STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-LAPORTE	1700 I ST LA PORTE, IN 46350

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	This visit was for a Recertification and State Licensure Survey. Survey dates: March 31, April 1, 2, 3, and 4, 2014. Facility number: 00023 Provider number: 155062 Aim number: 100289400 Survey team: Yolanda Love, RN-TC Lara Richards, RN Heather Tuttle, RN Cynthia Stramel, RN Census bed type: SNF/NF: 64 Total: 64 Census payor type: Medicare: 5 Medicaid: 54 Other: 5 Total: 64 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April 11, 2014, by Janelyn Kulik, RN.			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review and interview, the facility failed to ensure each resident's preferences were followed related to receiving wheat bread with meals for 1 of 3 residents reviewed for choices of the seven residents who met the criteria for choices. (Resident #45) Findings include: Interview with Resident #45 on 3/31/14 at 11:27 a.m., indicated she preferred to receive wheat bread with her meals, however, had only been receiving white bread with her meals. The record for Resident #45 was reviewed on 4/1/14 at 1:15 p.m. The resident was admitted to the facility on 2/28/13. The resident's diagnoses included, but were not limited to, hypertension, diabetes, and senile dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/13/13, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 indicating her cognition was moderately impaired. On 4/2/14 at 1:20 p.m., the resident was observed in her room seated in her recliner. At the time, she indicated she had been served white bread during lunch and had saved it. An observation of a slice of white bread was made at the time.	F000242	1. Dietary staff were inserviced on 4.23.14 on the need to follow the meal tickets for each resident. The DSM (or designee) will randomly monitor compliance to resident preferences through direct observation (no less than 5 meals per week) and document the results of those observations. (Test Tray Evaluation form attached) 2. All residents had the potential to be affected by the alleged negligent practice. 3. Test Tray Evaluation form will be reviewed by the Executive Director on a weekly basis to ensure that resident preferences are being honored. 4. The Executive Director will monitor compliance through review of the Test Tray Evaluation Forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly. 5. 5/2/2014	05/02/2014

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	On 4/4/14 at 8:24 a.m., the resident was observed seated at the table in the main dining room, at the time she indicated she had eaten all of her meal except the white bread she was served. An observation of the residents plate at the time indicated she had eaten all of her meal except a slice of white bread. Interview with the resident on 4/3/14 at 2:44 p.m., indicated she was served white bread during lunch. Interview with LPN #1 on 4/3/14 at 10:50 a.m., indicated the facility staff were aware of the resident's preference to receive wheat bread with her meals. She further indicated the resident's meal preferences could be found on her meal ticket. Interview with the Registered Dietitian on 4/3/14 at 11:00 a.m., indicated a meal ticket for each resident was populated with each meal. The meal ticket indicated the resident's dislikes and what item to substitute it with. Review of Resident #45's meal ticket indicated she dislikes white bread and the white bread should be substituted with wheat bread.			
F000248 SS=D	3.1-3(u)(1) 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each			

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	resident. Based on observation, record review and interview, the facility failed to provide activities for a dependant resident for 1 of 1 residents reviewed of the 1 residents who met the criteria for activities. (Resident #15) Findings include: The following observations were made of Resident #15: On 4/2/14 at 9:45 a.m., the resident was in her room, seated in a recliner with her eyes closed and her feet elevated, the TV was on. On 4/2/14 at 1:00 p.m., she was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 2:23 p.m., she was in her recliner with her eyes closed, the TV or radio was not on. On 4/3/14 at 7:00 a.m., the resident was in her room sitting in her wheelchair, the TV was on. On 4/3/14 at 9:55 a.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 11:00 a.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 12:00 p.m., the resident was in the assisted dining room for lunch. On 4/2/14 at 1:22 p.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 2:30 p.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 3:00 p.m., the resident was in	F000248	1. Unable to correct the missing documentation for 1:1 activities provided for resident #15 for January, February, and March of 2014. Resident's plan of care was reviewed per Activities Director (AD) and updated to better reflect her current activity needs based on her advanced disease process. 2. Plan of care for all residents requiring 1:1 activities were reviewed and updated as needed per the AD to ensure that interventions reflect current activity needs of each resident. AD reviewed all current 1:1 logs to ensure that each resident requiring 1:1 visits had a participation record in place to document activities provided. 3. Activities staff re-inserviced on providing appropriate activities for all residents (attachment "Activity Orientation Refresher Training) and documentation requirement for activity participation (attached"Recreation Participation Record" and "Documentation Training"). An attendance log for weekend managers was developed to record activity participation when Recreation staff is not available (attachment "Weekend Activity sheets) Weekend mangers were inserviced on completion of the	05/02/2014

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	her recliner with her eyes closed, the TV or radio was not on. The record for Resident #15 was reviewed on 4/1/14 at 1:28 p.m. The resident was admitted to the facility on 3/16/11. The resident's diagnoses included, but were not limited to, Alzheimer's dementia. The Quarterly Minimum Data Set (MDS) Assessment dated 3/20/14 indicated the resident was rarely or never understood due to severe cognitive deficit. Her functional status required two person assistance for transfers. A care plan dated 3/7/13 indicated the resident needed considerable assistance to participate in activities, and she did better in small groups. The goal was for the resident to be accepting of activities such as hand holding, hand massages with lotion, and simple games. The approaches included, transporting the resident to an activity just prior to the beginning of the program, provide shorter durations of an activity, and offer calming activities and soft music. An Activity Progress Note dated 10/2/13 indicated the resident needed total assistance to participate in activities and did best with small groups and 1:1 (one on one) sensory activities that did not require cognitive input. She should be seated outside of groups so she could see the entertainment, but that it was not too loud. Review of the activity logs for January, February and March of 2014 indicated the resident had attended an entertainment event only one time per month. There was no documentation of 1:1's, music groups,		Weekend Activity sheets per the AD. 4. AD to review all 1:1 Recreation Participation Records and 10% of all other residents participation logs weekly (attachment "Weekly Audit Participation Logs") and compare attendance lists from group activities on a weekly basis to ensure activities are being provided and accurately documented to meet the interests and physical, mental and psychosocial well being of each resident. Executive Director to randomly audit 10% of participation logs weekly. AD or designee will present findings of the audits to QAA committee monthly. QAA committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. 5. 5/2/2014	

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	manicures, television or radio, or any other activities recorded. Interview with Activity Director on 4/2/14 at 9:45 a.m., indicated she did 1:1 activities with the resident 2 or 3 times a week. She indicated the facility provided live entertainment 3-4 times a month for the residents. She indicated she would do hand massage, play music, or doll play with the resident. The Activity Director indicated she had played doll with the resident the previous day, and gave her a hand massage last week. She indicated she did not document the activities. Further interview with the Activity Director on 4/4/14 at 9:50 a.m., indicated the resident was often put back to bed after meals and it was difficult to get her back up for entertainment events.			
F000280 SS=A	3.1-33(a) 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal			

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	representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure a resident's responsible party was informed of the resident's care plan conferences for 1 of 1 residents reviewed for participation in care planning of the 1 resident who met the criteria for participation in care planning. (Resident #71) Findings include: Interview with Resident #71's responsible party member on 3/31/14 at 7:01 p.m., indicated that he had not attended a care plan conference for the resident nor received notice about a care plan conference. The record for Resident #71 was reviewed on 4/1/14 at 1:11 p.m. Review of the Care Plan Conference sign in sheets dated 7/9/13 and 10/1/13, indicated the sheet had not been signed by the resident's responsible party. Interview with the Social Service/Admissions staff member on 4/3/14 at 10:51 a.m., indicated residents and their family members were notified by the MDS (Minimum Data Set) Coordinator when the care plan conferences were to be held. Interview with the MDS Coordinator on 4/3/14 at 11:00 a.m., indicated families and residents were notified via a letter when the care plan conferences were going to be held. She indicated they were in transition for awhile and notification letters were not being sent out, but they have recently started doing	F000280	1. An invitation was sent to resident #71's responsible party on 4/18/2014 with care plan meeting scheduled for 4/23/2014. 2. All residents and/or their responsible party member had the potential to be affected per the deficient practice. All residents who are due for a care plan review/revision going forward from the date of the identified deficient practice (4/4/14) will be invited to participate, in person, per the MDS Coordinator and family members will be invited via US Mail. 3. A monthly calendar of all residents who are due for care plan development/revision is to be provided to all department heads per the MDS Coordinator. The MDS Coordinator will send an invitation letter to all the families of the residents due and provide a list to the Director of Nursing Services of all families invited/attending. If a family has not responded to the letter the MDS Coordinator will then do follow-up phone call to ensure the invitation has been received prior to the scheduled meeting. 4. Care Plan calendar will be reviewed every Monday in the daily stand-up meeting to ensure all residents who are due for Care Pan reviews for upcoming week been	05/02/2014

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	this again. She then indicated, if the resident's were cognitively impaired, they either phone the family or send a letter. She further indicated there was no documentation to indicate if Resident #71's family was notified of her previous care plan conferences.		invited and have responded to invitation. MDS Coordinator will present any issues identified monthly to the QAPI Committee for review. 5. 5/2/2014	
F000282 SS=D	3.1-35(c)(2)(C) 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 the resident's plan of care was followed related to anticoagulant therapy and activities for 1 of 3 residents reviewed for non pressure skin issues of the 5 residents who met the criteria for non pressure skin issues and for 1 of 1 residents reviewed for activities of the 1 resident who met the criteria for activities. (Residents #15 and #29) Findings include: 1. On 4/01/14 at 9:08 a.m., Resident #29 was observed in bed. At that time, the resident was wearing a short sleeved shirt. There was a blue/purple bruise noted to her left upper arm. On 4/1/14 at 1:21 p.m., the resident was observed in bed. At that time, the resident was wearing a short sleeved shirt. There was a blue/purple bruise noted to her left upper arm.	F000282	1. Bruise to resident #29 was measured per LPN #1, nurse practioner was notified and a "Wound Evaluation Flow Sheet" **(Attachment "Wound Evaluation Flow Sheet")** was completed to ensure on-going monitoring of the area. Unable to correct the missing documentation for 1:1 activities provided for resident #15 for January, February, and March of 2014. Resident's plan of care was reviewed per Activities Director (AD) and updated to better reflect her current activity needs based on her advanced disease process. 2. A facility wide audit was conducted per the Unit Managers (UM), Assistant Director of Nursing (ADNS), and the Director of Nursing Services (DNS) to identify any other residents with skin issues not	

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	On 4/2/14 at 7:30 a.m., the resident was observed in bed. At that time, she was asked to pull up her shirt sleeve. There was a blue/purple bruise noted to her left upper arm. On 4/2/14 10:45 a.m., the resident was observed sitting up in her wheelchair. At that time, there was a blue/purple bruise noted to her left upper arm. On 4/2/14 at 10:55 a.m., LPN #1 was asked to perform a skin assessment to the resident's left arm. She indicated at that time, she drew the resident's blood in that same spot on Monday 3/31/14. She indicated she did not see a bruise after she performed the blood draw, but was off work the next day. The LPN indicated at that time, she was unaware of the bruise and no staff had informed her of the bruise. The LPN indicated the protocol for assessing and monitoring bruises was to measure the bruise and document it on the non pressure ulcer sheet. Then monitor the bruise weekly until healed. The LPN took measurements of the bruise at that time. The bruise was described as dark purple and yellow and measured 2 centimeters (cm) by 4 cm. The record for resident #29 was reviewed on 4/1/14 at 1:25 p.m. The resident was admitted to the facility on 2/28/14. The resident's diagnoses included, but were not limited to, hypotension, tachycardia, muscle weakness, hypothyroidism, lower limb amputation below the knee, and acute osteomyelitis.		previously identified or monitored with no other issues noted. Plan of care for all residents requiring 1:1 activities were reviewed and updated as needed per the AD to ensure that interventions reflect current activity needs of each resident. AD reviewed all current 1:1 logs to ensure that each resident requiring 1:1 visits had a participation record in place to document activities provided. 3. Licensed Nursing staff to be re-inserviced related to skin assessment procedures, completion of the Wound Evaluation Flow sheet and continued monitoring of areas identified **(see attachments, "Wound Evaluation Flow Sheet," and "Skin Assessment Guidelines").** CNAs to be re-inserviced related to observing daily for changes in skin integrity and reporting to the nurses any changes noted (**Attachment "Know your Skin- CNA Education").** The Unit Mangers will assess all residents who have had labs drawn weekly to ensure all non-pressure related skin conditions are identified, assessed, documented on the "Wound Evaluation Flow sheet" and monitored weekly. The UM will also assess 10% of the other residents weekly x 4 weeks and then monthly to ensure all non-pressure related skin conditions are identified,	

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	Review of Physician Orders dated 3/31/14 indicated Coumadin (an anticoagulant) 8 milligrams(mg) daily. Review of the current care plan dated 3/2/14 indicated the resident was at risk for bleeding/bruising related to the use of Coumadin every night. The Nursing approaches were to observe for signs and symptoms of bleeding such as bruising. Interview with the Director of Nursing on 4/2/14 at 2:00 p.m., indicated there was a protocol for monitoring and assessing bruises in which Nurses were to assess, document and monitor all bruises that were identified. 2. The following observations were made of Resident #15: On 4/2/14 at 9:45 a.m., the resident was in her room, seated in a recliner with her eyes closed and her feet elevated, the TV was on. On 4/2/14 at 1:00 p.m., she was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 2:23 p.m., she was in her recliner with her eyes closed, the TV or radio was not on. On 4/3/14 at 7:00 a.m., the resident was in her room sitting in her wheelchair, the TV was on. On 4/3/14 at 9:55 a.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 11:00 a.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 12:00 p.m., the resident was in the assisted dining room for lunch. On 4/2/14 at 1:22 p.m., the resident was in		assessed, documented on the "Wound Evaluation Flow sheet" and monitored weekly. The DNS will complete weekly rounds of all residents who have had labs drawn and random monthly rounds of other residents in the facility. Activities staff re-inserviced on providing appropriate activities for all residents (attachment "Activity Orientation Refresher Training) and documentation requirement for activity participation (attached"Recreation Participation Record" and "Documentation Training"). AD to review all 1:1 Recreation Participation Records and 10% of all other residents participation logs weekly (attachment "Weekly Audit Participation Logs") and compare attendance lists from group activities on a weekly basis to ensure activities are being provided and accurately documented to meet the interests and physical, mental and psychosocial well being of each resident. Executive Director to randomly audit 10% of participation logs weekly. 4. DNS or designee will present findings of the Skin assessment audits to QAA committee monthly. QAA committee to review for any	

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	her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 2:30 p.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. On 4/2/14 at 3:00 p.m., the resident was in her recliner with her eyes closed, the TV or radio was not on. The record for Resident #15 was reviewed on 4/1/14 at 1:28 p.m. The resident was admitted to the facility on 3/16/11. The resident's diagnoses included, but were not limited to, Alzheimer's dementia. The Quarterly Minimum Data Set (MDS) Assessment dated 3/20/14 indicated the resident was rarely or never understood due to severe cognitive deficit. Her functional status required two person assistance for transfers. A care plan dated 3/7/13 indicated the resident needed considerable assistance to participate in activities, and she did better in small groups. The goal was for the resident to be accepting of activities such as hand holding, hand massages with lotion, and simple games. The approaches included transporting the resident to an activity just prior to beginning of program, provide shorter duration of an activity, and offer calming activities and soft music. An Activity Progress Note dated 10/2/13 indicated the resident needed total assistance to participate in activities and did best with small groups and 1:1 (one on one) sensory activities that did not require cognitive input. She should be seated outside of groups so she can see the entertainment, but that it was not too loud.		trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. AD or designee will present findings of the Recreation log audits to QAA committee monthly. QAA committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. 5. 5/2/2014	

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	Review of the activity logs for January, February and March of 2014 indicated the resident had attended an entertainment event only one time per month. There was no documentation of 1:1's, music groups, manicures, television or radio, or any other activity recorded. Interview with Activity Director on 4/2/14 at 9:45 a.m., indicated she did 1:1 activities with the resident 2 or 3 times a week. She indicated the facility provided live entertainment 3-4 times a month for the residents. She indicated she would do hand massage, play music, or doll play with the resident. The Activity Director indicated she had played doll with the resident the previous day, and gave her a hand massage last week. She indicated she did not document the activities. Further interview with the Activity Director on 4/4/14 at 9:50 a.m., indicated the resident was often put back to bed after meals and it was difficult to get her back up for entertainment events.			
F000309 SS=D	3.1-35(g)(2) 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	F000309	1. Bruise to resident #21 was measured per the DNS, nurse practitioner was notified and a	

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	interview, the facility failed to ensure an ongoing assessment and monitoring of bruises was completed for 2 of 3 residents reviewed for skin conditions (non-pressure related) of the 5 who met the criteria for skin conditions (non-pressure related). (Residents #21 and #29) Findings include: 1. On 3/31/14 at 11:00 a.m. and on 4/1/14 at 9:29 a.m. and 1:55 p.m., Resident #21 was observed with a large area of fading purplish bruising to the top of her right hand. On 4/2/14 at 8:41 a.m., the fading bluish/purple bruise was observed to the top of the resident's right hand. The record for Resident #21 was reviewed on 4/1/14 at 2:00 p.m. A Physician's order dated 3/26/14, indicated the resident was to have blood drawn on 3/27/14. The Weekly Skin Assessment dated 3/31/14 at 2:06 p.m., indicated the resident's skin was warm, dry, and natural in color with no bruises, rashes, skin tears or excoriations noted. Interview with LPN #2 on 4/2/14 at 10:55 a.m., indicated the area to the resident's right hand was from an old lab draw that never healed. She indicated the area was not new. The resident indicated at the time, that her blood draw last week was from that hand. On 4/3/14 at 11:52 a.m., the resident was observed with a dime sized area of purplish discoloration to the top of her left hand. The		"Wound Evaluation Flow Sheet" **(Attachment "Wound Evaluation Flow Sheet")** was completed to ensure on-going monitoring of the area. Bruise to resident #29 was measured per LPN #1, nurse practioner was notified and a "Wound Evaluation Flow Sheet" **(Attachment "Wound Evaluation Flow Sheet")** was completed to ensure on-going monitoring of the area. 2. A facility wide audit was conducted per the Unit Managers (UM), Assistant Director of Nursing (ADNS), and the Director of Nursing Services (DNS) to identify any other residents with skin issues not previously identified or monitored with no other issues noted. 3. Licensed Nursing staff to be re-inserviced related to skin assessment procedures, completion of the Wound Evaluation Flow sheet and continued monitoring of areas identified **(see attachments, "Wound Evaluation Flow Sheet," and "Skin Assessment Guidelines").** CNAs to be re-inserviced related to observing daily for changes in skin integrity and reporting to the nurses any changes noted (**Attachment "Know your Skin- CNA Education").** The Unit Mangers will assess all residents who have had labs drawn weekly to ensure all non-pressure	

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	resident indicated they drew blood from her last night. The area of dark discoloration with fading purple bruising to the area around her thumb was observed on the resident's right hand. On 4/4/14 at 9:05 a.m., the dime sized area of dark purple bruising to the top of the resident's left hand remained. The area of fading bruising around thumb to the resident's right hand remained. Additional record review on 4/4/14 at 8:45 a.m., indicated the last documented entry in the Nursing progress notes was on 4/2/14. There was no documentation related to the bruising on the resident's left hand. Interview with the Director of Nursing (DoN) on 4/4/14 at 9:05 a.m., indicated the resident did have an area of bruising to the top of her left hand that she was not aware of. She also indicated the resident had some faint bruising to her right hand which was from a previous lab draw. The DoN indicated when a bruise was observed, the physician was to be notified and a skin sheet was to be initiated. An entry in the Nursing Progress Notes dated 4/4/14 at 9:17 a.m., completed by the DoN, indicated the following: "resident noted to have a fading bruise to right lateral extending to medial posterior hand measuring 7 centimeters (cm) x 6 (cm) related to lab draw. Resident with no complaints of pain or discomfort to area, states she did not even know it was there. She is also noted to have a 2.0 cm x 1.5 cm purple bruise to her left lateral hand that she states "got stuck" but unable to remember what she got stuck on. NP (Nurse Practitioner) notified with no new		related skin conditions are identified, assessed, documented on the "Wound Evaluation Flow sheet" and monitored weekly. The UM will also assess 10% of the other residents weekly x 4 weeks and then monthly to ensure all non-pressure related skin conditions are identified, assessed, documented on the "Wound Evaluation Flow sheet" and monitored weekly. The DNS will complete weekly rounds of all residents who have had labs drawn and random monthly rounds of other residents in the facility. 4. DNS or designee will present findings of the audits to QAA committee monthly. QAA committee to review for any trends or patterns (3 deficient practices in 1 month will be considered a trend/pattern) and make recommendations. 5. 5/2/2014	

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	orders and daughter notified." 2. On 4/01/14 at 9:08 a.m., Resident #29 was observed in bed. At that time, the resident was wearing a short sleeved shirt. There was a blue/purple bruise noted to her left upper arm. On 4/1/14 at 1:21 p.m., the resident was observed in bed. At that time, the resident was wearing a short sleeved shirt. There was a blue/purple bruise noted to her left upper arm. On 4/2/14 at 7:30 a.m., the resident was observed in bed. At that time, she was asked to pull up her shirt sleeve. There was a blue/purple bruise noted to her left upper arm. On 4/2/14 10:45 a.m., the resident was observed sitting up in her wheelchair. At that time, there was a blue/purple bruise noted to her left upper arm. On 4/2/14 at 10:55 a.m., LPN #1 was asked to perform a skin assessment to the resident's left arm. She indicated at that time, she drew the resident's blood in that same spot on Monday 3/31/14. She indicated she did not see a bruise after she performed the blood draw, but was off work the next day. The LPN indicated at that time, she was unaware of the bruise and no staff had informed her of the bruise. The LPN indicated the protocol for assessing and monitoring bruises was to measure the bruise and document it on the non pressure ulcer sheet. Then monitor the bruise weekly until healed.			

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	The LPN took measurements of the bruise at that time. The bruise was described as dark purple and yellow and measured 2 centimeters (cm) by 4 cm. The record for resident #29 was reviewed on 4/1/14 at 1:25 p.m. The resident was admitted to the facility on 2/28/14. The resident's diagnoses included, but were not limited to, hypotension, tachycardia, muscle weakness, hypothyroidism, lower limb amputation below knee, and acute osteomyelitis. Review of Physician Orders dated 3/31/14 indicated Coumadin (an anticoagulant) 8 milligrams(mg) daily. Review of the skin conditions on the nursing admission assessment dated 2/28/14 indicated the resident was admitted to the facility with some bruising to her abdomen. Review of the current care plan dated 3/2/14 indicated the resident was at risk for bleeding/bruising related to the use of Coumadin every night. The Nursing approaches were to observe for signs and symptoms of bleeding such as bruising. Review of the non pressure wound sheets for the months of March and April 2014 indicated there was no evidence a form had been completed for the bruise to the left upper arm. Review of Nursing Progress Notes dated 3/24/14 at 2:06 p.m. indicated weekly skin assessment. Resident has no new reddened or open areas over bony prominence. Continued review of Nursing Notes dated 3/31/14 at 5:51 p.m.,			

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	indicated resident's skin is warm and dry and the skin turgor was elastic. There was no edema noted and no skin tears, bruises, rashes, or excoriated areas noted. Continued review of Nursing Notes from 3/31-4/2/14 indicated there was no documentation of any assessment of the resident's bruise to her left upper arm. Review of the current 8/04 Skin Assessment Guidelines provided by the Director of Nursing on 4/4/14 at 10:04 a.m., indicated "If an area is identified the following will occur: The nurse must assess the area and document the assessment in the medical record. The nurse will complete a pressure ulcer and/or non pressure ulcer sheet." Interview with the Director of Nursing on 4/2/14 at 2:00 p.m., indicated there was a protocol for monitoring and assessing bruises in which Nurses were to assess, document and monitor all bruises that were identified.			
F000323 SS=D	3.1-37(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interviews the facility failed to ensure the hot water temperatures in the residents' rooms were between 100 and 120 degrees Fahrenheit for 1 of 1 Units. This had the potential to affect 2 of the 64 residents who resided in the facility.	F000323	1. Maintenance was immediately called to rooms 7 and 18 to check the water temperature. Adjustments were made to the hot water heater to ensure that the water temperature in all rooms was between 100-120. The Maintenance Director was taught how to calibrate an analogue	

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	Findings include: On 3/31/2014 at 2:09 p.m., the hot water was hot to touch in room 7. At that time, a temperature of the hot water was obtained in which it was 145 degrees Fahrenheit. There was one resident who resided in this room. On 3/31/2014 at 2:15 p.m., the hot water was hot to touch in room 18. At that time, a temperature of the hot water was obtained in which it was 140 degrees Fahrenheit. There was one resident who resided in this room. On 3/31/14 at 2:50 p.m., the Environmental Supervisor obtained a hot water temperature from room 7 in which he obtained a reading of 122 degrees Fahrenheit. The hot water temperature was then obtained from room 18 in which the Environmental Supervisor obtained a reading of 110 degrees Fahrenheit. On 3/31/14 at 3:10 p.m., a hot water temperature reading was obtained in both rooms with a different thermometer in which both readings indicated 140 degrees Fahrenheit. On 3/31/14 at 3:40 p.m., a hot water temperature reading was obtained in both rooms with the same thermometer used during the temperature reading obtained at 3:10 p.m., the water temperatures were below 120 degrees Fahrenheit. On 3/31/14 at 4:10 p.m., the Daily Water Temperature Log dated 2/1/14 to 3/30/14 was reviewed. The log indicated all room water temperatures were below 120 degrees Fahrenheit.		thermometer by the Executive Director. 2. No significant resident impact was noted. 3. Water temperatures will continue to be monitored on a daily basis by maintenance and recorded on the Daily Water Temperature Log (example attached). Thermometers will be calibrated weekly and recorded on the Thermometer Calibration Log (attached). The Executive Director (or designee) will randomly monitor the water temperature in three rooms per week. Temps will be recorded on the Guardian Angel rounds form. 4. The Executive Director will monitor compliance through review of the Daily and Weekly Logs. Results of these reviews will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly. 5. 5.2.14	

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	Interview with the Environmental Supervisor on 4/4/14 at 11:45 a.m., the water temperatures were checked daily. He further indicated he does not calibrate his thermometer due to it being analog. On 4/3/14 at 1:21 p.m., during the Environmental Tour the hot water temperatures in the above mentioned rooms were less than 120 degrees Fahrenheit.			
F000371 SS=E	3.1-19(r)(1) 3.1-19(r)(2) 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was served and stored under sanitary conditions related the use of gloves and hairnets, dirty food prep tables, sinks and equipment for 1 of 1 kitchens observed. This had the potential to affect 63 of the 64 residents who obtained meals from the kitchen. (The Main Kitchen) Findings include: 1. On 3/31/14 at 8:55 a.m., during the Brief Kitchen Sanitation Tour with Dietary Cook #1 and Dietary Aide #1 the following was observed:	F000371	1. It was necessary to replace the Dining Service Manager (DSM); the new manager started on Day 2 of the survey. Under her direction, kitchen cleaning is in process. A "cleaning party" was held on April 22, 2014 after the last meal was served. Walls were washed, floors were scrubbed, exhaust fan hood was cleaned, shelving, tables, and equipments were thoroughly cleaned. The task list and the sign-in sheet are attached. An in-service was held on April 14 (materials attached) that covered sanitation and infection control, schedules, resident choices, code of conduct and issues raised by residents in food council. The use	

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	A. There was a moderate amount of black grease/stains on the stove. B. The sides of the stove, fryer and griddle were greasy and dirty. C. The oven hood was covered with large amounts of dust and dirt noted in the slats. D. The foil and pan under the griddle was dirty with food crumbs and hard fried potatoes noted on the pan. Interview with Dietary Aide #1 at that time, indicated the griddle was not used for breakfast today. E. The large whisk like beater to the stand mixer was dirty with dried food noted on it. F. The utility sink was very dirty on the inside and outside. G There was food splattered on the back food prep table. There were two electric outlets located on the floor and behind the food prep table that had a large amount of food and dirty adhered to the floor surrounding the base of those outlets. H. There was a large amount of dirt and food debris noted behind the stove, griddle and fryer. I. There was a ceiling vent located above the tray line table. The vent had a large accumulation of black dust and dirt noted on the inside and out. J. The floors under the food prep tables, the tray line tables, and the utility sink were dirty with food debris noted. K. Two shelves located by the food serving		and importance of the Daily, Weekly, and Monthly Checklists (attached) was reinforced with the staff. Staff who are serving from a steam table have been instructed to always wear a hair net when serving. The Executive Director and Dietary Service Manger will make random observations to ensure compliance. 2. No direct resident impact was noted. 3. Checklists will be monitored for completion and accuracy, by the Dining Service Manager (or designee), no less than 5 times per week, using the Daily Start-up Checklist (attached) and will be ongoing. The Executive Director (or designee) will make weekly rounds of the kitchen and storeroom for 90 days to monitor cleanliness (monitoring tool attached). 4. The Executive Director will monitor compliance through review of all audits and checklists. Results of these reviews and rounds will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly. 5. 5.2.14	

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	table and where the spices were stored were dusty and greasy. Review of the daily cleaning schedule which included the trash can containers, hand sink, exhaust hood, gas range, work tables, doors, shelves and legs indicated they were to be cleaned daily. Further review of that cleaning schedule indicated the last documented time they were cleaned was on 1/26/14. Review of the weekly cleaning schedule which included the ovens, deep fryers, and the moist heat steam table indicated these items were to be cleaned on a weekly basis. Further review of that cleaning schedule indicated they were last cleaned on 1/23/14. Interview with the Registered Dietitian on 4/3/14 at 11:00 a.m., indicated all of the above was in need of cleaning and or repair. She further indicated the last time the facility had put a plan of action in place after the complaint survey which was completed in November 2013. She indicated she had made thorough cleaning schedules which were being followed, however, after the end of January 2014, there was no documentation to indicate the above items were cleaned as per the plan of correction. 2. On 3/31/14 at 12:00 p.m. during the lunch meal observation in the Main Dining Room, the B and C Wing Unit Manager was observed passing milk, coffee, and water to residents. At that time, the Unit Manager was not wearing a hairnet. At 12:08 p.m., the Unit Manager was observed standing by a portable steam table that was located in the back of the dining room and plugged into the wall. The Unit			

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	Manager was observed to prepare the food from the portable steam table. She used the utensils provided by the kitchen and scooped the food onto each resident's plate. The Unit Manager would prepare a plate and pass the plate to the resident who was seated at the table. At that time, the Unit Manager's hair was noted to be in a hair clip but not restrained with a hairnet. Review of the current 2011 Dining Services Employee Hair Guidelines policy provided by the Registered Dietitian on 4/3/14 at 12:00 p.m., indicated "All staff (whether a Dining Service employee or not) in the preparation area or steam table and meal line area must wear appropriate hair restraints covering all hair." Interview with the Registered Dietitian on 4/3/14 at 12:00 p.m., indicated all staff preparing the meals from the portable steam tables should have their hair restrained. 3. On 4/3/14 at 10:15 a.m., Dietary Cook #1 was observed preparing the mechanical soft diets of baked fish. The cook was observed picking up the cooked fish cutlets with her gloved hands and placing them into the food processor. Prior to picking up the fish she was observed touching other items including the pan, the food processor lid, and tongs. The cook then stopped the food processor and lifted the lid with her gloved hands. At that time, she placed her right gloved hand into the processor and picked up some of the fish that had been separated. The cook indicated the texture was to "mushy" and indicated she was just going to make this the pureed fish and chop up the other fish with a knife for the mechanical soft diets. She then proceeded to pick up four more pieces of fish			

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	with her gloved hands and placed the fish into the food processor and put the lid over it. The Dietary Cook did all of the above with the same pair of gloved hands and did not change the gloves in between. Review of the current 2011 Disposable Gloves policy provided by the Registered Dietitian on 4/3/14 at 11:00 a.m., indicated "Single use, FDA-approved gloves shall be used for only one task: gloves must be worn when touching any food item. Bare hand contact with foods is prohibited, such as working with ready-to-eat foods or with raw animal foods. These gloves should be used for no other purpose and discarded when damaged or soiled or when interruption occurs in the operation. Dining Service Employees should change gloves after touching items, equipment, utensils, trash can lids or soiled work areas and after obtaining additional supplies, equipment, or utensils." Interview with the Registered Dietitian at that time, indicated the Dietary Cook should have changed her gloves after touching the other equipment.			
F000441 SS=D	3.1-21(i)(2) 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. (a) Infection Control Program The facility must establish an Infection			

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	Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and interview the facility failed to maintain infection control policies and standards related to properly storing a resident's urine collection container for 2 rooms in a sample of 35 rooms. (Room #38 and #39) Findings include: On 4/1/14 at 9:34 a.m., the restroom in Room 38 was observed. A urine collection container was observed uncovered and	F000441	1. Residents with no noted negative outcome related to clean, un-used Nun's Cap being stored uncovered on top of paper towel dispenser in bathroom. 2. All residents have the potential to be affected by the same deficient practice. Facility rounds completed per the DNS, ADNS, and UM to identify and correct any other infection control issues noted. 3. Nursing staff to be re-inserviced related to proper storage of urine collection	05/02/2014

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	stored on top of the paper towel dispenser. The restroom was shared with Room 39. Interview with the Director of Nursing (DoN) on 4/4/14 at 12:56 p.m., indicated resident's urine collection containers should not be stored uncovered on top of paper towel dispensers. 3.1-18(j)		containers and infection control (see attachments, " Infection Control Issues" and "Standard Universal Precautions)." The Director of Clinical Education (DCE) or designee to conduct weekly infection control rounds on all 3 shifts (see attached ("**CALL LIGHT/ INFECTION CONTROL/ENVIRONMENTAL ROUNDS" audit tool attachment).** Guardian Angels or designee will also conduct weekly infection control rounds and the DNS will conduct monthly infection control rounds. 4. The DCE will report results of the infection control rounds monthly to the QAA committee for revision of the action plan if any trends or patterns are noted (3 deficient practices in 1 month will be considered a trend). 5. 5/2/2014	
F000463 SS=D	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. Based on observation and interview, the facility failed to ensure residents were provided functioning call system devices at their bedsides, for 1 room in a sample of 35 rooms. (Room #3) Findings include: On 4/01/2014 at 9:25 a.m., an observation was made in Room 3. The call light system	F000463	1. The call light in room 3 was replaced as soon as it was noted to be problematic. 2. No significant resident impact was noted. 3. Call lights will be checked at least on a weekly basis by the assigned Guardian Angel using the attached	

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	failed to function properly. When the call button was pressed the light outside of Room 3 did not illuminate nor did it alert at the nursing station. Interview with the Enviornmental Supervisor at the time indicated he was not aware the call light system was not working properly in Room 3. The call button was immediately replaced and functioning properly. 3.1-19(u)(1)		form. Any lights identified as non-functional, will be immediately repaired/replaced. Monitoring tool and Guardian Angel assignments are attached. 4. The Executive Director or designee will monitor compliance through review of the checklist. Results of these reviews will be reviewed monthly at the QAPI meeting times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly. 5. 5/2/2014	
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the environment was clean and in good repair related to dirty walls, dirty white PVC pipes, food debris under the dish machine, missing floor tile, and dirty ceiling vents for 1 of 1 kitchens. The facility also failed to keep the resident's environment clean and in good repair related to stained ceiling tiles, stained floor tile, chipped paint on the doors and walls, dusty ceiling vents, and urine odors for 3 of 3 units. (The main kitchen and Units A, B, and C) Findings include:	F000465	1. Immediately following the 3.31.14 (Monday) tour by the surveyor, kitchen staff were mobilized and cleaning of items noted during the tour began. Two employees were called in to work on Tuesday specifically to address many of these items. The Maintenance Director and Housekeeping Director also began addressing issues noted. A "cleaning party" was held on April 22, 2014 after the last meal was served. Walls were washed, floors were scrubbed, exhaust fan hood was cleaned, shelving, tables, and	

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	1. On 3/31/14 at 8:55 a.m., during the Brief Kitchen Sanitation Tour with Dietary Cook #1 and Dietary Aide #1 the following was observed: A. There were food crumbs and dirt observed along the baseboard under the dishwashing machine. B. There were two ceiling vents located in the dish room that had a large accumulation of black dirt and dust noted. C. The entire wall under the dish machine was noted with dried food spillage. D. A one foot by four inch piece of floor tile was missing by doorway into dish room. E. The white PVC pipes under the three compartment sink and dish machine were dirty with dried food spillage. The white foam covering the metal pipes under the dish machine was cracked and dirty. F. The outside of the all the garbage cans and their lids were very dirty with dried food spillage noted. G. A ceiling light was noted to be burned out and not functioning. Interview with Dietary Cook #1 and Dietary Aide #1 at that time, indicated all of the above was in need of cleaning and/or repair. 2. On 4/3/14 at 10:15 a.m., during the Full Kitchen Sanitation Tour the following was observed: A. There was six inch piece of baseboard		equipments were thoroughly cleaned. The task list and the sign-in sheet are attached. An in-service was held on April 14 (materials attached) that covered sanitation and infection control, schedules, resident choices, code of conduct and issues raised by residents in food council. The use and importance of the Daily, Weekly, and Monthly Checklists (attached) was reinforced with the staff. Maintenance has addressed chipped door paint, missing tile in the dish room, loose baseboard, stained ceiling tiles, batteries in the carbon monoxide detector, holes in walls/wallpaper, discolored flooring in bathrooms (new VCT ordered; will be installed no later than 5.2.14), and frayed wheel chair arms. Housekeeping addressed soiled floors, vents, and lights. 2. No significant resident impact was noted. Golden Living has a Guardian Angel program to survey/monitor resident rooms. Each member of the management team (including the Executive Director and the Director of Nursing Service) is assigned at least three rooms to survey. Monitoring tools were developed specific to these concerns; all resident rooms are surveyed two times per week. A copy of the monitoring tool is attached. As an additional step, Housekeeping rounds are conducted weekly by the Housekeeping Manager and monthly by the Housekeeping district	

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	peeling away from the wall by the pan storage rack. B The metal pipes behind the stove were greasy, dirty and dusty. C. There were four stained ceiling tiles located in the kitchen area. The entire ceiling frame that in between the drop ceiling tiles was rusty and in need of painting. D. The carbon monoxide detector was beeping and was in need of a battery change. Review of the daily cleaning schedule which included the trash can containers, hand sink, exhaust hood, gas range, work tables, doors, shelves and legs indicated they were to be cleaned daily. Further review of that cleaning schedule indicated the last documented time they were cleaned was on 1/26/14. Review of the weekly cleaning schedule which included the ovens, deep fryers, and the moist heat steam table indicated these items were to be cleaned on a weekly basis. Further review of that cleaning schedule indicated there were last cleaned on 1/23/14. Interview with the Registered Dietitian at that time, indicated all of the above was in need of cleaning and or repair. She further indicated the last time the facility had put a plan of action in place after the complaint survey which was completed in November 2013. She indicated she had made thorough cleaning schedules which were being followed, however, after the end of January 2014, there was no documentation to indicate the above items were cleaned as per the plan of correction.		manager. (copies attached) 3. Room monitoring, via the attached tools, will continue, to prevent a recurrence of the above issues. The Executive Director (or designee) will conduct random reviews of the completed monitoring tools. 4. The results of the room audits will be reviewed 5times/week in the daily morning meeting and will be on-going. Results will also be reviewed monthly at the QA meeting x 90 days. If after 90 days of review no trends or patterns are noted (3 deficient practices per month will be considered a tend/pattern), then results will be reviewed quarterly. 5. 5/2/2014	

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	3. During the Environmental Tour on 4/3/14 at 1:21 p.m., with the Enviornmental Supervisor and the Executive Director (ED), the following was observed: Unit A: a. There were brown stained tiles in Room 1 located near bed 2's night stand. Two residents resided in this room. b. There were discolored floor tiles in Room 3's bathroom near the toilet. Two resident's resided in this room. c. The caulking around the bathroom sink in Room 5 was cracked. Two resident's resided in this room. d. There were two holes in the wall near bed 2 in Room 11. One resident resided in this room. e. There were discolored floor tiles in Room 14's bathroom near the toilet. One resident resided in this room. f. The wallpaper behind bed 2 in Room 16 was torn at the base. There were discolored floor tiles in the bathroom around the toilet. Two resident's resided in this room. Unit B: a. The closet door in Room 26 was marred. One resident resided in this room. b. The toilet paper holder in Room 28 was loose. There was debris in the bathroom's light fixture. Two residents resided in this room.			

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	c. The paint was peeling from the back of the bedroom door in Room 29. One resident resided in this room. d. The bathroom floor in Room 30 was dirty. The bathroom light fixture was dirty/dusty. e. The plastic on the arm of a resident's wheelchair in Room 34 was warn and the white fabric was exposed. Two residents resided in this room. f. The bathroom floor was dirty in Room 36. There was a pink substance spilled in front of the TV near bed 2. Two residents resided in this room. Unit C: a. The ceiling vent in the bathroom in Room 38 was dirty/dusty. The bathroom had an odor of urine. Two residents resided in this room. b. The ceiling vent in the bathroom in Room 40 was dirty/dusty. The white foam over the piping in the bathroom was torn. Two residents resided in this room. c. There was rusty caulking around the base of the toilet in Room 45. The bathroom had an odor of urine. The ceiling vent was dirty/dusty. One resident resided in this room. d. The ceiling vent in the bathroom in Room 46 was dusty/dirty. Two residents resided in this room. e. The ceiling vent in the bathroom in Room 47 was dusty/dirty. Two residents resided in			

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	this room. Interview with ED at this time indicated the above mentioned items were in need of cleaning and or repair.			
F000520 SS=E	3.1-19(f) 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to identify non-compliance of the facility's Kitchen/Sanitation Plan of Corrections (POC)dated 12/15/13 related to the cleaning schedule through the quality assurance	F000520	1. An Adhoc QA&A meeting was held related to kitchen sanitation; the meeting included the new Director of Dining Services (DSM). Survey results were reviewed and an action plan was developed that included a "cleaning party" that was held on 4.22.14. The DSM began daily	

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	protocol. Findings include: Interview with the Executive Director (ED) and the Director of Nursing (DoN) on 4/4/14 at 10:23 a.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, Social Service, Dietary, Activities, Nursing, as well as the Medical Director. The ED indicated at the time, Kitchen/Sanitation related areas such as the POC related to the cleaning schedule had not been discussed, addressed or identified as being a problem in Quality Assurance. On 3/31/14 at 8:55 a.m., during the Brief Kitchen Sanitation Tour with Dietary Cook #1 and Dietary Aide #1 the following was observed: dirty walls, dirty white PVC pipes, food debris under the dish machine, missing floor tile, and dirty ceiling vents. Interview with Dietary Cook #1 and Dietary Aide #1 at that time, indicated all of the above was in need of cleaning and/or repair. On 4/3/14 at 10:15 a.m., during the Full Kitchen Sanitation Tour the following was observed: greasy metal pipes behind the stove, stained ceiling tiles, and the carbon monoxide detector was beeping indicating the battery needed to be changed. Interview with the Registered Dietitian at that time, indicated all of the above was in need of cleaning and or repair. She further indicated the last time the facility had put a plan of action in place after the complaint survey which was completed in November 2013. She indicated she had made thorough		rounds and inspections to ensure that sanitation standards are met. The Executive Director (or designee) conducts weekly kitchen inspections. 2. No significant resident impact was noted. 3. In-servicing of kitchen staff on cleaning procedures and schedules took place on 4.14.14. Daily, Weekly, and Monthly checklists were reviewed with the new DSM prior to the 4.14.14 meeting. 4. The Executive Director will ensure that the DSM presents the results of inspections, rounds, etc. at each QA & A meeting. The committee will monitor the effects of the corrections. 5. 5/2/2014	

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	cleaning schedules which were being followed, however, after the end of January 2014, there was no documentation to indicate the above items were cleaned as per the plan of correction. Review of the daily cleaning schedule which included the trash can containers, hand sink, exhaust hood, gas range, work tables, doors, shelves and legs indicated they were to be cleaned daily. Further review of that cleaning schedule indicated the last documented time they were cleaned was on 1/26/14. Review of the weekly cleaning schedule which included the ovens, deep fryers, and the moist heat steam table indicated these items were to be cleaned on a weekly basis. Further review of that cleaning schedule indicated they were last cleaned on 1/23/14. Review of the POC dated 12/15/13 indicated, "Kitchen cleaning is underway to correct issues noted during and prior to the survey. Maintainance and housekeeping are assisting the dietary dept with this. Training is underway for all dietary staff on proper cleaning protocols and use of the daily, weekly, monthly checklists, to document cleaning activities. Staff are being trained not only on how to successfully complete the items on the checklist but also on how to properly document completion of the checklist items." Interview with the ED on 4/4/14 at 10:55 a.m., indicated she was aware the POC related to the Kitchen/Sanitation's cleaning schedule had not been followed since January 2014. She further indicated it was her responsibility to monitor the Kitchen/Sanitation cleaning schedules to ensure staff were following the			

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	POC. 3.1-52(b)(2)			