STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF VALPARAISO	3405 N CAMPBELL RD VALPARAISO, IN 46385

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: January 20, 21, 22, 23, 26, and 27, 2015 Facility number: 000224 Provider number: 155331 AIM number: 100267700 Survey team: Jennifer Redlin, RN-TC (1/20, 1/21, 1/22, 1/26, 1/27/15) Heather Hite, RN Julie Ferguson, RN Regina Sanders, RN (1/23/15) Census bed type: SNF: 24 SNF/NF: 84 Total: 108 Census payor type: Medicare: 36 Medicaid: 60 Other: 12 Total: 108 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F000000	I respectfully request consideration for paper compliance. I have forwarded additional supportive documentation via fax today (2-12-15) to 1-317-233-7322. Please reference the attached 2567 as "Credible Allegation of Compliance" for our annual survey conducted on January 20-27, 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director	

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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	Quality review completed on January 30, 2015, by Janelyn Kulik, RN.			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to develop a care plan for a resident receiving Aspirin for 1 of 5 residents reviewed for unnecessary medications. (Resident #15) Finding includes: The record for Resident #15 was reviewed on 1/11/15 1:22 p.m.	F000279	F 279 1.Resident #15 had a care plan developed to address the risk of bleeding related to aspirin therapy on 1/27/2015 by the DON. 2.A listing of all residents with orders for aspirin was requested and obtained from Care Pharmacy medical records staff and all residents with aspirin orders had care plans developed for the risk of bleeding with aspirin therapy.	02/20/2015

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	Diagnoses included, but were not limited to, edema, spinal stenosis, difficulty in walking, muscle weakness, dysphagia, pain, hypertension (high blood pressure), anemia, anxiety, coronary artery disease, and stage 3 chronic kidney disease. Review of the Physician's Order Summary dated 1/2015 indicated Aspirin 81 mg chewable tablet po (by mouth) daily for coronary arteriosclerosis (narrowing of the heart artery). The original start date for the Aspirin was 4/30/13. Review of the 1/2015 MAR (Medication Administration Record) indicated the Aspirin was given as ordered. The record lacked a current care plan for Aspirin. Interview with MDS (Minimum Data Set) staff #1 on 1/22/15 at 1:54 p.m., indicated there was not a care plan for Aspirin. 3.1-35(a) 3.1-35(b)(1) .		3.Education regarding the development of care plans to address the risk of bleeding with aspirin therapy will be presented to the Care Plan Coordinators by the Staff Development Coordinator by 2/20/2015. Starting 1/27/2015, new admission orders will be screened by nursing administrative staff on a designated chart audit schedule to determine if aspirin is ordered and care plans for risk of bleeding will be addressed by the auditor on the interim care plan. Upon completion of the admission MDS, the Care Plan Coordinators will place a "risk of bleeding" care plan into the care plan data base for any resident ordered aspirin therapy. Care Pharmacy will provide the facility a listing of all residents with orders for aspirin therapy weekly. Medical Records staff will screen daily telephone orders for new aspirin therapy orders five days per week and alert the Care Plan Coordinator to the presence of the aspirin order so care planning the "risk for bleeding" can be accomplished within the next 48 hours. 4.Audits for the presence of a "risk for bleeding" care plan will be completed twice weekly by the DON or designee for six months. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for	

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			determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 2-20-2015	
F000309 SS=D	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, interview, and record review, the facility failed to ensure each resident received the necessary treatment and services related to assessment upon return from dialysis for 1 of 1 residents reviewed for dialysis of the 2 residents who met the criteria for dialysis and related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 5 residents who met the criteria for non pressure related skin conditions. (Residents #110 and #44) Findings include:	F000309	F 309 1.Resident #44 was assessed by licensed nursing staff on 1/22/15. Any areas of bruising were measured and documented in the clinical record and on the Non-Pressure Skin Condition Record. Change of condition charting for 72 hours was initiated, the POA and physician were notified and her care plan was updated to include the information regarding her bruising by the DON on 1/22/2015. Resident #110 was assessed using the Pre and Post Dialysis Form on Wednesday 1/28/2015 and 1/30/2015. 2.Nursing administrative staff	02/20/2015

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	1. During an observation of Resident #44 on 1/21/15 at 9:18 a.m., discolored purplish areas were noted to the back of both hands and a dark puffy area to the right thumb. At the time of the observation, Resident #44 indicated her skin was very sensitive and "holding on to the princess lift will do that." During an observation of Resident #44 on 1/22/15 at 3:08 p.m., dark purple discolored areas were noted to the back of both hands and a deep puffy area to the right thumb. She indicated at that time she also had bruises on both arms, but was unable to pull her sleeves up to visualize. During an interview with LPN #1 on 1/22/15 at 3:44 p.m., she checked Resident #44's Treatment Administration Record (TAR), progress notes and chart plus the unit skin book and indicated staff was not currently charting any skin concerns right now for the resident. At that time, an observation of Resident #44 was done with LPN #1 and she indicated she was unaware of the bruising to her hands. She further indicated the bruising should have been reported by the aide giving daily care and should have been charted on. Geri sleeves were on but pulled up and the resident refused to pull		will perform head to toe skin inspections by 2/20/2015 on all current facility residents to identify any unreported areas of concern such as bruising, skin trauma or skin breakdown. A skin integrity data collection tool will be utilized to document the resident skin assessment was done and document any symptoms of skin injury or skin breakdown. Appropriate follow-up will be completed immediately for any areas identified. After 2/20/2015, nursing administrative staff will audit new admissions for accuracy of skin assessments using the initial admission skin inspection and comparing that data to a skin inspection for that resident. Any negative findings will be addressed with re-education and or discipline. There is only one other resident in the facility at this time who receives dialysis services. His chart was reviewed by the DON and all Pre and Post Dialysis Communication information was completed by facility staff as per policy. 3.The Staff Development Coordinator and DON developed training on Skin Assessments and the role of all nursing staff in observing for skin changes; reporting any findings to the nurse for follow-up and the utilization of the Pre and Post Dialysis Communication Form with every dialysis transfer. This training was provided to nursing	

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	them over her hands. The resident indicated "It's from the princess lift." During an interview with the Director of Nursing (DON) on 1/23/15 at 1:42 p.m., she indicated CNAs and nursing staff were instructed to inspect skin with daily care in addition to weekly skin checks by a licensed nurse. She would have hoped that someone would have noticed the bruise to Resident #44's thumb, but no staff recalled seeing anything when questioned by the DON. She further indicated the other spots to her arms and the back of her hands were purpura per the Physician. Resident #44's record was reviewed on 1/22/15 at 3:03 p.m. Diagnoses included, but were not limited to, muscular wasting and disuse atrophy, muscle weakness, abnormal gait, thoracic or lumbosacral neuritis, and diabetes mellitus. The annual Minimum Data Set (MDS) assessment dated 12/22/14 indicated Resident #44 was cognitively intact. Review of weekly skin sheets indicated the last assessment was completed on 1/18/15 and Resident #44's skin was intact. Review of the unit skin book indicated a		staff by the Staff Development Coordinator by 2/20/2015. 4.The DON and designees will audit all Pre and Post Dialysis Communication Forms and weekly skin assessments to correlate findings with a visual inspection of the resident's skin for five residents three times per week for 6 months. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 2-20-15	

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	lack of charting on any current skin conditions for Resident #44. Review of the Progress Notes indicated the last entry was made on 1/9/15 and was not related to skin discoloration. A Progress Note dated 1/22/15 at 5:25 p.m. indicated, "Late entry for 3:40 p.m. Nurse informed by ISDH surveyor of bruising on right thumb. Examined area. Bruise is dark purple measuring 3 cm x 2.5 cm, is non-tender and no limitation in mobility noted with assessment. States she bumped her thumb when her hand slipped a little using the princess lift. Also noted 2 cm x 1.2 cm area of dark purple discoloration to mid right anterior forearm and 1.5 cm diameter faint purplish area to left anterior surface of hand that are consistent with capillary effusion. Denies trauma or harm from staff. Denies pain and related discoloration to fragile skin. Is wearing geri-sleeves to bilateral arms. Resident states that she removes her thumbs from sleeves herself because she prefers them not to be over the thumb...." Review of Resident #44's Care Plans indicated very high risk for skin impairment. Approaches included, but were not limited to, bi-weekly head-to-toe assessment per licensed staff			

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	and direct care staff to inspect skin with all routine care and notify nursing promptly of any reddened or open areas. A facility policy titled "Evaluations, Screenings and Assessments" was received from the Administrator on 1/23/15 at 8:20 a.m. and deemed as current. The policy indicated, ".... all residents receive a weekly skin integrity check performed by licensed personnel. Skin should be checked daily ...." 2. The record for Resident #110 was reviewed on 1/22/15 at 2:20 p.m. Diagnoses included, but were not limited to, end stage renal failure, renal dialysis status, and diabetes mellitus with renal manifestations. The "Pre/Post Dialysis Communication," sheets dated 12/21/14, 1/12/15, 1/14/15, 1/16/15, 1/19/15, 1/21/15, and one undated note, indicated lack of documentation for "Post Dialysis (to be completed by SNF) vital signs and assessment." The post dialysis assessment included, but was not limited to, temperature, pulse, respirations, blood pressure, weight, condition of access/site, bruit present, thrill present, and change of site. The resident's record lacked documentation in the Nurse's Notes for			

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	post dialysis assessment. Interview on 1/26/15 at 1:20 p.m. with LPN #2, indicated the post dialysis assessment included assessing the site for active bleeding, checking the blood sugar, feeling the resident's arm for lumps, and checking the thrill and bruit. She further indicated it was not necessary to check the resident's vital signs. Interview on 1/26/15 at 2:48 p.m. with the Director of Nursing, indicated there should have been a pre and post assessment including vital signs completed on a dialysis communication form. The dialysis form was to have been completed each time the resident goes for dialysis. She further indicated the resident's record lacked post dialysis assessments on indicated dates. On 1/26/15 at 8:15 a.m., the Nurse Consultant provided the policy titled, "Dialysis." This current policy indicated, "...Post-Dialysis: 1. Obtain vital signs of resident upon return from dialysis...." 3.1-37(a)			
F000323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident			

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	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 interview, the facility failed to ensure residents' environment was safe from hazards, related to razors stored unlocked on the bathroom shelf and bathroom doors with splintered wood for 8 of 23 rooms observed for environmental concerns, on 3 of 3 units. (100, 200, and 300) Findings include: 1. During the environmental tour on 01/23/15 at 1:16 p.m. through 2:01 p.m., with the Corporate RN Consultant, the Director of Maintenance, and the Housekeeping Supervisor present, the following was observed: A. The Bathroom door was gouged and splintered in room 105, 108, 111, 123, 212, and 318. During the tour, the Director of Maintenance indicated the facility had budgeted for new Bathroom doors and was waiting for the approval from the Corporate office. The Director of Maintenance acknowledged the gouges in the doors were splintered. B. There were two razors stored,	F000323	F 323 1.Bathroom doors in rooms 105, 108, 111, 123, 212 and 318 were repaired by maintenance on 2-4-15. The two razors in the bathroom of room 207 and four razors in the bathroom of room 223 were removed by the nurse consultant immediately and discarded in the sharps containers. 2.All resident rooms were audited by 2-10-15 for splintered bathroom doors. On 2-5-15, a facility wide audit was conducted to ensure no razors were found in the resident bathrooms. Any findings were immediately addressed with prompt disposal of razors in sharps containers and/or repairing of splintered doors. 3.The facility has ordered replacement bathroom doors for all resident rooms that will be installed upon delivery. Our estimated time of arrival from the manufacturer is 3-9-15. The Staff Development Coordinator provided education by 2/20/2015 for nursing and housekeeping staff on discarding all disposable razors in sharps containers immediately after use and/or if found in resident bathrooms. The Executive Director attended the resident council meeting on 2-6-15 to discuss proper storage	02/20/2015

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	unlocked on the shelf above the sink in the bathroom in room 207. C. There were 4 razors stored, unlocked on the shelf above the sink in the bathroom in room 223. The Corporate RN Consultant indicated one of the residents who resided in the room was cognitively impaired and the razors should not be stored in the bathroom. 3.1-45(a)(2)		of personal items with the residents. 4.Audits are being performed during facility rounds to observe for splintered bathroom doors and proper storage of razors by the Maintenance Supervisor or designee twice weekly for six months. The Executive Director or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 2-20-15	
F000371 SS=E	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, interview and record review, the facility failed to ensure food was prepared, served, and stored under sanitary conditions related to food	F000371	F 371 1.The box of frozen turkeys was removed on 1-20-15. The cook using the thermometer to test food temperatures was educated on the policy for sanitizing this	02/20/2015

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	stored on the floor in the walk-in freezer, improper sanitation of the food thermometer between testing food on the steam table, staff touching prepared food with bare hands, and lack of hand washing after touching contaminated surfaces. This had the potential to affect all residents who receive food from the kitchen. (Kitchen, Rehab dining room) Findings include: 1. During an initial brief kitchen tour with the Dietary Supervisor on 1/20/15 at 9:09 a.m., a cardboard box filled with frozen whole turkeys was observed sitting directly on the floor of the walk-in freezer. Interview with the Dietary Supervisor at the time of the observation indicated food should not be kept on the floor in the freezer. A policy titled "Food Safety" was presented by the Administrator on 1/22/15 at 10:00 a.m. and deemed as current. The policy indicated, "Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth ... Cold Food Storage: Food in a walk-in cooler/ freezer is stored six inches off the		equipment and proper hand washing on 1-26-15. The QMA assisting with serving food on the 300 hall was educated verbally upon discovery of the concern and again, in writing, by the Staff Development Coordinator on food handling and hand washing on 2-6-15. 2.The Dietary Manager provided education on proper procedure for sanitizing food thermometers and hand washing for dietary staff on 1-26-15. The Dietary Manager, Dietician, and Staff Development Coordinator will provide additional education to Dietary and Nursing staff regarding food storage, sanitizing of thermometers, food handling, and handwashing by 2-20-15. 3.The Dietary Manager or designee will audit food storage, food preparation and food service three times weekly for six months to observe for proper sanitation of thermometers, handling of food items, food storage and hand washing per policy. Any findings will be addressed with immediate re-education and/or discipline. 4.The Executive Director or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue	

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	floor ...." 2. During an observation of checking the steam table food temperatures with Cook #1 on 1/26/15 at 10:59 a.m., the following was observed: Cook #1 pulled the thermometer out of a tater tot sitting on the steam table shelf and used it to check the temperature of the beef stew. He then pulled a washcloth from under a tray of biscuits setting on the stove burners, wiped off the thermometer with the washcloth, moved to place the thermometer in the pureed beef stew and was stopped. He indicated that was what he would normally use to wipe off the thermometer, "I just pulled it from the drawer to grab the hot biscuits." Interview during the observation with the Dietary Supervisor indicated staff should use alcohol wipes to clean the thermometer off between foods. There were none available in the drawer so he went to obtain them. Then, after Cook #1 used an alcohol wipe to clean the thermometer, he checked the temperatures of the pureed beef stew, mechanical soft beef stew, super soup, pureed bread, and tater tots, cleaning the thermometer with an alcohol wipe in between each food. He then checked the temperature of the alternate meal pizza, using his bare left hand to hold the pizza		at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 2-20-15	

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	while he inserted the thermometer. He then proceeded to lift the garbage can lid with the back of his right hand while holding the thermometer to throw away the alcohol wipes and did not wash his hands before reaching into the fridge for the 3 bean salad. He also failed to clean the thermometer after checking the pizza temperature. Interview with the kitchen manager at the time of the observation indicated the cook should not have touched the food with his hand and definitely should have washed his hands after opening the garbage can. He further indicated again alcohol wipes, not used cloths should be used to clean the thermometer between foods. A policy titled "Proper Use and Maintenance of a Food Thermometer" was provided by the Nurse Consultant on 1/26/15 at 3:45 p.m. and deemed as current. The policy indicated, ".... 3. Sanitize the thermometer before each use ... How to Sanitize a Food Thermometer: Use alcohol swabs to carefully sanitize the thermometer, or use the three-compartment sink method to wash, rinse, and sanitize the thermometer ...." 3. In the Rehab Dining Room on 1/20/15 from 11:52 a.m. to 12:42 p.m., the following was observed:			

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	QMA #1 served a cold plate from the food cart to a resident, then placed a roll with her bare hand on a another plate from the steam table server and served another resident that plate. Then QMA #1 received another plate from the steam table server, placed a roll onto that plate using her bare hand and then place tarter sauce onto the same plate with her bare hand and served the resident. She then received another plate from the steam table server, placed a roll onto the plate with her bare hand. QMA #1 did not use hand sanitizer or wash her hands in between serving residents or handling the rolls or tarter sauce. Interview with QMA #1 at that time indicated she should have used hand sanitizer in between serving the residents, serving the rolls and tarter sauce. At 12:25 p.m., during same dining room observation, QMA #1 grabbed the resident's menu paper, received a plate from the steam table server, placed a roll with same right gloved hand, handed that plate to another server, received another plate from the steam table server using the same right gloved hand, place a roll, tarter sauce packet and butter pat from basket and placed them onto the resident's food on the plate. Interview with QMA #1 at that time, indicated she			

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	should have just touched the rolls with gloved hand and nothing else, or use hand sanitizer and re-gloved. On 1/22/15 at 10:00 a.m., the Administrator provided the policy titled, "Hand Washing." This current policy indicated, "...Guidelines: Staff washes hands at the minimum as necessary to remove contamination and after the following...Handling soiled utensils or equipment, During food preparations...After engaging in other activities that contaminate the hands...." 3.1-21(i)(3)			
F000441 SS=E	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 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.			

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	(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 ensure resident's personal items, were stored in a sanitary manner, related to wash and emesis basins stored uncovered on the floor, bedpans stored on the handicap railing in the bathroom, dentures stored in an unmarked cup in the bathroom, and toothbrushes stored, uncovered on the shelf above the sink in the bathrooms for 5 of 23 rooms observed on the environmental tour on 2 of 3 units. (100 and 200) Findings include: 1. During the environmental tour on 01/23/15 at 1:16 p.m. through 2:01 p.m.,	F000441	F 441 1.The dentures stored in an unmarked cup in the bathroom of room 105 were promptly identified and placed in a clean, marked container by the DON on 1/23/2015. The unlabeled, uncovered basins in the bathroom and in the room of room 105 were discarded by the DON on 1/23/2015.The uncovered, unlabeled bedpan and bath basin in room 108 were discarded by the DON on 1/23/2015. The three uncovered, toothbrushes and the uncovered, unlabeled bedpan in the bathroom of room 206 were discarded by the DON on 1/23/2015. The two uncovered, unlabeled bath basins, an uncovered, unlabeled emesis basin and uncovered, tooth brush in the bathroom of room 207	02/20/2015

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	with the Corporate RN Consultant, the Director of Maintenance, and the Housekeeping Supervisor present, the following was observed: A. There was a full set of dentures stored in an unmarked cup on the shelf above the sink, a unlabeled bath basin and emesis basin stored uncovered behind the toilet and another unlabeled bath basin and emesis basin stored under the sink in room 105. B. There was an uncovered, unlabeled bedpan stored on the handicap rail and an uncovered, unlabeled bath basin stored on the floor in room 108. C. There were three toothbrushes, uncovered and stored on the shelf above the sink and an unlabeled, uncovered bedpan stored on the handicap rails in the bathroom of room 206. D. There were two unlabeled, uncovered bath basins stored inside each other and an emesis basin on the floor and a toothbrush, uncovered stored on the shelf above the sink in the bathroom of 207. E. There was an uncovered, unlabeled bath basin stored on the floor in the bathroom of room 212.		were discarded by the DON on 1/23/2015. The uncovered, unlabeled bath basin in 212 was discarded on 1/23/2015 by the DON. Residents in these rooms were advised of sanitary storage requirements by the DON, replacement items with proper labels were provided and all items placed in baggies. 2.A facility wide audit was completed by environmental services for all resident rooms to observe for the proper storage of personal items by 2-11-15. Any deficient findings were immediately corrected. 3.Education will be provided by the Staff Development Coordinator to nursing and housekeeping staff by 2/20/2015 addressing sanitation in the storage of resident items. Facility rounds will be initiated on 2-9-15 twice weekly for six months by administrative staff to focus on the sanitary storage of resident items. Any findings will be addressed with immediate action per Infection Control Guidelines. 4.The Executive Director or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at that same schedule for	

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	The Corporate RN Consultant indicated at the time of the observations, the items should not be stored in the bathroom. 3.1-18(b)(1)		an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 2-20-2015	
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure residents environments was sanitary and comfortable, related to stains on a privacy curtain, chipped paint on the walls, stained call light cord in the bathroom, stained and chipped toilet seat, for 4 of 23 rooms observed on the environmental tour on 1 of 3 units. (100) Findings include: 1. During the environmental tour on 01/23/15 at 1:16 p.m. through 2:01 p.m., with the Corporate RN Consultant, the Director of Maintenance, and the Housekeeping Supervisor present, the following was observed: A. The privacy curtain in room 108 was stained and there was a gouge in the wall of the bathroom.	F000465	F 465 1.The privacy curtain was taken down and washed by the housekeeping supervisor on 1-23-15. The chipped paint areas in the corner by the bathrooms of rooms 111 and 119 were repaired by maintenance staff on 1-26-15. The call light cord and toilet seat in the bathroom of room 121 were replaced by maintenance on 1-23-15. 2.A facility wide audit was completed by Housekeeping and Maintenance Supervisor for all resident rooms to observe for a safe, comfortable resident environment by 2-6-15. Any findings were addressed by the Housekeeping/Maintenance supervisors by 2-11-15. 3.Education will be provided by the Staff Development Coordinator by 2/20/2015 addressing a safe, comfortable resident environment. Facility rounds will be initiated on 2-9-15 twice weekly for six months by	02/20/2015

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	During an interview at the time of the observation, the Housekeeping Supervisor indicated the curtain had been on a list to be washed for a week. She indicated the facility can only wash, "so many". B. The corner by the bathroom had chipped paint in room 111. C. The corner by the bathroom had chipped pain in room 119. D. The call light cord in the bathroom of 121 was stained brown, the toilet seat was stained and had chips out of it. During an interview at the time of the observations. The Director of Maintenance indicated he does five rooms per week to patch and paint. During an interview at the end of the tour, the Director of Maintenance indicated the maintenance staff were fixing the chipped paint on the walls and changing the toilet seat. 3.1-19(f)		Maintenance Supervisor or designee/Housekeeping Supervisor or designee to focus on ensuring a safe, comfortable resident environment. Any findings will be addressed immediately. 4.The Executive Director or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. If audits do not meet this criteria, audits shall continue at that same schedule for an additional six months. At that time, analysis of the data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 2-20-15	