

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155003	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2016
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NAME OF PROVIDER OR SUPPLIER  MASON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 900 PROVIDENT DRIVE WARSAW, IN 46580
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00203293.</p> <p>Survey dates: June 22, 23, 24, 27, 28 and 29, 2016</p> <p>Facility number: 000003 Provider number: 155003 AIM number: 100290600</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 13 Medicaid: 48 Other: 7 Total: 68</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on July 8, 2016.</p>	F 0000		
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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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F 0156 SS=B Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of</p>			

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	<p>services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the</p>			

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	<p>physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interviews, the facility failed to ensure that 1 of 3 residents reviewed for discharge from Medicare services received notification in a timely manner. (Resident #84)</p> <p>Finding includes:</p> <p>The OMB (Office of Management and Budget) Approval 0938-0953 form Notice of Medicare Provider Non-Coverage (NOMNC) for Resident #84 indicated, "The effective date coverage of your current Medicare Part B Therapy services will end: 8/5/15." The form was signed on 8/5/15.</p> <p>During an interview, on 6/24/16 at 2:15 P.M., the Business Office Manager indicated the resident or their representative should be given a 2 day notice prior to their services ending. She indicated if the resident or representative were notified by telephone the correspondence would be indicated on the form. She indicated there was no note on the form that the representative was</p>	F 0156	<p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests paper review.</p> <p>Corrective action cannot be taken for resident number #84 due to the alleged deficiency occurred in the past.</p> <p>All residents participating in therapy have the potential to be affected by the alleged deficiency.</p> <p>MDS and Business Office Manager have been in-serviced on new policy related to the procedure issuing Notice of Medicare Non-Coverage. Business Office Manager/Designee will monitor weekly for four weeks, then bi-weekly for eight weeks, and then monthly times three months. Administrator will monitor monthly through Quality Assurance until 100% compliance is achieved.</p>	07/22/2016

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F 0280 SS=D Bldg. 00	<p>notified by phone prior to the services ending.</p> <p>During an interview, on 6/24/16 at 2:57 P.M., the Administrator indicated there was currently no policy regarding the 2 day notice. She indicated they just follow the state regulation.</p> <p>3.1-4(f)(3)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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 record review and interviews, the facility failed to ensure a care plan was revised and interventions implemented after a significant decline in bladder continency for 3 of 3 residents</p>	F 0280	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not	07/27/2016

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	<p>reviewed for bladder continency. (Resident #15, #17 and #33)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #15 was reviewed on 06/27/2016 at 9:20 A.M. Resident #15 was admitted to the facility on 03/21/11. The diagnoses included, but were not limited to: heart failure, Alzheimer's disease, major depressive disorder, hypertension, osteoarthritis, anxiety disorder and Chronic Obstructive Pulmonary Disease.</p> <p>The MDS (Minimum Data Set) assessment, completed due to a significant change in condition on 02/22/16, indicated Resident #15 required the extensive staff assistance of one for toileting needs and was occasionally incontinent of her bladder. The assessment indicated the resident's incontinence was not new and the toileting program was to be continued.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 05/24/16, indicated Resident #15 still required the extensive staff assistance for toileting and had declined and was now frequently incontinent of her bladder and always continent of her bowels.</p>		<p>individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests paper review. New 3day voiding diaries and Bowel and Bladder Evaluations will be completed for residents #15 and 33. Resident #17 no longer resides in the facility. Restorative nurse will review all residents who have the potential to be affected by this deficient practice by completing a Bowel and Bladder Assessment and Plan for each resident with the next MDS on OBRA schedule. If a Bowel and Bladder Evaluation and Plan is already complete, then a Bowel and Bladder Quarterly Evaluation will be completed per the MDS OBRA schedule. Nursing staff to be in-service regarding bowel and bladder policy and procedure with supporting documentation. Corporate consultant to in-service MDS coordinators on appropriate care planning related to B&amp;B. DON/licensed designee will monitor Voiding Diaries to ensure completeness and accuracy. DON/licensed designee will monitor MDS documentation related to Care Plan evaluations; and the MDS will be monitored for accuracy and change in function as indicated under Section H of the MDS. This will be done weekly for 12 weeks, then monthly</p>		

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	<p>A care plan regarding incontinence, initiated on 12/02/14 and last revised on 02/22/16, indicated the resident was frequently incontinent of her bladder and would benefit from an individualized toileting program. The interventions included " Allow ample time for voiding, assist with cleansing after incontinent episodes and during toileting, cue resident to toilet per individualized program, encourage participation in program, frequently refused to wear undergarments or incontinence products, scheduled bladder program 7 am, 9 am, 12 pm, 6 pm and 8 pm and prn [as needed]..." There were no interventions added to the plan after 02/22/16.</p> <p>2. The closed clinical record for Resident #17 was reviewed on 06/27/2016 at 2:25 P.M. Resident #17 was admitted to the facility on 12/16/15 and readmitted to the facility on 12/28/15. The diagnoses included, but were not limited to: respiratory failure, sleep apnea, cellulitis of right and left lower limb, muscle weakness, osteoarthritis, chronic obstructive pulmonary disease, cognitive communication deficit, diabetes mellitus and hypertension.</p> <p>The admission MDS (Minimum Data</p>		for 3 months.QA: VoidingDiaries, MDS Section H and associated Care Plan monitoring will be completed weeklyby the DON/Designee weekly x 12 weeks, then monthly x 3 months, with ongoingmonitoring determined by the QA committee.Substantial compliance will be achieved by July 27, 2016.				

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	<p>Set) assessment, completed on 01/04/16, indicated the resident was occasionally incontinent of his bladder.</p> <p>The initial bowel and bladder evaluation, completed on 01/04/16, indicated the resident was occasionally incontinent of his bladder, utilized antidepressants and narcotics, had restricted mobility, needed assistance to toilet, was diabetic, had depression and had functional incontinence. He was to be toileted before meals, upon rising, bedtime and as requested.</p> <p>A care plan regarding incontinence, initiated on 01/08/16 and revised on 03/30/16, indicated the resident needed a scheduled bladder program to improve his continence. The interventions included a plan to assist him with toileting before meals, upon rising, at bedtime and as requested. There were no revisions to the interventions made after 01/08/16.</p> <p>A bowel and bladder evaluation, completed on 04/25/16, indicated the resident was frequently incontinent of his bladder, still received antidepressants and narcotics, needed assistance to toilet, had diabetes and depression, still exhibited functional incontinence. The toileting plan remained the same.</p>			

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	<p>The most recent quarterly MDS assessment, completed on 04/27/16, indicated the resident was had declined and was always incontinent of his bladder.</p> <p>3. The clinical record for Resident #33 was reviewed on 06/27/16 at 9:45 A.M. Resident #33 admitted to the facility on 02/26/13 and readmitted on 11/25/15. The diagnoses included, but were not limited to: vascular dementia with behavioral disturbance, Alzheimer's disease, difficulty in walking, muscle weakness, open- angle glaucoma, major depressive disorder, allergies, hypertension and hypothyroidism.</p> <p>A quarterly MDS assessment, completed on 10/12/15, indicated the resident was occasionally incontinent of her bladder and always continent of her bowels and required extensive staff assistance.</p> <p>A quarterly MDS assessment, completed on 12/29/15, indicated the resident required extensive staff assistance for toileting and personal hygiene and was now frequently incontinent of her bladder and occasionally incontinent of her bowels.</p> <p>The most recent quarterly MDS</p>			

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F 0282 SS=D Bldg. 00	<p>assessment, completed on 06/10/16, indicated the resident still required extensive staff assistance for hygiene and toileting needs and was still frequently incontinent of her bowels and bladder.</p> <p>The care plan for Resident #33 regarding bladder incontinence, initiated on 06/13/13 and last revised on 12/26/14, indicated the resident would benefit from a toileting program. The interventions included the program to "Take/Assist/Cue her to go to bathroom twice during the night and after meals." The program was initiated on 06/13/13.</p> <p>During an interview on 06/29/16 at 10:25 A.M., LPN (Licensed Practical Nurse) #25 indicated the documentation during the March evaluation was correct and there had been no changes to her toileting program because there was no change in her voiding patterns.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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>			

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	<p>Based on observation, record review and interviews, the facility failed to ensure a toileting plan was followed for 1 of 3 residents reviewed for bladder incontinence needs. (Resident #15) In addition, the facility failed to ensure a physician's order regarding blood pressure monitoring parameters for a blood pressure medication were followed for 1 of 1 residents reviewed for death. (Resident #120)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #15 was reviewed on 06/27/2016 at 9:20 A.M. Resident #15 was admitted to the facility on 03/21/11. The diagnoses included, but were not limited to: heart failure, Alzheimer's disease, major depressive disorder, hypertension, acquired hemolytic anemia, osteoarthritis, anxiety disorder and chronic obstructive pulmonary disease.</p> <p>The most recent MDS (Minimum Data Set) assessment, completed on 05/24/16, indicated Resident #15 scored of 3 out of 15 on a BIMS (Brief Interview for Mental Status) assessment indicating she was severely cognitively impaired. Resident #15 required extensive staff assistance for dressing, personal hygiene and toileting, supervision for transfers</p>	F 0282	<p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests paper review. New 3 day voiding diary and Bowel and Bladder Evaluation will be completed for residents #15. Resident #120 no longer resides in the facility. All residents have the potential to be affected by the alleged deficient practice regarding the Bowel and Bladder evaluation. Only residents receiving anti-hypertensive medication have the potential to be affected by the alleged deficient practice of blood pressure monitoring. Nursing staff to be in-serviced regarding bowel and bladder policy and procedure with supporting documentation. Nurses and QMA's to be in-serviced on the appropriateness and frequency of monitoring blood pressure during the administration of anti-hypertensive medications. DON/licensed designee will monitor Voiding Diaries to ensure completeness and accuracy. DON/licensed</p>	07/27/2016

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	<p>and ambulation, was frequently incontinent of her bladder and always continent of her bowels.</p> <p>The most recent recent bowel and bladder evaluation, completed on 02/22/16, indicated the resident was occasionally incontinent of her bladder and totally content of her bowels. The assessment indicated she took diuretics and antidepressants, needed assistance to toilet and demonstrated functional incontinence. The assessment indicated the incontinence was not a new problem and the toileting program was to continue.</p> <p>A care plan for grooming and hygiene, initiated in 2013, and last revised in 2014 and current through 09/15/16, indicated the resident required set up and cueing for washing her face, brushing her teeth and combing hair and dressing/undressing daily. The interventions indicated she had a history of refusing to wear any type of undergarments and was to be encouraged and cued to wear undergarments.</p> <p>A care plan regarding incontinence, initiated on 12/02/14 and current through 09/15/16, indicated the resident would benefit from an individualized toileting program and the interventions included:</p>		<p>designee will monitor MDS documentation for accuracy and change in function as indicated under Section Hof the MDS. This will be done weekly for 12 weeks, then monthly for 3 months. The charts of all residents receiving anti-hypertensives reviewed for blood pressure monitoring parameters. New admissions will be audited for ensuring blood pressure parameters are entered accurately into the EMR weekly x 12 weeks, then monthly x 3. QA: Voiding Diaries, MDS Section H review and new admission audits will be completed weekly by the DON/Designee x 12 weeks, then monthly x 3 months, with ongoing monitoring to be determined by the QA committee. Substantial compliance will be achieved by July 27, 2016</p>	

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	<p>"Allow ample time for voiding, assist with cleansing after incontinent episodes and during toileting, cue resident to toilet per individualized program, encourage participation in program, frequently refused to wear undergarments or incontinence products, scheduled bladder program 7 am, 9 am, 12 pm, 6 pm and 8 pm and prn [as needed]..."</p> <p>On 06/27/2016 at 8:44 A.M., Resident #15 was observed seated in the day lounge in a side chair sleeping. At 9:12 A.M., she got up from the chair in lounge and ambulated with her cane back to her room, sat on the side of her roommate's stripped bed and pulled her pants down. She was not wearing any underclothes or briefs. The nursing assistant and her roommate were in the restroom with the door closed. Resident #15 then pulled her pants back up and continued to sit on the stripped bed of her roommate until 9:19 A.M. At 9:19 A.M., she walked back to the lounge and sat down for a few minutes. She then got back up and ambulated by herself with her cane into her room and toileted herself in the bathroom. She was noted to exit the bathroom without flushing the stool or washing her hands at 9:27 A.M. There was stool noted in the toilet and it was unclear if she had urinated as the water in the toilet was not discolored. There was</p>			

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	<p>no toilet paper in the toilet. Resident #15 remained either in the lounge or seated in the dining room area from 9:27 A.M. to 12:21 P.M. At 12:21 P.M., Resident #15 was ambulating down the hallway towards her room, however, a housekeeper asked her if she wanted to watch television and she turned around and ambulated back to the lounge area. She remained in the lounge watching television and whistling to herself until 3:13 P.M. when she got up and walked back to her room and into her bathroom. A CNA (Certified Nursing Assistant) noticed she was toileting herself without shutting the bathroom or room door and did enter the room and shut the doors. CNA #24 was noted to be getting incontinent products and clothing out of a closet. CNA #24 indicated sometimes Resident #15 did toilet herself but it was better if she was assisted. The CNA did not seem aware of any specific toileting program or plan.</p> <p>On 06/28/16 at 8:25 A.M., Resident #15 was observed in the dining room seated at a table. At 8:30 A.M., she got herself up from the table and ambulated with her cane into the lounge area and sat on a couch. At 9:27 A.M., Resident #15 ambulated to her room and back in less than a minute's time. She sat back down in the lounge and remained in the lounge</p>			

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	<p>and/or dining room area until 11:25 A.M., when she was observed to get up, walk past CNA #20 and the Activity Assistant, Employee #21. Resident #15 went into her room and toileted herself in the bathroom. The resident did not flush the toilet or wash her hands prior to exiting the bathroom. A small stool was noted in the toilet and there was no toilet paper. The floor to her room had just been mopped and was visibly wet and there was a "Wet Floor" sign in the doorway to her room.</p> <p>During an interview, on 06/28/2016 at 1:14 P.M., CNA #20, indicated Resident #15 toileted herself. She indicated she would have checked on the resident if she had not returned and had stayed in the bathroom "for a long time." She indicated Resident #15 did need assistance for hygiene and dressing needs.</p> <p>During an interview, on 6/28/16 at 1:14 P.M., the Activity Assistant, CNA #21 indicated Resident #15 usually toileted herself independently but had "good" and "bad" days. She indicated she was not certain how continent the resident was as she mainly focused on providing activities for the Dementia Unit.</p> <p>The CNA Flow Sheet, which provided</p>			

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	<p>instructions for nursing staff, indicated Resident #15 required one assist for grooming and dressing and was to be toileted per schedule as needed.</p> <p>During an interview on 6/29/16 at 10:15 A.M., the Nursing Consultant, RN (Registered Nurse) #23, indicated the electronic Kiosk screen did have the scheduled toileting times for the nursing assistants.</p> <p>2. On 6/29/16 at 9:19 A.M., a review of the clinical record for Resident #120 was conducted. The record indicated the resident was admitted on 2/4/16. The resident's diagnoses included, but were not limited to: pneumonia, sepsis, chronic obstructive pulmonary disease, congestive heart failure, hypertension and nonrheumatic aortic valve stenosis with insufficiency. The resident was a full code per physician order, dated 2/4/16.</p> <p>A History &amp; Physical, dated 1/25/16, indicated the resident's past medical history included but was not limited to: significant coronary artery disease post Myocardial Infarction (MI), post stent placement, moderate-to-severe aortic stenoses, diastolic congestive heart failure, and an ejection fraction of 45% in November of 2015.</p>			

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	<p>An Order Summary Report, dated 2/4/16, indicated the physician had reviewed and signed the resident's orders, which included "...Coreg [an antihypertensive medication] Tablet 6.25 mg (Carvedilol Sodium) Give 1 capsule by mouth two times a day for HTN [hypertension] hold for SBP [systolic blood pressure] &lt; [less than] 100 or pulse &lt; 60..."</p> <p>An Admission MDS (Minimum Data Set) Assessment, dated 2/11/16, indicated the resident's BIMS (Brief Interview Mental Status) was 11 (moderate dementia). The prognosis indicated the resident did not have a condition or chronic disease resulting in a life expectancy of less than 6 months. A care plan for hypertension included interventions to observe for confusion, lethargy &amp; shortness of breath, B/P taken as ordered, medications as ordered and report edema.</p> <p>A Change in Condition Evaluation, dated 2/20/16 at 21:47 (9:47 P.M.), indicated the resident had an altered mental status with unresponsiveness, labored breathing/shortness of breath. The evaluation indicated the most recent vital signs were on 2/9/16 at 2:40 A.M. - Blood Pressure (B/P) 108/60, Pulse (P) 16, temperature (T) 98.2 and O2 sats (oxygen saturation) was 92% (percent) on</p>			

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	<p>room air. The most recent Respirations (R) were-16, on 2/4/16 at 17:41 (5:41 P.M.).</p> <p>A Nursing Home to Hospital Transfer Form, dated 2/20/16 at 22:00 (10:00 P.M.), indicated resident was sent to a local hospital, unresponsive with the following vital signs: B/P 108/67, P69, R12, T-98.2, Sats 88% with oxygen via nasal cannula at 3 liters/minute.</p> <p>The February 2016 Medication Administration Record (MAR) indicated resident was on Carvedilol (Coreg, an antihypertensive) 6.25 milligrams (mg) twice a day (BID) with instructions to hold medication for Systolic Blood Pressure less than 100 and pulse less than 60. The MAR did not include blood pressure or pulse documentation prior to giving the Carvedilol.</p> <p>A list of Medications for which Blood Pressure and Pulse Monitoring are Recommended, dated 2013, from the facility's pharmacy indicated Coreg (Carvedilol) required blood pressure and pulse monitoring.</p> <p>During an interview, on 6/29/16 at 1:19 P.M., the Director of Nursing indicated the only recorded blood pressures and pulses were on 2/4, 2/8, 2/9, 2/12 and</p>			

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F 0315 SS=D Bldg. 00	<p>2/20. She explained the directions to hold the medication were a facility protocol, as the admission orders did not indicate to hold the medication for a Systolic Blood Pressure less than 100 and pulse less than 60.</p> <p>A policy for following physician's orders was requested, but not received.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure 3 of 3 residents reviewed for significant declines in bladder continency were thoroughly assessed, including an accurate attempt to assess individualized toileting patterns and care plan revised</p>	F 0315	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety	07/27/2016			

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	<p>and/or other interventions attempted to restore as much normal bladder function as was possible. (Resident #15, #17, and #33)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #15 was reviewed on 06/27/2016 at 9:20 A.M. Resident #15 was admitted to the facility on 03/21/11. The diagnoses included but not limited to: heart failure, Alzheimer's disease, major depressive disorder, hypertension, acquired hemolytic anemia, hyperlipidemia, osteoarthritis, anxiety disorder, dysphagia and Chronic Obstructive Pulmonary Disease.</p> <p>The MDS (Minimum Data Set) assessment, completed due to a significant change in condition on 02/22/16, indicated Resident #15 required the extensive staff assistance of one for toileting needs and was occasionally incontinent of her bladder. The assessment indicated the resident's incontinence was not new and the toileting program was to be continued.</p> <p>The most recent quarterly MDS (Minimum Data Set) assessment, completed on 05/24/16, indicated Resident #15 required the extensive staff</p>		<p>of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests paper review. New 3 day voiding diaries and Bowel and Bladder Evaluations will be completed for residents #15 and 33. Resident #17 no longer resides in the facility. Restorative nurse will review all residents who have the potential to be affected by this alleged deficient practice by completing a Bowel and Bladder Assessment and Plan for each resident with the next MDS on OBRA schedule. If a Bowel and Bladder Evaluation and Plan is already complete, then a Bowel and Bladder Quarterly Evaluation will be completed per the MDS OBRA schedule. Nursing staff to be in-serviced regarding bowel and bladder policy and procedure with supporting documentation. DON/licensed designee will monitor Voiding Diaries to ensure completeness and accuracy. DON/licensed designee will monitor MDS documentation for accuracy and change in function as indicated under Section H of the MDS. This will be done weekly for 12 weeks, then monthly for 3 months. QA: Voiding Diaries and MDS Section H monitoring will be completed weekly by the DON/Designee x 12 weeks, then monthly x 3 months, with ongoing monitoring determined by the QA committee. Substantial</p>		

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	<p>assistance for toileting and had declined and was now frequently incontinent of her bladder and always continent of her bowels.</p> <p>The most recent quarterly bowel and bladder evaluation form, completed on 05/24/16, indicated there had been changes to the 3 day void and the toileting program was effective. The form referred to an MDS progress note. The progress note, dated 05/24/16, did not include any specific information regarding the resident's toileting program, incontinence or decline in continency.</p> <p>During an interview, on 06/29/2016 at 8:52 A.M., the Nursing Consultant, RN #23, indicated a 3 day voiding pattern was not completed during a quarterly bowel and bladder evaluation assessment.</p> <p>A care plan regarding incontinence, initiated on 12/02/14 and last revised on 02/22/16, indicated the resident was frequently incontinent of her bladder and would benefit from an individualized toileting program. The interventions included " Allow ample time for voiding, assist with cleansing after incontinent episodes and during toileting, cue resident to toilet per individualized program, encourage participation in program, frequently refused to wear</p>		compliance will be achieved by July 27, 2016		

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	<p>undergarments or incontinence products, scheduled bladder program 7 am, 9 am, 12 pm, 6 pm and 8 pm and prn [as needed]...."</p> <p>On 06/27/2016 at 8:44 A.M., Resident #15 was observed seated in the day lounge in a side chair sleeping. At 9:12 A.M., she got up from the chair in lounge and ambulated with her cane back to her room, sat on the side of her roommate's stripped bed and pulled her pants down. She was not wearing any underclothes or briefs. The nursing assistant and her roommate were in the restroom with the door closed. Resident #15 then pulled her pants back up and continued to sit on the stripped bed of her roommate until 9:19 A.M. At 9:19 A.M., she walked back to the lounge and sat down for a few minutes. She then got back up and ambulated by herself with her cane into her room and toileted herself in the bathroom. She was noted to exit the bathroom without flushing the stool or washing her hands at 9:27 A.M. There was stool noted in the toilet and it was unclear if she had urinated as the water in the toilet was not discolored. There was no toilet paper in the toilet. Resident #15 remained either in the lounge or seated in the dining room area from 9:27 A.M. to 12:21 P.M. At 12:21 P.M., Resident #15 was ambulating down the hallway</p>			

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	<p>towards her room, however, a housekeeper asked her if she wanted to watch television and she turned around and ambulated back to the lounge area. She remained in the lounge watching television and whistling to herself until 3:13 P.M. when she got up and walked back to her room and into her bathroom. A CNA (Certified Nursing Assistant) noticed she was toileting herself without shutting the bathroom or room door and entered the room and shut the doors. CNA #24 was noted to be getting incontinent products and clothing out of a closet. CNA #24 indicated sometimes Resident #15 did toilet herself but it was better if she was assisted. The CNA did not seem aware of any specific toileting program or plan.</p> <p>On 06/28/16 at 8:25 A.M., Resident #15 was observed in the dining room seated at a table. At 8:30 A.M., she got herself up from the table and ambulated with her cane into the lounge area and sat on a couch. At 9:27 A.M., Resident #15 ambulated to her room and back in less than a minute's time. She sat back down in the lounge and remained in the lounge and/or dining room area until 11:25 A.M., when she was observed to get up and walk past CNA #20 and the Activity Assistant, Employee #21. Resident #15 went into her room and toileted herself in</p>			

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	<p>the bathroom in her room. The resident did not flush the toilet or wash her hands prior to exiting the bathroom. A small stool was noted in the toilet and there was no toilet paper. The floor to her room had just been mopped and was visibly wet and there was a "Wet Floor" sign in the doorway to her room.</p> <p>During an interview, on 06/28/2016 at 1:14 P.M., CNA #20, indicated Resident #15 toileted herself. She indicated she would have checked on the resident if she had not returned and had stayed in the bathroom "for a long time." She indicated Resident #15 did need assistance for hygiene and dressing needs.</p> <p>During an interview, on 6/28/16 at 1:14 P.M., with the Activity Assistant, CNA #21 indicated Resident #15 usually toileted herself independently but had "good" and "bad" days. She indicated she was not certain how continent the resident was as she mainly focused on providing activities for the Dementia unit.</p> <p>The CNA Flow Sheet, which provided instructions for nursing staff, indicated the resident required one assist for grooming and dressing and was to be toileted per schedule as needed.</p>			

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	<p>During an interview, on 6/29/16 at 10:15 A.M., the Nursing Consultant, RN (Registered Nurse) #23 indicated the electronic Kiosk screen (electronic charting system) did have the scheduled toileting times for the nursing assistants.</p> <p>There was no documentation to indicate causative factors were assessed regarding the resident's decline in bladder continency and interventions implemented in an attempt to restore as much bladder continency as possible.</p> <p>2. The closed clinical record for Resident #17 was reviewed on 06/27/2016 at 2:25 P.M. Resident #17 was admitted to the facility on 12/16/15 and readmitted to the facility on 12/28/15. The diagnoses included, but were not limited to: respiratory failure, sleep apnea, cellulitis of right and left lower limb, muscle weakness, osteoarthritis, chronic obstructive pulmonary disease, cognitive communication deficit, diabetes mellitus and hypertension.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 01/04/16, indicated the resident was occasionally incontinent of his bladder.</p> <p>The initial bowel and bladder evaluation,</p>			

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	<p>completed on 01/04/16, indicated the resident was occasionally incontinent of his bladder, utilized antidepressants and narcotics, had restricted mobility, needed assistance to toilet, was diabetic and had depression and had functional incontinence. He was to be toileted before meals, upon rising, bedtime and as requested.</p> <p>A bowel and bladder evaluation, completed on 04/25/16, indicated the resident was frequently incontinent of his bladder, still received antidepressants and narcotics, needed assistance to toilet, had diabetes and depression and still exhibited functional incontinence. The toileting plan remained the same.</p> <p>The most recent quarterly MDS assessment, completed on 04/27/16, indicated the resident had declined and was always incontinent of his bladder.</p> <p>A care plan regarding incontinence, initiated on 01/08/16 and revised on 03/30/16, indicated the resident needed a scheduled bladder program to improve his continence. The interventions included a plan to assist him with toileting before meals, upon rising, at bedtime and as requested. There were no revisions to the interventions made after 01/08/16.</p>			

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	<p>During an interview was conducted on 06/29/2016 at 10:25 A.M. with MDS coordinators, RN (Registered Nurse) #24 and LPN (Licensed Practical Nurse) #25. Both nurses indicated the patterning and voiding diaries, completed on the electronic record, did not provide accurate information as to the actual times of toileting due to a 'software' issues and the way CNA's documented. LPN #25 indicated the aides often put in the toileting documentation at different times but not necessarily when they actually toileted the resident. When asked how a pattern could be determined when there were sometimes 4 - 8 hour gaps between documentation on the incontinence record and/or a 3 day voiding pattern forms, RN #24 indicated "We can't." LPN #25 indicated she counted the number of times incontinence was documented and also asked nursing staff their opinion regarding if there had been a change in the resident's continence.</p> <p>The 3 day voiding diary, completed for 12/31/15 - 01/02/16, indicated in the 3 day time frame there were 5 incontinent episodes documented.</p> <p>The 7 day documentation of scheduled toileting, completed 04/19/16 - 04/25/16,</p>			

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	<p>there were 38 incontinent episodes and there was no day without at least 4 incontinent episodes.</p> <p>There was no documentation to indicate causative factors were assessed regarding the resident's decline in bladder continency and new interventions implemented in an attempt to restore as much bladder continency as possible.</p> <p>3. The clinical record for Resident #33 was reviewed on 06/27/16 at 9:45 A.M. Resident #33 admitted to the facility on 02/26/13 and readmitted on 11/25/15. The diagnoses included , but were not limited to: vascular dementia with behavioral disturbance, Alzheimer's disease, difficulty in walking, muscle weakness, open- angle glaucoma, contact dermatitis, major depressive disorder, allergies, hypertension, hypothyroidism, and hyperlipidemia.</p> <p>A quarterly MDS assessment, completed on 10/12/15, indicated the resident was occasionally incontinent of her bladder and always continent of her bowels and required extensive staff assistance.</p> <p>A quarterly MDS assessment, completed on 12/29/15, indicated the resident required extensive staff assistance for toileting and personal hygiene and was</p>			

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	<p>frequently incontinent of her bladder and occasionally incontinent of her bowels.</p> <p>The most recent quarterly MDS assessment, completed on 06/10/16, indicated the resident still required extensive staff assistance for hygiene and toileting needs and was still frequently incontinent of her bowels and bladder.</p> <p>The most recent Bowel and bladder evaluation assessment, completed on 03/08/16, indicated the resident was occasionally incontinent of her bladder and was continent of her bowels. The assessment indicated the resident had a psychiatric problem and was receiving antipsychotic and antidepressant medications, needed assistance for toileting, exhibited functional incontinence and had an individual toileting plan.</p> <p>The care plan for Resident #33 regarding bladder incontinence, initiated on 06/13/13 and last revised on 12/26/14, indicated the resident would benefit from a toileting program. The interventions included the program to "Take/Assist/Cue her to go to bathroom twice during the night and after meals." The program was initiated on 06/13/13.</p> <p>During an interview, on 06/29/2016 at</p>			

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	<p>9:30 A.M., LPN #25, one of the MDS coordinators, indicated the March 2016 Bowel and Bladder Evaluation had incorrectly marked "Occasionally" incontinent.</p> <p>However, during an interview with LPN #25 on 06/29/16 at 10:25 A.M., she indicated the documentation during the March evaluation was correct and there had been no changes to her toileting program because there was no change in her voiding patterns. She indicated she thought staff had also requested a urinalysis in March but no documentation was provided regarding this test.</p> <p>The voiding diary, completed on 03/03/16 to 03/05/16, indicated the resident was incontinent at least 11 times and at least twice or more daily. LPN #25 indicated sometimes the resident was assessed to be "frequently" incontinent on the MDS assessment but on the Bowel and Bladder Evaluation, completed during the same time frame, the resident was assessed to be "occasionally" incontinent.</p> <p>During an interview, on 06/29/016 at 10:29 A.M., LPN #25 indicated Resident #33 had went back and forth on the bowel and bladder evaluation assessment and the MDS time frames between</p>			

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	<p>occasionally and frequently. LPN #25 indicated they had determined this by the "number of times" she was marked incontinent. LPN #25 indicated during the March assessment time frame, Resident #33 was actually only incontinent 6 times which did meet their criteria for "occasionally" but for the MDS assessment, during the same timeframe but over 7 days instead of 3 days, she met the criteria for "frequently" incontinent of her bladder.</p> <p>The Director of Nursing provided the facility policy and procedure, titled "Bowel and Bladder: Incontinence Management," last revised on 05/2016, on 06/29/16 at 10:00 A.M., and indicated this was the policy currently used by the facility. The policy included the following: "...1. Residents will be patterned over 3 days after admission and as needed for significant change in bowel or bladder function...3. Residents will have a Bowel and Bladder Evaluation completed within 7 days of admission, annually, and with a significant change in bowel or bladder function..." There were no specific instructions regarding how to complete and document a 3 day voiding diary or patterning assessment.</p> <p>During an interview on 06/29/16 at 11:00 A.M., Corporate Nurse #23 indicated</p>			
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F 0323 SS=E Bldg. 00	<p>there were no instructions on how to complete the voiding diary piece of the bladder incontinence assessments. There were types of toileting plans and classifications and definitions for types of incontinence, but there were no specific instructions for the actual assessment information to be utilized to assess bladder continency.</p> <p>3.1-41(a)(2)</p> <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, interview and record review, the facility failed to ensure chemicals were out of the reach of residents who were severely cognitively impaired. This deficient practice had the potential to affect 2 of 19 residents on the 200 unit, 2 of 9 residents residing in the dementia unit, and 1 of 22 residents on</p>	F 0323	This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate	07/27/2016

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	<p>the 300 unit. (Resident # 48, #80, #29, #156, &amp; #3)</p> <p>Finding includes:</p> <p>On 6/23/2016 at 9:30 A.M., Resident #156 was observed wondering in the hallway and going into different resident rooms on the dementia unit.</p> <p>On 6/23/2016 at 10:17 A.M., a bottle of hair spray, a bottle of body spray, mouth wash, tooth adhesive, and denture cleanser tabs were observed to be sitting in Resident #48's restroom.</p> <p>On 6/23/2016 at 11:08 A.M., denture tabs were observed in Resident #3's restroom.</p> <p>On 6/23/2016 at 11:10 A.M., denture tabs were observed in Resident #29's restroom.</p> <p>On 6/24/2016 at 8:20 A.M., a tube of denture adhesive and lotion were located in a plastic container and a bottle of medicated powder was observed on the windowsill in Resident #80's room.</p> <p>During an environmental observation tour on 6/28/2016 at 9:30 A.M., the following was observed:</p> <p>-A package of denture tabs were in</p>		<p>care. In lieu of survey results the facility respectfully requests paper review.</p> <p>Resident number 48, 29, 80, 156, and 3 have had all items of concern removed from their rooms.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>Unit Managers/Designee have audited all residents rooms to ensure appropriateness of items in the room. Nursing staff have been in-serviced on items that need to be removed from resident's room unless resident has a careplan stating they can keep in their room due to resident rights. Unit Mangers/Designees will conduct walking rounds each business day to ensure compliance.</p> <p>Director of Nursing /Designee to review completed rounds checklists to ensure appropriate compliance and follow-up weekly for four weeks, then bi weekly for 8 weeks, and then monthly until 100 percent compliance is achieved.</p> <p>QA Rounds Checklist will be reviewed at Quality Assurance Meetings monthly.</p>				

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	<p>Resident #3's restroom.</p> <p>-A package of denture tabs were in Resident #29's restroom.</p> <p>-A tube of denture adhesive, toothpaste, and body spray were in Resident #80's room.</p> <p>-A bottle of hairspray and a tube of denture adhesive were in Resident #48's room.</p> <p>On 6/28/2016 at 9:50 A.M., record review was completed for Resident #28, #80, #29, &amp; #3. The following was noted:</p> <p>-An MDS (Minimum Data Set) Assessment, dated 5/29/2016, indicated Resident #48's BIMS (Brief Interview for Mental Status) was 3, severe impairment.</p> <p>-An MDS assessment, dated 3/23/2016, indicated Resident #80's BIMS score was 9, moderate impairment. Resident 80 resides in the dementia unit.</p> <p>-An MDS assessment, dated 6/7/16, indicated Resident #29's BIMS score was 4, severe impairment.</p> <p>-An MDS assessment, dated 5/31/2016, indicated Resident #3's BIMS score was 3, severe impairment.</p> <p>During an interview, on 6/28/2016 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated Resident #48 was physically able to get around in her wheelchair.</p>				

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	<p>During an interview, on 6/28/2016 at 10:20 A.M., Employee #15 and Employee #16 indicated Resident #3 could ambulate and Resident #29 was mobile with his wheelchair.</p> <p>During an interview, on 6/28/2016 at 10:30 A.M., Employee #17 indicated that Resident #80 was physically able to ambulate.</p> <p>During an environmental tour, on 6/28/2016 at 2:00 P.M., with the Administrator, DON (Director of Nursing), and the Maintenance Director, the following was noted:                      -A package of denture tabs were in Resident #3's restroom.                      -A package of denture tabs were in Resident #29's restroom.                      -A tube of denture adhesive, toothpaste, and body spray were in Resident #80's room.                      -A bottle of hairspray and a tube of denture adhesive were in Resident #48's room.</p> <p>During an interview, on 6/28/2016 at 2:15 P.M., the Administrator, DON, and Maintenance Director indicated the package of denture tabs in Resident #3 and #29's restrooms, the tube of denture adhesive, toothpaste, and body spray in Resident #80's room, and the bottle of</p>			

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F 0465 SS=D Bldg. 00	<p>hairspray and denture adhesive in Resident #48's room. The Administrator indicated Resident #156 has wondering behaviors.</p> <p>On 6/28/2016 at 2:30 P.M., a policy on chemicals in resident rooms was requested and the administrator indicated that the facility does not have a policy to address chemicals in resident rooms.</p> <p>3.1-45(a)(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, interviews and record review, the facility failed to ensure 3 of 35 resident rooms were free of insects and/or cobwebs. (Resident G, F and E)</p> <p>Finding includes:</p> <p>On 6/23/16 at 9:12 A.M., in Resident G's room, with the Activity Director, a live beetle bug was observed crawling in the middle of the room. The Maintenance Director came into the room and he</p>	F 0465	<p>This plan of correction has been prepared and executed because it is required by the provisions of state and federal law. Mason Health and Rehab maintains that the alleged deficiency does not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. In lieu of survey results the facility respectfully requests paper review. Residents G's, F's, and E's rooms have been deep cleaned. Our contracted pest</p>	07/22/2016

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	<p>observed the beetle also. He destroyed the bug. Further observations of the resident's room with Maintenance Director was conducted. The Maintenance Director located a spider web with 2 small dead black bugs, in a corner of the resident's room. The maintenance man indicated the facility had an exterminator in the facility to spray for insects every month.</p> <p>An observation was made, on 6/23/16 at 9:30 A.M., of Resident F's room with the Housekeeping Manager. A dead bug with many legs was found near the heater/air conditioner unit. Behind the resident's door to his room, along the baseboard, was a large spider web with a live spider in the web and 3 dead bugs in it.</p> <p>During an interview, on 6/23/16 at 9:41 A.M., the Maintenance Director indicated the bug problem was more of a housekeeping issue since most of the bugs were dead. The Maintenance Director indicated an exterminator had been in the building spraying about 10 days ago and someone wasn't cleaning in the corners and behind the doors.</p> <p>During an observation, on 6/23/16 at 9:55 A.M., a dead ant was located in a spider web, lying along the baseboard near the restroom of Resident E's room. Another</p>		<p>control company has completed their monthly treatment. All residents have the potential to be affected by the alleged deficient practice. All housekeeping staff have been re-educated on their daily room cleaning sheets. Housekeeping/Designee will conduct weekly audits through TELS program for four weeks, then bi-weekly for eight weeks, and then monthly for three months. Administrator will review TELS audits. Audits will be reviewed by the Quality Assurance Meetings monthly.</p>		

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	<p>dead black bug was located inches away from the ant in a cobweb.</p> <p>On 6/23/16 at 10:15 A.M., the Maintenance Director provided local Pest Control Service/Invoice. The invoice indicated an exterminator had been in the building monthly and sprayed for ants, roaches and rodents on 4/20/16, 5/18/16 and 6/16/16. The 6/16/16 invoice indicated the company had completed the following: powerspray to exterior foundation, surrounding soil, soffits, vents, overhangs and around doors. Under the technician comments was the word ants.</p> <p>On 6/27/16 at 11:45 A.M., the Nurse Consultant provided a blank, Resident Room Cleaning Schedule-Check off Sheet (Daily). This form indicated "...5 c. Remove cobwebs from corners and door frames...6. Dust Mop floor, giving attention to corners remove dust buildup...."</p> <p>On 6/27/16 at 11:45 A.M., the Nurse Consultant provided an undated Weekly Special Focus form. The form indicated on Thursdays housekeeping's focus would be the top of bed lights, cobwebs in corners and clean lifts in hallway.</p> <p>3.1-19(f)</p>			

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

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FORM APPROVED

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