

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155387	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/31/2014
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NAME OF PROVIDER OR SUPPLIER CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 27, 28, 29, 30, and 31, 2014</p> <p>Facility number: 000318 Provider number: 155387 AIM number: 100266550</p> <p>Survey team: Diana Sidell RN-TC Barbara Gray RN Leslie Parrett RN Angel Tomlinson RN (October 27, 29, 30, and 31, 2014)</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 1 Medicaid: 36 Other: 10 Total: 47</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>November 18, 2014 Indiana State Department of Health Long Term Care Division RE: Plan of Correction – (Adams County Memorial Hospital dba Caroleton Manor) Credible Allegation of Compliance Dear Ms. Rhoades: Enclosed you will find the Statement of Deficiencies (CMS 2567) completed, with the Facility's Plan of Correction for the deficiencies identified in the survey dated October 31, 2014. Please consider this letter and the Plan of Correction to be the Facility's credible allegation of compliance. The Facility asserts substantial compliance with the applicable certification requirements on November 24, 2014. This letter is also the Facility's request for a re-survey, if one is necessary, to verify that the Facility has achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance. Thank you for your assistance in this matter. Respectfully, Daulphine Day Administrator Preparation and submission of this plan of correction by Caroleton Manor does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The</p>	

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

TITLE

(X6) DATE

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

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F000242 SS=D	<p>Quality review completed on November 6, 2014 by Cheryl Fielden, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure one resident had a choice of when to arise each day for 1 of 3 residents interviewed in the sample of 23 who met the criteria for choices. (Resident #33)</p> <p>Findings included:</p> <p>During an interview on 10/28/14 at 9:13 a.m., Resident #33 indicated he did not choose when to get up in the morning; that "they get us up for breakfast, [I] would like to get up by 10:00 a.m. or 11:00 a.m." He also indicated he used to work second shift and would get up later.</p> <p>During an interview, on 10/29/2014 at</p>	F000242	<p>plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p>F242</p> <p>1. Resident #33 was interviewed on 11-10-14 by Social Services related to the time of day he prefers to get up in the morning.</p> <p>2. Social services will complete an audit by 11-21-14 to ensure residents are allowed choices about aspects of their life in the facilities that are significant.</p> <p>3. The nursing staff will be re educated by the Director of Nursing or designee by 11-21-14</p>	11/24/2014

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	<p>11:22:18 a.m., Resident #33 indicated staff got him up this morning between 7:00 a.m., and 8:00 a.m., and they didn't ask him when he wanted to get up.</p> <p>Resident #33's record was reviewed on 10/29/14 at 11:30 a.m. The record indicated Resident #33 was admitted with diagnoses that included, but were not limited to, high blood fats, high blood pressure, depressive disorder, atrial fibrillation, chronic kidney disease, and diabetes mellitus.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 3/10/14, indicated Resident #33 was independent in cognitive skills for daily decision making, and it was very important for him to choose his own bedtime.</p> <p>An "Activity Assessment", dated 3/5/14, indicated under "Daily Routine" that Resident #33's usual time for arising is 7:00 to 9:00 a.m., and bedtime is around 9:00 p.m.</p> <p>"Resident Activities Progress Notes", dated 8/26/14, indicated: "Quarterly Assessment Review: [Resident #33] is alert and oriented. Up daily in W/C...He does stay up late. He is not an early riser as this is his preference. Care plan goal will continue."</p>		<p>related to ensuring residents are allowed choices that are significant to their life in the facility.</p> <p>4. The Social Service Director will audit 10 residents weekly for 4 weeks and monthly for 2 months to ensure residents continue to be offered choices that are significant to their life in the facility. The Administrator will submit a report to the Quality Assurance committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up.</p> <p>Date Compliance: 11-24-14</p>	

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F000282 SS=D	<p>3.1-3(u)(1) 3.1-3(u)(3)</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> <p>Based on observation, interview and record review, the facility failed to follow a resident's plan of care recommendation not to provide the resident with a straw, for 1 of 23 residents reviewed for care plans. (Resident #20)</p> <p>Findings include: On 10/29/14 at 9:40 a.m., Resident #20's bedroom bedside table was observed to have a Styrofoam cup with liquid in it. The Styrofoam cup had a lid and straw. Resident #20 was not present in the bedroom.</p> <p>Resident #20's record was reviewed on 10/29/14 at 11:34 a.m. Diagnoses</p>	F000282	<p>F282</p> <p>1. Resident #20's room was checked by the Charge nurse on 10-31-14 to ensure there no straws in the resident's room.</p> <p>Resident #20 was re-assessed by the licensed nurse on 11-4-14 with no change in condition noted.</p> <p>2. An audit will be completed by Director of Nursing by 11-21-14 to ensure the resident's plan of care is being followed related to adaptive feeding devices including no straws recommendations.</p>	11/24/2014

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	<p>included but were not limited to, esophageal reflux, aphasia, dysphagia and hemiplegia on her upper and lower dominant side.</p> <p>Resident #20's Annual Minimum Data Set (MDS) assessment dated 8/13/14, indicated her speech was unclear. She scored 12 on her Brief Interview for Mental Status (BIMS) exam indicating she was moderately impaired in her cognitive ability for daily decision making. She was sometimes understood and had the ability to understand others.</p> <p>Resident #20's October 2014 physician's recapitulation orders indicated she would receive (name brand tube feeding) 1.2 nutrition through a feeding tube and a regular mechanical soft diet for pleasure foods. She would be served regular liquids in a sippy cup with sip tip and no straws.</p> <p>Resident #20's Nutrition Plan of Care updated 8/13/14, indicated the following approaches: On 7/15/14, her regular liquids from a sippy cup was changed to a spouted cup. She was not to use straws.</p> <p>On 10/29/14 at 12:10 p.m., Resident #20 was observed seated upright in her wheelchair in her bedroom. She had a Styrofoam cup with liquid in it on her</p>		<p>3. The nursing staff will be re-educated by Director of nursing or designee by 11-21-14 related to the requirements of following the resident's plan of care including no straws or other adaptive feeding devices.</p> <p>4. The Director of Nursing will complete an audit weekly for 4 weeks and monthly for 2 months to ensure staff continues to follow the resident's plan of care including no straws recommendations. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up</p> <p>Date of Compliance: 11-24-14</p>	

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	<p>bedside table with a lid and straw.</p> <p>On 10/30/14 at 9:50 a.m., Resident #20 was observed seated upright in her wheelchair in her bedroom. . She had a Styrofoam cup with liquid in it on her bedside table with a lid and straw.</p> <p>On 10/30/14 at 10:35 a.m., the Dietary Manager indicated Resident #20 used sippy cups in the dining room. She indicated Resident #20 was not supposed to have straws.</p> <p>On 10/30/14 at 2:22 p.m., CNA #2 indicated Resident #20 picked her cup up and drank out it once in awhile but most of the time just picked the cup up, looked at it and set it back down. She indicated Resident #20 would take a drink sometimes and then let the fluid run back out of her mouth. She indicated Resident #20 would not allow staff to give her a drink and would shove staff's hand away. She indicated Resident #20 used a sippy cup at all times. She indicated staff passed fresh cups and fluids early in the morning before her shift started. She indicated she had got Resident #20 fresh water earlier that day in the same Styrofoam cup with a lid and straw. She indicated she knew resident #20 used a sippy cup all the time but didn't think about getting her a sippy cup from the</p>			

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F000323 SS=D	<p>kitchen when she freshened her water. She indicated she was not aware Resident #20 was not supposed to use straws. She indicated no one had told her about it.</p> <p>On 10/30/14 at 2:26 p.m., CNA #3 indicated Resident #20 usually had a sippy cup and a Styrofoam cup on her bedside table. She indicated she would freshen Resident #20's water in her sippy cup from ice she put in the Styrofoam cup. She indicated she had never seen Resident #20 drink out of a straw. She indicated she was not aware Resident #20 was not supposed to use a straw. She reviewed her "ADL Care Guide" she was carrying with her and said it didn't mention anything about a straw.</p> <p>3.1-35(g)(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 attempt new and appropriate intervention for a resident with impaired cognition to</p>	F000323	F323	11/24/2014

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	<p>prevent falls and failed to implement an intervention of getting the resident out of bed when awake to prevent falls for 1 of 5 residents who met the criteria for accidents of 3 residents reviewed for falls. (Resident #51)</p> <p>Finding include:</p> <p>Interview with RN #1, on 10/27/14 at 12:12 p.m., indicated Resident #51 had a fall on 10/2/14 with no injuries.</p> <p>During observation on 10/29/14 at 10:15 a.m., RN #1 and CNA #6 transferred Resident #51 from his wheelchair to his recliner with a gait belt. The resident required the extensive assistance of the two staff and the gait belt, the resident was rigid and slow with the transfer. RN #1 indicated Resident #51 woke up in the early morning hours every day due to his past profession as a farmer it was normal for him to get up early.</p> <p>Review of the record of Resident #51 on 10/30/14 at 9:40 a.m., indicated the resident's diagnoses included, but were not limited to, hypertension, psychosis, dementia with behaviors and advanced Parkinson disease with difficulty walking.</p> <p>The fall risk assessment for Resident #51,</p>		<p>1. Resident #51's care plan was reviewed and updated by the interdisciplinary team on 11/11/14 to ensure fall interventions reflect the resident's condition and needs.</p> <p>2. The MDS coordinator will audit fall care plans by 11-21-14 to ensure new interventions are implemented after each fall and the interventions reflect the resident's current condition and needs</p> <p>3. The nursing staff will be reeducated by Director of nursing or designee by 11-21-14 to ensure Resident#51 is assisted out of bed by staff when awake to prevent falls</p> <p>The licensed nurses will be reeducated by Director of Nursing by 11-21-14 related to the requirements of implementing new interventions after each fall that meet the residents current condition and needs.</p> <p>4. The Director of Nursing will complete an audit weekly for 4 weeks and monthly for 2 months to ensure fall interventions</p>				

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	<p>dated 8/11/14, indicated the resident was at high risk for falls related to confusion, history of falls, wears glasses and had limited range of motion in the upper and lower extremities.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #51, dated 8/15/14, indicated the following: Brief Interview for Mental Status (BIMS) was 4 indicating severe impairment, bed mobility-extensive assistance of one person, transfer- extensive assistance of one person, walk in room-extensive assistance of two people, walk in corridor- extensive assistance of two people, balance moving from seated to standing position-not steady only able to stabilize with staff assistance and falls since admission-yes.</p> <p>The fall careplan for Resident #51, dated 8/21/14, indicated the resident was high risk for falls related to poor safety awareness, weakness, Parkinson, dementia and incontinence. The resident does not use call light, had restless episodes and was an early riser was added on 9/22/14. The fall intervention included, but were not limited to, if the resident was not sleeping then get the resident up in the wheelchair and bring him to the dining room/nursing station, the resident is an early A.M. riser.</p>		<p>continue to be implemented after each resident falls that meet the residents' current condition and needs. The Director of Nursing will submit a report to the Quality Assurance committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of Compliance: 11-24-14</p>	

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	<p>The incident report for Resident #51, dated 8/23/14 at 5:55 a.m., indicated the resident fell in his room. The fall was not witnessed by staff. The resident was found laying beside his bed. The resident indicated he needed to get up. The resident was alert and confused as normal. The resident's call light was in reach and he can use the call light at times. The resident had a history of self transfers resulting in falls. The resident disregards alarms sounding. The fall could have been prevented if the resident would have used his call light for staff assistance and heeded alarm when sounding. The immediate action after the incident to prevent further risk of injury and to prevent future recurrences of this incident was resident encourage to use call light for assistance and to sit back down when the alarm was sounding.</p> <p>The incident report for Resident #51, dated 8/25/14 at 6:15 a.m., indicated the resident had a fall in his room and the fall was not observed by staff. The resident was on landing strips facing the bed. The resident indicated he was getting things out of the drawer. The resident's call light was in reach and he did not use it. The resident transferred self unassisted and found on the floor. The fall alarm was sounding and was answered in 20</p>			

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	<p>seconds. The resident is noncompliant with getting up with assistance. The resident does not use the call light. The resident was reminded to use the call light for assistance and staff will respond to the alarm faster to prevent further incident.</p> <p>The incident report for Resident #51, dated 9/19/14 at 9:45 a.m., indicated the resident had a fall in his room and the fall was not observed by staff. The resident was laying on his back in front of his wheelchair. The resident indicated he was going to the kitchen where everyone else was. The resident's call light was in reach, but he did not use it. The resident reminded to use call light and heed alarms sounding and sit down.</p> <p>The incident report for Resident #51, dated 9/22/14 at 8:00 p.m., indicated the resident had a fall in his room and the fall was not observed by staff. The resident indicated that he was looking for a hook that goes to a screen door. The resident's call light was in reach and he did not use it. The immediate action to prevent further risk of injury and incident was when the resident was restless offer to bring the resident out into the common areas for more staff to monitor the resident and provide diversional activities.</p>			

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	<p>The incident report for Resident #51, dated 10/2/14 at 5:05 a.m., indicated the resident had a fall in his room and the fall was not witnessed by staff. The resident indicated he did not know what happened. The resident was found on the floor between the bed and the bathroom. The resident is impulsive and had a history of of falls with self transfers. The resident's gait and balance was unsteady. The resident's call light was in reach and the resident did not use the call light for staff assistance. The resident had poor safety awareness. The immediate action to prevent further risk of injury and incident was get up in a chair in early mornings when he awakens and remind the resident to use call light. The staff witness account of the incident indicated RN #7 seen the resident five minutes before the fall and he was trying to get out of bed, CNA #8 indicated she had seen the resident 2-3 minutes before the fall and he was trying to get out of the bed, CNA #9 indicated she had seen the resident 30-45 minutes before the fall and he was trying to get out of bed and was restless.</p> <p>Interview with the Director of Nursing (DON) on 10/31/14 at 9:55 a.m., indicated Resident #51 did not use the call light consistently for assistance and</p>			

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	<p>was impulsive. When queried why the prevention intervention updates for Resident #51's falls were "encourage to use the call light" when the resident was confused, the DON indicated because the facility had put a lot of interventions in place when he was first admitted to the facility because he was at high risk for falls. The DON indicated she was unsure why the staff did not get the resident up on the morning of 10/2/14 when the resident was trying to get out of bed and fell. The DON indicated she thought the staff were assisting other residents at the time of Resident #51's fall on 10/2/14.</p> <p>Interview with Resident #51's family member on 10/31/14 at 11:35 a.m., indicated the resident had days that he could use the call light for assistance and then there were days he was too confused to use it. The family member indicated Resident #51 had always gotten up early in the mornings because he was a farmer. Resident #51's family member asked Resident #51 at this time if he knew how to use the call light for assistance, Resident #51 indicated "I don't know where I slept last night".</p> <p>The fall potential and risk reduction policy provided by the Administrator on 10/30/14 at 2:05 p.m., indicated it was the policy of the facility to assess</p>			

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NAME OF PROVIDER OR SUPPLIER CAROLETON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 IOWA AVE CONNERSVILLE, IN 47331
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F000431 SS=E	<p>residents for the potential for falls and identify the factors that might contribute to falls. The facility will address those factors identified in order to reduce the risk for falls.</p> <p>3.1-545(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked,</p>			

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	<p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure medications were stored in clean medication carts for 2 of 2 observations of 2 of 2 medication carts, and had the potential to affect 47 residents on the North and South Halls.</p> <p>Findings include:</p> <p>On 10/30/14, at 10:55 a.m., with RN #1, the following was observed in the medication cart on the South Hall:</p> <ul style="list-style-type: none"> - The second drawer from the top had 3 pills, tiny bits of scattered white paper, rubber bands, and foil from the back of the blister packs that contained pills, scattered in the bottom of the drawer, under the blister pack cards. - The third drawer from the top had 11 pills, foil pieces, and paper bits under the blister pack cards. - The fourth drawer from the top had 4 pills, 3 half pills, foil pieces, clear plastic pieces, a white powdery substance, rubber bands, and small white paper pieces under the blister pack cards. 	F000431	<p>F431</p> <ol style="list-style-type: none"> 1. The 2 medication carts were cleaned by North and South charge nurses on 11-14-14 2. Medication carts will be audited by Director of nursing or designee by 11-21-14 to ensure carts are clean. 3. The licensed nurses will be re-educated by Director of Nursing by 11-21-14 related to requirements of maintaining clean medication carts. 4. The Nursing Supervisor will complete audits weekly for 4 weeks and monthly for 2 months to ensure medication carts continue to be clean as required. The Director of Nursing will submit a report to the Quality 	11/24/2014

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F000465 SS=E	<p>RN #1 indicated at that time the pills had fallen out of the blister packs.</p> <p>On 10/30/2014, at 12:57 p.m., with LPN #5, the following was observed in the medication cart on the North Hall:</p> <ul style="list-style-type: none"> - The second drawer from the top had 4 pills, a white powdery substance, bits of foil, rubber bands, and a paper clip. LPN #5 indicated the powdery substance was from bits of paper that had shredded off the blister pack medication cards. - The third drawer from the top had 3 pills, paper debris, and bits of foil. LPN #5 indicated she did not know when the cart was last cleaned, and there is no schedule for cleaning the medication carts. <p>During an interview, on 10/30/2014 at 2:03 p.m., the Administrator indicated they do not have a policy for cleaning the medication carts, but each nurse is responsible to clean their medication cart after they use it, by the end of their shift.</p> <p>3.1-25(o)</p>		<p>Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of Compliance: 11-24-14</p>				
483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR							

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	<p>TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide residents with clean bathroom sink faucets and toilet, including a sink and baseboard in 1 bathroom not attached properly, for 5 of 8 bathrooms adjoined to the resident's bedrooms observed. (Bathroom #N1, #N10, #N11, #N8, #S6)</p> <p>Findings include:</p> <p>On 10/27/14 at 12:45 p.m., room #N1's bathroom sink faucet had a thick lime looking substance on it. There was a yellowish/brown ring stain inside the toilet bowl.</p> <p>On 10/27/14 at 3:01 p.m., room #N10's bathroom sink faucet had a thick lime looking substance on it.</p> <p>On 10/28/14 at 9:34 a.m., room #N11's bathroom sink faucet had a thick lime looking substance on it.</p> <p>On 10/28/14 at 10:05 a.m., room #N8's bathroom sink was pulled away from the wall and the baseboard trim was loose.</p> <p>On 10/28/14 at 12:16 p.m., room #S6's</p>	F000465	<p>F465</p> <p>1. The bathroom sink and faucet will be replaced in #N1 by the Maintenance Director by 11-21-14.</p> <p>The bathroom sink and faucet will be replaced in #N10 by maintenance director by 11-21-14.</p> <p>The bathroom sink and faucet will be replaced in #N11 by the maintenance director by 11-21-14.</p> <p>The sink that is pulled away from the wall and the loose baseboard will be reattached in #N8 by the Maintenance Director by 11-21-14.</p> <p>The sink and faucet will be replaced in #S6 by the Maintenance Director by 11-21-14.</p> <p>2. The sinks and faucets will be checked by the House keeping Supervisor by 11-21-14 to ensure there is no lime build-up.</p>	11/24/2014

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	<p>bathroom sink faucet had a thick lime looking substance on it.</p> <p>On 10/31/14 at 11:47 a.m., the Administrator indicated housekeeping staff were responsible to clean the sinks and sink hardware and maintenance staff were responsible if there were issues related to a sink being loose. She indicated room #3's bathroom was in the process of being updated with a new sink, toilet, medicine cabinet, and flooring. She indicated each bathroom in need of remodeling would be placed on a schedule and bathrooms that were not a priority for remodeling would be getting repaired with a new faucet, paint or whatever needed to update them to an acceptable standard.</p> <p>On 10/31/14 at 2:47 p.m., Housekeeper #4 indicated housekeeping staff were responsible to clean the resident's sinks and toilets. She indicated there was a problem with build up on the sinks and toilets in the resident's bathrooms because the housekeeping staff did not have a chemical strong enough to remove the build up. She indicated "we used to have chemicals that would clean that off."</p> <p>On 10/31/14 at 2:53 p.m., the Maintenance Supervisor indicated he was</p>		<p>The Maintenance Director will check sinks and base boards by 11-21-14 to ensure they are securely attached to the wall.</p> <p>3. The Maintenance Director will be re-educated by the Administrator by 11-21-14 related to ensuring base boards and sinks are securely attached to the wall as required</p> <p>The House keeping supervisor will be re educated by the Administrator by 11-21-14 related to the requirements of ensuring there is no thick lime build-up on the sinks or faucets.</p> <p>4. The Housekeeping supervisor will complete audits weekly for 4 weeks and monthly for 2 months to ensure the sinks and faucets continue to be free of lime build up.</p> <p>The Maintenance Director will complete an audit weekly for 4 weeks and monthly for 2 months to ensure sinks and baseboards continue to be attached to the walls as required.</p> <p>The Housekeeping Supervisor and Maintenance Director will submit a report of findings to the Quality Assurance Committee monthly for 3 months. The</p>	

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	<p>responsible for resident's basic bathroom repairs. He indicated room #S3's bathroom was getting remodeled. He indicated the upkeep of the bathrooms would be done as "we go along." He indicated if they needed new flooring, sinks, etc..., the facility would be taking care of that. He indicated he was aware of the build up on the sink faucets. He indicated some of the sink faucets needed to be changed out.</p> <p>3.1-19(f)</p>		<p>Administrator is responsible for monitoring and follows up</p> <p>Compliance date: 11-24-14</p>		