

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/07/2013
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NAME OF PROVIDER OR SUPPLIER  ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00138634.</p> <p>Survey dates: October 31, November 1, 4, 5, 6, and 7, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Yolanda Love, RN-TC (October 31, November 1, 4, 5, and 7, 2013) Cynthia Stramel, RN (October 31, November 1, 4, 5, and 7, 2013) Lara Richards, RN Heather Tuttle, RN</p> <p>Census bed type: SNF 31 SNF/NF 119 Total 150</p> <p>Census payor type: Medicare 37 Medicaid 94 Other 19</p>	F000000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. We are requesting paper compliance for this survey	

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><b>Total 150</b></p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 14, 2013, by Janelyn Kulik, RN.</p>			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained related to being called "honey" and "dear" during 1 of 1 meals observed in the Main dining room. (Residents #19 and #39)</p> <p>Findings include:</p> <p>On 10/31/13 at 11:59 a.m., in the Main dining room, CNA #4 called Resident #39 "honey." The Customer Service Representative referred to Resident #19 as "honey" and "dear."</p> <p>Interview with the Assistant Director of Nursing on 11/7/13 at 10:30 a.m., indicated staff should address the residents by their names not by "honey" or "dear."</p> <p>3.1-3(t)</p>	F000241	<p>F- 241: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? The resident preferences worksheets for residents # 39 and # 19 have been reviewed. Both residents stated that they prefer to be called by their names. Employees have been re-inserviced on resident dignity as it pertains to proper communication with residents. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. The activity director or designee has reviewed or will review all resident preferences worksheets to see what the resident prefers to be called. If it is anything other than by his or her name the careplan coordinator will be</p>	12/06/2013			

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			informed to ensure that such information is added to the careplan and resident care cards. The estimated completion date for this is 12/6. Measures the facility will take to ensure that the alleged deficiency will not recur: Employees have been re-inserviced on resident dignity as it pertains to proper communication with residents. How the facility will monitor for compliance: The Administrator or designee will use the attached QA tool to conduct random audits on 5 residents weekly for 6 months to monitor for compliance. Any issues or trends noted will be discussed with the members of the QA committee at the QA meeting which is held monthly in the facility. Completion date: 12/6/13		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure each resident had a choice on when to get up in the morning and how they wanted to be bathed for 2 of 3 residents who were reviewed for choices of the three residents who met the criteria for choices. (Residents #152 and #158)</p> <p>Findings include:</p> <p>1. On 11/01/13 at 9:26 a.m., Resident #152 was interviewed. At that time, the resident indicated she does not get to choose when to get out of bed in the morning. She further indicated the staff just tell her she has to get up.</p> <p>The record for Resident #152 was reviewed on 11/4/13 at 8:40 a.m. The resident was admitted to the facility on 4/25/11.</p> <p>The resident's diagnoses included,</p>	F000242	F- 242: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? Resident # 152 was not listed as an "early riser" or "midnight get-up". Her care card and care plans state that she prefers to stay in bed past 7 AM. The resident preference worksheet for resident # 158 has been updated. The care card and careplan has been updated with the fact that she prefers to have a bath as well. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the same alleged deficient practice. The activity director or designee has reviewed or will review all resident	12/06/2013	

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	<p>but were not limited to paranoid personality, schizophrenia, and multiple sclerosis.</p> <p>Review of the Resident Preferences for Customary Routine worksheet dated 12/31/12 indicated the resident normally woke up "whenever" and she woke herself up.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated 12/31/12 indicated the resident's Brief Interview for Mental Status (BIMS) score was 12, indicating she was alert and oriented. The resident's preferences indicated it was very important to choose her bed time.</p> <p>Review of the CNA assignment sheet indicated the resident was not checked to be an early riser. The CNA sheet further indicated, "Family prefers resident to stay in bed until 7:00 a.m."</p> <p>Interview with CNA #3 on 11/4/13 at 9:10 a.m., indicated she had worked with the resident before. She indicated the resident was a "midnight get up", indicating she was up before 6:00 a.m., but did not really know the specific time, it was just before 6:00 a.m., because that was when her shift started.</p>		<p>preferences worksheets to see if there are any preferences related to resident care. Any such preferences will be reported to the careplan coordinator to ensure that it is added to the careplan and resident care cards. The estimated completion date for this is 12/6 Measures the facility will take to ensure that the alleged deficiency will not recur: Nursing staff has been re-inserviced on following the careplan as it pertains to resident preferences. The activity director has been re-inserviced on filling out the "resident preferences worksheet" completely, and on notifying the unit managers of the residents' preferences. The unit managers and careplan coordinators have been re-inserviced on placing those preferences on the care cards and careplans. How the facility will monitor for compliance: The careplan coordinator or designee will use the attached QA tool to randomly audit 5 resident charts a week for 6 months. Any trends or patterns will be discussed with the members of the QA committee at the QA meetings which are held monthly at the facility. Completion date: 12/6/13</p>				

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	<p>Interview with CNA #2 on 11/5/13, at 9:30 a.m., indicated she had worked on the unit for the last two months and had worked with the resident before. She indicated her shift starts at 6:00 a.m., and the resident was always up when she got to work. The CNA indicated the resident was up today before she got to work, because she was an "early get up".</p> <p>Interview with the 300 Unit Manager on 11/5/13 at 1:10 p.m., indicated she tells the staff if the resident was up early in the morning then it was okay to get them out of bed. She indicated the resident was not listed as an early riser and her mother did say she wanted the resident to stay in bed until 7:00 a.m.</p> <p>2. On 11/01/13 at 10:56 a.m., Resident #158 was interviewed. At that time, the resident indicated she does like to take showers, however, she prefers to take a bath.</p> <p>The record for Resident #156 was reviewed on 11/4/13 at 1:58 p.m. The resident was admitted to the facility on 11/1/11.</p> <p>The resident's diagnoses included, but were not limited to, high blood</p>						

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	<p>pressure, stroke, and left hemiplegia.</p> <p>Review of the annual Minimum Data Set (MDS) dated 6/18/13 indicated the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating the resident was alert and oriented. The resident indicated it was very important to choose between a tub bath, shower, bed bath or sponge bath. The resident was totally dependent on staff with a two person assist for transfers and bathing.</p> <p>Review of the Resident Preference worksheet dated 6/18/13, indicated it was very important to choose between a shower or a tub bath. Further review of the worksheet indicated the section for what type of bath do you prefer was not completed.</p> <p>Review of the shower list indicated the resident's shower days were in the mornings on Tuesdays and Fridays. The shower list did not indicate the resident preferred a bath rather than a shower.</p> <p>Interview with the Activity Director on 11/4/13 at 2:45 p.m., indicated she completes the section for the resident's customary routines. She</p>				

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	<p>further indicated after she completes the sections she does not do anything with the information she obtains from the resident. She further indicated since the worksheet was dated in June 2013 she really does not remember why it was not completed.</p> <p>Interview with the 300 Unit Manager on 11/4/13 at 3:00 p.m., indicated she was not aware the resident preferred to take a bath over a shower. She further indicated the 300 unit did not have a tub bath, and she knew the 100 unit had a tub bath but did not know if it was working or not.</p> <p>Interview with CNA #1 on 11/4/13 at 10:00 a.m., indicated the resident had not expressed the fact she would like to take a bath. She further indicated she had given the resident showers in the past but never a bath.</p> <p>3.1-3(u)(3)</p>				

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's Orders and/or the Plan of Care was followed as written related to monitoring for a Gradual Dose Reduction (GDR) for an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure a resident was not left unattended in the bathroom for 1 of 3 residents reviewed for accidents of the 3 residents who met the criteria for accidents as well as monitoring bruises and skin tears for 2 of 3 residents reviewed for skin conditions non-pressure related of the 5 residents who met the criteria for skin conditions non-pressure related. (Residents #78, #136, #158, and #211)</p> <p>Findings include:</p> <p>1. The record for Resident #136 was reviewed on 11/4/13 at 11:11 a.m. The resident's diagnosis included, but was not limited to, dementia with psychosis.</p>	F000282	F- 282: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? The psychiatric nurse practitioner updated her note for resident # 136 and her careplan was updated as well. A circumstance form for the bruise to the hand of resident # 158 was completed during the survey process. The resident was assessed and the careplan was updated. The care plan and care cards for resident # 211 were updated on 9/26/13 to include not being left alone in the restroom. The skin treatment order for resident # 78 was discontinued during the survey process and the careplan was updated. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. During	12/06/2013			

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	<p>A Physician's order dated 3/22/13, indicated the resident was to receive Seroquel (an anti-psychotic medication) 25 milligrams (mg) by mouth daily and 50 mg by mouth twice a day.</p> <p>The Plan of Care dated 7/28/13, indicated the problem of "Psychotropic drug use: antidepressant/antipsychotic potential for adverse side effects. Diagnoses of Developmental disability, anxiety and depression."</p> <p>The approaches included, but were not limited to, coordinate with the Interdisciplinary Team (IDT), Pharmacy, and Physician to provide lowest therapeutic dose.</p> <p>Review of the Gradual Dose Reduction (GDR) form completed by the Psychiatric Nurse Practitioner on 9/5/13, indicated the following: Diagnosis acute psychotic episodes. Antipsychotic medication: Seroquel 50 mg twice a day and 25 mg at 2:00 p.m. The Physician response section of the form indicated, "A GDR is contraindicated due to the resident has behavioral symptoms secondary to a dementia-related psychiatric diagnosis as defined above. I feel that</p>		<p>the survey process the unit managers audited all residents with skin treatment orders to ensure that they were being followed per the careplan and Physicians orders. All residents at risk for bruising due to lab draws were assessed during the survey process with no undocumented bruising noted. During the survey process nursing management reviewed the careplans and care cards of all residents determined to be at risk for falls to ensure that all appropriate measures were in place. The Social Services directors maintain a list of all residents receiving psychotropic medications and when they last received a GDR, or if a GDR was contraindicated. The Social services directors or designees will review the charts of all residents who did not receive a GDR due to it being contraindicated to ensure that there is adequate documentation to contraindicate the GDR. The estimated completion date for this is 12/6 Measures the facility will take to ensure that the alleged deficiency will not recur: Social services staff has been re-inserviced on ensuring that all residents on psychotropic medications have gradual dose reductions, unless a GDR is contraindicated, in which case there must be adequate documentation as to why. The psychiatric nurse practitioner was inserviced as well. Nursing staff</p>		

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	<p>if a dose reduction were done at this time, the behavioral symptoms would present an on-going risk of danger to self or others and/or would be significant enough that they could cause significant decline in functions and/or ability to receive care and/or persistent distress." This part of the form was pre-printed. The section to explain the behaviors in detail was left blank.</p> <p>Interview with the Unit Manager for 200 hall on 11/7/13 at 9:25 a.m., indicated an explanation was not documented as to why a GDR would not be appropriate at this time and she would discuss this with the Psychiatric Nurse Practitioner.</p> <p>2. On 11/1/13 at 11:02 a.m., Resident #158 was observed sitting in her wheelchair. At that time, she was noted to have a red/purple bruise to the right ring finger knuckle and by her thumb.</p> <p>On 11/4/13 at 8:45 a.m., the resident was observed sitting in her wheelchair. At that time, she was noted to have a red/purple bruise to the right ring finger knuckle and by her thumb.</p>		<p>have been re-inserviced on monitoring and reporting bruises. Nursing staff has been re-inserviced on not leaving residents at risk for falls unattended in the restroom. Nurses have been re-inserviced on doing skin treatments per physician's orders How the facility will monitor for compliance: The DON, social services directors or designees will use the attached QA tools to randomly audit 5 residents a week for 6 months. Any trends or patterns will be presented to the members of the QA committee at the QA meeting which is held monthly at the facility. Completion date: 12/6/13</p>				

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	<p>On 11/4/13 at 3:02 p.m., the 300 Unit Manager was asked to assess the resident's skin. The Unit Manager indicated there was a purple/red bruise noted to the resident's knuckle on the ring finger and on the back of her right hand. The Unit Manager indicated she was unaware of the resident's bruises. She further indicated the bruises might be from a lab draw.</p> <p>The record for Resident #158 was reviewed on 11/4/13 at 1:58 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, congestive heart failure, stroke, and left hemiplegia.</p> <p>Review of Physician Orders on the current 11/13 recap indicated the resident was receiving Coumadin (an anticoagulant medication) 5.5 milligrams (mg) daily.</p> <p>Review of the Care Plan dated 6/24/13 and updated 9/30/13 indicated the resident was at risk for bleeding related to anticoagulant use. The Nursing approaches were to assess for negative outcomes of anticoagulant drug use and assess for signs and symptoms of bleeding.</p>			

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	<p>Interview with LPN #1 the 3-11 nurse on 11/4/13 at 3:08 p.m., indicated there was no report from the day nurse passed onto to her regarding any type of bruising to the back of the resident's hand.</p> <p>Interview with the 300 Unit Manager on 11/4/13 at 3:30 p.m., indicated the resident should have been monitored for bruising due to the anticoagulant therapy.</p> <p>3. On 11/4/13 at 9:16 a.m., Resident #211 was observed sitting up in her wheelchair. The resident was seated in the lounge by the nurse's station. The resident was observed wearing non skid socks to both of her feet. The resident was also observed with an alarm to the back of her chair.</p> <p>The record for Resident #211 was reviewed on 11/4/13 at 9:17 a.m. The resident was admitted to the facility on 6/21/13.</p> <p>The resident's diagnoses included, but were not limited to, high blood pressure, stroke, and congestive heart failure.</p> <p>Review of the Care Plan with an original date of 6/24/13 and updated through 12/30/13 indicated the</p>						

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	<p>resident was at risk for fall/injury. The Nursing approaches were to use the fall risk assessment to identify risk factors, report falls to the Physician, provide environmental adaptations: such as one half side rails, place the call light in reach, and appropriate footwear. There were two added Nursing approaches on the bottom of the care plan one dated 8/29/13 which indicated educate on calling for assistance prior to transfers, and one dated 9/26/13 which indicated do not leave on commode alone and re-educate resident.</p> <p>Review of Nursing Progress Notes dated 9/26/13, at 10:40 p.m., indicated "Resident was found sitting on the floor in her bathroom, by the CNA. The CNA called this nurse. This nurse had just walked out of this resident's bathroom and had told resident she would be right back no more than four or five minutes. No apparent injuries at this time."</p> <p>Review of the Incident and Accident Investigation dated 9/26/13 indicated under the description of the incident and investigative findings: "Staff educated/insericed regarding leaving resident unattended in bathroom." The prevention update indicated: "nonskid footwear, call bell, ensure</p>			

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	<p>w/c (wheelchair) brakes are locked, bed in low position, bed and or chair alarm."</p> <p>Review of the CNA assignment sheet indicated the resident was a fall risk and was to have alarms to chair and bed. The CNA assignment sheet further indicated "fall risk residents were not to be left unattended while on toilet."</p> <p>Interview with the 300 Unit Manager on 11/4/13 at 1:51 p.m., indicated staff were to stay with the resident while they were in the bathroom at all times and not leave them unattended. She further indicated that was the facility's policy for any resident who was a fall risk.</p> <p>4. On 11/5/13 at 9:50 a.m., Resident #78 was observed seated near the nurses station. He had a "c" shaped laceration approximately 3 centimeters long on top of his left hand. There was no dressing noted on the wound. At 12:30 p.m., the resident was in the dining room, there was no dressing noted on his left hand.</p> <p>On 11/7/13 at 8:00 a.m., the resident was in the dining room. There was no dressing on his left hand.</p>						

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	<p>The resident's record was reviewed on 11/5/13 at 9:55 a.m. The resident was admitted to the facility on 11/17/12. Diagnoses included, but were not limited to, dementia and anemia. A nursing note dated 11/3/13 at 9:40 a.m. indicated the resident had a new skin tear on his left hand. A Physician's order was received to apply steri strips, a dry dressing, and to assess daily and as needed to ensure the dressing was intact.</p> <p>A care plan was initiated on 10/22/13 for skin tears related to fragile skin. Approaches included to, "Administer/ monitor effectiveness of/ response to preventive treatment(s) as ordered."</p> <p>Interview with LPN #2 on 11/7/13 at 8:10 a.m., indicated she had not seen a dressing on the wound that day.</p> <p>Interview with Unit Manager on 11/7/13 at 8:10 a.m., indicated there was no dressing on the resident's hand as ordered. She further indicated the treatment order should be changed because the wound was healing.</p> <p>3.1-35(g)(2)</p>						

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to monitoring and assessing non pressure related skin conditions of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 5 residents who met the criteria for non pressure related skin conditions. (Resident #158)</p> <p>Findings include:</p> <p>On 11/1/13 at 11:02 a.m., Resident #158 was observed sitting in her wheelchair. At that time, she was noted to have a red/purple bruise to the right ring finger knuckle and by her thumb.</p> <p>On 11/4/13 at 8:45 a.m., the resident was observed sitting in her wheelchair. At that time, she was noted to have a red/purple bruise to the right ring finger knuckle and by</p>	F000309	F- 309: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? A circumstance form for the bruise to the hand of resident # 158 was completed during the survey process. The resident was assessed and the careplan was updated. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. All residents at risk for bruising due to lab draws were assessed during the survey process with no undocumented bruising noted Measures the facility will take to ensure that the alleged deficiency will not recur: Nursing staff have been inserviced on monitoring and	11/22/2013	

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	<p>her thumb.</p> <p>On 11/4/13 at 3:02 p.m., the 300 Unit Manager was asked to assess the resident's skin. The Unit Manager indicated there was a purple/red bruise noted to the resident's knuckle on the ring finger and on the back of her right hand. The Unit Manager indicated she was unaware of the resident's bruises. She further indicated the bruises might be from a lab draw.</p> <p>The record for Resident #158 was reviewed on 11/4/13 at 1:58 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, congestive heart failure, stroke, and left hemiplegia.</p> <p>Review of Physician Orders on the current 11/13 recap indicated the resident was receiving Coumadin (an anticoagulant medication) 5.5 milligrams (mg) daily.</p> <p>Review of the Care Plan dated 6/24/13 and updated 9/30/13 indicated the resident was at risk for bleeding related to anticoagulant use. The Nursing approaches were to assess for negative outcomes of anticoagulant drug use and assess for signs and symptoms of bleeding.</p>		<p>reporting bruises. How the facility will monitor for compliance: The DON or designee will monitor for compliance by randomly assessing 5 residents weekly for 6 months using the attached QA tool. The results of these audits will be presented to the QA committee at the QA meetings which are held monthly at the facility. Completion date: 11/22/13</p>				

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	<p>Interview with LPN #1 the 3-11 p.m. nurse on 11/4/13 at 3:08 p.m., indicated there was no report from the day nurse passed onto to her regarding any type of bruising to the back of the resident's hand.</p> <p>Interview with the 300 Unit Manager on 11/4/13 at 3:30 p.m., indicated the area to the right thumb measured 3 centimeters (cm) by 1 cm.</p> <p>3.1-37(a)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure each resident was free from falls related to a resident who was left unattended on the toilet and was a risk for falls for 1 of 3 residents reviewed for accidents of the 3 who met the criteria for accidents. (Resident #211)</p> <p>Findings include:</p> <p>On 11/4/13 at 9:16 a.m., Resident #211 was observed sitting up in her wheelchair. The resident was seated in the lounge by the nurse's station. The resident was observed wearing non skid socks to both of her feet. The resident was also observed with an alarm to the back of her chair.</p> <p>The record for Resident #211 was reviewed on 11/4/13 at 9:17 a.m. The resident was admitted to the facility on 6/21/13.</p> <p>The resident's diagnoses included, but were not limited to, high blood</p>	F000323	F- 323: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? The care plan and care cards for resident # 211 were updated on 9/26/13 to include not being left lone in the restroom. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. During the survey process nursing management reviewed the careplans and care cards of all residents determined to be at risk for falls to ensure all appropriate measures were in place Measures the facility will take to ensure that the alleged deficiency will not recur: Nursing staff has been re-inserviced on not leaving residents at risk for falls unattended in the restroom.	11/22/2013			

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	<p>pressure, stroke, and congestive heart failure.</p> <p>Review of the Assessment Review and Considerations dated 6/21/13 indicated a care plan had been initiated to address the resident's risk for falls.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated 7/1/13 indicated the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was alert and oriented. The facility was unable to determine if the resident had a history of falls prior to admission or fracture in the last six months. The resident had no falls noted since admission. The resident was not steady moving on and off the toilet and was only able to stabilize herself with staff assistance. The resident had impairment to both sides of her lower extremities, and was an extensive assist with one person physical assist for transfers and toilet use.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated 7/3/13 indicated to proceed to the Care Plan for falls.</p> <p>Review of the Care Plan with an</p>		<p>How the facility will monitor for compliance: The DON or designee will use the attached QA tool for 5 residents a week for 6 months to ensure compliance. The results of these audits will be presented to the QA committee at the QA meetings which are held monthly at the facility. Completion date: 11/22/13</p>		

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	<p>original date of 6/24/13 and updated through 12/30/13 indicated the resident was at risk for fall/injury. The Nursing approaches were to use the fall risk assessment to identify risk factors, report falls to the Physician, provide environmental adaptations: such as one half side rails, place the call light in reach, and appropriate footwear. There were two added Nursing approaches on the bottom of the care plan one dated 8/29/13 which indicated educate on calling for assistance prior to transfers, and one dated 9/26/13 which indicated do not leave on commode alone and re-educate resident.</p> <p>Review of the Fall Circumstance assessment dated 9/26/13 indicated the resident was found on the floor and it was not witnessed. The resident's vital signs were taken at that time. The assessment indicated the resident had history of falls in the last three months.</p> <p>Review of the Incident and Investigation dated 9/26/13 indicated under the description of the incident and investigative findings: "Staff educated/insericed regarding leaving resident unattended in bathroom. "The prevention update indicated: "nonskid footwear, call bell, ensure</p>			

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	<p>w/c (wheelchair) brakes are locked, bed in low position, bed and or chair alarm."</p> <p>Review of Nursing Progress Notes dated 9/26/13, at 10:40 p.m., indicated "Resident was found sitting on the floor in her bathroom, by the CNA. The CNA called this nurse. This nurse had just walked out of this resident's bathroom and had told resident she would be right back no more than four or five minutes. No apparent injuries at this time."</p> <p>Review of the CNA assignment sheet indicated the resident was a fall risk and was to have alarms to chair and bed. The CNA assignment sheet further indicated "fall risk residents were not to be left unattended while on toilet."</p> <p>Interview with CNA #1 on 11/4/13 at 10:30 a.m., indicated the resident was at risk for falls and wears an alarm to the chair and the bed at all times. She further indicated the resident does use the toilet and was not to be left on the toilet by herself.</p> <p>Interview with the 300 Unit Manager on 11/4/13 at 1:51 p.m., indicated staff were to stay with the resident while they were in the bathroom at all</p>						

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	<p>times and not leave them unattended. She further indicated that was the facility's policy for any resident who a fall risk.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure a Gradual Dose Reduction (GDR) was completed for a resident who was receiving an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #136)</p> <p>Findings include:</p> <p>The record for Resident #136 was reviewed on 11/4/13 at 11:11 a.m.</p>	F000329	F- 329: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? The psychiatric nurse practitioner updated her note for resident # 136 on 11/21. The careplan was updated as well. How the facility	12/06/2013			

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	<p>The resident's diagnosis included, but was not limited to, dementia with psychosis.</p> <p>A Physician's order dated 3/22/13, indicated the resident was to receive Seroquel (an anti-psychotic medication) 25 milligrams (mg) by mouth daily and 50 mg by mouth twice a day.</p> <p>The Plan of Care dated 7/28/13, indicated the problem of "Psychotropic drug use: antidepressant/antipsychotic potential for adverse side effects. Diagnoses of Developmental disability, anxiety and depression."</p> <p>The approaches included, but were not limited to, coordinate with the Interdisciplinary Team (IDT), Pharmacy, and Physician to provide lowest therapeutic dose.</p> <p>Review of the Gradual Dose Reduction (GDR) form completed by the Psychiatric Nurse Practitioner on 9/5/13, indicated the following: Diagnosis acute psychotic episodes. Antipsychotic medication: Seroquel 50 mg twice a day and 25 mg at 2:00 p.m. The Physician response section of the form indicated, "A GDR is contraindicated due to the resident</p>		<p>will identify other residents having the potential to be affected by the same alleged deficient practice: All residents who are on psychotropic medications have the potential to be affected by the alleged deficient practice. The Social Services directors maintain a list of all residents receiving psychotropic medications and when they last received a GDR, or if a GDR was contraindicated. The Social services directors or designees will review the charts of all residents who did not receive a GDR due to it being contraindicated to ensure that there is adequate documentation to contraindicate the GDR. The estimated completion date for this is 12/6 Measures the facility will take to ensure that the alleged deficiency will not recur: Social services staff has been re-inserviced on ensuring that all residents on psychotropic medications have gradual dose reductions, unless a GDR is contraindicated, in which case there must be adequate documentation as to why. The psychiatric nurse practitioner was inserviced as well How the facility will monitor for compliance: The social services directors or designee will use the attached QA tool to randomly audit the charts of 5 residents on psychotropics a week for 6 months. Any trends or patterns will be presented to the members of the QA committee at the QA</p>		

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	<p>has behavioral symptoms secondary to a dementia-related psychiatric diagnosis as defined above. I feel that if a dose reduction were done at this time, the behavioral symptoms would present an on-going risk of danger to self or others and/or would be significant enough that they could cause significant decline in functions and/or ability to receive care and/or persistent distress." This part of the form was pre-printed. The section to explain the resident's behaviors in detail and why the GDR was contraindicated was left blank.</p> <p>Interview with the Unit Manager for 200 hall on 11/7/13 at 9:25 a.m., indicated an explanation was not documented as to why a GDR would not be appropriate at this time and she would discuss this with the Psychiatric Nurse Practitioner.</p> <p>3.1-48(b)(2)</p>		meeting which is held monthly at the facility. Completion date: 12/6/13		

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F000371 SS=F	<p>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</p> <p>Based on observation and interview, the facility failed to ensure food was stored, prepared and distributed under sanitary conditions related to staff not wearing hair restraints and beard guards, the dishwasher temperature being too low, staff picking up food with gloved hands, dirty stoves, ovens, and grills, food spillage on walls, food warmers and reach in coolers and dust on ceiling vents and sprinkler heads. This had the potential to affect 147 residents who received food from the Main kitchen.</p> <p>Findings include:</p> <p>1. On 10/31/13 at 11:59 a.m., in the Main dining room, CNA #4 was observed to walk out of the kitchen. The CNA did not have a hair restraint in place.</p> <p>At 12:15 p.m., The Dietary Food Manager came out of the kitchen. He was not wearing a hair restraint.</p>	F000371	F- 371: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice: There were no residents identified on the CMS 2567 The dish machine was repaired during the survey process. The paper towel dispenser in the dish room was refilledThe griddle, stove, oven hoods, deep fryer; the floors under the tilt skillet, fryers and convection oven; the wall behind the stove, convection oven, steamer, fryer, griddle and tilt skillet; the 2 convection ovens; the oven doors and the bottom of both ovens; the outside of the steamer and the shelf below the steamer; the 3 ceiling vents; the bread rack and the wheels to the bread rack; the green electric pole by the food prep area; the stand mixer; the sides and bottom of the warmer cart; the sides and	11/29/2013

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	Interview with the Administrator on 11/6/13 at 11:45 a.m., indicated staff should wear hair restraints when in the kitchen.		bottom of the baking cart; the outside of the ice machine; and the bottom shelf of the reach in cooler have or will be cleaned. This will be completed between 11/21 to 11/29 How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. Measures the facility will take to ensure that the alleged deficiency will not recur: Dietary staff have been re-inserviced regarding taking the temp of the dish machine prior to washing dishes and recording the temp on the temp log A sign was placed on the door to the kitchen reminding staff that hair and beard nets must be worn in the kitchen at all timesDietary staff have been re-inserviced regarding the need to wear hair and beard nets at all times in the kitchenDietary staff has been re-inserviced to not use gloves when serving mealsA daily, weekly and monthly cleaning schedule has been implemented and will be followed by dietary staff. How the facility will monitor for compliance: the dietician/ food service director will monitor for compliance by completing a "dietary sanitation checklist" once a week for 6 months. The results will be presented to the QA committee at the QA meeting which is held monthly at the facility. Completion date:		

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	<p>2. On 10/31/13 at 9:21 a.m. during the brief Kitchen Sanitation tour the following was observed:</p> <p>A. The wash cycle for the dish machine registered at 124 degrees. The Dietary Food Manager indicated at that time, the wash cycle was to reach 140 degrees or above. At that time, there were two dietary aides washing the breakfast dishes. Interview with Dietary Aide #1, indicated she had not tested the dish machine's temperature. Interview with Dietary Aide #2 at the time, also indicated she had not tested the dish machine, however, they were doing the breakfast dishes.</p> <p>On 10/31/13 at 9:30 a.m., both Dietary Aides indicated the wash cycle still had not reached 140 degrees. At that time, the Dietary Food Manager placed a thermometer into the dish machine during the wash cycle. After the wash cycle had ended, the thermometer read only 120 degrees.</p> <p>Interview with the Dietary Food Manager on 11/6/13 at 8:40 a.m., indicated the a lab guy came out to the facility on 10/31/13 and took a look at the dish machine. He</p>		11/29/13		

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	<p>indicated the problem was with the internal thermostat which had a large build up of lime on it. He indicated it had so much build up it prevented the machine from producing high heat. The part was replaced that evening, but lunch and supper meals were served on paper products.</p> <p>B. The Dietary Food Manager was observed with no hair net or beard guard to his facial hair.</p> <p>C. There were no paper towels in the dispenser above the hand washing sink in the dish room.</p> <p>D. The grates on the griddle had a large accumulation of grease and grime and burned food underneath it. There was also a large accumulation of grease on the sides of the griddle.</p> <p>E. The grates on the stove were dirty and there was black burned food substances beneath the grates.</p> <p>F. Both oven hoods were greasy and dirty. The metal slats on the hoods were also dirty and greasy.</p> <p>3. On 10/31/13 at 11:55 a.m., during the noon meal on the 300 unit the following was observed:</p>				

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	<p>A. Dietary Cook #1 was observed wearing clean gloves to both of his hands. He was then observed touching the utensils, the clean plates, the lids to the food on the steam table, and the trays. He was then observed preparing the meal trays for the residents with the same pair of gloves to both of his hands. The Dietary Cook was observed to pick up a piece of white bread with his gloved hands and placed it on the resident's plates. He was not observed to change his gloves at that time. He continued to served the resident trays with the same gloved hands and picked up the white bread and placed it onto the trays with his gloved hands for eight room trays.</p> <p>After preparing the room trays, the Dietary Cook was not observed to change the gloves to his hands. He continued to pick up utensils, handle the plates, and the lids on the steam table. He also touched the cord for the electric skillet and plugged it into the wall with same gloved hands. The Dietary Cook continued to prepare (picking up the white bread with his gloved hands) and serve 17 resident trays before he was given a pair of tongs to use.</p> <p>Interview with the Food Service</p>				

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	<p>Consultant who was standing by the steam table observing the cook prepare the meal trays was informed about using his gloved hands to pick up the slices of white bread.</p> <p>Interview with Dietary Cook #1 on 10/31/13 at 12:40 p.m., indicated he was unaware he needed to change his gloves before picking up food and touching all the utensils.</p> <p>Interview with the Dietary Food Manager on 11/6/13 at 8:40 a.m., indicated he was informed regarding the glove usage and now has inserviced his staff not to use gloves at all while serving the food.</p> <p>4. During the full Kitchen Sanitation Tour on 11/6/13 at 8:40 a.m., the following was observed:</p> <p>A. The Dietary Food Manager had no hair restraint on nor was he wearing a beard guard over his facial hair on his chin and face.</p> <p>B. The second deep fryer had a large accumulation of food crumbs and grease noted. Dietary Cook #2 indicated at the time, she did not use that deep fryer that morning for breakfast.</p>				

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	<p>C. The sides of the griddle had a large accumulation of grease.</p> <p>D. The floor under the tilt skillet, fryers, and the convection ovens was dirty. There was a large accumulation of grease, dirt and food particles on the floor.</p> <p>E. The white wall located behind the stove, convection ovens, steamer, fryer, griddle and tilt skillet was dirty. There was a large accumulation of food splattered and grease.</p> <p>F. The two convection ovens had a large accumulation of grease noted on the outside. All four oven doors had a large accumulation of grease and dried food substances that had been baked on them. The bottom of both ovens was noted with a large accumulation of burned food.</p> <p>G. The outside of the steamer and the shelf below the steamer had a large amount of food particles and grease noted.</p> <p>H. There were three ceiling vents located above food prep areas that were dirty and dusty.</p> <p>I. The bread rack was dusty and greasy. The wheels were also noted</p>						

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	<p>to be greasy and dirty.</p> <p>J. The green electric pole by the food prep area had a large amount dust noted throughout.</p> <p>K. The stand mixer was noted with a large amount of food particles and crumbs all around the outside.</p> <p>L. The warmer cart had a large amount of food crumbs and grease noted on the bottom shelf and on the sides.</p> <p>M. The baking cart was dirty on the sides and on the bottom. The wheels on the cart were dirty and greasy.</p> <p>N. The outside of the ice machine was dirty.</p> <p>O. The reach in cooler was noted with brown food spillage on the bottom shelf.</p> <p>P. Dietary Cook #1 was observed with no hair restraint covering his hair.</p> <p>Interview with Dietary Cook #2 on 11/6/13 at 9:20 a.m., indicated all the above was in need of cleaning.</p>				

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	<p>5. On 10/31/13 at 11:59 a.m., the Home Again dining room was observed. There were 29 deserts observed on a cart with no plastic wrap noted to be covering the deserts. Interview with CNA #5 at the time, indicated the cart was transported from the kitchen to the dining room with no plastic wrap covering the deserts.</p> <p>3.1-21(i)(3)</p>				

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F000463 SS=D	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure emergency call lights were functioning in the bathroom of 1 of 9 rooms, where the call lights had been checked, on the 400 unit. (Room 428)</p> <p>Findings include:</p> <p>On 11/1/13 at 2:23 p.m., the call light in the bathroom of Room 428 was not working. One resident resided in this room.</p> <p>Maintenance employee #1 was informed at this time and indicated the call light was not working and would be repaired.</p> <p>3.1-19(u)(2)</p>	F000463	<p>F- 463 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice: There were no residents identified on the CMS 2567. The call light in the bathroom of room 428 has been repaired How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All call lights in the building were inspected for function by the maintenance supervisor on 11/19/13. Measures the facility will take to ensure that the alleged deficiency will not recur: The maintenance director or designee will continue to conduct monthly inspections of the call light system to ensure that all call lights work How the facility will monitor for compliance: The maintenance director or designee will conduct random audits of 5 rooms daily for 6 months to ensure that the call lights are</p>	11/19/2013

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			working. Results of the audits will be presented to the QA committee at the QA meeting which is held monthly at the facility. Completion date: 11/19/13	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to scratched and paint chipped walls and doors, discolored counter tops, and dust in ceiling vents on 4 of 4 units throughout the facility. The facility also failed to ensure the kitchen was maintained in a sanitary manner related to dusty and dirty pipes and ceiling vents, dirty floors as well as a dirty garbage disposal and dirty wheels on the transportation carts in 1 of 1 kitchens throughout the facility. This had the potential to affect the 147 residents who received food from the kitchen. (The 100, 200, 300 and 400 units and the Main kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 11/6/13 at 1:40 p.m., with the Maintenance Director and the Administrator, the following was observed:</p> <p>100 unit:</p>	F000465	<p>F- 465: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. What corrective actions have been accomplished for those residents found to have been affected by the alleged deficient practice? The right arm for the wheelchair for resident # 4 (E. B.) has been replacedThe closet door to room 119 and bathroom door to room 124 will be touched upThe cable cord outlet in room 119 will be repairedThe door to room 211 and the edge of the wall across from the door will be touched up. The doorknob to the bathroom door in room 211 will be repairedThe door to room 222 and the closet and bathroom doors to room 230 will be touched up. The hole in the bathroom door in room 211, and the cove base near the bathroom sink in room 230 will be repairedThe doors in room 303 and the toilet bowl to the bathroom in room 303 will be touched up and repaired.The bathroom door and the base of the wall next to the door in room 308, and the wall behind the TV in</p>	11/29/2013	

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	<p>a. The closet door in Room 119-D was scratched and marred. The plastic cable cord outlet was loose and detached from the wall. Two residents resided in this room.</p> <p>b. The bathroom walls in Room 124 were paint chipped and marred. Two residents resided in this room.</p> <p>200 unit:</p> <p>a. The door in Room 211 was scratched and marred. The edge of the wall located across from the door was paint chipped and marred. The door knob on the bathroom door was loose. There was no drain stopper in the sink in the bathroom and there was no cover on the paper towel dispenser. Two residents resided in this room.</p> <p>b. The door in Room 222 was scratched and marred. There was no cover on the paper towel dispenser. There was a small hole in the base of the bathroom door. Two residents resided in this room.</p> <p>c. The closet doors in Room 230 were paint chipped and marred. The inside of the bathroom door was paint chipped and marred. The cove base</p>		<p>room 309 will be been touched up The mirror in the bathroom of room 312 will be repaired/ replaced The ceiling vents in the bathroom of rooms 316 and 318 have been cleaned The base of the bathroom door and countertop in the bathroom of room 318, and the countertop in room 320 will be cleaned. The trim on the doors and plastic cover on the edge of the bed light in room 321 will be repaired. The door to the bathroom will be touched up. The peeling wood on the door to the bathroom of room 323 will be repaired. The doors to the bathrooms in room 410 and room 426 will be touched up. These items will be completed by 11/29/13 The wheels to the transportation carts will be cleaned. The entire area around the dish machine and the 3 compartment sink will be cleaned. The ceiling in the dish room and in the kitchen will be cleaned. The outside of the garbage can will be cleaned. The table legs of the food prep table, the floor under the juice machines and the 6 sprinkler heads will all be cleaned. These items will be completed by 11/29/13 How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. Measures the facility will take to ensure that the alleged</p>		

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	<p>was pulling away from the tile underneath the bathroom sink. One resident resided in this room.</p> <p>300 unit:</p> <p>a. The doors to the room and bathroom in Room 303 were scratched and marred. There were rust stains inside the toilet bowl. The right arm of the w/c for Resident #4, who resided in this room, was cracked and torn. Two residents resided in this room.</p> <p>b. The bathroom door in Room 308 was marred and splintered in sections. The base of the wall next to the door was paint chipped and marred. Two residents resided in this room.</p> <p>c. The wall behind the television for Room 309-D was scratched and marred. Two residents resided in this room.</p> <p>d. The mirror in the bathroom of Room 312 was discolored at the base and along the edges. Two residents resided in this room.</p> <p>e. A large accumulation of dust was observed in the ceiling vent of the bathroom in Room 316. Two</p>		<p>deficiency will not recur: Environmental services staff have been re-inserviced to notify maintenance via maintenance work orders during their daily cleaning of the facility of any repairs that need to be madeA daily, weekly and monthly cleaning schedule has been implemented and will be followed by dietary staff. How the facility will monitor for compliance: The housekeeping supervisor, maintenance director or designee will monitor for compliance by inspecting 5 rooms a day for 6 months using the attached QA tool. Any issues or trends noted will be presented to the QA committee at the QA meeting which is held monthly at the facility. The dietician, food service director or designee will monitor for compliance by completing a "dietary sanitation checklist" once a week for 6 months. The results of these audits will be presented to the QA committee at the QA meeting which is held monthly at the facility. Completion date: 11/29/13</p>		

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	<p>residents resided in this room.</p> <p>f. The bathroom ceiling vent in Room 318 had an accumulation of dust. The base of the bathroom door was gauged and marred. The yellow countertop in the bathroom was discolored with a white substance. Two residents resided in this room.</p> <p>g. The yellow countertop in the bathroom of Room 320 was discolored with a white substance. Two residents resided in this room.</p> <p>h. The plastic trim on the edge of the closet doors in Room 321 were peeling in sections. The plastic cover on the edge of the over bed light was missing for 321-D. The bathroom door was splintered and marred at the base. Two residents resided in this room.</p> <p>i. There was a section of peeling wood on the upper portion of the bathroom door in Room 323. Two residents resided in this room.</p> <p>400 unit:</p> <p>a. The base of the bathroom door was chipped and marred in Room 410. One resident resided in this room.</p>			
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	<p>b. The base of the bathroom door in Room 426 was chipped and marred. One resident resided in this room.</p> <p>Interview with the Maintenance Director and Administrator at the time, indicated the above areas were in need of cleaning and/or repair.</p> <p>2. During the brief Kitchen Sanitation Tour 10/31/13, at 9:16 a.m., with the Dietary Food Manager, the following was observed:</p> <p>A. The wheels on five transportation carts were dirty and greasy.</p> <p>B. The white PVC pipes below the dish machine had a large accumulation of dirt and dried food substance on them. The metal pipes below the dish machine were rusty and dirty. The white back splash below the dish machine was also dirty and was noted to have a large accumulation of dried food substance.</p> <p>C. The garbage disposal below the dish machine had a large accumulation of dried food substance on the outside and was dirty.</p>			

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	<p>D. The baseboard behind the entire dish machine and under the three compartment sink was dirty with adhered dirt noted in the grout of the tile.</p> <p>E. The white grease container located on the floor under the three compartment sink was greasy and dirty.</p> <p>F. The ceiling in dish room had dried food splattered all over and was noted with dried food spillage.</p> <p>3. During the full Kitchen Sanitation Tour on 11/6/13 at 8:40 a.m., the following was observed:</p> <p>A. There was a large amount of dried food spillage noted on the ceiling throughout the kitchen</p> <p>B. The outside of the garbage can was dirty with dried food spillage noted.</p> <p>C. The table legs on the food prep table were dirty.</p> <p>D. The floor under the juice machines was dirty and greasy with food crumbs and wrappers.</p>			

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	<p>E. There were six sprinkler heads that had a heavy accumulation of dust on them</p> <p>Interview with Dietary Cook #2 on 11/6/13 at 9:20 a.m., indicated all the above was in need of cleaning.</p> <p>3.1-19(f)</p>			