

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/03/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 29, 30, October 1, 2, and 3, 2014</p> <p>Facility number: 000253 Provider number: 155362 AIM number: 100266660</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Cynthia Stramel, RN</p> <p>Census bed type: SNF/NF: 128 Total: 128</p> <p>Census payor type: Medicare: 6 Medicaid: 107 Other: 15 Total: 128</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 7, 2014, by Janelyn Kulik, RN.</p>	F000000		

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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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident's dignity was maintained related to uncovered urinary catheter bags for 2 of 4 residents reviewed for dignity out of the 8 that met the criteria for dignity. (Residents #11 and #9)</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 9/30/14 at 2:30 p.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident, hemiplegia and a sacral pressure ulcer. She had a urinary catheter and a feeding tube.</p> <p>On 10/1/14 at 9:00 a.m., the resident was observed in her bed. There was an uncovered urinary catheter bag with yellow urine visible hanging from the side of the bed.</p>	F000241	<p>F241</p> <p><b>Residents #11 and #9 had their urinary catheter bags placed into privacy bags.</b></p> <p><b>All residents with indwelling catheters have the potential to be affected by the alleged deficient practice. Residents with catheter bags that do not have the built in privacy cover were issued privacy bags to cover their catheter bags</b></p> <p><b>Additional catheter privacy bags were ordered by central supply</b></p> <p><b>Clinical staff was educated to utilize either the catheter bags with the built in privacy cover or to place the catheter bag into the privacy bag.</b></p> <p><b>Unit managers will audit 3x week x 4 weeks, weekly x 4 weeks and then monthly x 4 months to ensure that catheter</b></p>	11/02/2014
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	<p>On 10/1/14 at 3:10 p.m., the resident was observed seated in her wheelchair in the dining room. The urinary catheter bag was hanging underneath the wheelchair, uncovered, with yellow urine visible.</p> <p>Interview with the D Wing Unit Manager at that time indicated the catheter bag should be covered with a dignity bag.</p> <p>2. On 9/29/2014 at 03:25 p.m., Resident #9's urinary catheter bag was observed hanging from the side of his bed, uncovered and urine visible.</p> <p>On 10/2/14 at 9:00 a.m., Resident #9's urinary catheter bag was observed hanging from the side of his bed, uncovered and urine visible.</p> <p>On 10/2/2014 at 2:00 p.m., Resident #9's urinary catheter bag remained hanging from the side of his bed, uncovered and urine visible.</p> <p>During a brief tour and interview on 10/2/2014 at 2:08 p.m. with the D Wing Unit Manager (UM), Resident #9's urinary catheter bag was observed uncovered hanging from the side of his bed with urine visible. At that time, the UM indicated the catheter bag should be covered with a dignity bag and directed staff to do so.</p>		<p><b>drainage bags either have the built in privacy cover or they are placed in a privacy bag.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p><b>November 2, 2014</b></p>				

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F000282 SS=D	<p>The current undated policy Indwelling Catheter Justification/ Decision Diagram was received from the Director of Nursing on 10/2/14 at 10:45 a.m. The policy indicated, "Provide a catheter bag cover to promote dignity".</p> <p>3.1-3(t)</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. Based on observation, record review and interview, the facility failed to ensure Physician orders or care plans were followed as written related to the application of hand splints for a resident with contractures (Resident #11), urinary catheter bag laying on the floor (Resident's #147 and #11), and not providing non-pharmacological interventions prior to administering pain medication (Resident #182).</p> <p>Findings include:</p>	F000282	<p><b>F282</b></p> <p><b>Resident #11 had palm protector applied on 10/1/2014. Order obtained and resident care sheet updated.</b></p> <p><b>Residents #11 and #147 had their urinary catheter bags placed into privacy bags in order to keep the drainage bag or tubing from touching the floor.</b></p> <p><b>Resident #182 had prn pain medication order updated to include documentation of pain</b></p>	11/02/2014

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	<p>1. On 9/30/14 at 10:50 a.m., a urinary catheter bag was laying on the floor next to Resident #11's bed.</p> <p>On 10/2/14 at 9:55 a.m., the urinary catheter bag was on the floor next to the resident's bed. CNA #1 indicated at that time that the catheter should not be on the floor</p> <p>The record for Resident #11 was reviewed on 9/30/14 at 2:30 p.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident, hemiplegia and a sacral pressure ulcer. She had contractures to both hands.</p> <p>The Significant Change Minimum Data Set assessment dated 7/21/14, indicated the resident had severe cognitive impairment, and required extensive assistance for bed mobility and personal hygiene.</p> <p>A Physician order dated 8/26/14 was for Occupational Therapy (OT) to provide individual skilled services five times a week for four weeks to address therapeutic exercises and orthotic fit/ training for muscle weakness. Another OT order dated 8/26/14 was for diathermy and moist heat to both hands for pain management.</p>		<p><b>scale and non-pharmacological interventions.</b></p> <p><b>Residents discharged from therapy within the past 2 weeks reviewed and no other residents affected.</b></p> <p><b>All residents with indwelling catheters have the potential to be affected by the alleged deficient practice. Residents with catheter bags were issued privacy bags to place the urinary drainage bag in to keep it from touching the floor.</b></p> <p><b>Other residents receiving prn pain medications have the potential to be affected by the alleged deficient practice.</b></p> <p><b>A therapy to Nursing communication form was created. Therapy staff to be educated that when a resident is to discharge with new devices such as a palm protector that they will complete the communication form and give it to the nursing supervisor.</b></p> <p><b>Additional catheter privacy bags were ordered by central supply</b> <b>Clinical staff was educated to utilize the privacy bags as needed to place the urinary drainage bag into to keep it from touching the floor.</b></p>		

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	<p>A care plan updated 5/9/14 indicated the resident had Foley (urinary) catheter and a history of urinary tract infections (UTI). The goal to was to be free of UTI thru next review. Interventions included, but were not limited to, "Keep drainage bag of catheter below the level of the bladder at all times and off the floor".</p> <p>Interview with the OT Supervisor on 10/1/14 at 2:55 p.m., indicated the resident had been on services for management of contractures and pain to both hands. The Discharge Summary dated 9/19/14, indicated nursing staff was provided training on how to apply bilateral palm protectors and the resident required assistance from staff for bilateral hand management including hygiene, passive range of motion and palm protectors on and off.</p> <p>The resident was observed on 10/1/14 at 3:10 p.m. seated in the dining room in her wheelchair. She had a palm protector on the left hand, the right hand was contracted and did not have a palm protector. The Unit Manager indicated at that time she only used the palm protector on the left hand.</p> <p>On 10/1/14 at 3:30 p.m., after further review the Unit Manager indicated the resident should have palm protectors on</p>		<p><b>Residents prn pain medication orders were revised to include documentation of pain scale and non-pharmacological interventions.</b></p> <p><b>Licensed staff were re-educated on documenting pain level and non-pharmacological interventions on the MAR or in the progress notes.</b></p> <p><b>The DNS or designee will receive a copy of the communication form from therapy. DNS or designee will audit each form to ensure an order was obtained, plan of care was updated and the device is in place.</b></p> <p><b>Unit managers will audit 3x week x 4 weeks, weekly x 4 weeks and then monthly x 4 months to ensure catheter bags are not touching the floor.</b></p> <p><b>Unit managers will review daily for prn usage and audit to ensure pain level and non-pharmacological interventions are documented for all prn medications administered. Unit managers will review any new prn pain medication order to ensure orders include pain level and</b></p>	

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	<p>both hands.</p> <p>Interview with the Director of Nursing on 10/2/14 at 2:15 p.m., indicated catheters should not be on the floor.</p> <p>2. Observation on 9/29/14 at 10:58 a.m., Resident #147's catheter bag was hanging from the side of the bed. The bottom of the bag was touching the floor.</p> <p>Observation on 9/30/14 at 11:51 a.m., the resident's catheter bag was hanging from the side of the bed. The bottom of the bag was touching the floor.</p> <p>Observation on 10/2/14 at 11:45 a.m., the resident's catheter bag and catheter tubing was on the floor. Interview with CNA #2 at the time of the observation indicated the bag was not supposed to be on the floor but it kept falling to the floor because the bed was so low.</p> <p>Record review for Resident #147 was completed on 9/30/14 at 1:45 p.m. The diagnoses included, but were not limited to, personal history of urinary tract infection, hypertension, autistic disorder, and pressure ulcer. The Quarterly Minimum Data Set (MDS) assessment completed on 8/7/14 indicated the resident was cognitively impaired. The resident had an indwelling urinary catheter.</p>		<p><b>non-pharmacological interventions.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p><b>November 2, 2014</b></p>				

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	<p>The October 2014 Physician Orders indicated the resident had a 20fr. (french) (size of catheter) indwelling urinary catheter.</p> <p>A care plan dated 4/22/13 and revised on 9/11/13 indicated Resident #147 had an alteration in elimination of bowel and bladder. The resident was totally incontinent of bowel and had an indwelling catheter for a stage 4 pressure ulcer to the coccyx. A nursing intervention included to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor.</p> <p>Interview with the C Wing unit manager on 10/3/14 at 11:07 a.m., she indicated the catheter bag should be hanging on the side of the bed and not touching the floor.</p> <p>3. Resident #182's record was reviewed on 9/30/14 at 2:09 p.m. The resident's diagnoses included, but were not limited to, closed fracture of the ankle, hypertension, and anxiety.</p> <p>Review of the 9/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 10/325 mg (milligrams) 1 tablet every 6 hours as needed for pain.</p>			

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	<p>Review of the Medication Administration Record (MAR), dated 9/2014, indicated there was no indication any interventions were attempted prior to the administration of the Norco on 9/25/14, 9/26/14, 9/27/14, 9/28/14, 9/29/14, and 9/30/14. There was no indication the resident's pain was assessed prior to the administration of the Norco on 9/26/14, 9/27/14, 9/29/14, and 9/30/14.</p> <p>Resident #182 had a care plan for pain management related to ankle fracture. The nursing interventions included, "...Evaluate characteristics and frequency/pattern of pain...Evaluate what makes the patient's pain worse..."</p> <p>Interview with the C-Wing Unit Manager on 10/2/14 at 2:04 p.m., indicated she could not find in the nurses notes where prior interventions had been attempted and charted. She further indicated the staff should be doing interventions. She indicated the resident's pain had not been ranked on a pain scale because there was only one PRN pain medication prescribed. She indicated if there had been two different medications then the staff would have had to rate the pain in order to know which medication to give.</p> <p>A facility policy, dated 2013, titled, "Pain</p>			

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F000309 SS=D	<p>Management Guideline," received from the Assistant Director of Nursing (ADON) as current on 10/3/14 at 10:36 a.m., indicated, "...Guidelines...Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired...Using non-drug interventions to assist in pain management...Monitoring Compliance...The documentation will be reflected on the EMAR and progress notes..."</p> <p>3.1-35 (g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure each resident receive necessary treatment and services related to providing post dialysis assessments for a resident receiving hemodialysis for 1 out of 1 residents reviewed for dialysis. (Resident #147)</p>	F000309	<p>F309</p> <p><b>We were unable to correct the alleged deficient practice for resident #147</b></p> <p><b>No other residents have the potential to be affected by the alleged deficient practice. There are currently no other residents in the facility</b></p>	11/02/2014

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	<p>Findings include:</p> <p>The record for Resident #147 was reviewed on 9/30/14 at 2:05 p.m. The resident's diagnoses included, but were not limited to, diabetes, renal failure and heart failure. The resident received hemodialysis three times a week related to renal failure.</p> <p>The Significant Change Minimum Data Set assessment dated 6/9/14 indicated the resident's Brief Interview for Mental Status score was 11 out of 15, which indicated she had some cognitive impairment.</p> <p>Review of Dialysis Observation Communication Forms indicated many of the forms post-dialysis sections were not completed. The forms had three sections; a pre dialysis assessment, a section to be completed by the dialysis unit, and a post dialysis assessment. The assessment included vital signs, mental status, edema, skin concerns, access site and pain concerns.</p> <p>Interview with LPN #1 on 10/1/14 at 10:10 a.m., indicated the nurse was to complete the pre dialysis assessment, the form went with the resident to the dialysis facility where they should complete the second portion. Upon</p>		<p><b>receiving dialysis services.</b></p> <p><b>Licensed nursing staff will be re-educated on Dialysis Guideline including providing and documenting a post dialysis assessment of the resident upon return from dialysis.</b></p> <p><b>An order has been placed on the MAR for the licensed nurse to sign that she has completed an assessment with vitals post dialysis and any abnormal findings will be reported to the MD.</b></p> <p><b>Unit managers will audit weekly to ensure that residents have post dialysis assessments completed.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p><b>November 2, 2014</b></p>				

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	<p>return to the nursing facility, the post dialysis section should be completed.</p> <p>Interview with the Unit Manager on 10/1/14 at 11:00 a.m., indicated the post dialysis assessment should be completed or the information should be documented in the Nurses notes.</p> <p>A sample of three Dialysis Observation Communication Forms were further reviewed. The form dated 9/19/14 had no post dialysis documentation. Nurses' notes indicated the resident returned from dialysis at 4:15, there was no pain or nausea noted, no additional assessment information provided. The form dated 9/22/14 had no post dialysis documentation. Nurses' notes indicated the resident had returned from dialysis, there was no pain or nausea, resident was tired, no additional assessment information was provided. The form dated 9/24/14 had no post dialysis documentation. There were no Nurse notes documented that day.</p> <p>The care plan dated 6/13/13 for alteration in kidney function due to end stage kidney disease requiring hemodialysis indicated, "observe for post-dialysis hang over - vital signs, mental status, excessive weight gain between treatments, nausea, vomiting..."</p>			

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F000315 SS=D	<p>The current policy dated 2013 for Dialysis Guidelines, was received from the Director or Nursing on 10/3/14 at 3:20 p.m. The policy indicated Other Areas of Risk for the Resident on Hemodialysis was, "3. Fluid balance and Congestive Heart Failure. The resident's goal would be to maintain optimal fluid volume status and not develop CHF (congestive heart failure)...Assess resident's blood pressure and heart rate, respiratory status on return from dialysis..."</p> <p>3.1-37(a)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident with a urinary catheter received</p>	F000315	F315  <b>Residents #11 and #147 had their urinary catheter bags</b>	11/02/2014

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	<p>the necessary treatment and services to prevent urinary tract infections, related to the placement of the urinary catheter tubing and drainage bag for 2 of 3 residents reviewed for urinary catheters out of the 40 residents that met the criteria for urinary catheters . (Resident's #11 and #147).</p> <p>Findings include:</p> <p>1. The record for Resident #11 was reviewed on 9/30/14 at 2:30 p.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident, hemiplegia and a sacral pressure ulcer. She had a urinary catheter and a feeding tube.</p> <p>On 9/30/14 at 10:50 a.m., the urinary catheter bag was laying on the floor next to Resident #11's bed.</p> <p>On 10/2/14 at 9:55 a.m., the urinary catheter bag was on the floor next to the resident's bed. CNA #1 indicated at that time that the catheter should not be on the floor.</p> <p>A care plan updated 5/9/14 indicated the resident had Foley (urinary) catheter and a history of urinary tract infections (UTI). The goal to was to be free of UTI thru next review. Interventions included, but</p>		<p><b>placed into privacy bags in order to keep the drainage bag or tubing from touching the floor.</b></p> <p><b>All residents with indwelling catheters have the potential to be affected by the alleged deficient practice. Residents with catheter bags were issued privacy bags to place the urinary drainage bag in to keep it from touching the floor.</b></p> <p><b>Additional catheter privacy bags were ordered by central supply</b></p> <p><b>Clinical staff was educated to utilize the privacy bags as needed to place the urinary drainage bag into to keep it from touching the floor.</b></p> <p><b>Unit managers will audit 3x week x 4 weeks, weekly x 4 weeks and then monthly x 4 months to ensure catheter bags are not touching the floor.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p>November 2, 2014</p>	

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	<p>were not limited to, "Keep drainage bag of catheter below the level of the bladder at all times and off the floor".</p> <p>Interview with the Director of Nursing on 10/2/14 at 2:15 p.m., indicated catheters should not be on the floor.</p> <p>2. Observation on 9/29/14 at 10:58 a.m., Resident #147's catheter bag was hanging from the side of the bed. The bottom of the bag was touching the floor.</p> <p>Observation on 9/30/14 at 11:51 a.m., the resident's catheter bag was hanging from the side of the bed. The bottom of the bag was touching the floor.</p> <p>Observation on 10/2/14 at 11:45 a.m., the resident's catheter bag and catheter tubing was on the floor. Interview with CNA #2 at the time of the observation indicated the bag was not supposed to be on the floor but it kept falling to the floor because the bed was so low.</p> <p>Record review for Resident #147 was completed on 9/30/14 at 1:45 p.m. The diagnoses included, but were not limited to, personal history of urinary tract infection, hypertension, autistic disorder, and pressure ulcer. The Quarterly Minimum Data Set (MDS) assessment completed on 8/7/14 indicated the resident was cognitively impaired. The</p>			

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F000318 SS=D	<p>resident had an indwelling urinary catheter.</p> <p>The October 2014 Physician Orders indicated the resident had a 20fr. (french) (size of catheter) indwelling urinary catheter.</p> <p>A care plan dated 4/22/13 and revised on 9/11/13 indicated Resident #147 had an alteration in elimination of bowel and bladder. The resident was totally incontinent of bowel and had an indwelling catheter for a stage 4 pressure ulcer to the coccyx. A nursing intervention included to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor.</p> <p>Interview with the C Wing unit manager on 10/3/14 at 11:07 a.m., she indicated the catheter bag should be hanging on the side of the bed and not touching the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services</p>			

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	<p>to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to ensure a resident received appropriate treatment to prevent further decrease in range of motion related to not applying a splint to a contracted hand for 1 of 3 resident's reviewed for range of motion of the 8 who met the criteria for range of motion. (Resident #11).</p> <p>Findings include:</p> <p>The record for Resident #11 was reviewed on 9/30/14 at 2:30 p.m. The resident's diagnoses included, but was not limited to, cerebral vascular accident, hemiplegia and a sacral pressure ulcer. She had contractures to both hands.</p> <p>The Significant Change Minimum Data Set assessment dated 7/21/14, indicated the resident had severe cognitive impairment, and required extensive assistance for bed mobility and personal hygiene.</p> <p>A Physician order dated 8/26/14 was for Occupational Therapy (OT) to provide individual skilled services five times a week for four weeks to address therapeutic exercises and orthotic fit/training for muscle weakness. Another</p>	F000318	<p>F318</p> <p><b>Resident #11 had palm protector applied on 10/1/2014. Order obtained and resident care sheet updated.</b></p> <p><b>Residents discharged from therapy within the past 2 weeks reviewed and no other residents affected.</b></p> <p><b>A therapy to Nursing communication form was created. Therapy staff to be educated that when a resident is to discharge with new devices such as a palm protector that they will complete the communication form and give it to the nursing supervisor.</b></p> <p><b>The DNS or designee will receive a copy of the communication form from therapy. DNS or designee will audit each form to ensure an order was obtained, plan of care was updated and the device is in place.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p>November 2, 2014</p>	11/02/2014

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	<p>OT order dated 8/26/14 was for diathermy and moist heat to both hands for pain management.</p> <p>Interview with the OT Supervisor on 10/1/14 at 2:55 p.m., indicated the resident had been on services for management of contractures and pain to both hands. The Discharge Summary dated 9/19/14, indicated nursing staff was provided training how to apply bilateral palm protectors and the resident required assistance from staff for bilateral hand management including hygiene, passive range of motion and palm protectors on and off.</p> <p>The Resident Report Sheet, used by CNA's to determine resident care, printed on 10/1/14, indicated the resident was to have a palm protector applied to her left hand when up.</p> <p>The resident was observed on 10/1/14 at 3:10 p.m. seated in the dining room in her wheelchair. She had a palm protector on the left hand, the right hand was contracted and did not have a palm protector. The Unit Manager indicated at that time she only used a palm protector on the left hand.</p> <p>Further interview with the Unit Manager, after she reviewed the OT discharge</p>			

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F000325 SS=D	<p>summary on 10/1/14 at 3:30 p.m., indicated the resident should have palm protectors on both hands.</p> <p>3.1-42(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure nutritional guidelines were followed related to monitoring fluid intake for a resident on fluid restrictions for 1 of 6 residents reviewed for nutrition. (Resident #47)</p> <p>Findings include:</p> <p>The record for Resident #47 was reviewed on 9/30/14 at 2:05 p.m. The resident's diagnoses included, but were not limited to, diabetes, renal failure and heart failure. The resident received hemodialysis three times a week related to renal failure.</p>	F000325	<p>F325</p> <p><b>Resident #47 had fluid intake monitoring implemented. Meal ticket was revised to include the fluid restriction.</b></p> <p><b>Two other residents with fluid restriction orders were added to fluid intake monitoring and meal tickets reviewed to include fluid restriction is listed.</b></p> <p><b>Clinical staff were educated to document intake of nursing provided between fluids in care tracker.</b></p> <p><b>Unit managers will audit care</b></p>	11/02/2014

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	<p>The Significant Change Minimum Data Set assessment dated 6/9/14 indicated the resident's Brief Interview for Mental Status score was 11 out of 15, which indicated she had some cognitive impairment.</p> <p>A Physician order dated 6/19/14 indicated the resident was to receive 1500 milliliters (ml) of fluid daily.</p> <p>A care plan dated 2/21/14 indicated the resident had increased nutritional needs related to receiving hemodialysis. The goal was to maintain weight without significant fluctuations thru next review and not observe any signs of dehydration. The interventions included, "observe intakes daily".</p> <p>The Treatment Administration Record (TAR) for September 2014 indicated, "fluid restrictions of 1500 ml daily, dietary provide 960 ml qd (daily) and nursing provide 540 ml qd (every day) related to unspecified renal failure". The TAR had a checkmark in each day and shift. There was no indication or documentation of how much fluid the resident had consumed.</p> <p>Interview with the Unit Manager on 10/1/14 at 11:00 a.m., indicated nursing</p>		<p><b>tracker daily during clinical start up to ensure fluid intake provided by nursing is documented.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p>November 2, 2014</p>	

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	<p>provided 540 ml of fluids daily. She indicated the resident didn't drink very much, and the cups used with medication pass were 120 ml. They did not document how much the resident actually consumed.</p> <p>On 10/3/14 at 8:15 a.m., the resident was observed eating breakfast in the main dining room. There was a cup of coffee, a 4 ounce cup with milk in it, an empty 4 ounce cup and an empty 6 ounce cup. The meal ticket sitting on the resident's table did not indicate the resident was on fluid restriction.</p> <p>Interview with Dietary Manager on 10/3/14 at 8:40 a.m., indicated the meal ticket should indicate when a resident was on fluid restriction. At 8:55 a.m., the Dietary Manager indicated the meal ticket had been updated to include fluid restrictions.</p> <p>Interview with the resident on 10/3/14 at 9:30 a.m., indicated she did not think she was on a fluid restricted diet.</p> <p>Further interview with the Unit Manager on 10/3/14 at 9:37 a.m., indicated she had updated the TAR to require the amount of fluid the resident consumed to be input.</p>			

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F000329 SS=D	<p>3.1-46(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure pain was assessed and non-pharmacological interventions for pain were attempted prior to PRN (as needed) medications being given for 1 of 5 residents reviewed for unnecessary medications (Residents #182).</p>	F000329	<p>F329</p> <p><b>Resident #182 had prn pain medication order updated to include documentation of pain scale and non-pharmacological interventions.</b></p> <p><b>Other residents receiving prn pain medications have the</b></p>	11/02/2014
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	<p>Findings include:</p> <p>Resident #182's record was reviewed on 9/30/14 at 2:09 p.m. The resident's diagnoses included, but were not limited to, closed fracture of the ankle, hypertension, and anxiety.</p> <p>Review of the 9/2014 Physician's Order Summary, indicated an order for Norco (a narcotic pain medication) 10/325 mg (milligrams) 1 tablet every 6 hours as needed for pain.</p> <p>Review of the Medication Administration Record (MAR), dated 9/2014, indicated there was no indication any interventions were attempted prior to the administration of the Norco on 9/25/14, 9/26/14, 9/27/14, 9/28/14, 9/29/14, and 9/30/14. There was no indication the resident's pain was assessed prior to the administration of the Norco on 9/26/14, 9/27/14, 9/29/14, and 9/30/14.</p> <p>Resident #182 had a care plan for pain management related to a fractured ankle. The nursing interventions included, "...Evaluate characteristics and frequency/pattern of pain...Evaluate what makes the patient's pain worse..."</p> <p>Interview with the C-Wing Unit Manager on 10/2/14 at 2:04 p.m., indicated she</p>		<p><b>potential to be affected by the alleged deficient practice.</b></p> <p><b>Residents prn pain medication orders were revised to include documentation of pain scale and non-pharmacological interventions.</b></p> <p><b>Licensed staff were re-educated on documenting pain level and non-pharmacological interventions on the MAR or in the progress notes.</b></p> <p><b>Unit managers will review daily for prn usage and audit to ensure pain level and non-pharmacological interventions are documented for all prn medications administered. Unit managers will review any new prn pain medication order to ensure orders include pain level and non-pharmacological interventions.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p>November 2, 2014</p>	

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F000371 SS=E	<p>could not find in the nurses notes where prior interventions had been attempted and charted. She further indicated the staff should be doing interventions. She indicated the resident's pain had not been ranked on a pain scale because there was only one PRN pain medication prescribed. She indicated if there had been two different medications then the staff would have had to rate the pain in order to know which medication to give.</p> <p>A facility policy, dated 2013, titled, "Pain Management Guideline," received from the Assistant Director of Nursing (ADON) as current on 10/3/14 at 10:36 a.m., indicated, "...Guidelines...Assessing pain and evaluating response to pain management interventions using a pain management scale based on resident self-report or objective assessment for the cognitively impaired...Using non-drug interventions to assist in pain management...Monitoring Compliance...The documentation will be reflected on the EMAR and progress notes..."</p> <p>3.1-48(a)(6)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -</p>			

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	<p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility staff failed to distribute and serve food under sanitary conditions for room trays delivered on 1 of 3 units observed during dining. (C Wing). This had the potential to affect the 7 residents who received their meals on room trays.</p> <p>Findings include:</p> <p>During a dining lunch observation on C Wing on 9/29/14, the following was observed:</p> <p>At 11:30 a.m., the tray cart arrived from the kitchen and was parked in the hallway outside the unit dining room. Trays were removed from the cart by staff and put on a serving tray and taken into the unit dining room for the 5 residents who were waiting to eat. Another staff member distributed room trays from the cart. Drinks were poured and placed on the trays, then carried down the hall from the serving cart outside the dining area. Drinks and desserts were uncovered on the tray. Staff delivered four room trays to individual rooms in this manner. Three more trays were placed on a rolling cart and taken to rooms with drinks and</p>	F000371	<p>F 371 Dietary</p> <p>The staff was immediately in-serviced regarding covering all food that leaves the kitchen. As of 9-30-14 all food leaving the kitchen was covered in the delivery carts.</p> <p>All residents that receive room trays have the potential to be effected by this deficient practice. Kitchen staff was in-serviced to cover all food leaving in a delivery cart. Floor staff was as well in-serviced to cover all drinks that are poured for room tray delivery.</p> <p>The kitchen and floor staff have been in-serviced on the covering of food and drink along with the Wrapped Food Tracking Form being utilized by the Dietary Manager and the Director of Clinical Education.</p> <p>The Wrapped Food Tracking Form will be used 5x a week for 4 weeks then 3x a week for 4 weeks then once a week for 3 months then weekly for one additional month. This monitoring will be brought to QAPI for 6 months to track any issue or show compliance.</p> <p>Date of Compliance: November 2, 2014</p>	11/02/2014

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F000441 SS=E	<p>desserts uncovered.</p> <p>During an interview with CNA #3 on 9/29/14 at 11:40 a.m., she indicated drinks and desserts that are normally for room tray residents do not have covers. The only ones covered are those for residents requesting a room tray who usually eat in the Main dining room.</p> <p>During an interview with the Dietary Manager (DM) and Dietary Consultant on 9/30/14 at 11:05 a.m., indicated staff should not be carrying food or drinks uncovered down the hallways on room trays. They further indicated staff should roll the tray carts down the hall &amp; deliver trays from outside each room.</p> <p>3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>			

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	<p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure infection control was maintained related to improperly stored washbasins and bedpans on 2 of 4 units throughout the facility (D Wing and ACU), and clean laundry on a laundry cart touching the floor. (D Wing)</p> <p>Findings include:</p> <p>1. On 10/2/14 at 8:10 a.m., a gray uncovered wash basin was on top of the paper towel dispenser in the bathroom of</p>	F000441	<p>F441</p> <p><b>Rounds were completed on D wing and ACU and any basins or bedpans found to be on the floor, not bagged or unlabeled were put in the trash.</b></p> <p><b>Residents on C wing have the potential to be affected by the alleged deficient practice. Rounds were completed on c wing and any basins or bedpans found to be on the floor or not bagged/unlabeled were put in the trash.</b></p>	11/02/2014

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	<p>Room 119.</p> <p>On 10/3/14 at 10:00 a.m., the wash basin was still uncovered on the paper towel dispenser in bathroom of Room 119. Two resident's resided in the room.</p> <p>Interview with the ACU Manager at that time, indicated basins should be covered in plastic bags when not in use.</p> <p>2. During an observation of Room 333 on 9/29/14 at 3:00 p.m., two bath basins were on the floor under the bathroom sink uncovered.</p> <p>During an observation of Room 333 on 10/2/2014 at 8:35 a.m., two bath basins remained on the floor under the bathroom sink uncovered.</p> <p>During an observation of Room 333 on 10/02/2014 2:05 p.m., two bath basins remained on the floor under the bathroom sink uncovered. One resident resided in the room.</p> <p>3. During an observation of Room 327 on 9/30/14 at 9:00 a.m., one bath basin was on the floor under the bathroom sink uncovered.</p> <p>During an observation of Room 327 on 10/2/2014 at 8:33 a.m., one bath basin remained on the floor under the bathroom</p>		<p><b>Clinical staff will be re-educated on infection control procedures with bedpans or basins.</b></p> <p><b>Unit managers will make rounds 3x week x 4 weeks, weekly x 4 weeks and then monthly x 4 months ensure that bedpans or basins are not left on the floor, not bagged or unlabeled.</b></p> <p><b>DNS will review for any trends or patterns and bring results to QAPI monthly x 6 months.</b></p> <p>November 2, 2014 F 441 Laundry</p> <p>The items in question were returned to the laundry room to be washed. The staff was immediately notified to make sure all top and bottom areas of the clean laundry cart are covered appropriately.</p> <p>All residents receiving laundry from the in-house services have potential to be effected by this deficient practice. The Landry staff will be in-serviced by the Laundry and Housekeeping Supervisor on the appropriate protocol of clean laundry delivery.</p> <p>Housekeeping Supervisor will monitor the delivery of laundry daily x 4 weeks then weekly times 5 months to ensure deficient practice</p>	
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	<p>sink uncovered.</p> <p>During an observation of Room 327 on 10/02/2014 at 2:03 p.m., one bath basin remained on the floor under the bathroom sink uncovered. Two residents resided in the room.</p> <p>4. During an observation of Room 322 on 9/30/14 at 10:24 a.m., a bedpan was on the floor under the bathroom sink uncovered.</p> <p>During an observation of Room 322 on 10/2/2014 at 8:37 a.m., a bedpan remained uncovered on bathroom floor under the sink.</p> <p>During an observation of Room 322 on 10/2/2014 at 2:00 p.m., a bedpan remained on the floor under the sink, now in a plastic bag. Two residents resided in the room.</p> <p>On 10/2/2014 at 2:09 p.m., during a brief tour of the above rooms with the D Wing Unit Manager (UM), she indicated personal care equipment including bath basins and bedpans should not be stored on the floor or uncovered.</p> <p>During a follow up interview with the DON on 10/03/2014 at 11:12 a.m. regarding uncovered basins and bedpans,</p>		<p>does not reoccur.</p> <p>The Housekeeping and Laundry Supervisor will add a Monitoring Form to do visual checks daily and then weekly checks to include the monitoring of this deficient practice. Please see attached.</p> <p>The findings will be brought to QAPI each month for 6 months to ensure there are no further laundry delivery issues.</p> <p>Date of Completion: November 2, 2014</p>	

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	<p>she indicated staff should be placing those personal care items in a plastic bag, labeled with the resident's name and then in a storage area such as the bedside table.</p> <p>The DON provided a policy on Infection Control Program Guidelines - Patient/ Resident Care on 10/3/14, deemed as current and applicable to resident personal care items. The policy indicated, "Policy: It is the policy of this facility to appropriately handle patient/ resident care use items and body/ blood fluids as potentially hazardous per the Bloodborne Pathogens Standard definitions ... Bagging of articles: Objects that are contaminated with potentially infectious materials shall be placed in an impervious bag ..." The DON further indicated there was no specific policy regarding the distribution of clean linens.</p> <p>5. During an observation on 9/29/14 at 10:30 a.m. on the D Wing, the clean laundry cart was observed outside Room 322. The leg of a fabric doll on the bottom shelf was dragging on the floor as the cart was being pushed down the hallway by staff. The lower shelf items were not covered and the sheet covering the top shelf of hanging clothes was left pulled up.</p>			

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F000463 SS=D	<p>On 10/03/2014 at 8:45 a.m., an interview with the Laundry/ Housekeeping Supervisor indicated the rolling carts distribute only clean laundry. A white sheet should be used to cover both the top hanging clothes and the lower shelf area of bigger items such as comforters &amp; bedding. Items should definitely not be dragging on the floor.</p> <p>During the Infection Control interview on 10/3/10 at 10:00 AM with the Director of Clinical Education (DCE) and Director of Nursing (DON), the DCE indicated housekeeping and laundry staff are inserviced upon hire and periodically on facility infection control practices. The DON indicated personal care items should not be stored uncovered or on the floor and clean laundry should be covered and positioned fully on the laundry cart.</p> <p>3.1-18(a) 3.1-19(g)(2)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation and interview, the</p>	F000463	F 463 Maintenance	11/02/2014			

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	<p>facility failed to ensure residents were provided a functioning call system device at the bedside for 1 of 40 residents whose call lights were observed. (Resident #9)</p> <p>Findings include:</p> <p>On 9/29/2014 at 3:20 p.m., an observation was made in Room 330-1 with Resident #9. The call light system failed to function properly after several attempts by the resident. When the call button was pressed the light failed to illuminate; the call light also failed to alert at the Nursing station.</p> <p>Interview with LPN #2 on 9/29/14 at 3:22 p.m., indicated staff was not aware Resident #9's call light system was not working properly. Maintenance was immediately called to replace the call light at the time.</p> <p>Interview with the Maintenance Director on 10/03/2014 2:40 p.m., indicated random quarterly room checks are done and room 330 was last checked, including the call system, on 9/4/14.</p> <p>3.1-19(u)(1)</p>		<p>The call light bulb was changed out immediately by the Maintenance Director.</p> <p>All residents who actively use call lights have potential to be effected by this deficient practice. The call lights will be monitored on a daily basis for proper functioning and illumination. 10% of call lights will be checked on each unit daily for 4 weeks then weekly for 3 months then back to regular Quarterly checks.</p> <p>A line item will be added to the Daily Rounding Sheet to include the monitoring of the function and illumination of the call lights. Please see attached.</p> <p>The Maintenance Supervisor will bring the findings of the call light rounding to QAPI for a period of 6 months to ensure there are no patterns of deficiency and that the call lights are properly monitored.</p> <p>Date of Completion: November 2, 2014</p>	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a functional and safe environment related to marred walls and doors, gouged walls, rusted heating units, stained call light cord, chipped paint, ripped couch, and loose base boards throughout the facility. (C Wing, D Wing and Alzheimer's Care Unit (ACU/B Wing).</p> <p>Findings include:</p> <p>During an environmental tour with the Maintenance Director and Housekeeping Supervisor on 10/3/14 at 9:45 a.m. through 10:30 a.m., the following was observed:</p> <p>1. B Wing ACU Lodge</p> <p>a. Room 105-1: The floor tiles were cracked in between the beds in the center of the room. The bottom of the bathroom door was marred. Two residents resided in the room.</p> <p>b. Room 117-2: The inside bottom of the bathroom door was marred. The walls in</p>	F000465	<p>F 465 Maintenance</p> <p>The floor tiles, marred doors, gouged walls, ajar door, heating unit cover, heating unit rusted, call light cord, closet doors, chipped paint, foot board of bed, baseboard, ripped couch, door jam marred, faucet rusted, hole in bathroom floor, and sink caulking were all repaired or replaced. 28 of the 128 residents were effected by this deficient practice.</p> <p>All residents have the potential to be effected by this deficient practice. The Maintenance Director will be doing daily environmental rounding with specific focus on doors, wall, tiles and heating units. 10% of all rooms on each unit will be monitored daily for 4 weeks then weekly for 5 months and then Quarterly thereafter.</p> <p>A line item will be added to the Daily Rounding Sheet to monitor these environmental issues (Please see attached form). ACE Rounding will be discussed each morning in Stand up to notify Maintenance Director of the need to repair as well our staff has been in-serviced to put any items found deficient into</p>	11/02/2014
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	<p>the bathroom were gouged. Two residents resided in the room.</p> <p>c. Room 120-1: The bathroom door would not close. Two residents resided in the room.</p> <p>d. Garage Room: The bottom of the heating unit was missing.</p> <p>2. B Wing ACU Cottage</p> <p>a. Room 123-1: The heating unit was rusted. The walls in the bathroom were gouged. Two residents resided in the room.</p> <p>b. Room 124-1: The emergency call light cord in the bathroom had a dark color throughout the cord. There was a crack in the floor tile from the closet to the door by bed 2. Two residents resided in the room.</p> <p>c. Room 125-2: The bottom of the closet door had a corner missing. The heating unit had chipped paint. The foot board of the bed was chipped. Two residents resided in the room.</p> <p>d. Room 126-1: The baseboard under the bathroom sink was separated from the wall. Two residents resided in the room.</p>		<p>Building Engines within our computer system. Please see attached form and in-service.</p> <p>The Maintenance Director will QAPI for 6 months the findings of this monitoring.</p> <p>Date of Completion: November 2, 2014</p>	

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	<p>e. Lounge Area: The couch was ripped. The heating unit had paint chipped.</p> <p>f. Dining Area/Kitchen: The walls had paint chipped.</p> <p>3. C Wing</p> <p>a. Room 224-1: The walls were marred beside bed 2. Two residents resided in the room.</p> <p>b. Room 228-1: The bathroom door jam was marred. Two residents resided in the room.</p> <p>c. Room 232-1: The bathroom faucet was rusted. The closet corner was chipped. Two residents resided in the room.</p> <p>4. D Wing</p> <p>a. Room 327-1: The bathroom baseboard was pulled away from the wall. There was a hole in the bathroom floor. Two residents resided in the room.</p> <p>b. Room 330-1: The wall behind bed 1 was marred. The wall had chipped paint by the closet. The closet door had chipped wood. Two residents resided in the room.</p> <p>c. Room 331-1: The bathroom tile was</p>			

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	<p>peeled away from the wall behind the toilet. The baseboard was pulling away from the wall in the bathroom. The corners of the wall were marred across from bed 1. Two residents resided in the room.</p> <p>d. Room 332-2: The bathroom wall tile was pulled away from the wall behind the sink. The sink caulk was cracked and pulled away from the wall. The tile was chipped by bed 1. Two residents resided in the room.</p> <p>Interview with the Maintenance Director and the Housekeeping Supervisor at the time of the tour indicated all above areas were in need of repair or cleaning.</p> <p>3.1-19(f)</p>			