

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 6,7,8, and 9, 2013</p> <p>Facility number: 000360 Provider number: 155733 AIM number: 100290370</p> <p>Survey team: Caitlyn Doyle, RN-TC Regina Sanders, RN Jennifer Redlin, RN Heather Hite, RN Janelyn Kulik, RN (August 6, 2013)</p> <p>Census bed type: SNF/NF: 23 NF: 16 Total: 39</p> <p>Census payor type: Medicare: 8 Medicaid: 24 Other: 7 Total: 39</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August</p>	F000000	<p>The plan of correction is to serve as Colonial Nursing & Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Colonial Nursing & Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement of admission of the survey allegations.</p>	
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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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	15, 2013, by Janelyn Kulik, RN.				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting a suspicious bruise of unknown origin to the Administrator of the facility, for 1 of 1 suspicious bruising observed. (Resident #4)</p> <p>Findings include:</p> <p>A facility policy, dated 07/11, titled, "Abuse Prevention", and received from the Director of Nursing as current, indicated, "...Signs of /Actual Physical Abuse: Welts or bruises...Employees...must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately..."</p> <p>During an observation on 08/06/13 at 9:51 a.m., Resident #4 had a bruise around her right wrist and splotches of bruises on her lower left arm and inner left upper arm.</p> <p>The resident indicated, at the time of</p>	F000226	<p>1. The incident was investigated and reported to the required agencies. The staff member was immediately inserviced about reporting timely.2. A review of all incidents was completed for the last 30 days. No other findings of possible allegations was noted.3. All staff were inserviced on the proper policy and procedure for reporting allegations of abuse. All incident reports will be reviewed during morning meeting to ensure that all required incidents are reported to the proper agencies.4. The incident log will be reviewed by the Administrator weekly for 3 months and the results will be reviewed during the monthly quality improvement meetings. The same auditw will be completed monthly on an ongoing bases and the results will be reviewed in Quality Assurance Meetings.5. September 8, 2013</p>	09/08/2013	

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	<p>the observation, the bruises were, "from shots in my butt and they said they would just wash off."</p> <p>The resident's record was reviewed on 08/07/13 at 1:03 p.m. The resident's diagnoses included, but were not limited to, history of blood clots and paranoid psychosis.</p> <p>During an interview on 08/07/13 at 2:08 p.m., LPN #1, the MDS (Minimum Data Set) Assessment Nurse, and the ADoN (Assistant Director of Nursing), indicated they had not seen bruises on the resident's arms.</p> <p>During an observation on 08/07/13 at 3:30 p.m., the MDS Assessment Nurse and ADoN were measuring the resident's bruises on her arm. The MDS Assessment Nurse indicated the resident's left arm had two bruises to the side and three bruises which were separated, with faint bruising which connected the bruises together. The ADoN indicated the bruises looked like finger prints, then held her hand over the areas to indicate where the finger marks were.</p> <p>During an interview on 08/08/13 at 9:00 a.m., the MDS Assessment Nurse indicated she had reported the</p>			

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	<p>bruising and what it looked like to the Administrator and the DoN during the afternoon meeting on 08/07/13.</p> <p>During an interview on 08/08/13 at 9:00 a.m., the DoN indicated it was passed on to her the Indiana State Department of Health Surveyor had said it looked like fingerprints, not the facility staff member.</p> <p>During an interview on 08/08/13 at 9:22 a.m., the Adminsitrator indicated no one had reported the facility nurse had indicated the bruises looked like finger print marks. He indicated it should have been reported to him and then he would have immediately reported the information to the Indiana State Department of Health.</p> <p>3.1-28(a)</p>				

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F000280 SS=B	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a resident's Responsible Party had been invited to participate in the resident's care plan review, for 1 of 1 resident reviewed for care plan participation. (Resident #1)</p> <p>Findings include:</p> <p>During a family interview on 08/06/13 at 2:26 p.m., Resident #1's Responsible Party indicated she had not been invited to attend the resident's care plan meeting for a long time.</p>	F000280	<p>1. Resident #1 family was invited to attend the residents care plan meeting.2. Residents were reviewed and no other deficient practice was found.3. Copies of all invitations will be retained with the care conference schedule for a minimum of 1 year by MDS Coordinator and/or designee.4. Weekly the care conference schedule will be compared to the invitation letters to ensure all residents families are invited by the MDS Coordinator and/or designee. Those results will be submitted to the Quality assurance committee for three months. If 100% compliance then the reviews will be discontinued.5. September 8,</p>	09/08/2013	

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	<p>Resident #1's record was reviewed on 08/08/13 at 6:45 p.m. The resident's diagnoses included, but were not limited to, mental impairment and cerebral palsy.</p> <p>The resident had Quarterly Minimum Data Set (MDS) Assessments completed on 2/6/13 and 5/8/13.</p> <p>A Care Conference sign in sheet, indicated the resident's care plan had been reviewed on 02/13/13 and 08/06/13. The form lacked documentation the resident's Responsible Party had been invited and/or attended the care plan conference.</p> <p>During an interview on 08/09/13 at 8:43 a.m., Receptionist #2 indicated she sent the invitations out to the families/Responsible Party. She indicated the MDS Assessment Nurse would give her a list and then she would send the invitations out. She indicated Resident #1 was not on the list from April 2013 forward, so an invitation had not been sent out. She indicated she had not kept records of the invitations so she was unsure if Resident #1's family had been sent an invitation for the care plan conferences prior to April 2013.</p>		2013	

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	3.1-35(d)(2)(B)				

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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 the monitoring and assessment of bruises for 1 of 1 resident reviewed for bruising. (Resident #4)</p> <p>Findings include:</p> <p>During an observation on 08/06/13 at 9:51 a.m., Resident #4 had a bruise around her right wrist and scattered bruises on her lower left arm and inner left upper arm.</p> <p>The resident indicated, at the time of the observation, the bruises were, "from shots in my butt and they said they would just wash off."</p> <p>The resident's record was reviewed on 08/07/13 at 1:03 p.m. The resident's diagnoses included, but were not limited to, history of blood clots and paranoid psychosis.</p>	F000309	<p>1. Resident had assessment done of bruises and documented during survey. Bruises will be monitored until all skin issues are resolved.2. All residents skin assessments were reviewed to ensure all are meeting the regulation. No deficient practice was noted.3. Staff were inserviced on skin assessments and documenting on bathing skin sheet. Bathing skin sheets will be turned in to DON and / or desginee upon completion. Any new skin issues will be assessed and documented on.4. Skin sheets will be audited at a minimum of three times a week by DON and /or designee to ensure any new issues are assessed and documented on. Those audits will be monitored by the Quality Assurance Committee for three months. If in compliance of regulation then the monitoring will be decreased to once per week for another six months. At that time, if in compliance of regulation the matter will be considered resolved.5. September 8, 2013</p>	09/08/2013	

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	<p>The Physician's Recapitulation Orders, dated 08/13, indicated the resident had received Coumadin (blood thinner), two milligrams every other day and one milligram every other day (alternated).</p> <p>A PT/INR (blood tests for blood clotting) laboratory result, dated 08/05/13, indicated the PT was critically high at 65.3 (normal 10-14) and the INR was critically high at 6.5 (normal 2-3).</p> <p>A Critical Lab Assessment Form, dated 08/05/13, indicated the resident's Physician, Responsible Party, and the Director of Nursing (DoN) were notified, and there was no new and/or abnormal bruising or bleeding noted. The form was signed by LPN #3 and the DoN.</p> <p>A Physician's Order, dated 08/05/13, indicated to not give the Coumadin on August 5, 6, and 7, 2013 and to repeat a PT/INR on 08/07/13</p> <p>A care plan, dated 07/10/13, indicated the resident had a potential for complications related to anticoagulant (blood thinning) therapy and the interventions included, "...Monitor/document/report...bruising.</p>			

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	<p>.."</p> <p>A Weekly Skin Assessment, dated 08/06/13 (no time documented), indicated there were no areas of concern and on the back of the form, LPN #3 indicated there were no known injuries or bruising noted.</p> <p>During an interview on 8/7/13 at 10:30 a.m. the DoN indicated the bruising was from the numerous laboratory blood draws the resident had.</p> <p>During an interview on 08/07/13 at 2:08 p.m., LPN #1, the MDS (Minimum Data Set) Assessment Nurse, and the ADoN (Assistant Director of Nursing), indicated they had not seen bruises on the resident's arms.</p> <p>During an observation on 08/07/13 at 3:30 p.m., the MDS Assessment Nurse and ADoN were measuring the resident's bruises on her arm. The MDS Assessment Nurse indicated the resident's left arm had two bruises to the side and three bruises which were separated, with faint bruising which connected the bruises together. The ADoN indicated the bruises looked like finger prints, then held her hand over the areas to indicate where the finger marks were. The MDS</p>						

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	<p>Assessment Nurse indicated the bruised areas were visible on the arms.</p> <p>The MDS Assessment Nurse measured the bruised areas as followed:</p> <p>Left forearm: 5.4 cm (centimeter) x 7.0 cm, "Cluster like bruising c/ (with) dark read purple bruising areas and light red lace like areas attaching the dark areas together-bridging"</p> <p>Left mid-arm-near elbow: 8.2 cm x 11.6 cm red, purple bruise</p> <p>Left forearm down from anticubical: 2.3 cm x 3.0 cm red/purple bruise</p> <p>Left forearm most distal near wrist thumb side: 1.1 cm x 2.5 cm purple bruise</p> <p>Right Forearm above wrist: 7.5 cm x 12.5 cm dark purple bruise</p> <p>Right forearm below elbow: 1 cm x 3.0 cm red purple bruise</p> <p>Right forearm above wrist: 3.5 cm x 3.0 cm red, purple-faint.</p> <p>During an interview on 8/7/13 at 2:08 p.m., the DoN indicated if a bruise</p>			

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	<p>was found, the nurse was to document on an occurrence form and notify the DoN, the Physician, and the family. She indicated this should be completed if the resident was on a blood thinner or not.</p> <p>3.1-37(a)</p>				

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F000323 SS=E	<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 the residents' environment was free of accidents and hazards, related to a mattress, which did not fit a resident's bed (Resident #4) and sharp's and medications stored unlocked (second floor Nurses' Station, first floor Nurses' Station, and first floor Dining Room) and accessible to residents, which had the potential to affect one confused resident who resided on the second floor and 13 confused residents who resided on the first floor.</p> <p>Findings include:</p> <p>1. During an observation on 8/7/13 at 10:26 a.m., Resident #4 was in her bed with the head of the bed up. The resident's scoop mattress had a large gap between the edge of the mattress and the raised side rail on the right side of the bed.</p> <p>During an interview on 8/7/13 at 10:26 a.m., at the time of the</p>	F000323	<p>1. 1. During the survey the mattress for Resident #4 was replaced. 2 - 4 Also during survey all doors were locked that were cited in this regulation.2. A facility tour was conducted to ensure the facility is in compliance of this regulation for both mattresses and locked items and no deficiant practice was found.3. Staff was inserviced on making sure items are securely locked according to the regulation. Also a lock audit will be used by the DON and / or designee to be completed a minimum of three times per week. Rounds will be made a minimum of three times per week monitoring any specialty mattresses by the DON and /or designee.4. Results of the lock audit will be submitted to the Quality Assurance Committee for three months for review. Also the mattress rounds will be submitted to the Quality Assurance Committee for three months for review. If 100% compliance is met for both mattress rounds and lock audits these matters will be considered resolved. If not then the audits will continue on until 100% for three consecutive</p>	09/08/2013

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	<p>observation, LPN #1 indicated the resident had just received a new mattress and it did not look like the mattress fit the bed.</p> <p>During an observation on 8/7/13 at 10:33 a.m., the Director of Maintenance measured the gap between the mattress and the side rail, at 8 1/4 inches. The Director of Maintenance indicated he had not put the mattress on the bed, he indicated the bed frame was an extra large frame and the scoop mattress did not fit on the bed frame.</p> <p>During an interview on 08/07/13 at 10:36 a.m., the Director of Nursing (DoN) indicated she was not aware the mattress did not fit the bed and did not know who put the mattress on the bed. She indicated the mattress had been applied on 07/29/13.</p> <p>During an interview on 08/07/13 at 10:41 a.m., the Administrator indicated he had the mattress brought up to the resident's room because he was concerned about the resident leaning in the bed. He indicated he was not sure who put the mattress on the bed.</p> <p>The resident's record was reviewed on 08/07/13 at 1:03 p.m. The</p>		months. 5. September 8, 2013		

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	<p>resident's diagnoses included, but were not limited to, history of blood clots and paranoid psychosis.</p> <p>A Physician's Order, dated 07/29/13, indicated an order for a scoop mattress.</p> <p>The most current bed rail safety assessment, dated 04/04/13, indicated the resident used the bed rails for support or positioning and the gap between the rails and mattress edges was not greater than 2.5 inches.</p> <p>2. During an observation on 08/06/13 at 10:46 a.m., the door to the second floor Nurses' Station was unlocked, inside the Nurses' Station, there was an unlocked refrigerator which contained a box of Brovana(bronchodilator) inhalation solution and Foradil aerolizer (bronchodilator). There were no staff in the area.</p> <p>QMA #4 then exited a resident's room, in which the door was closed, and came into the Nurses' Station. QMA #4 indicated the Nurses' Station did not have a lock. She indicated this was first time she had seen medications in the refrigerator and the medications should not be stored in</p>			

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	<p>the unlocked refrigerator.</p> <p>During an observation of the second floor Nurses' Station on 08/09/13 at 9:33 a.m., with QMA #5 present, there was a box of Brovana inhalation solution and Foradil Aerolizer stored in the unlocked refrigerator. QMA #5 indicated the door to the Nurses' Station locked but the facility did not have a key to the door. She indicated there were nine residents who resided on the second floor and one of the residents was confused.</p> <p>3. During an observation on 8/7/13 at 9:39 a.m., the personal care cabinet, located in the first floor Dining Room was unlocked. Inside the cabinet was a plastic bin of razors and eight jars of A&D ointment, which indicated on the side of the jars, "if swallowed get medical help or contact a poison control center right away".</p> <p>There were 10 residents in the Dining Room and no staff were present during the time of the observation.</p> <p>CNA #6 then entered the dining room at 9:48 a.m.. CNA #6 indicated she was unsure if the cabinet was suppose to be locked or not. She indicated all of the residents in the dining room were confused.</p>			

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	<p>4. During an observation on 08/09/13 at 11:21 a.m., with LPN #3 present, there was an unlocked cabinet at the Nurses Station, which contained a box of decongestant medication, a bottle of laxatives, a box of hemorrhoidal suppositories, six insulin pens, and a sack which contained two bottles of acetaminophen, two bottles of prilosec (stomach medication), one bottle of metoprolol (blood pressure medication), one bottle of a probiotic, one bottle of an anti-histamine, one bottle of lomotil (anti-diarrhea medications), and one bottle of namenda (Alzheimer's medication).</p> <p>During an interview at the time of the observation, LPN #7 came to the Nurses' Station. LPN #7 indicated the cabinet should have been locked. LPN #3 indicated since LPN #7 said it should have been locked, she would lock the cabinet.</p> <p>A hand written note from the Minimum Data Set Assessment Nurse, received on 08/09/13 at 12:45 a.m., indicated there were 13 confused residents who resided on the first floor.</p> <p>A facility policy, dated 01/13, titled, "Storage and Expiration of</p>			
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	<p>Medications, Biologicals, Syringes, and Needles", received from the Director of Nursing as current, indicated, "...Facility should ensure that all medications and biologicals (sic)...are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..."</p> <p>3.1-45(a)(1)</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 attempt a gradual dose reduction for the antidepressant medication Remeron for 1 or 5 residents reviewed for unnecessary medications. (Resident #37)</p> <p>Findings include:</p> <p>The clinical record was reviewed on 08/07/2013 at 12:43 p.m.</p>	F000329	<p>1. Resident #37 was reassessed for medical symptoms, behaviors and mood conditions, and care plan and behavior tracking sheets were revised.2. All residents receiving psychoactive medications were identified through review of physician's orders. Care plans and behavior tracking sheets for all identified residents were reviewed and updated to reflect each residents current needs.3. All nursing staff and social service will be educated on the provision of psychoactive medications,</p>	09/08/2013	

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	<p>Diagnoses included, but were not limited to: urinary tract infection, chronic indwelling catheter/ neurogenic bladder, history of constipation, hypothyroidism, esophageal reflux, hypokalemia.</p> <p>A Consult Note, dated 9/7/12, indicated Resident #37 was currently taking Remeron 15mg (milligram) at bedtime prior to admission to the facility.</p> <p>The Physician's Recapitulation Orders dated 7/23/13, indicated an order for Remeron 15 mg (milligram) - give one tablet orally at bedtime for appetite stimulant, initiated on admission 9/14/12.</p> <p>The Quarterly Minimum Data Set (MDS) assessments dated 12/15/12, 3/14/13 and 6/12/13 all indicated no significant weight loss or nutritional interventions.</p> <p>The initial Nutritional Assessment dated 9/13/12 indicated "mechanical soft NAS (no added salt) diet with ensure 1 can BID (twice daily)... Intake 50-75%...Wt acceptable...No nutritional problems at this time."</p> <p>A review of the Physician's Progress Notes, Nutrition Progress Notes and</p>		<p>appropriate use, behavior tracking, qualitative and quantitative documentation and gradual dose reductions.4. The SSD will conduct an audit of all phychoactive medications to identify diagnosis for use, date of most recent gradual dose reduction, medical symptoms, behaviors and mood, behavior tracking in place and care plan reflective of resident's needs initially and then monthly through the Behavior Management Meeting. The DON or designee will monitor pharmacy recommendations to assure gradual dose redictions are completed or that appropriate documentation is in place when dose rediction is declined. Results will be presented in Quality Assurance Meeting monthly on an ongoing bases.5. September 8, 2013</p>	

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	<p>Pharmacy Recommendations indicated a lack of documentation regarding Remeron use since admission on 9/14/12</p> <p>The Medication Administration Record dated August 2013 indicated Remeron had been given as ordered.</p> <p>In an interview with the Assistant Director of Nursing (ADON) on 08/08/13 at 9:10 a.m., she indicated she is part of the Gradual Dose Reduction (GDR) process and discussions. She also indicated if Remeron is being used as an appetite stimulant, it should be addressed by dietary as well as the physician and pharmacy. She further indicated any GDR recommendations should be handled and initiated by pharmacy. The ADON reviewed the chart and confirmed no notes were found concerning Remeron since admission.</p> <p>A policy titled Psychopharmacological Medication Use dated 1/1/13 was provided by the Director of Nursing (DoN) on 8/8/13 at 10:15 a.m. It indicated: "1) The facility should comply with the Psychopharmacologic Dosage Guidelines created by the Centers for Medicare and Medicaid Services</p>						

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	<p>("CMS"), the State Operations Manual, and all other Applicable Law relating to the use of psychopharmacologic medications including gradual dose reductions...</p> <p>3) Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychopharmacological medications, per facility policy or applicable state regulations."</p> <p>3.1-48(a)(2)</p>			

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 9 residents observed during 6 medication pass observations. Three errors in medications were observed during 26 opportunities for errors in medications administration. This resulted in a medications error rate of 11.53%. (Residents #16 and #39)</p> <p>Findings include:</p> <p>1. During an observation of a medication administration pass on 08/07/13 at 11:03 a.m., with LPN #3, she indicated Resident #16 should have received Sustane Eye Drops (for dry eyes), but the facility was waiting for the family to bring the medication into the facility. LPN #3, then indicated the resident was to receive Acyclovir (medication for shingles) 800 milligrams and Levetiracetam (for seizures) 500 milligrams through the resident's g-tube (feeding tube).</p> <p>LPN #3 indicated the resident was to receive 200 cc (cubic centimeters) of</p>	F000332	<p>1. Medications were received and being given according to physician order for resident #16. The order for Resident #39 was clarified and the MAR was corrected to match order.2. Review of all residents MARs were completed to ensure all medications are available and dosage correct.3. Nursing staff was educated on the medication administration policy for ordering medications. Also education included proper documentation for dosage on the MAR. The inservice also covered proper g-tube medication administration. 4. MAR audits will be completed at a minimum of three times a week by the DON and / or designee. Also medication observations of medication administration for including each shift will be conducted a minimum of three times a week by the DON and /or designee. The results of these audits and the observations will be submitted to the Quality Assurance committee for a minimum of three months. If 100% compliance is met for three consecutive months then the audits will be reduced to weekly audits on an ongoing bases.5. September 8, 2013</p>	09/08/2013	

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	<p>water for a flush after the medications were given.</p> <p>LPN #3 then removed the Acyclovir and crushed the medication. LPN #3 then placed the powdered medication in a plastic medication cup.</p> <p>LPN #3 entered the resident's room, checked the g-tube for placement and residual, then attached the syringe to the g-tube and flushed the tube with 50 cc of water. LPN #3 then placed the liquid Levetiracetam into the g-tube and the medication administered by gravity.</p> <p>LPN #3 then poured the dry powdered Acyclovir into the syringe, then added water and shook the syringe to mix the medication with the fluid, which was still attached to the resident's g-tube. Resident #16 then stated, "that has to be mixed with water before you put it in (in the syringe)".</p> <p>The medication was clogged at the end of the syringe, which was still attached to the resident's g-tube. LPN #3 then attempted to milk the g-tube, and stated, "that is clunked up a lot." LPN #3 then unhooked the syringe from the g-tube and poured the water with part of the medication</p>			

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	<p>out into a plastic medication cup. There was still dried medication clogged in the end of the syringe, and LPN #3 then took a little water and attempted to purge the water and the medication out of the bottom of the syringe, spraying the medication and water out onto the bedside table.</p> <p>At 11:22 a.m., LPN #3 then reattached the syringe to the g-tube and stated she was going to, "flush with a little more water." After the flush, LPN #3 then poured the diluted medication into the syringe and let the medication flow into the resident by gravity. The resident stated, "See I told you". LPN #3 then informed the resident she could not dilute the medication prior to placing it into the syringe because of the regulations. She indicated to the resident the medication did dissolve better when it was diluted in water.</p> <p>During an interview with LPN #3, after the observation, LPN #3 indicated she had always put the dry medication into the g-tube then added the water. She indicated that was the policy at the facility.</p> <p>LPN #3 also indicated the Sustane eye drops were not given as ordered because the facility did not have the</p>			

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	<p>eye drops to give.</p> <p>Resident #16's record was reviewed on 08/09/13. The resident's diagnoses included, but were not limited to, history of shingles, seizures, and neurotropic keratitis.</p> <p>The Physician's Recapitulation Orders, dated 08/13, included orders for Acyclovir 800 mg, twice a day for shingles and Systane Ultra, instill one drop into the left eye four times a day.</p> <p>An undated, facility policy, titled, "Administering Medications through an Enteral Tube", received from the Assistant Director of Nursing on 08/07/13 at 11:40 a.m., indicated, "...4. dilute medications and flush the tube with room temperature or warm liquids...9...b. Dilute powdered, crushed, or split (capsule) medications...18. Dilute the crushed or split medication with 30 ml (milliliters)..."</p> <p>2. During an observation of a medication administration pass on 08/08/13 at 6 p.m., LPN #7 prepared Resident # 39's medications, which included Floranex (medication for stomach distress) one tablet.</p> <p>LPN #7 administered the medications</p>						

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	<p>to Resident #39.</p> <p>The Medication Administration Record (MAR), dated 08/13, indicated the Floranex was to be administered two times a day at 9 a.m. and 5 p.m. and had been administered at these times on 08/01/13 through 08/08/13.</p> <p>Resident #39's record was reviewed on 08/09/13 at 9 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's type dementia and gastro-intestinal distress.</p> <p>The Physician's Orders, dated 07/31/13, indicated an order for acidophilus/bulgaricus (Floranex) one tablet daily.</p> <p>During an interview on 8/9/13 at 9:28 a.m., LPN #7 indicated the resident should not have received the Floranex twice a day.</p> <p>A facility policy, dated 05/10, titled, "General Dose Preparation and Medication Administration", received from the Director of Nursing as current, indicated, "...Confirm that the MAR reflects the most recent medication order..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review, and interview, the facility failed to ensure medications were obtained for a resident, related to eye drops not available to administer to a resident as ordered by the resident's physician, for 1 of 9 residents reviewed for medication administration. (Resident #16)</p> <p>Findings include:</p> <p>During an observation of a medication administration pass on 08/07/13 at 11:03 with LPN #3, she indicated Resident #16 should have received</p>	F000425	<p>1. Medication were received and being given according to physician order for resident #16.2. Review of all residents MARs were completed to ensure all medications are available.3. Nursing staff was educated on the medication administration policy for ordering medications.4. MAR audits will be completed at a minimum of three times a week by the DON and / or designee. The results of these audits will be submitted to the Quality Assurance Committee for a minimum of three months. If 100% compliance is met for three consecutive months then the audits will be reduced to monthly</p>	09/08/2013	

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	<p>Sustane Eye Drops (for dry eyes), but the facility was waiting for the family to bring the medication into the facility.</p> <p>Resident #16's record was reviewed on 08/09/13. The resident's diagnoses included, but were not limited to, history of shingles, seizures, and neurotropic (decreased corneal sensitivity) keratitis.</p> <p>The Physician's Recapitulation Orders, dated 08/13, included an order for Systane Ultra, instill one drop into the left eye four times a day.</p> <p>Resident #16's Medication Administration Record (MAR), dated 08/13, indicated the Sustane eye drops had not been administered to the resident as ordered on August 1-7, 2013.</p> <p>The MAR, dated 07/13, indicated the resident did not receive the Sustane eye drops on 07/31/13 at 5 p.m. and 9 p.m.</p> <p>During an interview on 08/08/13 at 12 p.m., the Director of Nursing (DoN) indicated the physician had been notified on 08/04/13 about the Sustane eye drops not being available and the facility was waiting</p>		audits on an ongoing bases.5. September 8, 2013	

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	<p>on the family to bring in. She indicated she just investigated why the eye drops were not at the facility and found the Sustane eye drops should have been ordered from the pharmacy and not the family. She indicated when she notified the family, the family had informed her no one had called them about the eye drops and they would have informed the facility to order the eye drops from the pharmacy because they did not supply the eye drops. She indicated the resident went for over seven days without the eye drops but once the pharmacy was notified, the eye drops were delivered.</p> <p>3.1-25(a)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to store all drugs and biologicals in a locked compartment, related to</p>	F000431	<p>1. 1. Second floor nurses station refrigerator had a lock placed on it so both station and refrigerator can be locked. 2. Unlocked cabinet at the nurses station was</p>	09/08/2013			

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	<p>medications stored in an unlocked refrigerator in an unlocked Nurses' Station and in an unlocked cabinet at the Nurses' Station for 2 of 2 Nurses' Stations (First and Second floor Nurses' Stations) and medications stored in uncleaned medication carts for 2 of 3 medication carts observed (first floor carts).</p> <p>Findings include:</p> <p>1. During an observation on 08/06/13 at 10:46 a.m., the door to the second floor Nurses' Station was unlocked, inside the Nurses' Station, there was an unlocked refrigerator which contained a box of Brovana(bronchodilator) inhalation solution and Foradil aerolizer (bronchodilator). There was no staff in the area.</p> <p>QMA #4 then exited a resident's room, in which the door was closed, and came into the Nurses' Station. QMA #4 indicated the Nurses' Station did not have a lock. She indicated this was first time she had seen medications in the refrigerator and the medications should not be stored in the unlocked refrigerator.</p> <p>During an observation of the second floor Nurses' Station on 08/09/13 at</p>		<p>checked to ensure lock function and is locked. 3. C hall medication caart has been cleaned.2. Rounds were conducted to ensure all items are locked to meet this regulation and all medication carts were checked. 3. Inservice was completed to educate nursing staff on properly securing items and keeping medication carts in proper order.4. An audit will be completed by DON and / or designee a minimum of three times a week to ensure all items are properly secure and medication carts are in proper order. These audits will be submitted to the Quality Assurance committee for minimum of three months. If 100% compliance is met the audits will be discontinued. If compliance is not met the audits will continue until 100% is met for three consecutive months.5. September 8, 2013</p>		

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	<p>9:33 a.m., with QMA #5 present, there was a box of Brovana inhalation solution and Foradil Aerolizer stored in the unlocked refrigerator. QMA #5 indicated the door to the Nurses' Station locks but the facility did not have a key to it.</p> <p>2. During an observation on 08/09/13 at 11:21 a.m., with LPN #3 present, there was an unlocked cabinet at the Nurses Station, which contained a box of decongestant medication, a bottle of laxatives, a box of hemorrhoidal suppositories, six insulin pens, and a sack which contained two bottles of acetaminophen, two bottles of prilosec (stomach medication), one bottle of metoprolol (blood pressure medication), one bottle of a probiotic, one bottle of a anti-histamine, one bottle of lomotil (anti-diarrhea medications), and one bottle of namenda (Alzheimer's medication).</p> <p>During an interview at the time of the observation, LPN #7 came to the Nurses' Station. LPN #7 indicated the cabinet should have been locked. LPN #3 indicated since LPN #7 said it should have been locked, she would lock the cabinet.</p> <p>A facility policy, dated 01/13, titled,</p>			

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	<p>"Starage and Expiration of Medications, Biologicals, Syringes, and Needles", received from the Director of Nursing as current, indicated, "...Facility should ensure that all medications and biologicals (sic)...are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..."</p> <p>3. During an observation of the C-Hall Medication Cart with LPN #7 on 8/9/13 at 11:03 a.m., there were dried white liquid spills in the bottom drawer of the cart and on top of the narcotic box in the bottom of the medication cart. There was debris and white powder on the bottom of the inside of the drawer. LPN #7 indicated the white liquid dried spills looked like stomach medication. She indicated 15 residents' received medications from this medication cart.</p> <p>During an observation of the A/B Hall Medication Cart with LPN #3, on 08/09/13 at 11:15 a.m., there was an accumulation of dried white powder and white dried liquid on the inside of the bottom drawer. LPN #3 indicated she was unsure how often the medication carts were cleaned. She indicated 22 residents received their medications from the A/B Medication</p>			

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	<p>Cart.</p> <p>3.1-25(m)</p>			

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F000458 SS=D	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation and record review, the facility failed to provided the required square footage per resident in 1 or 5 single resident rooms and for 7 of 19 multiple resident rooms. The deficient practice had the potential to affect 12 of 13 residents in the 7 two person rooms and 1 of 1 resident in the one person room. (Rooms 101, 104, 111, 201, 2202, 204, 206, and 208.)</p> <p>Finding include:</p> <p>Review of the facility's Room Size Certification, received form the Administrator on 8/6/13, the following measurements of the rooms were:</p> <p>1. The floor area of the following single resident room measured: *Room 111-1 resident, 96.2 SQ (Square) FT (feet). NF.</p> <p>2. The floor areas of the following multiple resident rooms measured: *Room 101-2 residents, 150.3 SQ FT,</p>	F000458	<p>1. All effected rooms were measured and floor planned including furniture2. All effected resident's conditions were reviewed for safety, comfort, nursing care delivery and privacy to assure that there were no adverse effects to placement in rooms with square footage waivers.3. Prior to admission resident's assessments will be reviewed to determine appropriate room assignment for potential residents. Residents will be assigned rooms by medical necessity and resident and family preference.4. Residents conditions will be monitored by the Interdisciplinary Team during Care Plan Conferences for appropriateness of room assignments. The team will make recommendations to the Administrator of a potential difficulty with room assignment. The residents needs will be evaluated and if necessary a room change will be initiated. Social Services will discuss room transfers with resident and/or responsible party to arrange a smooth transition to a new room.5. September 8, 2013</p>	09/08/2013

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	<p>75.2 SQ FT per bed. NF. *Room 104-2 residents, 145.0 SQ FT, 72.5 SQ FT per bed. NF. *Room 201-no residents, 149.0 SQ FT, 74.5 SQ FT per bed. NF. *Room 202-no residents, 144.0 SQ FT, 72.0 SQ FT per bed. NF. *Room 204-no residents, 144.0 SQ FT, 72.0 SQ FT per bed. NF. *Room 206-no residents, 140.0 SQ FT, 70.5 SQ FT per bed. NF. *Room 208-1 resident, 146.9 SQ FT, 73.4 SQ Ft per bed, NF.</p> <p>The facility rooms with room variances were observed on 8/9/13 at 11:45 a.m. The rooms were observed to have the following amounts of bed: Room 101-2 beds Room 104-2 beds Room 111-1 bed Room 201-2 beds Room 202-2 beds Room 204-2 beds Room 206-1 bed Room 208-2 beds</p> <p>During an interview on 8/6/13 at 3:30 p.m., the Administrator indicated these were the rooms which had the waivers.</p> <p>3.1-19(l)(2)</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, interview, and record review, the facility failed to ensure resident room and bathroom call lights were available and in working order for 4 of 30 resident room observations. (Bathroom shared by rooms 206 and 208, Bathroom shared by room 205 and 207, and resident room 208)</p> <p>Findings include:</p> <p>1. During an observation on 08/06/13 at 10:51 a.m. and 11:13 a.m., the alarm, which was used for a call light in the bathroom between rooms 206 and 208, was housed in a plastic container on the wall beside the toilet. When the string was pulled to activate the alarm, the clip from the alarm could not be pulled out of the alarm to activate the sound. When the alarm was removed from the plastic container and the clip was removed from the alarm, the alarm did not sound.</p> <p>During an interview on 08/06/13 at 10:54 a.m., QMA #4 indicated the</p>	F000463	<p>1. Bathroom between room 206 and 208 along with bathroom between 205 and 207 had a call light installed / repaired during survey process.2. All rooms were audited for call lights and functionality of call lights. Audit showed no compliance issues.3. The call light system will be inspected twice weekly by the Maintenance Director to assure they are in place and working.4. Weekly checks by Maintenance Director plus the Administrator during regular rounds will spot check call light system. The Maitnenance Director will report the inspections to the Administrator who will present the finding to the Quality Assurance committee for 3 months. If 100% compliance is obtained then the inspections will be weekly on an ongoing bases.5. September 8, 2013</p>	09/08/2013

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	<p>bathroom alarm did not work.</p> <p>2. During an observation of the room 208 on 08/06/13 at 11:13 a.m., the call lights on Bed 1 and Bed 2 (only Bed 2 occupied) did not activate when pressed.</p> <p>During an interview on 08/06/13 at 11 a.m., QMA #4 indicated the resident who resided in the room had a bed alarm, so if she attempted to get out of bed, the bed alarm would activate. She indicated the resident was usually alert and oriented.</p> <p>3. During an observation of the bathroom, shared by rooms 205 and 207, on 08/06/13 at 10:37 a.m., there was no call light/alarm located in the bathroom.</p> <p>During an interview with the residents of the rooms at the time of the observation, they indicated the call light had fell out a couple days ago and had not yet been replaced.</p> <p>During an interview with the Director of Maintenance on 08/09/13 at 1:30 p.m., he indicated the call lights are checked daily. The preventative maintenance log, indicated the call lights had been checked and were functioning on 08/05/13.</p>			

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	3.1-19(u)(1) 3.1-19(u)(2)			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the facility was kept sanitary, safe, and comfortable for the residents, related to marred walls, doors, and handrails, torn floor pads and arms of chairs, dirty Broda chair (Resident #32), chipped bedside table, a dirty window blind, scratches on a dresser, dirty floors and stained floor tiles, cracked plastic door protectors, no hot water available from a faucet, dirty and frayed carpeting and an unclean Beauty shop for 2 of 2 resident care areas (First and Second Floor), 1 of 2 dining room (First Floor), and 1 of 1 Beauty Shop.</p> <p>Findings include:</p> <p>During the environmental tour on 08/09/13 at 12:40 p.m. with the Administrator, the Director of Housekeeping, and the Director of Maintenance, the following was observed:</p> <p>1) First floor:</p> <p>A) Room 101: there were gouges</p>	F000465	<p>1. All of the issues stated in citation were either cleaned, fixed or replaced to meet according to the regulation.2. A complete facility round was made to ensure the facility meets the regulation.3. A minimum of three days a week the Environmental Director or Maintenance Director will make rounds and submit them to the Administrator. Any issues mentioned on audits will be addressed and resolved according to policy.4. The results of those rounds will be submitted to the Quality Assurance Committee for the next three months. Then the rounds will be made weekly and submitted to the Quality Assurance Committee on an ongoing bases.5. September 8, 2013</p>	09/08/2013	

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	<p>behind the window bed, an accumulations of dust and dirt on the floor near the base board, the bedside table was chipped, and the window shade was dirty.</p> <p>The Director of Housekeeping indicated the window shade would be replaced.</p> <p>B) Room 102: The floor was dirty, the dresser was scratched and the floor mat was torn.</p> <p>C) Room 104: There were holes in the wall, water stains on the ceiling tiles, and the wall by the sink and closet was marred.</p> <p>During an interview at the time of the observation, the Director of Housekeeping indicated the room needed painted.</p> <p>D) Room 106: The resident's geri-chair (reclining chair) arm's were torn, there was an accumulation of dust and dirt on the floor, and when the hot water faucet was turned on, no water came from the faucet.</p> <p>During an interview at the time of the observation, the Administrator acknowledged the arms on the geri-chair were torn and no water</p>				

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	<p>came from the faucet. The Director of Housekeeping acknowledged the floor was dirty.</p> <p>E) The hand rails through out the hallway's of the first floor were scuffed and marred and the rail by the Nurses' Station had a screw sticking out the end of it.</p> <p>F) Room 111: There were gouges in door and the plastic protective covering was torn with sharp edges.</p> <p>G) Room 114: The door to the room was scuffed and the plastic protective covering was torn with sharp edges.</p> <p>H) Room 116: The plastic protective covering on the door was torn with sharp edges and was loose at the bottom of the door.</p> <p>I) The door to the soiled utility room was scuffed and dirty.</p> <p>J) Resident #32's Broda Chair was dirty.</p> <p>During an interview at the time of the observation, the Administrator acknowledged the dirty Broda Chair.</p> <p>K) Room 124: The bathroom door was marred and cracked. The plastic</p>			

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	<p>protective covering on the room door was cracked with sharp edges and there were gouges on the wall behind both beds.</p> <p>L) Room 126: There were gouges on the wall behind both beds and the door to room had gouges.</p> <p>M) Shower Room: The shower curtain rod, the soap dispenser, and the glove dispenser in the room were rusty.</p> <p>N) Carpet on the wall in the Dining Room was dirty and frayed.</p> <p>During an interview at the time of the observation, the Director of Housekeeping indicated the carpeting was suppose to be replaced.</p> <p>2. Second Floor:</p> <p>A) Room 202: The bathroom floor tile was stained.</p> <p>B) Room 205: There was loose baseboard outside the bathroom door.</p> <p>C) Room 206 and 208 bathroom: The wall was marred under the sink</p> <p>D) Room 208: The wall by heat</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2013
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NAME OF PROVIDER OR SUPPLIER COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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	<p>register had cracked and peeling plaster.</p> <p>E) The hand rails through out the hallways were chipped and marred.</p> <p>3. Beauty Shop: There was an accumulation of dirt and hair on the floor by the baseboard, stained floor tiles, the hair washing bowl was dirty, and the wall under the wash bowl was cracked and bubbling.</p> <p>During an interview at the time of the observation, the Director of Maintenance indicated the Beautician cleans her own room.</p> <p>During an interview on 08/09/13 at 1:30 p.m., the Director of Housekeeping indicated she checked the residents rooms twice a week and the other Department Heads are suppose to check the rooms daily. She indicated there were concerns but when there were no more concerns she decreased the checks of the rooms to twice a month.</p> <p>3.1-19(f)</p>			