

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DRIVE WINONA LAKE, IN46590		
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F0000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Date of Survey: June 13, 14, 15, and 16, 2011</p> <p>Facility Number: 000501 Provider Number: 155635 AIM Number: 100266260</p> <p>Survey Team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Diane Nilson, RN (June 14, 15, and 16, 2011)</p> <p>Census bed type:: Snf: 14 Snf/nf: 65 Residential: 50 Total: 129</p> <p>Census payor type: Medicare: 13 Medicaid: 35 Other: 81 Total: 129</p> <p>Sample: 16 Residential sample: 07</p>	F0000	Submission and implementation of this plan of correction shall not constitute an admission by Grace Village Health Care to any allegations of deficiency as stated within the "Summary Statement of Deficiencies" or an agreement with any conclusions therein. Rather, this plan of correction is submitted in accordance with State and Federal requirements. Facility administration requests desk review of this plan of correction.		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/22/11 Cathy Emswiller RN</p>				

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of an increased urinary retention issue for 1 of 16 residents reviewed for physician orders in a sample of 16. (Resident #9)</p> <p>Finding includes:</p>	F0157	I. Corrective actions: Resident #9 was not adversely affected by the late notification to the physician of outputs greater than 600cc. Her physician made no changes based on notification sent on 5/26/11 and 5/27/11. Physician responded and stated, "No Foley." Routine catheterization order has since been	07/16/2011	

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	<p>1. Resident #9's record was reviewed 6/14/2011 at 9:30 a.m. Resident #9's diagnoses included, but were not limited to, urinary retention, diabetes, and arthritis.</p> <p>A physician's order was received on 5-21-2011 to straight catheterize Resident #9 every shift and call the physician if the output obtained was more then 600 cc [cubic centimeters].</p> <p>A review of the outputs for Resident #9 revealed outputs greater than 600 cc at the following times: on 5/26/2011 a.m. 750 cc, p.m. 800 cc; 5/27/2011 a.m. 750 cc, p.m. 900 cc, noc 900 cc; and 6/1/2011 noc 700 cc.</p> <p>No outputs were recorded/available for the dates 5/21 through 5/25/2011.</p> <p>A review of nurse's notes indicated the physician had been notified by fax of outputs on 5/26 and the morning of 5/27/2011 at 1:15 p.m. on 5/27/2011. There were no further notes indicating the physician had been notified of the outputs the afternoon and night of 5/27 and the night of 6/1/2011.</p> <p>In an interview on 6/15/2011 at 12:30 p.m., RN #3 indicated Resident #9 had</p>		<p>discontinued and notification is no longer required.II. Potential for other residents to be affected:No other residents have orders that their physicians be notified regarding outputs after catheterization.III. Systemic changes:A new policy on notification to physicians has been developed and nursing staff will be in-serviced and tested. (See Attachment A) The staff development coordinator will now be responsible to complete a weekly chart audit to ensure that all required physician notifications have been made.IV. Monitoring of corrective actions:For the next 60 days, the DON or her designee will review weekly the audit reports completed by the staff development coordinator. If no concerns are identified, the reports will be reviewed quarterly thereafter. Any concerns with notifications will be addressed immediately with the appropriate staff and the incident will be discussed by the Quality Assurance Committee.</p>		

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F0275 SS=D	<p>been catheterized once each shift, but was unsure why the physician had not been called as ordered.</p> <p>In an interview on 6/16/2011 at 11:10 a.m., the Director of Nursing indicated there was no policy regarding following physician's orders, but it was understood physician's orders were to be followed.</p> <p>3.1-5(a)(2) A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.</p> <p>Based on record review and interview, the facility failed to complete a comprehensive annual Minimum Data Set (MDS) assessment in a timely manner for 2 of 14 residents (residents' #9, #53) in a sample of 14.</p> <p>Findings include:</p> <p>1. Resident #79's clinical record was reviewed on 6/14/11 at 10:45 A.M.. The record indicated the resident was admitted to the facility on 3/18/05. The resident's previous comprehensive annual MDS was completed on 1/28/10.</p> <p>An interview with the MDS coordinator, Employee #1, on 6/14/11 at 3:00 P.M. indicated when the facility switched from MDS 2.0 to 3.0 in October 2010 the</p>	F0275	<p>I. Corrective actions:No adverse affects were noted with residents #79 and #53 as a result of their annual MDS assessments not being completed in a timely manner. Those annual assessments have since been completed.II. Potential for other residents to be affected:The MDS assistant has conducted a review of all residents' assessment due dates and none have been found to be out of compliance.III. Systemic changes:An in-service was conducted for all MDS staff on June 20, 2011 by the MDS consultant from BKD in regard to timeliness of assessments. (See Attachment B) The MDS assistant has revised the process for tracking due dates and the facility is now working with two nurse consultants who will provide back up MDS staff in the event of extended absences by</p>	07/16/2011	

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	<p>resident's annual MDS's and quarterly MDS's were put off their correct times resulting in the untimeliness of resident #79's annual MDS.</p> <p>2. Resident # 53's record was reviewed 6/15/2011 at 2:30 p.m. Resident # 53's diagnoses included but were not limited to, bladder cancer, arthritis, and diabetes.</p> <p>A review of Minimum Data Sets scheduled and completed revealed a comprehensive assessment dated 3/23/2011, and quarterly assessments dated 6/22/2010, 9/20/2010, 12/23/2010, and 3/21/2011.</p> <p>In an interview on 6/15/2011 at 3:15 p.m., LPN #6 indicated a full assessment was not, but should have been completed in March 2011.</p> <p>3.1-31(d)(2)</p>		<p>facility staff.IV. Monitoring of corrective actions:The DON, or her designee, will audit completion dates of all quarterly and annual assessments weekly for the next 30 days. (See Attachment C) If no concerns are identified, audits will continue bi-monthly for the next 90 days. If any assessments are found to have been completed untimely, they will be completed immediately, brought to the attention of the Quality Assurance Committee, and the audits will continue for another 90 day period.</p>		

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>3. Resident #79's clinical record was reviewed on 6/14/11 at 10:45 A.M.. The record indicated the resident was admitted to the facility on 3/18/05 and had diagnoses including, but not limited to, Alzheimer's disease and Diabetes Mellitus.</p> <p>Review of the Physician's orders and Medication Administration Record (MAR) indicated the resident had an order for routine Namenda 10 milligrams (mg) twice daily for Alzheimer's disease. According to the MAR resident #79 did not received her Namenda 10 mg at 8:00 A.M. on 4/24/11 and 4/25/11.</p> <p>Review of resident #79's nurse's notes the Namenda not administered on 4/24/11 and 4/25/11 at 8:00 A.M. due to the medication not being available from the pharmacy.</p> <p>An interview with the Assistant Director of Nursing (ADN) on 3/16/11 at 11:50 A.M. indicated no information available why the 2 missed doses of Namenda were not available from the pharmacy.</p>	F0282	<p>I. Corrective action:A) Both resident #57 and #79 have been assessed and were not found to have been adversely affected due to the temporary unavailability of three medications. Both residents are currently receiving all prescribed medications.B) Resident #9 was not adversely affected by the failure to notify the physician for outputs greater than 600 cc. Her physician made no changes based on notification sent on May 26, 2011 and May 27, 2011. Physician responded and stated, "No Foley." Routine catheter order has been discontinued and notification is no longer required.II. Potential for other residents to be affected:An audit of all resident Medication Administration Records (MARs) has confirmed that no other residents' medications are being held due to the unavailability of medications from the pharmacy.No other residents have orders to notify physicians regarding outputs after the catheterization process.III. Systemic changes:A) A new facility policy has been developed regarding unavailability of medications from the pharmacy. The policy provides guidelines for</p>	07/16/2011	

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	3.1-35(g)(2)		notifying the pharmacy when a medication is needed and describes the procedure for contacting the pharmacy when the medication has not arrived timely. (See attachment D) All nurses will be in-serviced and tested on the policy. Additionally, Grace Village is switching to a new in-house pharmacy effective August 1, 2011 who promises more consistent and timely medication delivery.B) A new policy on notification to physicians has been developed and nursing staff will be in-serviced and tested on the policy. (See attachment A) The staff development coordinator will now be responsible to complete a weekly chart audit to ensure that all required physician notifications have been made.IV. Monitoring of corrective actions:A) For the next 30 days, the staff development coordinator will audit the MARs for all residents 5 days per week. The DON and ADON will be notified of any medication(s) that are not available for a resident medication pass. The pharmacy will be contacted immediately for STAT delivery. Completed audit sheets will be turned into the DON or ADON. If any concerns are identified, they will be brought to the attention of the Quality Assurance Committee and monitoring will continue for another 30 day period.B) For the next 60 days, the DON or her		

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	<p>Based on record review and interviews, the facility failed to ensure physician's orders related to medications were followed for 2 of 16 residents reviewed for physician orders in a sample of 16. (Residents' #57 and #79) In addition, the facility failed to ensure an order to notify the physician of urinary retention and anchor an indwelling catheter were followed for 1 of 16 residents reviewed for physician orders in a sample of 16. (Resident #9)</p> <p>Findings include:</p> <p>1. a. Resident #57's record was reviewed 6/13/2011 at 11:30 a.m. Resident #57's diagnoses included but were not limited to dementia, cancer and depression.</p> <p>A physician's order for Norco 7.5/325 mg to be given twice daily routinely was written 9/30/2010 for Resident #57. The physician's order for Norco was current on the June 2011 physician order rewrites.</p>		<p>designee, will review weekly the audit reports completed by the staff development coordinator. If no concerns are identified, the reports will be reviewed quarterly thereafter. Any concern with notifications will be addressed immediately with the responsible nurse and will be discussed by the Quality Assurance Committee.</p>		

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	<p>A review of Resident #57's Medication Administration Record for 3/2011 indicated Norco had not been given as scheduled on 3/8/2011.</p> <p>A review of Resident #57's nurse's notes for 3/8/2011 indicated Norco had been held because the medication was not available.</p> <p>A physician's order for Vancomycin 125 mg to be given four times per day for 10 days was written 4/23/2011 for Resident #57.</p> <p>A review of Resident #57's Medication Administration Record for 4/2011 indicated Vancomycin had not been given 4/24 and 4/25/2011. Documentation on the Medication Administration Record indicated the first Vancomycin dose was given 4/26/2011 at midnight.</p> <p>A review of Resident #57's nurse's notes indicated the Vancomycin was held because the medication was not available.</p> <p>A fax record for pharmacy notification was provided by the ADON on 6/16/2011 at 11:47 a.m. the record indicated the pharmacy had been contacted on 4/22/2011 then not again until 4/25/2011.</p>				

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	<p>2. Resident #9's record was reviewed 6/14/2011 at 9:30 a.m. Resident #9's diagnoses included but were not limited to urinary retention, diabetes, and arthritis.</p> <p>A physician's order was received on 5-21-2011 to straight catheterize Resident #9 every shift and call the physician if the output obtained was more then 600 cc.</p> <p>A review of the outputs for Resident #9 revealed outputs greater than 600 cc at the following times: on 5/26/2011 a.m. 750 cc, p.m. 800 cc; 5/27/2011 a.m. 750 cc, p.m. 900 cc, noc 900 cc; and 6/1/2011 noc 700 cc.</p> <p>No outputs were available for the dates 5/21 through 5/25/2011.</p> <p>A review of nurse's notes indicated the physician had been notified by fax of outputs on 5/26 and the morning of 5/27/2011 at 1:15 p.m. on 5/27/2011. There were no further notes indicating the physician had been notified of the outputs the afternoon and night of 5/27 and the night of 6/1/2011.</p> <p>In an interview on 6/15/2011 at 12:30 p.m., RN #3 indicated Resident #9 had been catheterized once each shift, but was unsure why the physician had not been called as ordered.</p>				

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	<p>In an interview on 6/16/2011 at 11:10 a.m., the Director of Nursing indicated there was no policy regarding following physician's orders, but it was understood physician's orders were to be followed.</p>			

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F0287 SS=D	<p>Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <p>Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment.</p> <p>Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following:</p> <p>Admission assessment. Annual assessment. Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.</p>				

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	<p>The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview the facility failed to ensure timely information completion (encoding) of Minimum Data Set information for 1 of 16 residents reviewed for information encoding in a sample of 16. (Resident #9)</p> <p>Findings include:</p> <p>Resident #9's record was reviewed 6/14/2011 at 9:30 a.m. Resident #9's diagnoses included but were not limited to, left elbow and hip fracture, diabetes, and rheumatoid arthritis.</p> <p>Resident #9 was admitted to the facility on 5/19/2011.</p> <p>Resident #9's Minimum Data Set (MDS) review of information revealed a 5-day assessment had been completed on 5/19/2011. An admission comprehensive assessment, required to be completed by day 14, had been scheduled with an assessment reference date of 5/29/2011.</p> <p>On 6/14/2011 at 9:30 a.m. while reviewing MDS information, the 5/29/2011 assessment had not been completed. This was 17 days after the</p>			F0287	<p>I. Corrective action:Resident #9 has not been adversely affected by the failure to complete the admission comprehensive assessment within the 14 day guidelines. The admission comprehensive assessment has since been completed.II. Potential for other residents to be affected:The MDS assistant has conducted a review of all residents' assessment due dates and none have been found to be out of compliance. All MDS assessments are now completed according to RAI guidelines.III. Systemic changes:An in-service was conducted for all MDS staff on June 20, 2011 by the MDS consultant from BKD in regard to timeliness of assessments. (See attachment B) The MDS assistant has revised the process for tracking due dates. The facility is now working with two nurse consultants who will provide back up MDS staff in the event of extended absences by facility staff to make sure that MDS's are completed in a timely manner.IV. Monitoring of corrective actions:The DON, or her designee, will audit the timeliness of all quarterly and annual assessments weekly for the next 30 days. (See attachment C) If no concerns are identified, audits will continue</p>		07/16/2011

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	<p>assessment reference date. The sections incomplete were: Section J, concerning health conditions; Section L, concerning dental status; Section M, concerning skin condition; Section N, concerning medications; Section O, concerning treatments and procedures; Section P, concerning restraints; Section Q, concerning participation in the assessment and goal setting; Section V, concerning the care area assessment; and Section Z, concerning assessment administration.</p> <p>In an interview with LPN #6 on 6/14/2011 at 1:45 p.m., it was indicated the assessment should have been completed by 6/12/2011.</p> <p>A completed copy of the MDS with the assessment reference date of 5/29/2011 was provided by LPN #6 on 6/14/2011 at 3:20 p.m.</p> <p>In an interview 6/15/2011 at 1:30 p.m. the MDS Coordinator indicated there was no facility based policy for time frames related to encoding the MDS. She further indicated the facility followed the MDS 3.0 Resident Assessment Instrument guideline.</p> <p>A copy of The Resident Assessment Instrument guidelines pages 2-15 and 2-16 were provided 6/14/2011 at 3:20</p>		<p>bi-monthly for the next 90 days. If any assessments are found to have been completed untimely, they will be completed immediately, brought to the attention of the Quality Assurance Committee, and the audits will continue for another 90 day period.</p>				

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F0314 SS=G	<p>p.m. by LPN #6. The guidelines indicated if the assessment was an admission comprehensive assessment, the assessment reference date should be scheduled no later than 14 days after the date of the resident's admission. Additionally, the MDS should be completed (encoded) no later then 14 days after the assessment reference date.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interviews, the facility failed to implement measures to prevent pressure ulcers for 1 of 2 residents with pressure ulcers reviewed in a sample of 16. This resulted in resident # 31 developing "new area... a decub was found on right heel. It is eschar, very dark reddish brown color. Size 2.5 cm by 2.0 centimeters. (Resident #31)</p>	F0314	<p>I. Corrective action:Additional documentation located and dated 12/17/10 states that a clinical assessment was completed and a "pressure reducing device for bed" was in place. Care plan for resident #31 was updated on 2/16/10 with interventions to aide in healing the pressure ulcer. Care plan was reviewed and updated with interventions on 6/28/11. Resident is on the skin/wound tracking sheet and</p>	07/16/2011			

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	<p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 06/13/11 between 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #31 required total staff assistance for transferring and mobility issues, was pushed in her wheelchair by staff, had a urinary catheter due to "retractable pain", received oxygen therapy, and had been readmitted to the facility with pressure ulcers on her right foot and heel.</p> <p>The clinical record for Resident #31 was reviewed on 06/13/11 at 2:35 P.M. The resident was initially admitted to the facility on 08/10/10. She was transferred to an acute care center on 12/09/10 and readmitted to the facility on 12/14/10.</p> <p>Interview with the Assistant Director of Nursing, LPN 8 on 06/16/11 at 1:45 P.M. indicated prior to her hospital stay, Resident #31 was able to be up and get around by herself but her mobility status had significantly decline after her hospital stay.</p> <p>Review of the initial MDS (Minimum Data Set) assessment for Resident #31, completed on 12/28/10 after she was readmitted to the facility, indicated the</p>				<p>receives weekly skin assessments and treatments as ordered. Eschar has been removed and the pressure ulcer is healing. Resident attended an appointment at the wound clinic on 6/16/11 and is scheduled for a follow up appointment in August 2011.II. Potential for other residents to be affected:All other resident at risk for development of pressure ulcers have been assessed and care plans updated as needed.III. Systemic changes:The skin/wound nurse, will do skin assessments for all new admissions and for residents readmitted from the hospital for either initiation of care plan or updating of care plan. Changes have been added to the electronic charting system (ECS) to include MDS staff in notifications of any skin documentation for immediate updating of care plans. ECS has also been changed to now automatically prompt nurses after completing a skin assessment to go to the BRADEN scale and then to the care plan for review or updating. Care plan interventions will be put in place for any resident identified as at risk for skin concerns.IV. Monitoring of corrective actions:The DON, or her designee will review daily skin notifications and care plans 5 times per week for 30 days to ensure that interventions have been added when appropriate. If no concerns are identified, the DON or her designee will review</p>		

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	<p>resident required extensive staff assistance for transferring needs, dressing, and hygiene needs, and moderate staff assistance for locomotion needs.</p> <p>The health care plans for Resident #31, current upon her readmission, included a plan for the potential for an alteration in skin integrity. The plan had been initiated on 08/30/10 with her original admission and reviewed as current upon her readmission. The plan had interventions to check diagnosis that may also trigger risk factors for skin breakdown, complete a skin integrity risk factors for skin breakdown, complete a skin integrity assessment quarterly and skin assessment weekly, assess skin status, note any skin problems on skin condition report sheet, and assess nutritional status, keep skin clean and dry, ambulate daily. There were no interventions added to prevent and/or reduce pressure while the resident was in bed or sitting in her chair.</p> <p>Review of a skin risk assessment, completed on 12/14/10, when the resident was readmitted from an acute care facility, indicated the resident had very limited mobility, a potential for friction and sheering, was chair fast, was occasionally moist, had adequate nutrition, and had no sensory impairments.</p>		<p>all skin documentation, care plans and MDS assessments weekly for the next 90 days. Any concerns will be brought to the attention of the Quality Assurance Committee and extend the monitoring for another 90 day period.</p>		

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	<p>Review of the CNA, [Certified Nursing Assistants], documentation, from 12/14/10 - 12/31/10 indicated the only preventative measure documented was applying ointment to the resident's excoriated buttocks and peri area.</p> <p>Nursing notes, dated 01/01/11 at 23:57 (11:57 P. M) indicated the following: "new area... a decub was found on right heel. It is eschar, very dark reddish brown color. Size 2.5 cm by 2.0 centimeters. Area was cleansed and Auaclear dressing was applied...."</p> <p>On 06/16/11 at 11:00 A.M., the pressure ulcers were observed for Resident #31. The resident had a dime sized shallow pressure ulcer on the top of her right foot. The center of the wound bed had yellow slough. There was an unstageable, quarter sized pressure ulcer on the resident's right heel. The wound bed was covered with thick black eschar with loose edges. There was a thick yellow green odorous exudate noted oozing from around the edges of the wound. Interview with Lpn #9 indicated the resident was supposed to see the wound clinic on 06/17/11 and she was sure they would remove the eschar as there was only a little bit holding the eschar on the wound bed in the middle.</p> <p>After the open area was discovered, the</p>						

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F0329 SS=D	<p>care plan was then updated on 02/16/11, to include interventions to elevate the resident's legs when she was in bed or the recliner, develop and implement a turning schedule, and the application of an air mattress on her bed. Although the area was first identified on 01/01/11 the care plan was not updated until 02/16/11.</p> <p>3.1-40(a)(1)</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>				

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	<p>2. The clinical record for Resident #21 was reviewed on 06/16/11 at 11:00 A.M. The resident was admitted to the facility on 02/22/11 with physician orders for the medication, Ativan 1 mg to be given three times a day for anxiety as needed.</p> <p>Nursing notes, dated 02/23/11 at 22:46 P.M. (10:46 P.M.), 02/24/11 at 20:24 (8:24 P.M.), 02/25/11 at 21:02 (9:02 P.M.), 02/27/11 at 20:56 P.M. (8:56 P.M.), 03/01/11 at 20:16 P.M., 03/11/11 at 19:46 P.M. (7:46 P.M.), 03/13/11 at 22:11 P.M. (10:11 P.M.), and 03/17/11 at 19:36 P.M. (7:36 P.M.) indicated there were no alternatives documented as attempted prior to administering the Ativan medication to Resident #21.</p> <p>In addition, on 02/26/11 at 19:39 P.M. (7:39 P.M.) and on 03/13/11 at 22:11 P.M. (10:11 P.M.) nursing documented the Ativan was administered for "agitation" and on 03/20/11 at 22:07 P.M. (10:07 P.M.) nursing documented the Ativan was administered for "all over itching."</p> <p>3. During the initial tour of the facility, conducted on 06/13/11 between 10:30 A.M. - 11:30 A.M., LPN #9 indicated Resident #25 was confused, had behavioral issues especially at night, received psychotropic medications, and</p>	F0329	<p>I. Corrective action:Neither Resident #21 nor resident #25 were adversely affected by the administration of Ativan for reasons other than those diagnosed. Resident #21 is no longer receiving Ativan for anything other than his specific diagnosis and alternatives are being attempted prior to its administration. Per physician order, resident #25's diagnosis for Ativan has been changed to "anxiety" and his diagnosis for Seroquel has been changed to "dementia with behaviors".II. Potential for other residents to be affected:Nursing notes and MARs for all other residents will be reviewed to ensure that all PRN anti-psych and anti-anxiety medications are being given according to physician's orders and that appropriate interventions are being attempted first. Any instances of improper medication administration will be corrected immediately and the Director of Nursing Services notified.III. Systemic changes:Nurses and QMAs were given an in-service and tested regarding the administration of PRN anti-psych and anti-anxiety medications. ECS has been modified to prompt nurses or QMA's to document interventions.IV. Monitoring of corrective actions:On a weekly basis for the next 30 days, the DON, or her designee, will review the PRNs given to all residents to confirm that appropriate</p>	07/16/2011	

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	<p>had recent falls. The resident was observed seated in a wheelchair across from the nurse's station. The resident was restrained in the wheelchair with a lap buddy cushion. LPN #9 indicated the resident was able to remove the lap buddy by himself very easily.</p> <p>Resident #25 was admitted to the facility on 10/05/09 and readmitted after a hospital stay on 02/11/10. The resident had diagnosis, including but not limited to, Alzheimer's dementia, irritability, bipolar disorder, agitation, and tremors.</p> <p>The resident's medication regimen included the medication, Seroquel 50 mg at bedtime for "bipolar." In addition, the resident had an order for Ativan (an antianxiety medication) 2 mg every 6 hours for "tremors" and .5 mg three times a day as needed for anxiety.</p> <p>A physician's order, dated 11/23/10 indicated the Seroquel was discontinued per the family's request. Another physician's order, dated 12/4/10 indicated another antipsychotic medication, Risperdal was to be tapered down and discontinued after two weeks at the lower dose. Yet another physician's order, dated 12/27/10 indicated an order for Seroquel 50 mg every day was ordered due to "Bipolar Disorder."</p>		<p>interventions are documented and that they are administered according to the physicians' orders. Any instances of non-compliance found will be corrected immediately and will be reported to the QA Committee. Reviews will continue on a monthly basis for six months thereafter.</p>				

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	<p>Review of the nursing notes and behavior tracking for Resident #25 for December 2010 indicated the resident had displayed agitation and anxiety effectively treated with the Ativan medication, and had displayed no "mood" issues. In addition, the resident was noted to have difficulty pocketing his medications in his mouth instead of swallowing his medications. A nursing note, dated 12/26/10 at 10:12 A.M. indicated the following: "Residents wife would like him to be put back on his Seroquel 50 mg tablet one po (orally) daily. He is very agitated, throwing his clothing, for example his shoes, he is up all hours of the night and refuses to eat his meals, he also tries to throw his food tray on the floor." There was no documentation of increased agitation and no documentation of bipolar mood disorder issues warranting the re initiation of Seroquel for bipolar disorder.</p> <p>In addition, on 01/01/11 the resident was assessed in an emergency room for "jerking movements." The resident was diagnosed with "tremors" and an order for Ativan 2 mg every 6 hours as needed for tremors was received. The resident already had an order for Ativan .5 mg orally or intramuscularly three times a day as needed for anxiety.</p>				

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	<p>Review of the March Mar (medication administration record) indicated Resident #25 received a 2 mg (milligram) tablet of Ativan on 03/23/11, 03/26/11 and 03/31/11. However, review of the nursing notes for 03/23/11, 03/26/11, and 03/31/11 indicated the resident received the medication for agitation, anxiety, and/or restlessness. There was no documentation the resident was having any type of "tremors."</p> <p>The May Mar indicated Resident #25 received a 2 tablet of Ativan on 05/04/11, 05/11/11, 05/12/11, 05/24/11, and 05/27/11. Review of the nursing notes on 05/04/11, 05/11/11, 05/12/11, 05/24/11, and 05/27/11 indicated the resident received the medication for agitation, anxiety, restlessness, and/or combative behavior. There was no documentation, except of 05/23/11 of any type of "tremor" experienced by Resident #25.</p> <p>Interview with LPN # on 06/15/11 at 2:45 P.M. confirmed the resident was only supposed to receive the .5 mg tablet or the .5 mg injection for anxiety type behaviors.</p> <p>3.1-48(a)(4)</p>						

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	<p>Based on record review and interview the facility failed to ensure 3 of 5 residents reviewed for psychotropic medication in a sample of 16 had adequate indications for administration (Residents #79, 21, and 25).</p> <p>Findings include:</p> <p>1. Resident #79's clinical record was reviewed on 6/14/11 at 10:45 A.M.. The record indicated the resident was admitted to the facility on 3/18/05 and had diagnoses including, but not limited to, Alzheimer's disease, psychosis not otherwise specified and paranoid dementia.</p> <p>On 2/16/11 resident #79 had a physician's order for Risperdal (an antipsychotic medication) 0.25 milligrams (mg) to be administered as needed (PRN) for agitation every 6 hours.</p> <p>Review of the resident's nurse's notes and medication administration record (MAR) between 4/1/11 and 6/14/11 the resident received 16 doses of Risperdal 0.25 mg for agitation. On 5 of the administrations 4/4/11 at 4:41 A.M.; 4/7/11 at 12:18 A.M.; 4/7/11 at 6:18 P.M.; 4/11/11 at 6:20 P.M.; 4/20/11 at 5:41 P.M.) of PRN Risperdal 0.25 mg, the facility failed to</p>				

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F0371 SS=F	<p>attempt non-pharmacological interventions before administration of the medication.</p> <p>Review of the facilities' undated policy and procedure, provided by the ADON on 06/16/11 and indicated as current, titled, "Medication, Anti-Psychotic" indicated no policy to attempt non-pharmacological interventions before administration of a PRN anti-psychotic medication.</p> <p>An interview with the ADON on 6/16/11 at 11:50 A.M. indicated no information was available concerning the 5 incidents of PRN Risperdal administration which were given without first attempting non-pharmacological interventions.</p> <p>An interview with the social service director (SSD) on 6/14/11 at 3:30 P.M. indicated staff had been instructed to attempt and document non-pharmacological interventions before administration of PRN anti-psychotic medication.</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure</p>	F0371	I. Corrective actions:None of the ten residents referenced were	07/16/2011	

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	<p>adequate cleaning of microwaves located in four of five areas surveyed. This has the potential to affect 82 of 83 residents residing in the facility. The facility further failed to ensure safe storage of health shakes (a food supplement) in 2 of 4 refrigerators reviewed. This had the potential to affect 6 of 6 residents for whom health shakes had been ordered on the rehab unit and 4 of 4 residents for whom health shakes had been ordered on the healthcare unit. (Residents #150, 151, 152, 153, 154, 155, 156, 157, 158, and 159)</p> <p>Findings include:</p> <p>1. During environmental tour on 6/15/2011 at 8:30 a.m. the microwave in the rehabilitation unit kitchen was noted to have brown splattered spots on the inside top of the heating area. The spots were able to be rubbed off with a paper towel.</p> <p>In an interview on 6/15/2011 at 8:30 a.m. RN #3 indicated the microwave was utilized for heating or reheating food for residents and that the kitchen was responsible for cleaning the microwave.</p> <p>During environmental tour on 6/15/2011 at 8:57 a.m. the microwave in the therapy area was noted to have brown splattered</p>		<p>found to be adversely affected by the outdated health shakes. All outdated health shakes were immediately disposed of and replaced with product within the acceptable date range. All of the microwaves identified to have food spatters on them were cleaned immediately. II. Potential for other residents to be affected: No residents with orders for health shakes were found to have been adversely affected by an undated or outdated health shake. No residents were found to have been adversely affected from the food spatters on any of the microwaves. III. Systemic changes: A policy has been implemented regarding the proper labeling and useful life of health shakes. (See attachment E) Dietary staff has been in-serviced on the policy. Cleaning of unit microwaves has been assigned solely to housekeeping staff to eliminate confusion of whose responsibility it is. A daily microwave cleaning log has been implemented. (See Attachment F) Housekeeping staff has been in-serviced on the cleaning schedule and log. IV. Monitoring of corrective actions: The Dietary Manager, or her designee, will conduct a daily inspection of the refrigerators on all units for 1 week and a weekly inspection for the next 30 days. If any undated or outdated health shakes are found, they will be disposed of immediately. Any instances of</p>				

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	<p>spots on the inside of the microwave. The spots were dry, but able to be rubbed off.</p> <p>In an interview with Occupational Therapist #6 on 6/15/2011 at 8:57 a.m., he indicated the microwave was utilized to heat food for the residents and housekeeping was responsible for cleaning the microwave.</p> <p>During environmental tour on 6/15/2011 at 9:23 a.m. the microwave in the health care nutrition pantry was noted to have red and goldish colored splattered spots over the inside of the microwave. The spots were able to be rubbed off.</p> <p>In an interview on 6/15/2011 at 9:30 a.m. LPN #4 indicated the microwave was utilized to reheat food for the residents and housekeeping was responsible for cleaning the microwave routinely, but that nursing was responsible for cleaning it whenever the microwave had been used.</p> <p>During environmental tour on 6/15/2011 at 9:35 a.m. the microwave in the activity room was noted to have yellow splattered spots on the inside top of the heating area. The spots were able to be rubbed off.</p> <p>In an interview with Housekeeper #5 on 6/15/2011 at 9:35 a.m., she indicated the microwave was utilized by families to</p>		<p>non-compliance will extend the inspections for 30 more days and will be brought to the attention of the QA Committee. The Director of Environmental Services, or his designee, will conduct a daily inspection of all unit microwaves for 1 week and a weekly inspection for the next 30 days. If any microwaves are found to have dried on food splatters, they will be cleaned immediately. Any instances of non-compliance will extend the inspections for 30 more days and will be brought to the attention of the QA Committee.</p>		

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	<p>reheat food for residents and housekeeping was responsible for cleaning.</p> <p>On 6/16/2011, a census list provided by the Director of Nursing indicated 83 residents resided in the facility.</p> <p>On 6/13/2011 at 10:25 a.m. during initial tour, LPN #4 indicated one resident was fed via feeding tube.</p> <p>In an interview on 6/16/2011 at 10:50 a.m., the Director of Nursing indicated there were no cleaning schedules for the microwaves, staff were responsible to keep the microwaves clean.</p> <p>2. During environmental tour on 6/15/2011 at 8:30 a.m. 5 health shakes dated 5/27/2011 and 12 health shakes without a date were noted in the refrigerator of the rehab unit.</p> <p>In an interview on 6/15/2011 at 8:30 a.m., Dietary Aide #7 indicated the health shakes were to be dated when thawed and only kept 14 days after being thawed.</p> <p>During environmental tour on 6/15/2011 at 9:23 a.m., 2 undated health shakes were noted in the refrigerator in the health care unit pantry.</p>						

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	<p>In an interview on 6/16/2011 at 9:10 a.m., the Dietary Manager indicated 6 residents on the Rehab unit (Residents #150, 151, 152, 153, 154, and 155) and 4 residents on the Healthcare unit (Residents #156, 157, 158, and 159) had orders for health shakes.</p> <p>An undated product information document titled Health Shake provided by the Dietary Manager on 6/15/2011 at 11:45 a.m. indicated shelf life of the shake was 2 weeks after thawing.</p> <p>In an interview on 6/16/2011 at 9:40 a.m., the Dietary Manager indicated there was no policy for dating or storing health shakes and the product information was the guideline to be followed.</p> <p>3.1-21(i)(2)</p>						

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F0425 SS=E	<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 record review and interview, the facility failed to ensure the pharmacy delivered and dispensed medications timely to meet the needs of 4 of 16 residents reviewed in a sample of 16. (Residents #20, 25, 57, and 79)</p> <p>Findings include:</p> <p>1. During the annual survey the clinical records for Residents #20, 25, 57, and 79 were reviewed. Nursing notes, and Medication Administration Records indicated there were multiple entries documented regarding medications not administered timely due to unavailability.</p> <p>Interview with the Executive Director and</p>			F0425	<p>I. Corrective actions: The unavailable medication concerns for all identified residents have been resolved and they are currently receiving all medications as ordered. II. Potential for other residents to be affected: A review of all residents' MARs was conducted and confirmed that no other residents were affected by unavailable medications. III. Systemic changes: A new facility policy has been developed regarding unavailability of medications from the pharmacy. The policy provides guidelines for notifying the pharmacy when a medication is needed and describes the procedure for contacting the pharmacy when the medication has not arrived timely. (See attachment D) All nurses will be in-serviced and</p>		07/16/2011

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	<p>the Director of Nursing, on 06/15/11 at 3:30 P.M. during the daily exit conference confirmed there had been an issue obtaining medications timely from their contract pharmacy and they were going to change to another pharmacy service in the near future.</p> <p>A timeline and documentation regarding the issue and the facility's attempts to work with the current pharmacy was requested on 06/15/11 at 3:30 P.M.</p> <p>However, on 06/16/11 at the final exit, conducted at 3:15 P.M. the facility Director of Nursing and the Executive Director confirmed there was no information regarding the facility's issues and attempts to resolve the issue.</p> <p>2. Review of the clinical record for Resident #20, conducted on 06/13/11 at 2:30 P.M. indicated a physician's order, dated 05/19/11, for the medication, Nascobal 500 mcg/.1 ml nasal spray 1 x a week due to a vitamin b12 deficiency. The May 2011 mar indicated the resident did not receive the medication on 05/20/11 or 05/27/11. The nursing notes for 05/20/11 and 05/27/11 indicated the medication was not available.</p> <p>3. Review of the clinical record for Resident #25, conducted on 06/14/11 at</p>		<p>tested on the policy. Additionally, Grace Village is switching to a new in-house pharmacy effective August 1, 2011 who promises more consistent and timely medication delivery.IV. Monitoring of corrective actions:For the next 30 days, the staff development coordinator will audit the MARs for all residents 5 days per week. The DON and ADON will be notified of any medication(s) that are not available for a resident medication pass. The pharmacy will be contacted immediately for STAT delivery. Completed audit sheets will be turned into the DON or ADON. If any concerns are identified, they will be brought to the attention of the Quality Assurance Committee and monitoring will continue for another 30 day period.</p>				

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	<p>11:35 A.M. indicated a physician's order, initiated on 01/01/11, for the medication, Depotestosterone 200 mg/ml intramuscularly 2 ml every three weeks for low testosterone. The March 2011 mar indicated the scheduled 03/26/11 injection was not administered. Nursing notes, dated 03/26/11, indicated the medication was unavailable.</p> <p>4. Resident #79's clinical record was reviewed on 6/14/11 at 10:45 A.M.. The record indicated the resident was admitted to the facility on 3/18/05 and had diagnoses including, but not limited to, Alzheimer's disease and Diabetes Mellitus.</p> <p>Review of the Physician's orders and Medication Administration Record (MAR) indicated the resident had an order for routine Namenda 10 milligrams (mg) twice daily for Alzheimer's disease. According to the MAR on 4/24/11 and 4/25/11 resident #79 did not received her Namenda 10 mg at 8:00 A.M..</p> <p>Review of resident #79's nurse's notes the Namenda not administered on 4/24/11 and 4/25/11 at 8:00 A.M. due to the medication not being available from the pharmacy.</p> <p>An interview with the Assistant Director</p>				

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	<p>of Nursing (ADN) on 3/16/11 at 11:50 A.M. indicated no information available why the 2 missed doses of Namenda were not available from the pharmacy.</p> <p>5. Resident #57's record was reviewed 6/13/2011 at 11:30 a.m. Resident #57's diagnoses included but were not limited to dementia, cancer and depression.</p> <p>A physician's order for Norco 7.5/325 mg to be given twice daily routinely was written 9/30/2010 for Resident #57.</p> <p>A review of Resident #57's Medication Administration Record for 3/2011 indicated Norco had not been given as scheduled on 3/8/2011.</p> <p>A review of Resident #57's nurse's notes for 3/8/2011 indicated Norco had been held because the medication was not available.</p> <p>A physician's order for Vancomycin 125 mg to be given four times per day for 10 days was written 4/23/2011 for Resident #57.</p> <p>A review of Resident #57's Medication Administration Record for 4/2011 indicated Vancomycin had not been given 4/24 and 4/25/2011. Documentation on the Medication Administration Record</p>				

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	<p>indicated the first Vancomycin dose was given 4/26/2011 at midnight.</p> <p>A review of Resident #57's nurse's notes indicated the Vancomycin was held because the medication was not available.</p> <p>A fax record for pharmacy notification was provided by the ADON on 6/16/2011 at 11:47 a.m. the record indicated the pharmacy had been contacted on 4/22/2011 then not again until 4/25/2011.</p> <p>6. Review of the facility's contract with the pharmacy, titled, "pharmacy services agreement, dated 09/16/08 indicated the pharmacy was to "provide medications and supplies ...as required for residents of facility on a day to day basis in accordance with state and federal laws" and was to " deliver medication and supplies according to a mutually agreeable schedule." Lastly, the pharmacy was to provide a 24 hour emergency coverage seven days a week either by staff of pharmacy or a local backup pharmacy mutually acceptable to both parties.</p> <p>There were no defined timelines in the pharmacy services agreement to ensure the medications were available in a timely manner. Interview with the Director of Nursing, on 06/15/11 at 2:50 P.M. indicated the facility had no local back up</p>				

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F0465 SS=A	<p>pharmacy but the rather the backup pharmacy was located 3 hours away.</p> <p>Review of the facility's pharmacy policy and procedures, dated 01/01/2004 and indicated as current by the Director of Nursing, indicated there were no designated time frames for medication delivery and no specific instructions on how to obtain a medication that was not delivered. The only timeframe indicated was a "stat" order was to be delivered to the facility within 4 hours.</p> <p>3.1-25(a)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review the facility failed to ensure timely repair of wall board in the lounge area of the healthcare unit and room #207. This affected 1 of 16 residents rooms observed on tour and 1 of 1 lounge on the healthcare unit. (Resident #175)</p> <p>Findings include:</p>	F0465	<p>I. Corrective actions:Repairs on both ceiling and wall areas indicated have been completed.II. Potential for other residents to be affected:Walls and ceilings in all other resident rooms and common areas have been inspected and areas needing repair have been completed.III. Systemic changes:Weekly inspections of</p>	07/16/2011	

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	<p>During environmental tour on 6/15/2011 at 9:10 a.m. in the dayroom of the health care unit, on the ceiling above the aviary, an area approximately 3 feet long and 2 inches wide was noted without tape or drywall mud.</p> <p>In an interview on 6/15/2011 at 9:10 a.m., the Director of Maintenance indicated he was unsure how long the area had been there, but the facility had plans to fix it.</p> <p>During environmental tour on 6/15/2011 at 9:34 a.m. an area of rough spackle about 3 feet by 1 foot was noted on the wall of room #207 by the bathroom.</p> <p>In an interview on 6/15/2011 at 9:34 a.m., the Maintenance Director indicated he was unaware of the area, but it should be fixed.</p> <p>In an interview on 6/15/2011 at 9:34 a.m., in a confidential interview, resident #175, indicated she had been aware of the area on the wall of room 207 the last four months. She also indicated she had made the facility aware of the area and nothing had been done to fix the area.</p> <p>In an interview on 6/16/2011 at 11:00 a.m., the Maintenance Director indicated there was no schedule for reviewing walls</p>		<p>walls and ceilings in resident rooms and common areas have been added to Environmental Services' preventative maintenance (PM) checklist. Facility staff have been reminded of and in-serviced on the importance of and the procedure by which resident requests for facility maintenance services are to be directed to the Environmental Services department. Residents will be encouraged to make environmental concerns known at their resident councils. IV. Monitoring of corrective actions: The Director of Environmental Services will review the PM log monthly for four months to ensure that any wall/ceiling repair needs have been entered on a work order and completed in a timely manner. The Social Services coordinator will forward any resident concerns regarding wall/ceiling disrepair noted at the resident councils to the Director of Environmental Services and the Health Facility Administrator for a period of one year. Any environmental concerns identified with wall or ceiling disrepair not addressed in a timely fashion will be discussed in the QA Committee meetings.</p>		

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

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FORM APPROVED

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	and items were fixed as work orders were received. 3.1-19(f)				