident identification and paperwork until admission. 4. A QA audit will be conducted weekly for the 1st 4 weeks and then monthly x 6 months thereafter to ensure potential admissions have a preadmission evaluation conducted. The DON or Designee will be responsible for this audit and compliance. QA committee will make recommendations for ongoing audit.</p> <p>Date of Completion: 06/26/2021</p>	06/26/2021			

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	<p>mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure residents had a weight obtained semi-annually for 2 of 8 residents reviewed. (Residents 6 and 9)</p> <p>Findings include:</p> <p>1. Record review for Resident 6 was completed on 5/26/21 at 11:58 a.m. Diagnoses included, but were not limited to, ostomy. The resident was admitted to the facility on 5/1/18.</p> <p>There was no documentation in the resident's record that a weight was obtained during the past year.</p> <p>Interview with the Administrator on 5/26/21 at 3:30 p.m., indicated she was unable to locate any documentation the resident's weight was obtained during the past year.2. Resident 9's closed record was reviewed on 5/25/21 at 10:27 a.m. Diagnoses included, but were not limited to, heart failure and lymphedema. The resident was admitted to the facility on 7/28/20 and expired on 3/17/21.</p> <p>There was an admission weight documented on 7/28/20. There was lack of documentation of any other weights for the resident.</p> <p>Interview with the Administrator on 5/26/21 at</p>	R 0216	<p>Belvedere Senior Housing Facility # 014178 Survey Date: 05/26/2021 Plan of Correction R -216 Weights –Deficiency</p> <ol style="list-style-type: none"> 1. Resident # 6-weights were taken on 6/2021. Resident #8 and #9- closed charts 2. All residents were weighed on 6/2021. 3. Nursing personnel was in-serviced June 9, 2021 by Regional nurse on obtaining weights upon admission and semi-annually. 4. A QA audit will be conducted by the DON or designee weekly x 4 months for new move-ins, then monthly x 6 months and every 6 months thereafter to assure compliance with obtaining weights semi –annually. Date of Completion: 06/26/2021 	06/26/2021

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R 0217 Bldg. 00	<p>11:57 a.m. indicated she could not find any further documentation.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure Service Plans were signed by the resident and/or their responsible party for 8 of 8 records reviewed. (Residents 2, 3, 4, 5, 6, 7, 8, and 9)</p>	R 0217	<p>Belvedere Senior Housing Facility # 014178 Survey Date : 05/26/2021</p> <p>Plan of Correction</p>	06/26/2021

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NAME OF PROVIDER OR SUPPLIER BELVEDERE SENIOR HOUSING	STREET ADDRESS, CITY, STATE, ZIP CODE 343 E 90TH DRIVE MERRILLVILLE, IN 46410
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	<p>Findings include:</p> <ol style="list-style-type: none"> Resident 2's record was reviewed on 5/25/21 at 1:15 p.m. The most recent service plan was completed on 5/21/21. There was not a copy signed by the resident or a representative in the record. Resident 4's record was reviewed on 5/26/21 at 10:40 a.m. The most recent service plan was completed on 4/18/21. The was not a copy signed by the resident or a representative in the record. Resident 8's closed record was reviewed on 5/25/21 at 10:33 a.m. The most recent service plan provided was completed on 10/21/17 and was unsigned. 4. Record review for Resident 3 was completed on 5/25/21 at 2:18 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, and hyperlipidemia. The resident was admitted to the facility on 10/8/2020. <p>The resident's Service Plan, dated 10/26/20, was not signed by the resident or the resident's Power of Attorney (POA).</p> <ol style="list-style-type: none"> Record review for Resident 5 was completed on 5/26/21 at 9:42 a.m. Diagnoses included, but were not limited to, osteoarthritis, urinary retention, and hypertension. The resident was admitted to the facility on 6/5/2020. <p>The resident's Service Plan, dated 6/18/20, was not signed by the resident or the resident's POA.</p> <ol style="list-style-type: none"> Record review for Resident 6 was completed on 5/26/21 at 11:58 a.m. Diagnoses included, 		<p>R -217 Evaluation –Deficiency Corrective Action:</p> <ol style="list-style-type: none"> Residents # 2, 3, 4, 5, 6,7, have been reviewed with resident and signatures obtained. Resident #8 and #9 are closed charts. All residents have the potential to be affected. All residents and/or their representative will sign the service plan form that will be placed in their chart or a binder to indicate their involvement in their services/plan. Nursing personnel was in-serviced on June 9, 2021 by Regional Nurse consultant on service plans being signed and placed in resident chart/binder to assure resident and/or representative participated and understood service plan update. A QA audit will be conducted by the DON and/or designee weekly x 8 weeks, then monthly x 6 months to assure all service plans completed and/or updated during the week have been signed by resident or their representative as proof of their participation/understanding of the service plan. Quarterly QA committee will review audits and make recommendations for need for further auditing. <p>Date of Completion: 06/26/2021</p>	
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R 0240 Bldg. 00	<p>but were not limited to, ostomy.</p> <p>The resident's Service Plan, dated 3/23/21, was not signed by the resident or the resident's POA.</p> <p>7. Record review for Resident 7 was completed on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to, schizophrenia.</p> <p>The resident's Service Plan, dated 2/15/21, was not signed by the resident or the resident's POA.8. Resident 9's closed record was reviewed on 5/25/21 at 10:27 a.m. Diagnoses included, but were not limited to, heart failure and lymphedema.</p> <p>A Service Plan was completed 3/4/21. The service plan had not been signed by the resident nor her responsible party.</p> <p>Interview with LPN 1 on 5/25/21 at 3:05 p.m., indicated the nurses complete the resident's Service Plans. They do not have the resident or the POA sign them.</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, record review and interview, the facility failed to ensure personal care and assistance was provided to residents related to inaccurate oxygen setting for 1 of 3 residents reviewed for oxygen and lack of coordination of services documentation for a resident receiving therapy for 1 of 3 residents reviewed for contracted services. (Resident 2)</p>	R 0240	<p>Belvedere Senior Housing Facility # 014178 Survey Date: 05/26/2021</p> <p>Plan of Correction R -240 Health Services -Deficiency Corrective Action: 1. Resident # 2 Oxygen setting</p>	06/26/2021

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	<p>Finding includes:</p> <p>On 5/26/21 at 9:05 a.m., Resident 2 was observed in her room. There was an Occupational Therapist in the room with her, who indicated she visited the resident three times a week, and the resident also received physical therapy.</p> <p>The resident's record was reviewed on 5/25/21 at 1:15 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and osteoarthritis.</p> <p>There were no orders or notes in the electronic or hard record related to therapy services. It was unclear when therapy had started, what services were provided, or how often therapy was visited.</p> <p>The therapy records were initially requested from the Administrator on 5/26/21 at 10:40 a.m. There were two additional requests made, however therapy records were never provided for Resident 2.</p> <p>On 5/26/21 at 9:55 a.m., the resident was observed again in her room. She had her oxygen on. The oxygen was set at 5 liters per minute. She indicated she didn't know who had set it, but she had not.</p> <p>The resident's record was reviewed on 5/25/21 at 1:15 p.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease and osteoarthritis.</p> <p>A Respiratory order, dated 4/27/21, indicated the resident was to be on continuous oxygen at 2 liters per minute.</p> <p>Interview with LPN 2 on 5/26/21 at 10:10 a.m.,</p>		<p>was adjusted immediately after being notified to current order Oxygen liter flow.</p> <p>Resident # 2 orders for therapy and therapy notes were located and placed in the clinical record.</p> <p>2. All residents that have oxygen orders for administration have the potential to be affected. All residents that are receiving therapy have the potential to be affected. No other resident was found to be affected.</p> <p>3. Nursing Personnel was in-serviced on June 9, 2021 on physician orders related to oxygen setting for residents on oxygen. Therapy Department and nurses were in-serviced on June 17, 2021 regarding assuring that orders for therapy and therapy notes are placed in the clinical record.</p> <p>4. A QA audit will be conducted weekly x 8 weeks, then bi-monthly x 8 weeks, then monthly x 4 by the DON and/or designee to assure all residents on oxygen have oxygen set to current oxygen order and that Therapy orders and therapy notes are in the clinical record. Audits will be reviewed at Quarterly QA committee meeting to make recommendations on on-going need for audits.</p> <p>Date of Completion: 06/26/2021</p>	

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R 0241 Bldg. 00	<p>indicated the nurses were responsible for maintaining the correct setting on the resident's oxygen, and she did not know of Resident 2 changing her oxygen setting by herself. She was unable to locate what the Physician order was for the resident's oxygen, but knew it wasn't 5 liters. She indicated she would correct it.</p> <p>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 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.</p> <p>Based on observation, interview and record review, the facility failed to provide or coordinate nursing care ordered by the physician and supervised by a licensed nurse related to wound care for an unstageable pressure sore to a resident's buttock for 1 of 3 residents reviewed for contracted services. (Resident 3)</p> <p>Finding includes:</p> <p>On 5/25/21 at 1:46 p.m., Resident 3 was observed and interviewed in her apartment. The resident indicated she had a pressure wound to her bottom. She saw a wound doctor who wanted her to have bandage treatment changes three times a week. The facility told her that she was denied Home Health treatment through her insurance company. She had been completing her own dressing changes to her wound but did not have the correct bandages. She asked a nurse at the facility for a bandage but the nurse only</p>	R 0241	<p>Belvedere Senior Housing Facility # 014178 Survey Date: 05/26/2021 Plan of Correction R -241 Health Services –Offense Corrective Action:</p> <ol style="list-style-type: none"> Nursing has coordinated wound care for resident #3 with Franciscan Home Health Care. Physician aware of care being provided by Home Health Care Company. Resident roster reviewed on 6/11/2021 by nursing to ensure no other residents were identified that required contracted services. No other residents were affected by alleged practice. Nurses has been in-serviced on June 9, 2021 by the regional nurse on notifying the physician of issues related to 	06/26/2021

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	<p>gave her a Band-Aid which would not cover the wound. She brought out a feminine pad which she indicated she was using to cover her wound. She was unsure if the facility was supposed to be dressing her wound or if they were still trying to get Home Health services for her.</p> <p>Record review for Resident 3 was completed on 5/25/21 at 2:18 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, and hyperlipidemia. The resident was admitted to the facility on 10/8/2020.</p> <p>A Wound Care Details report, dated 5/10/21, indicated the resident had an unstageable pressure injury to her lower buttock. The wound measured 1.5 cm (centimeters) x 3 cm x 0.1 cm.</p> <p>The Wound Care visit discharge instructions, dated 5/10/21, indicated the following treatment and dressing orders: -Topical Treatments: Hydroferablue (external dressing for use in local management of wounds): Apply skin protective or barrier ointment to protect surrounding skin. Slightly moisten Hydroferablue with saline and apply to wound bed and cover with a dry dressing. If wound has moderate drainage, do not moisten Hydroferablue. Change dressing 3 times a week or unless specified below. - Apply Santyl (medicine that removes dead tissue from wounds so they can start to heal) to wound bed moisten Hydroferablue cover Santyl then cover with a dry dressing.</p> <p>-Dressings: Santyl: Apply skin protective or barrier ointment to protect surrounding skin. Apply Santyl to wound bed nickel thickness and cover with a moisten dressing followed by a dry dressing. Unless wound has moderate drainage,</p>		<p>orders received and to discuss other options/orders provided by the physician to assure residents are receiving the necessary care. Nurses have been in-serviced on documenting in resident records regarding wound care was being completed by resident or services are being provided by an agency such as Home Health.</p> <p>4. A QA audit will be conducted weekly x 8 weeks, then monthly x 4 months by the Director of Nursing/designee to assure that a licensed nurse is following physician orders (wound care) and notifying the physician of issues related to being able to follow such orders and documentation for services being received by other entities such as Home Health. Audits will be reviewed at quarterly QA meeting, committee will review and make recommendations.</p> <p>Date of Completion: 06/26/2021</p>	

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	<p>apply dry dressing. Change dressing daily. - Apply Santyl to wound bed moisten Hydroferablue cover Santyl then cover with a dry dressing.</p> <p>The Physician's Order Summary, dated May 2021, indicated the following orders: -Santyl, to apply a nickel size amount to wound daily -Home Health Care evaluation and treatment related to leg wound.</p> <p>There was no documentation in the resident's record to indicate the wound dressing changes were being completed as ordered. There was no documentation that the resident was being seen by Home Health Care Services.</p> <p>Interview with RN 1 on 5/26/21 at 1:06 p.m., indicated the resident was observed to have a wound and was scheduled on 5/5/21 to see a wound care doctor. The resident saw the wound care doctor on 5/10/21. The doctor wanted the resident to have dressing and treatment orders put in place. The facility had contacted a Home Health Agency on 5/11/21 and the resident was denied coverage for services from her insurance. She believed they may have given the Home Health Agency the resident's incorrect insurance information. She did not know until 5/23/21 that no one had followed back up on contacting the Home Health Agency again for service. The nurses would put the Santyl into a medication cup and deliver it to the resident daily for the resident to use and apply her own bandage to the wound. She indicated the facility should have followed up about Home Health Services for the resident to receive services from Home Health and someone should have also notified the wound care doctor related to not having all the specific</p>			

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R 0272 Bldg. 00	<p>bandages he ordered to see if he had any new orders.</p> <p>410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature.</p> <p>Based on observation, record review and interview, the facility failed to ensure food temperatures were appropriate related to not checking food temperatures prior to serving in 1 of 1 kitchens observed. (Main Kitchen) This had the potential to affect all 110 residents who consumed food prepared from the main kitchen.</p> <p>Finding includes:</p> <p>On 5/26/21 at 8:37 a.m., residents were observed eating breakfast in the main dining room.</p> <p>Upon entry to the kitchen at 8:40 a.m., the temperature logs were observed. There were no entries for 5/26/21.</p> <p>Interview with the Culinary Director (CD) on 5/26/21 at 8:45 a.m., indicated breakfast service was completed and they had not taken food temperatures prior to breakfast service that day.</p> <p>The document Dietary Temperature Policy, undated, was provided by the CD on 5/25/21 at 9:25 a.m., indicated, "...All food temperatures must be taken at all 3 meals, breakfast, lunch and dinner...."</p>	R 0272	<p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -272 Food and Nutritional Services –Deficiency It is the policy of this community to assure that all foods are served at a safe and appropriate temperature.</p> <ol style="list-style-type: none"> 1. No residents were affected from alleged deficient practice. 2. All residents have the potential to be affected. No residents experienced adverse reactions to the deficient practices. 3. Dietary personnel have been in-serviced on 6/9/2021 regarding taking the temperatures and recording all hot food temperatures in the hot food log. 4. A QA audit will be conducted by the Dietary Manager/Designee 3 x a week for 8 weeks, and weekly thereafter for 4 months to assure that meals have been temped and logged daily for each meal and are at the appropriate temperature for ingestion. Audits will be presented at the quarterly QA meeting for review and recommendations. 	06/26/2021

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R 0273 Bldg. 00	<p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure a sanitary kitchen related to foods not properly labeled in refrigerator, freezer and dry storage, and dishwasher temperatures not monitored for 1 of 1 kitchen observed. This had the potential to affect all resident that received meals prepared from the kitchen.</p> <p>Findings include:</p> <p>1. During the initial tour of the kitchen with the Culinary Director (CD), on 5/25/21 at 8:50 a.m., the following was observed:</p> <p>a. In the dry storage room, there was a bin of grain that was identified by the CD as oatmeal. It was unlabeled and undated.</p> <p>b. On a kitchen shelf, there were four plastic containers of dry cereal. There were no labels or dates on the containers.</p> <p>c. In the walk in refrigerator, there was a container of garlic in water, a jar of pesto, a bag of shredded cheese, a bottle of barbeque sauce and a bag of lettuce. All items had been opened, but did not have an opened on date.</p> <p>d. In the walk in freezer, there were four packages wrapped in plastic. The CD identified</p>	R 0273	<p>Date of Completion: 06/26/2021</p> <p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -273 Food and Nutritional Services –Deficiency</p> <p>1. Food items were immediately labeled and dated in refrigerator, freezer and dry storage area. A new log for dishwasher temperatures was immediately initiated and temperature was taken and logged.</p> <p>2. All residents have the potential to be affected, however no adverse reactions occurred under this deficiency.</p> <p>3. The dietary staff were in-serviced on 6/9/2021 on labeling and dating all foods. The dietary staff were in-serviced on 6/9/2021 on taking the temperature of the dishwasher and logging it.</p> <p>4. A QA audit will be conducted 3 x week for 8 weeks to assure that every meal has been temped and logged daily by the Dietary Manager/designee. A</p>	06/26/2021

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R 0349 Bldg. 00	<p>them as turkey, french fries, Italian beef and corned beef. All items were unlabeled and undated.</p> <p>Interview with the CD at that time indicated the items should be labeled and dated.</p> <p>2. The dishwashing log was reviewed on 5/25/21 at 9:05 a.m. There was one entry made on the log for 5/25/21 for the dishwasher temperatures. There were no other entries for May.</p> <p>Interview with the CD at that time indicated they had not been monitoring the dishwasher temperatures.</p> <p>The undated "Leftover Food Policy" was provided by the CD on 5/25/21 at 9:25 a.m. and indicated, "...Label food items with initials, time of preparation, name of the product, and the discard date...Label all containers clearly with the date and time that the food was first prepared...."</p> <p>The undated "Mechanical Cleaning and Sanitizing Policy and Procedure" was provided by the CD on 5/25/21 at 9:25 a.m. and indicated, "...High temperature sanitation will be at 180 degrees F or higher..."</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.</p>		<p>QA audit will be conducted 3x a week for 8 weeks to assure that the dishwasher sanitation temperature is taken and logged daily by the Dietary Manager/designee. Monthly audits will be reviewed at the Quarterly QA meeting for review and recommendations.</p> <p>Date of Completion: 06/26/2021</p>	

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R 0356 Bldg. 00	<p>(4) Systematically organized. Based on record review and interview, the facility failed to maintain complete and accurate clinical records related to recording blood glucose results as ordered for 1 of 8 clinical records reviewed. (Resident 2)</p> <p>Finding includes:</p> <p>Resident 2's record was reviewed on 5/25/21 on 1:15 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus.</p> <p>A Physician's Order, dated 3/2/21, indicated to check the resident's blood glucose twice daily and record the results.</p> <p>The May 2021 Medication Administration Record lacked blood glucose results on the following dates:</p> <ul style="list-style-type: none"> - 5/2 a.m. - 5/5 a.m. - 5/10 a.m. - 5/12 a.m. - 5/12 p.m. - 5/14 p.m. - 5/15 a.m. - 5/17 p.m. <p>Interview on 5/26/21 at 10:10 a.m. with LPN 2 indicated the resident did not often refuse blood glucose testing and she did not know why there were so many unrecorded blood glucose results.</p> <p>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</p>	R 0349	<p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -349 Clinical Records -Deficiency It is the policy of this community to maintain complete and accurate clinical records related to blood glucose results. Corrective Action:</p> <ol style="list-style-type: none"> 1. Resident #2 had no negative affect from the alleged deficient practice. 2. All residents that have orders for Blood glucose have the potential to be affected. 3. The nursing personnel was in-serviced on June 9, 2021 by the regional nurse on assuring the blood glucose is taken as ordered by physician and documented in EMAR. 4. A QA audit will be conducted by the Director of Nursing/designee weekly times 8 weeks and then monthly for 4 months to assure residents with orders for blood glucose is documented in the MAR per physician orders. <p>Date of Completion: 06/26/2021</p>	06/26/2021			

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	<p>following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</p> <p>(2) The resident ' s hospital preference.</p> <p>(3) The name and phone number of any legally authorized representative.</p> <p>(4) The name and phone number of the resident ' s physician of record.</p> <p>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on record review and interview, the facility failed to ensure emergency information was immediately accessible for each resident related to missing emergency files for 4 of 6 resident records reviewed. (Residents 4, 5, 6 and 7)</p> <p>Finding includes:</p> <p>The binder titled "Emergency Evacuation Special Need Roster" (emergency files) was provided for review on 5/26/21 at 11:15 a.m. The binder did not have an emergency file for Residents 4, 5, 6 or 7.</p> <p>Interview with the Administrator and LPN 2 on 5/26/21 at 11:30 a.m., indicated they were unsure when the binder had last been updated.</p> <p>At 1:00 p.m., the Administrator indicated the emergency files had been updated.</p>	R 0356	<p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -356 Clinical Records -Deficiency Corrective Action:</p> <p>1. Residents 4, 5, 6 and 7 emergency information was updated and put into the file for immediate accessibility in case of emergency. Emergency binder is located in Reception area of community.</p> <p>2. Files were reviewed by Resident Service Director to assure that all required information is complete for each individual resident. No residents were affected by this alleged deficient practice.</p> <p>3. The staff was in-serviced and educated on the emergency</p>	06/26/2021
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R 0407 Bldg. 00	<p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those specific to properly prevent and/or contain COVID-19, related to not monitoring residents daily for signs and symptoms of COVID-19 for 3 of 3 resident records reviewed, (Residents 2, 3, and 4), random observations of staff not wearing face shields when within 6 feet of residents, and a CNA observed wearing a cloth face mask.</p> <p>Findings include:</p>	R 0407	<p>information file on June 9, 2021. The receptionist is responsible for keeping binder up to date. 4. A QA audit will be conducted by the Resident Service Coordinator/designee weekly x 8 weeks, then monthly x 6 to assure that the file is updated for all residents.</p> <p>Date of Completion: 06/26/2021</p> <p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -407 Infection Control -Deficiency Corrective Action: 1. Residents 2, 3, and 4 COVID symptoms logs were completed and documented for these residents. 2. COVID symptoms logs were completed on all residents and</p>	06/26/2021

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	<p>1. The Daily Temperature and Pulse Ox Log for April and May 2021 were reviewed on 5/25/21 at 12:00 p.m. and indicated the following:</p> <p>a. Resident 2- there were no entries from April 2 through April 24, 2021. There were no entries for May 2021.</p> <p>b. Resident 3- there were no entries from April 2 through April 24, 2021. There were no entries for May 2021.</p> <p>c. Resident 4- there were no entries for May 2021.</p> <p>Interview with the Director of Nursing, on 5/25/21 at 11:40 a.m., indicated all residents were monitored for COVID-19 daily by checking their temperature and oxygen saturation (pulse ox).</p> <p>Interview with CNA 1, on 5/25/21 at 12:00 p.m., indicated CNAs were responsible for obtaining vitals on the second and third floor and QMAs were responsible for the first floor. She indicated they did not always take them daily.2. On 5/25/21 the following was observed:</p> <p>- At 9:20 a.m., two Therapy staff members were assisting a resident with exercises in the fitness room. The staff were wearing surgical masks but not face shields.</p> <p>- At 9:58 a.m., the Receptionist was helping a resident at the front desk. She was wearing a surgical mask but no face shield.</p> <p>-At 10:25 a.m., the Receptionist was assisting a resident to ambulate to a seat in the Main Dining Room. She was wearing a surgical mask but no face shield.</p> <p>-At 11:17 a.m., CNA 4 was assisting a resident to</p>		<p>documented daily. Staff are wearing face shields and surgical masks when working within 6 feet of residents. All residents have the potential to be affected.</p> <p>3. All staff was in-serviced on June 9, 2021 by regional nurse to wearing face shields and surgical masks when working within 6 feet of a resident based on the CDC updated guidance (county) positivity rate and risk factor.</p> <p>4. A QA audit will be conducted by the DON/designee weekly x 8 weeks then bi-monthly x 2 months then monthly or until CDC guideline change to assure that residents are receiving daily COVID symptoms checks and documentation to assure residents are not displaying potential covid signs/symptoms. A QA audit will be conducted by DON/designee weekly x 8 weeks then bi-monthly x 2 months or until CDC guideline change to assure all staff are following the CDC COVID-19 updated guidance wearing face shields and surgical masks when working with residents (within 6 feet of resident). Administrator/designee will monitor County positivity rates weekly and instruct state on usage of face shields.</p> <p>Date of Completion: 06/26/2021</p>				

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R 0410	<p>ambulate to her room on the 200 floor. She was wearing a cloth mask under her face shield.</p> <p>Interview with the DON on 5/25/21 at 11:45 a.m., indicated if staff were going to be in the resident's room or with a resident for 5 to 15 minutes or longer they would wear a face shield. She was not aware all staff should have been wearing a face shield if within 6 feet of a resident. She indicated CNA 4 should have had a surgical mask on under her cloth mask if she wanted to wear the cloth mask.</p> <p>The Indiana State Department of Health, "COVID-19 LTC Facility Infection Control Guidance Standard Operating Procedure", updated 5/3/21 indicated, "...Direct care providers should wear a surgical mask for the duration of their shifts...To align with updated Centers for Disease Control and Prevention (CDC) updated guidance on potential transmission by aerosol transmission, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident in all levels of care in all long-term care facilities and assisted living...COVID -19 Negative (Green)...HCP (Health Care Providers) will wear face mask (medical) and eye protection with face shield /or goggles as a standard safety measure to protect LTC HCP (SNF/AL) who provide essential direct care within 6 feet of the resident, regardless of COVID-19 status, when there is moderate to substantial (high) community transmission..."</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance</p>			

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Bldg. 00	<p>(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.</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure residents had a documented Mantoux test (test for tuberculosis) completed yearly for 2 of 8 residents reviewed for Mantoux testing. (Residents 6 and 7)</p> <p>Findings include:</p> <p>1. Record review for Resident 6 was completed on 5/26/21 at 11:58 a.m. Diagnoses included, but were not limited to, ostomy. The resident was admitted to the facility on 5/1/18.</p> <p>There was a lack of documentation to indicate the resident had received a yearly Mantoux test in 2020.</p> <p>2. Record review for Resident 7 was completed</p>	R 0410	<p>Belvedere Senior Housing Facility #: 014178 Survey Date: 05/26/2021 Plan of Correction R -410 Infection Control -Deficiency It is the policy of this community to adhere to infection control practices for residents to receive a yearly Mantoux test. Corrective Action: 1. Resident # 6 received Mantoux test on 6/2/2021. Resident #7 received Mantoux test on 6/2/2021. All residents received Mantoux test during a TB clinic on 6/2/2021. 2. Nursing personnel was</p>	06/26/2021

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	<p>on 5/26/21 at 11:17 a.m. Diagnoses included, but were not limited to, schizophrenia. The resident was admitted to the facility on 6/30/18.</p> <p>There was a lack of documentation to indicate the resident had received a yearly Mantoux test in 2020.</p> <p>Interview with the Administrator on 5/26/21 at 3:30 p.m., indicated she could not find any documentation the residents had a yearly Mantoux test or a screening for tuberculosis completed in 2020.</p>		<p>in-serviced on June 9, 2021 by Regional nurse that all residents should be followed for TB testing via the regulations and annually. A TB binder has been developed for tracking resident TB tests. All residents have potential to be affect by this alleged deficient practice.</p> <p>3. A QA audit will be conducted by the DON/designee weekly x 8 weeks, then monthly to assure that residents have received the TB test upon admission / annually. Audits will be reviewed at quarterly QA meeting and make recommendations.</p> <p>Date of Completion: 06/26/2021</p>				