

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155449	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2012
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NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN 46703
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: 10/29, 10/30, 10/31, 11/1, 11/2, 11/7, and 11/8/2012</p> <p>Facility number: 000426 Provider number: 155449 AIM number: 100275480</p> <p>Survey team: Shelly Vice RN, TC (10/29, 10/30, 10/31, 11/1, 11/7 and 11/8/2012) Carol Miller RN Debora Kammeyer RN</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census Payor type: Medicare: 11 Medicaid: 45 Other: 19 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/19/12 by Suzanne</p>	F0000	<p>Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Included is the Plan of Correction for our annual recertification and state licensure survey for Northern Lakes Nursing & Rehabilitation Center. The Plan of Correction is also to serve as our Credible Allegation of Compliance. Northern Lakes respectfully requests that substantial compliance be established through all paperwork submitted with this plan of correction. This facility respectfully requests that with the submission of attachments that our plan of correction receive a desk review.</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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	Williams, RN			

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F0221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on interview, observation, and record review, the facility failed to ensure residents were free from physical restraints, for 3 of 3 residents randomly observed with physical restraints. (Resident # 9, Resident #81, and Resident #43)</p> <p>Findings include:</p> <p>1. On 10-30-12 at 1:15 p.m., Resident #9 was observed with a padded strap that went between her thighs and clasped behind her special wheelchair. The resident was unable to lift her thighs or reach the clasp at the back of the wheelchair.</p> <p>On 10-31-12 at 8:45 a.m. an interview with RN #27 indicated the special wheel chair was called a Broda wheelchair, and the straps were called "positioning straps" as they help to position the resident in the Broda chair. The RN was asked if the postponing straps were a restraint, and she stated, "they could be</p>	F0221	F 0221 - Right To Be Free From Physical Restraints 1. Therapy reassessed resident #9 for continued use of thigh belt for positioning and determined that we could maintain proper body alignment with the use of foot board and by reclining chair back a little further and this allows gravity to facilitate alignment. This was determined by completion of Physical Restraint Elimination Assessment. The MDS Coordinator did complete a significant correction MDS and submitted. The IDT did initiate a care plan for restraint use until therapy completed the Physical Restraint Elimination Assessment and a determination made that resident #9 did not require the use of thigh belts to maintain body alignment. The restraint care plan was then discontinued. 2. Resident #81 has significant uncontrolled body movement that makes it impossible to keep her safe without the use of the thigh straps. Therapy did reassess resident using the Physical Restraint Elimination Assessment and determination was made by	12/08/2012			

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	<p>considered that."</p> <p>The clinical record of Resident # 9 was reviewed on 11-2-12 at 8:45 a.m. The resident's diagnoses included, but were not limited to: hypertension hypothyroidism, edema, dementia, psychosis, depression, schizophrenia (residual type), anemia, chronic urinary tract infection and chronic loose stools.</p> <p>Review of the physician's orders indicated there was no order for a restraint for Resident #9. The occupational therapy note dated 10-10-12, indicated the resident was, "sitting well in the Broda chair and had improved with feeding since placed in Broda chair providing better positioning last week."</p> <p>Review of assessments indicated there was no pre-restraint assessment completed for the resident</p> <p>The Minimum Data Set (MDS) quarterly review assessment dated 8-12-12, was reviewed and indicated physical restraints were not being used for Resident #9. The resident's functional status was extensive assist with two person physical assisted needed. The resident could move</p>		<p>the IDT members that continued use of this device was necessary to try and maintain body alignment and decreases her risk for injury. The MDS Coordinator did complete a significant correction MDS and submitted. The restraint consent form has been signed, at the time of survey we were awaiting the husbands arrival for signsture. 3. Therapy reassessed resident #43 for continued use of thigh belt for positioning and determined that we would be able to maintain proper body alignment with the use of foot pedals and tilting chair back a little further, and this allows gravity to facilitate alignment in the BRODA chair. This was determined by completion of the Physical Restraint Elimination Assessment. The MDS Coordinator did complete a significant correction MDS and submitted. The IDT did initiate a care plan for restraint use until therapy completed the Physical Restraint Elimination Assessment and a determination made that resident #43 did not require the continued use of thigh belt to maintain body alignment. The restraint care plan was then discontinued. The Director of Nursing re-instructed all nurses on the Restraint Policy, the administrator re-educated therapist and IDT members on the Restraint Policy. The Therapist did complete</p>		

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	<p>from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p> <p>Review of the Care Plans for the resident, indicated there was no care plan for use of the restraint on the Broda chair.</p> <p>On 11-2-12 at 8:30 a.m., the resident was observed in the Broda chair without thigh straps. The resident was observed again at 11:51 a.m. in her Broda chair without the thigh straps in place.</p> <p>On 11-7-12 the resident was observed at 8:25 a.m. in the Piers dining area, seated in the Broda chair with thigh straps in place.</p> <p>On 11-7-12 at 8:30 a.m., an interview with Therapist #26 indicated Resident #9 had a Broda chair with a thigh belt. The Broda chair was initiated by a therapist and an order was to be obtained for a resident's use of the special wheelchair. The thigh straps were initiated by the therapy staff and an order was to be obtained for the use of the thigh strap. The thigh strap was used to "facilitate posture, hip</p>		<p>a facility wide reassessment of devices to determine if any further residents were affected by the deficient practice and did not find any further issues. The Director of Nursing & Therapy Director will complete weekly compliance rounds for Restraint Use and report findings to the QA Committee weekly for 4 weeks, if the QA Committee determines that compliance has been maintained this will be added to the QA Schedule to review for continued compliance on a quarterly basis. Therapy has included on their Interdisciplinary resident screen Restraint Use and this is completed on a Quarterly Basis or with significant change of condition, this will be reviewed by the IDT members during care plan review meetings.</p>		

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	<p>and pelvic alignment." The Broda chair was a pressure relieving chair and was used for residents at risk for pressure ulcers. The Broda chair can be tilted backwards and/or reclined. The resident had a tilt back and recline Broda chair.</p> <p>On 11-7-12 at 11:30 a.m., the Director of Nursing Services (DNS) indicated there was no order for the Broda chair or thigh belt for Resident #9.</p> <p>On 11-7-12 at 1:15 p.m., an undated Policy and Procedure was received from the DNS, titled Section Thirteen, Physical & Chemical Restraints, and was reviewed. The policy indicated the definition of a restraint included, but was not limited to: using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot easily remove to prevent the resident from rising.</p> <p>2. On 10-30-12 at 9:30 a.m., Resident #81 was observed in a special wheelchair with padded straps that went between her thighs and clasped in the back of the chair.</p> <p>On 10-31-12 at 8:45 a.m., the resident was observed in her special wheelchair (Broda Chair) with straps</p>				

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	<p>that went between the resident's legs and connected in the back of the wheelchair with a clasp. The resident was unable to release the strap herself. The strap was padded and could be raised off the resident's thighs. The resident could not stand with the straps in place.</p> <p>On 10-31-12 at 8:50 a.m., an interview with RN #27 indicated the straps on the resident's wheelchair were not self-releasing and are called "positioning straps." When asked if the positioning straps were a restraint, the RN stated, "it could be considered a restraint."</p> <p>On 10-31-12 at 10:20 a.m., the Minimum Data Set (MDS) quarterly review assessment dated 8-12-12, was reviewed and indicated that physical restraints were not being used for Resident #81. The resident's functional status was extensive assist with two person physical assistance needed. The resident could move from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p>						

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	<p>The clinical record of Resident #81 was reviewed on 11-2-12 at 11:15 a.m. The resident's diagnoses included, but were not limited to; dementia with behavior disturbances, hypertension, hypothyroidism, diabetes, and renal insufficiency. The Medication Administration Record (MAR) indicated the Broda chair was used when up for pressure relief.</p> <p>A review of the Consent for the Use of Physical Restraint Device dated 11-1-12, indicated the physician had ordered a thigh belt for Resident # 81 on 11-1-12, and the reason for the thigh belt was to facilitate good pelvic alignment and to allow upright posture. The restraint will be used while the resident was sitting in wheel chair (Broda). The resident's husband (the responsible party) had not signed the restraint consent. The consent did list the hazards and possible outcomes for the resident and legal representative.</p> <p>A Physical Restraint Elimination assessment form was completed on 11-2-12 and indicated the resident was a poor candidate for restraint reduction. The restraint elimination form indicated the assessment was to be completed at least quarterly. There was a pre-restraint assessment</p>				

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	<p>completed on 11-1-12 and it stated the resident "has been evaluated by Occupational Therapy for weak positioning. Broda chair with thigh belt is most appropriate for her." There was no pre-restraint assessment completed prior to 11-1-12.</p> <p>A review of physician's order dated 11-1-12, indicated an order for a thigh belt while in Broda chair to facilitate good pelvic alignment to allow improved postural control.</p> <p>A review of the Care Plan, dated 11-2-12, indicated the resident used a Broda chair and had a thigh belt to facilitate good pelvic alignment to allow improved upright posture. The approaches included, but were not limited to: assist resident with position changes per facility protocol and provide appropriate skin care, complete restraint reduction assessment at least quarterly, continue to address underlying conditions that may have prompted restraint use, document checks and release on facility restraint form, and notify resident and contact responsible party and explain risks, document notification and consent.</p> <p>A review of Occupational therapy</p>						

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	<p>note dated 6/8/12, indicated resident had Broda chair with lateral supports.</p> <p>On 11-7-12 at 1:15 p.m., an undated Policy and Procedure was received from the DNS titled, Section Thirteen, Physical & Chemical Restraints, and was reviewed. The policy indicated the definition of a restraint included, but was not limited to: using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident can not easily remove to prevent the resident from rising. The Physical Restraint Policy indicated, "...licensed staff will initiate the Pre-Restraining Assessment as soon as the potential need for a physical restraint device is identified."</p> <p>3. On 10-29-12 at 10:40 a.m., Resident #43 was observed in a special wheelchair that had a padded strap that went between the thighs and clasped to the back of the wheel chair. The resident was unable to stand or raise thighs.</p> <p>On 10-31-12 at 10:10 a.m., the resident was observed in the special wheelchair with straps between her thighs. The resident was unable to raise her thighs off the wheelchair or release the strap in back of her wheelchair.</p>				

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	<p>On 11-2-12 at 8:30 a.m. and at 11:50 a.m. the resident was observed without the thigh straps on her Broda wheelchair.</p> <p>On 10-31-12 at 10:00 a.m. the Minimum Data Set (MDS) annual assessment, dated 9-2-12, was reviewed and indicated that physical restraints were not being used for Resident #43. The resident's functional status was extensive assist with two person physical assisted needed. The resident could move from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p> <p>The clinical record of Resident #43 was reviewed on 11-2-12 at 10:50 a.m. The resident's diagnoses included, but were not limited to: insulin dependant diabetes, dementia with depression, dementia with behavioral features (aggression) and hypertension.</p> <p>A review of the Care Plan indicated no care plan for the use of the restraint.</p>						

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	<p>A review of the Physician's Orders indicated no order for the restraint.</p> <p>There was no pre-restraint assessment completed for the resident.</p> <p>The physical therapy note dated 8-27-12, indicated the resident sits upright in Broda chair; however, the note did not indicated the straps were being used for the resident while in the Broda chair.</p> <p>On 11-7-12 at 8:25 a.m., the resident was observed sitting in the Broda chair without the thigh straps in place.</p> <p>On 11-7-12 at 8:30 a.m. an interview with Therapist #26 indicated that Resident #43 has a Broda wheelchair with a thigh belt. A Broda chair was initiated by a therapist and an order was to be obtained for a resident's use of the special wheelchair. The thigh straps were also initiated by the therapy staff and an order was to be obtained for the use of the thigh strap. The thigh strap was used to "facilitate posture, hip and pelvic alignment." The Broda chair was a pressure relieving wheelchair that was used for residents at risk for pressure ulcers. The Broda chair can be tilted backwards and/or recline.</p>						

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	<p>Resident had a tilt back Broda chair.</p> <p>On 11-7-12 at 11:30 a.m., the DNS indicated there was no order for the Broda chair or thigh belt for Resident #43.</p> <p>3.1-3(w) 3.1-26(a) 3.1-26(o)</p>			

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F0272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview, observation, and record review, the facility failed to comprehensively assess residents for the use of physical restraints for 3 of 3 residents randomly observed with</p>	F0272	F272 Comprehensive Assessments 1. Therapy reassessed resident #9 for continued use of thigh belt for positioning and determined that we could maintain proper body	12/08/2012

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	<p>physical restraints. (Resident #9, Resident #81, and Resident #43)</p> <p>Findings include:</p> <p>1. On 10-30-12 at 1:15 p.m., Resident #9 was observed with a padded strap that went between her thighs and clasped behind her special wheelchair. The resident was unable to lift her thighs or reach the clasp at the back of the wheelchair.</p> <p>On 10-31-12 at 8:45 a.m. an interview with RN #27 indicated the special wheel chair was called a Broda wheelchair, and the straps were called "positioning straps" as they help to position the resident in the Broda chair. The RN was asked if the postponing straps were a restraint, and she stated, "they could be considered that."</p> <p>The clinical record of Resident # 9 was reviewed on 11-2-12 at 8:45 a.m. The resident's diagnoses included, but were not limited to: hypertension hypothyroidism, edema, dementia, psychosis, depression, schizophrenia (residual type), anemia, chronic urinary tract infection and chronic loose stools.</p>		<p>alignment with the use of foot board and by reclining chair back a little further and this allows gravity to facilitate alignment. This was determined by completion of Physical Restraint Elimination Assessment. As indicated on the 2567 the last MDS quarterly review was dated 8/12/12, the BRODA chair with thigh belt was not initiated until 8/28/12, this did not require us to submit another MDS, and her next quarterly MDS was not due to be completed until late November 2012 . The IDT did initiate a care plan for restraint use until therapy completed the Physical Restraint Elimination Assessment and a determination made that resident #9 did not require the use of thigh belts to maintain body alignment. The restraint care plan was then discontinued. 2. Resident #81 has significant uncontrolled body movement that makes it impossible to keep her safe without the use of the thigh straps. Therapy did reassess resident using the Physical Restraint Elimination Assessment and determination was made by the IDT members that continued use of this device was necessary to try and maintain body alignment and decreases her risk for injury. The MDS Coordinator did complete a significant correction MDS and submitted. The restraint consent form has been signed, at the time of survey we were awaiting the husbands</p>		

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	<p>Review of the physician's orders indicated there was no order for a restraint for Resident #9. The occupational therapy note dated 10-10-12, indicated the resident was, "sitting well in the Broda chair and had improved with feeding since placed in Broda chair providing better positioning last week."</p> <p>Review of assessments indicated there was no pre-restraint assessment completed for the resident</p> <p>The Minimum Data Set (MDS) quarterly review assessment dated 8-12-12, was reviewed and indicated physical restraints were not being used for Resident #9. The resident's functional status was extensive assist with two person physical assisted needed. The resident could move from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p> <p>On 11-7-12 at 8:30 a.m., an interview with Therapist #26 indicated Resident #9 had a Broda chair with a thigh belt. The Broda chair was initiated by a therapist and an order was to be</p>		<p>arrival for signsture. 3. Therapy reassessed resident #43 for continued use of thigh belt for positioning and determined that we would be able to maintain proper body alignment with the use of foot pedals and tilting chair back a little further, and this allows gravity to facilitate alignment in the BRODA chair. This was determined by completion of the Physical Restraint Elimination Assessment. The MDS Coordinator did complete a significant correction MDS and submitted. The IDT did initiate a care plan for restraint use until therapy completed the Physical Restraint Elimination Assessment and a determination made that resident #43 did not require the continued use of thigh belt to maintain body alignment. The restraint care plan was then discontinued. The Director of Nursing re-instructed all nurses on the Restraint Policy, the administrator re-educated therapist and IDT members on the Restraint Policy. The Therapist did complete a facility wide reassessment of devices to determine if any further residents were affected by the deficient practice and did not find any further issues. The Director of Nursing & Therapy Director will complete weekly compliance rounds for Restraint Use and report findings to the QA Committee weekly for 4 weeks, if</p>		

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	<p>obtained for a resident's use of the special wheelchair. The thigh straps were initiated by the therapy staff and an order was to be obtained for the use of the thigh strap. The thigh strap was used to "facilitate posture, hip and pelvic alignment." The Broda chair was a pressure relieving chair and was used for residents at risk for pressure ulcers. The Broda chair can be tilted backwards and/or reclined. The resident had a tilt back and recline Broda chair.</p> <p>On 11-7-12 at 11:30 a.m., the Director of Nursing Services (DNS) indicated there was no order for the Broda chair or thigh belt for Resident #9.</p> <p>2. On 10-30-12 at 9:30 a.m., Resident #81 was observed in a special wheelchair with padded straps that went between her thighs and clasped in the back of the chair.</p> <p>On 10-31-12 at 8:45 a.m., the resident was observed in her special wheelchair (Broda Chair) with straps that went between the resident's legs and connected in the back of the wheelchair with a clasp. The resident was unable to release the strap herself. The strap was padded and could be raised off the resident's</p>		<p>the QA Committee determines that compliance has been maintained this will be added to the QA Schedule to review for continued compliance on a quarterly basis. Therapy has included on their Interdisciplinary resident screen Restraint Use and this is completed on a Quarterly Basis or with significant change of condition, this will be reviewed by the IDT members during care plan review meetings.</p>		

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	<p>thighs. The resident could not stand with the straps in place.</p> <p>On 10-31-12 at 8:50 a.m., an interview with RN #27 indicated the straps on the resident's wheelchair were not self-releasing and are called "positioning straps." When asked if the positioning straps were a restraint, the RN stated, "it could be considered a restraint."</p> <p>On 10-31-12 at 10:20 a.m., the Minimum Data Set (MDS) quarterly review assessment dated 8-12-12, was reviewed and indicated that physical restraints were not being used for Resident #81. The resident's functional status was extensive assist with two person physical assistance needed. The resident could move from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p> <p>The clinical record of Resident #81 was reviewed on 11-2-12 at 11:15 a.m. The resident's diagnoses included, but were not limited to; dementia with behavior disturbances, hypertension, hypothyroidism,</p>						

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	<p>diabetes, and renal insufficiency. The Medication Administration Record (MAR) indicated the Broda chair was used when up for pressure relief.</p> <p>A review of the Consent for the Use of Physical Restraint Device dated 11-1-12, indicated the physician had ordered a thigh belt for Resident # 81 on 11-1-12, and the reason for the thigh belt was to facilitate good pelvic alignment and to allow upright posture. The restraint will be used while the resident was sitting in wheel chair (Broda). The resident's husband (the responsible party) had not signed the restraint consent. The consent did list the hazards and possible outcomes for the resident and legal representative.</p> <p>A Physical Restraint Elimination assessment form was completed on 11-2-12 and indicated the resident was a poor candidate for restraint reduction. The restraint elimination form indicated the assessment was to be completed at least quarterly. There was a pre-restraint assessment completed on 11-1-12 and it stated the resident "has been evaluated by Occupational Therapy for weak positioning. Broda chair with thigh belt is most appropriate for her." There was no pre-restraint</p>						

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	<p>assessment completed prior to 11-1-12.</p> <p>A review of physician's order dated 11-1-12, indicated an order for a thigh belt while in Broda chair to facilitate good pelvic alignment to allow improved postural control.</p> <p>A review of Occupational therapy note dated 6/8/12, indicated resident had Broda chair with lateral supports.</p> <p>On 11-7-12 at 1:15 p.m., an undated Policy and Procedure was received from the DNS titled, Section Thirteen, Physical & Chemical Restraints, and was reviewed. The policy indicated the definition of a restraint included, but was not limited to: using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident can not easily remove to prevent the resident from rising. The Physical Restraint Policy indicated, "...licensed staff will initiate the Pre-Restraining Assessment as soon as the potential need for a physical restraint device is identified."</p> <p>3. On 10-29-12 at 10:40 a.m., Resident #43 was observed in a special wheelchair that had a padded strap that went between the thighs and clasped to the back of the wheel</p>						

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	<p>chair. The resident was unable to stand or raise thighs.</p> <p>On 10-31-12 at 10:10 a.m., the resident was observed in the special wheelchair with straps between her thighs. The resident was unable to raise her thighs off the wheelchair or release the strap in back of her wheelchair.</p> <p>On 11-2-12 at 8:30 a.m. and at 11:50 a.m. the resident was observed without the thigh straps on her Broda wheelchair.</p> <p>On 10-31-12 at 10:00 a.m. the Minimum Data Set (MDS) annual assessment, dated 9-2-12, was reviewed and indicated that physical restraints were not being used for Resident #43. The resident's functional status was extensive assist with two person physical assisted needed. The resident could move from seated to standing position - not steady, only able to stabilize with human assistance. The cognitive status indicated the resident was severely impaired and never/rarely made decisions.</p> <p>The clinical record of Resident #43 was reviewed on 11-2-12 at 10:50 a.m. The resident's diagnoses</p>				

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	<p>included, but were not limited to: insulin dependant diabetes, dementia with depression, dementia with behavioral features (aggression) and hypertension.</p> <p>A review of the Physician's Orders indicated no order for the restraint.</p> <p>There was no pre-restraint assessment completed for the resident.</p> <p>The physical therapy note dated 8-27-12, indicated the resident sits upright in Broda chair; however, the note did not indicated the straps were being used for the resident while in the Broda chair.</p> <p>On 11-7-12 at 8:25 a.m., the resident was observed sitting in the Broda chair without the thigh straps in place.</p> <p>On 11-7-12 at 8:30 a.m. an interview with Therapist #26 indicated that Resident #43 has a Broda wheelchair with a thigh belt. A Broda chair was initiated by a therapist and an order was to be obtained for a resident's use of the special wheelchair. The thigh straps were also initiated by the therapy staff and an order was to be obtained for the use of the thigh strap. The thigh strap was used to</p>				

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	<p>"facilitate posture, hip and pelvic alignment." The Broda chair was a pressure relieving wheelchair that was used for residents at risk for pressure ulcers. The Broda chair can be tilted backwards and/or recline. Resident had a tilt back Broda chair.</p> <p>On 11-7-12 at 11:30 a.m., the DNS indicated there was no order for the Broda chair or thigh belt for Resident #43.</p> <p>3.1-31(a) 3.1-31(c)(4)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</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 reviews and interviews, the facility failed to assure one resident randomly reviewed for pressure ulcers did not develop a pressure ulcer. (Resident #43)</p> <p>Findings include:</p> <p>On 10-29-12 at 10:40 a.m., during the initial tour an observation was made of Resident # 43 in a special wheelchair. The wheelchair had padded straps that went between the legs, across the thighs and hooked to the back of the wheelchair with a clasp.</p> <p>On 10-31-12 at 10:10 a.m., the resident was observed in the special wheelchair with a strap between her thighs. The resident was unable to raise her thighs off the wheelchair or</p>	F0314	F 314 Treatment/SVCS To Prevent/Heal Pressure Sores The Wound Nurse and Director of Nursing reassessed the right thigh wound on resident #43 and has reclassified this as a Stage II Open Area that was caused by numerous factors including use of briefs, creased polyester pants, and use of thigh belt. Resident #43 no longer has thigh belt, and family was notified to purchase cotton pants that are loose fitting such as jogging pants to prevent increased perspiration & possible decrease circulation around upper legs. Central Supply has also re-sized resident to ensure briefs still properly fit without causing pressure or decreased circulation to groin area. The Director of Nursing, Wound Nurse, Administrator, and Medical Director reviewed all current skin/wound sheets to ensure appropriate classifications of wounds has been identified by the Wound Nurse. The Wound	12/08/2012	

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	<p>release the strap in back of her wheelchair.</p> <p>On 10-31-12 at 3:12 p.m., during observation of Resident #43, a right thigh wound was observed with the Wound Care Nurse. A stage II pressure ulcer was located in the area where the strap laid against the resident's right thigh. The ulcer was a shallow open ulcer with a red-pink wound bed, without slough. The wound had a scant amount of serous drainage. The wound nurse indicated the resident had a blister previously in the area, and the wound had healed. The resident had scratched the area and reopened the wound. The wound was covered by the strap when resident was placed in her Broda wheelchair.</p> <p>The clinical record of Resident #43 was reviewed on 11-1-12 at 10:50 a.m. The resident's diagnoses included, but were not limited to: insulin dependant diabetes, dementia with depression, dementia with behavioral features (aggression) and hypertension.</p> <p>A review of the Treatment Administration Record (TAR) for 10/2012 indicated the resident was in a Broda chair when up for pressure</p>		<p>Nurse and Director of Nursing has received additional training using the Indiana State Department of Health "Preventing Pressure Ulcer Education Modules". The MDS Coordinator has submitted a Significant Change MDS that now includes the Stage II Pressure Ulcer. The IDT members will review all orders at morning management meeting and if treatment order noted for any skin condition a review will be completed with the Wound Nurse to ensure appropriate classification of the wound. In addition, The Director of Nursing, Administrator, and Medical Director will review all skin/wound logs weekly to ensure appropriate classification of wounds and present findings to the QA Committee weekly for 4 weeks, at the end of this time period if the QA Committee determines continued compliance has been maintained, Pressure Ulcer review will be completed through the normal QA Process on a quarterly basis.</p>		

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	<p>release with an order date of 12-23-11. The treatment for a wound dated 11/2012 called the area, "...right inner thigh (old blister area)."</p> <p>A Wound Progress Report form was reviewed. The report indicated the resident had a right inner thigh wound that was first observed on 10-3-12. The wound measured 1.6 cm x 1.0 cm. with no drainage. The treatment ordered by the physician included skin integrity, silver alginate, and 4 x 4 tegaderm every other day and as needed until healed.</p> <p>On 10-30-12 the area measured 1.0 cm x 0.6 cm x <0.1 cm with serous drainage. The treatment changed to cover the wound with a folded 4 x 4 and cover with tegaderm every other day and as needed. The wound was never staged or called a pressure ulcer.</p> <p>On 11-2-12 at 10:15 a.m. review of Care Plan, dated 4-26-12, indicated on 8-16-12 there were blisters to both inner thighs related to resident refusing to allow the staff to fix pant legs or apply the brief properly allowing for creases in groin area. The intervention was to pad and protect the blisters on both inner thighs when a brief is on. On 8-31-12 the problem indicated a right inner</p>				

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	<p>thigh area had an old blister developing yellow tan eschar. The intervention included, "clean right inner thigh old blister area with skintegrity, pat dry. Apply silver Alg, cover with folded 4 x 4, secure with tegaderm and change every other day."</p> <p>On 11-5-12 at 4:40 p.m., a review of the MDS Annual Assessment indicated on 9-2-12 the resident did not have a pressure ulcer. The resident required extensive assistance with activities of daily living.</p> <p>On 11-7-12 at 12:35 p.m., a review of a Wound Progress Report form indicated, on 8-21-12 the resident had a open blister (measured 2.2 cm x 1.0 cm x 0.1 cm with serous drainage), 8-28-12 scabbed blister, 8-31-12 scratch open blister with yellow base, 9-4-12 open blister, 9-11-12 open blister (0.5 cm cm <0.1 cm) and on 9-14-12 healed.</p> <p>On 11-7-12 at 12:40 p.m. a review of the September TAR indicated the monitoring of the inner thigh area was discontinued.</p> <p>On 11-7-12 at 8:30 a.m., an interview</p>			

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	<p>with Therapist #26 indicated Resident #43 had a Broda wheelchair with a thigh belt. The Broda chair was initiated by a therapist and an order was to be obtained for a resident's use of the special chair. The thigh straps are also initiated by the therapy staff and an order was to be obtained for the use of the thigh strap. The thigh strap was used to "facilitate posture, hip and pelvic alignment." The Broda chair was a pressure relieving chair and was used for residents at risk for pressure ulcers. The Broda chair can be tilted backwards and/or reclined. The resident had a tilt back Broda chair.</p> <p>On 11-7-12 at 10:05 a.m. an interview with the wound care nurse indicated the wounds in August of 2012 on the thighs were blisters, not ulcers. She indicated that according to her wound education/literature, that a blister isn't a pressure wound. She was then asked if she had considered the thigh belt a possible cause of the "blisters" or a possible reason for the resident to scratch herself in that area, and she made no comment.</p> <p>On 11-7-12 at 2:15 p.m. a Classification of Pressure Ulcers, undated, was obtained from the Director of Nursing Services and</p>						

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NAME OF PROVIDER OR SUPPLIER NORTHERN LAKES NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 N WILLIAMS ST ANGOLA, IN 46703
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	<p>indicated..."Stage II: A partial thickness of skin loss involving epidermis and /or dermis, blister or shallow crater without measurable depth."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F0431 SS=F	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record reviews and interviews, the facility failed to ensure the medications being stored in the front nurses' medication room</p>	F0431	When the MDS Coordinator informed the administrator that the refrigerator was exceeding safe temperature range, she instructed the maintenance	12/08/2012			

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	<p>were stored within the appropriate temperatures for medication storage. This potentially affected 75 residents residing at the health care facility.</p> <p>Findings include:</p> <p>On 10/29/12 at 11:50 a.m., an observation was made of the front nurses' station medication room with the Minimum Data Set (MDS) assessment nurse. A medication refrigerator was noted with medications for staff (Hepatitis B Vaccine and Flu Virin) and residents of the facility. A quality assurance form was attached to the front of the refrigerator. It was noted to comprise the medication refrigerator and medication room temperatures. It was noted on the form that the temperatures had been documented to be above the 41 degree level. The form had a header which stated, "Northern Lakes Nursing & Rehabilitation Center. Medication Room/ Refrigerator Temperatures." Located at the bottom of this form were the directives for follow up for the one doing the temperature reading to follow if the temperatures were found to be out of the range for medication stability. The form noted, "Note: If temperature exceeds 41 degrees F, keep door</p>		<p>director to buy a new refrigerator immediately. The pharmacy was contacted and guidance received on all medications that had to be destroyed and replaced and this was completed. After this refrigerator was completed, maintenance checked all other refrigerators in the facility and found to be in temperature compliance. All nurses were inserviced on temperature storage guidelines and actions to take if temperatures are not within the safe temperature range. Maintenance repair slips were restocked at each nurses station, and also affixed to each refrigerator for easy access. Maintenance Director was re-instructed to restock Maintenance Repair Slips weekly. The medical director was notified by the Director of Nursing as well as, Novartis (the manufacturer of the Flu virin) to obtain guidance on the effectiveness of Flu virin when temperatures exceed storage parameters. the local health department was also contacted for guidance. Orders received to re-vaccinate all residents who were vaccinated between the dates of 10/1/12 - 10/29/12, when the new refrigerator was installed. Responsible Parties were notified by Director of Nursing and Consents/Declinations were received for re-vaccinations. A list of discharged residents and</p>		

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	<p>closed and recheck in 15 minutes, if it continues to be above 41 degrees, relocate all items to another refrigerator and complete repair request to maintenance."</p> <p>This form contained columns with the headers of: "Date/ Refrigerator/ Room/ Initials:"</p> <p>The readings were as follows for the last few days of September 2012 and the month of October 2012:</p> <p>"Date: 9/28 (nothing written- line drawn through columns); 9/29 Refrigerator 48/ Room 78/ Initials; 9/30 Refrigerator 54/ Room 78/ Initials; 10/1 Refrigerator 54/ Room 78/ Initials; 10/2 Refrigerator 48/ Room 78/ Initials; 10/3 Refrigerator 44/ Room 78/ Initials; 10/4 Refrigerator 44/ Room 78/ Initials; 10/5 Refrigerator 42/ Room 78/ Initials; 10/6 Refrigerator 42/ Room 78/ Initials; 10/7 Refrigerator 42/ Room 80/ Initials; 10/8 Refrigerator 42/ Room 78/ Initials; 10/9 Refrigerator 42/ Room 78/</p>		<p>new admissions during the time period of 9/28/12 - 10/29/12 was reviewed by the administrator and director of nursing to ensure no other past or present residents were affected by this practice. We reviewed employee records for the Hepatitis B Vaccine, only one employee had received the Hep B during this time period and the medical director was contacted for guidance on re-vaccination. No residents received a Hepatitis B Vaccination during this time period. According to the MDS Nurse and LPN #5 the surveyors did not request a list of residents that had used items from the refrigerated emergency drug kit. This facility always maintains EDK Usage Slips (Pharmacy form #1620-357). The Director of Nursing reviewed all EDK Usage Slips from 9/28/12 - 10/29/12 and no issues noted with this review by the Director of Nursing or Medical Director. Director of Nursing or designee to check refrigerator temperature logs daily x 30 days, then weekly x 4 weeks, and report findings to the QA Committee weekly. If the QA Committee determines that compliance is maintained, the Director of Nursing will place ongoing QA Checks monthly to ensure continued compliance.</p>		

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	Initials; 10/10 Refrigerator 50/ Room 78/ Initials; 10/11 Refrigerator 50/ Room 78/ Initials; 10/12 Refrigerator 52/ Room 78/ Initials; 10/13 (nothing written- columns left blank); 10/14 Refrigerator 52/ Room 78/ Initials; 10/15 Refrigerator 52/ Room 78/ Initials; 10/16 Refrigerator 50/ Room 78/ Initials; 10/17 Refrigerator 52/ Room 78/ Initials; 10/18 Refrigerator 52/ Room 75/ Initials; 10/19 Refrigerator 52/ Room 75/ Initials; 10/20 Refrigerator 52 / Room 75/ Initials; 10/21 Refrigerator 54/ Room 78/ Initials; 10/22 Refrigerator 52/ Room 78/ Initials; 10/23 Refrigerator 52/ Room 78/ Initials; 10/24 Refrigerator 54/ Room 78/ Initials; 10/25 Refrigerator 54/38/ Room 80/ Initial; 10/26 Refrigerator 50/ Room 80/ Initials;			

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	<p>10/27 (nothing written); 10/28 (nothing written); 10/29 at 11:45 a.m. the refrigerator temperature was read with the MDS nurse The refrigerator thermometer located inside the medication room refrigerator read to be 50 degrees Fahrenheit. This was read by the MDS nurse and observed while being read.</p> <p>On 10/29/12 at 11:45 a.m. an interview was conducted with the MDS nurse. She noted that the temperatures of the medication room refrigerator located at the front nurses station medication room were temped for quality control measures, "...on the night shift and then the temperature readings are written on this sheet..." to which she referred to the form noted above titled, " Northern Lakes Nursing & Rehabilitation Center. Medication Room/ Refrigerator Temperatures." The form was observed and noted with readings recorded to be above the 41 degrees noted for follow up.</p> <p>The MDS nurse indicated she could not tell by looking at this form if a 15 minute recheck of the temperature of the refrigerator had been conducted. The medications had not been , "...relocated...to another refrigerator..." at that time. The</p>						

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	<p>refrigerator was holding many medications. When a reference was made to the MDS nurse of the process of, "...complete repair request to maintenance," she indicated that a, "... sheet of paper... a form for the Maintenance man is completed and given to him for maintenance..."</p> <p>When requested to see the from, she could not locate the form for the maintenance follow up and stated, "... I don't see them anywhere... usually, they'll (the staff finding the improper temperature reading) write it down on a scrap piece of paper and give it to (the name of the Maintenance director)..."</p> <p>The medication refrigerator was holding medications and a list was requested of the contents. LPN #5 wrote all medications that were found in the refrigerator down on a piece of paper. LPN #5 then notified the Pharmacy of the findings in the refrigerator and asked for directions for proper follow up with the chemicals.</p> <p>On 10/29/12 at 11:55 a.m. an interview was conducted with the Maintenance Director, and he indicated that the refrigerator on the front nurses' station medication room had no maintenance slips for repair out for his service. He also indicated</p>						

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	<p>he was not aware of the temperatures exceeding the limits posted for quality assurance. He also noted that he could not recall the last maintenance that had been provided to the refrigerator.</p> <p>At 12:00 noon on 10/29/12, the MDS nurse indicated the list had been provided to the Pharmacy, and the facility had been directed to dispose of the, " ...flu, hepatitis B vaccines and the emergency drug kit and reorder replacements..." A record review of the 'Refill Reorder Form' was provided. The form had a handwritten note, "...Temp on refrigerator exceeded 50 degrees." This from contained a charge sticker with the medications: Fluvirin, Energix-B and Emergency Drug Kit.</p> <p>On 10/29/12 at 12:30 p.m., an interview with the Director of Nursing Service (DNS) was conducted and noted that there were no residents in the facility with signs and symptoms of flu.</p> <p>On 10/29/12 at 1:15 p.m. a list of residents from the Cove unit and the Piers unit was provided. The following Residents of these 2 units had received the flu vaccine from the flu vaccine stock having been stored in</p>						

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	<p>the front nurses' station medication room refrigerator in the month of October 2012: Residents #37, #60, #48, #70, #13, #30, #67, and #73. The facility had been requested to provide a list of staff and/or residents that had received the Hepatitis B vaccine and a list was not provided. The MDS nurse and LPN #5 indicated they did not know of a way to produce that information. The facility had been requested to provide a list of residents that had used items from the emergency drug kit and again the MDS nurse and LPN #5 had responded with an inability to retrieve this type of historical information.</p> <p>On 10/29/12 at 1:40 p.m. a telephone interview was conducted with a Pharmacist at the facility's contracted pharmacy. Pharmacist #7 was interviewed to verify if the flu and Hepatitis B vaccines being stored at the improper temperature could cause the vaccines to loose their stability of chemical properties for establishing immunity for the host. It was noted that the pharmacist would have to contact the manufacturers of the FluVirin (seasonal Flu vaccine) and the Energix-B (Hepatitis B vaccine). The manufacturers could not produce viable scientific</p>						

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	<p>information supporting the viability of the vaccines' stability to support immunity establishing properties. The pharmacy did support replacing the stored vaccines and emergency drug kit. The pharmacy and manufacturers did support the contacting of the local health departments for further local guidance in re vaccination guidance.</p> <p>On 11/8/12 at 2:00 p.m. an interview was conducted with the Administrator and the Director of Nursing Services (DNS) of the concern with the vaccines and emergency drug kit storage temperatures. It was indicated by the DNS that the facility had began to take steps to address the possible readministration of the vaccine and contacting the appropriate agency in concern.</p> <p>3.1-25(m)</p>			

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F0465 SS=B	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations, the facility failed to assure the corridor area outside of Island Park and Sandy Shores units was free of bad odors. This affected 2 of 4 unit areas in the facility. This potentially affected 55 of residents residing at the health care facility.</p> <p>Findings include:</p> <p>On 10/29/12 at 10:30 a.m. an observation was made, upon touring the facility, of a malodor at the back corridor between the Island Park unit and the Sandy Shores unit.</p> <p>On 10/29/12 at 3:00 PM an observation was made of a malodor at the back corridor between the Island Park unit and the Sandy Shores unit.</p> <p>On 10/30/12 at 2:10 PM an observation was made of a malodor at the back corridor between the Island Park unit and the Sandy Shores unit.</p> <p>On 10/31/12 at 9:30 a.m. an</p>	F0465	<p>F 0465 Safe/Functional/Sanitary/Comfortable Environment The Environmentl Director conducted an inspection of all resident rooms on Island Park and Sandy Shores and all ancillary rooms such as shower rooms, utility rooms, storage rooms etc. and found that one storage room had a floor drain that was dry causing a strong odor from the drain pipe, in addition we found that some residents residing on Island Park (Memory Care Unit), had hid some clothing items that were soiled. Maintenance was informed of the floor drain and poured an enzyme cleaner into the drain that took care of the odor, and laundry washed soiled clothing that was found on the memory care unit. Laundry staff and nurse aides were informed of residents on the memory care unit that was hiding soiled clothing, and these rooms are checked daily for dirty clothing that needs to be sent to laundry. Maintenance did inspect all floor drains throughout the facility and treated them with an enzyme cleaner, and has placed all drains on the Preventative Maintenance Schedule to ensure all are treated at least 2 times a year. The</p>	12/08/2012

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	<p>observation was made of a malodor at the back corridor between the Island Park unit and the Sandy Shores unit.</p> <p>On 11/1/12 at 11:00 am an observations was made of a malodor at the back corridor between the Island Park unit and the Sandy Shore unit. This also involved the corridor area leading away from the Island Park unit and the Sandy Shores unit into the area by the therapy department.</p> <p>On 11/7/12 at 10:30 a.m. an observation was made of a malodor at the back corridor between the Island Park unit and the Sandy Shores unit.</p> <p>3.1-19(f)</p>		<p>environmental director or designee will complete ongoing room inspections on the memory care unit to identify other residents that may start hoarding soiled clothing in their rooms and report this daily at morning management meeting. In addition, all environmental staff has been informed to inspect rooms on the memory care unit routinely for soiled clothing. Findings of ongoing room inspections, and odor control will be present to the QA Committee weekly for 4 weeks, if the QA Committee determines that substantial compliance has been maintained, this will be placed on Monthly QA Calendar for ongoing monitoring.</p>		