

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2015
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00181676 and IN00181862.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00178623 completed on July 28, 2015 which cited unrelated deficiencies.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00180090 completed on August 18, 2015 which cited unrelated deficiencies.</p> <p>Complaint IN00181676- Substantiated. Federal/State deficiencies related to the allegations are cited at F246 and F282.</p> <p>Complaint IN00181862- Substantiated. Federal/State deficiency related to the allegation is cited at F241.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 14, 15, &amp; 16, 2015.</p> <p>Facility number: 000253 Provider number: 155362</p>	F 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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F 0241 SS=E Bldg. 00	<p>AIM number: 100266660</p> <p>Census bed type: SNF/NF: 138 Total: 138</p> <p>Census payor type: Medicare: 14 Medicaid: 97 Other: 27 Total: 138</p> <p>Sample: 15</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on September 23, 2015</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure residents dignity was maintained related to staff placing and removing clothing</p>	F 0241	F241 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. <b>Unable to correct the alleged</b>	10/16/2015

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	<p>protectors, transferring residents, providing incontinence care, and repositioning resident's chairs without explaining the care to the residents, and not changing a resident's stained clothing for 4 of 5 residents reviewed for dignity during random observations in a sample of 15. (Residents #F, #J, #L, &amp; #N ) (CNA's #1 &amp; #2)</p> <p>Findings include:</p> <p>1. On 9/14/15 at 1:04 p.m. Resident #F was observed sitting in a high back wheel chair at a table in the B-wing dining room. CNA #1 approached the resident from behind and removed the resident's clothing protector which was snapped around the resident's neck in the back. The CNA did not speak to the resident to explain what she was doing before, during, or after removing the clothing protector.</p> <p>On 9/15/15 at 11:05 a.m., the resident was observed sitting up in high back wheel chair in the unit Dining Room. There was dried food on the front of the resident's shirt near her lower abdominal area. The resident did not have any lap blanket or other clothing covering the area. Activity staff was present next to the resident. The lunch meal had not been served.</p>		<p><b>deficient practice for residents #F, #J, #L, #N. CNA #1 &amp; CNA #2 were re-educated at the time of the event.</b> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Other residents on the B wing have the potential to be affected by the same deficient practice. Rounds were completed on the B wing to identify other residents. Residents found to have soiled clothing had their clothing changed. CNA staff member was immediately called and re-educated. No other staff members were identified as lacking communication with the residents during care. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Facility staff will be re-educated regarding F241 Dignity; focusing on communication- explaining care to the residents and changing of soiled clothing.</b> Facility ACE members will include dignity question, "Do staff treat you with respect and dignity?" as part of their facility rounds. Residents will be interviewed during ACE rounds to ensure the deficient practice does not recur.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>	

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	<p>On 9/15/15 at 12:26 p.m., the resident was observed sitting up in a high back wheelchair in the unit Dining Room. The resident's shirt had not been changed.</p> <p>On 9/15/15 at 1:25 p.m., the resident was observed sitting in her chair in her room. The resident was not receiving care from any staff members at this time. The resident's shirt had not been changed.</p> <p>The record for Resident #F was reviewed on 9/15/15 at 11:44 a.m. The resident's diagnoses included, but were not limited to, edema (swelling) shortness of breath, congestive heart failure, and dementia.</p> <p>Review of the 6/9/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of one staff member for dressing and personal hygiene.</p> <p>2. On 9/14/15 at 1:04 p.m., Resident #N was observed sitting in a wheel chair in the unit Dining Room. CNA #1</p>		<p>i.e., what quality assurance program will be put into place. <b>During rounds on all three shifts unit managers will audit residents to ensure residents dignity is being maintained. Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months. DNS will bring results of audits and ACE rounds to QAPI for 6 months identifying any trends or patterns.</b> By what date the systemic changes will be completed? October, 16, 2015</p>	

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	<p>approached the resident from behind and removed the resident's clothing protector which was snapped around the resident's neck in the back. The CNA did not speak to the resident to explain what she was doing before, during, or after removing the clothing protector.</p> <p>The record for Resident #N was reviewed on 9/15/15 at 11:10 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and glaucoma.</p> <p>Review of the 6/25/15 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact.</p> <p>Review of the Resident Report Sheet for Resident #N indicated the resident was legally blind and needed assistance with meals.</p> <p>3. On 9/14/15 at 11:52 a.m., Resident #L was observed seated in a high back specialty chair in the unit Dining Room. CNA #1 approached the resident and reclined her chair. The CNA then pushed the chair and then pulled the chair backward and placed the resident in a</p>			

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	<p>different direction in the Dining Room. The CNA did not speak to resident or attempt to explain to the resident what was being done at this time.</p> <p>On 9/14/15 at 1:27 p.m., the resident was observed in the unit Dining Room. CNA #1 approached the resident and pushed her in her chair into her room without speaking to the resident. CNA #2 entered the room. The two CNA's attached the strips of the Marissa lift (a mechanical lift device) to the sling pad. The CNA's transferred the resident into her bed. CNA #1 turned the resident to her right side and removed her pants and incontinence brief and began to provide incontinence care. The CNA's did not explain the above events to the resident prior to or during the above care.</p> <p>The record for Resident #L was reviewed on 9/15/15 at 11:20 a.m. The resident's diagnoses included, but were not limited to, depressive disorder, dementia, high blood pressure, and anxiety state.</p> <p>Review of the 8/16/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required extensive assistance of two staff members for bed mobility and was</p>			

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	<p>dependent on staff for dressing, eating, transfers, and personal hygiene. The assessment also indicated the resident was dependent on two staff members for transfers.</p> <p>The Resident Report Sheet for Resident #L was reviewed. The sheet indicated staff were to lay the resident down after meals.</p> <p>4. On 9/14/15 at 11:52 a.m., Resident #J was observed seated in a specialty chair in the unit Dining Room. CNA #1 approached the resident and placed a clothing protector on his chest and around his neck. The CNA did not speak to the resident to explain what she was doing at this time.</p> <p>The record for Resident #J was reviewed on 9/15/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, dementia, convulsions, and hearing loss.</p> <p>Review of the 8/24/15 Minimum Data Set (MDS) significant change assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident was dependent on staff for bed mobility and transfers. The assessment also indicated the resident</p>			

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F 0246 SS=D Bldg. 00	<p>required extensive assistance of one staff member for eating, dressing, and personal hygiene.</p> <p>When interviewed on 9/15/15 at 2:30 p.m., the Director of Nursing indicated the the staff should have spoken with the residents to explain care.</p> <p>This Federal tag relates to Complaint IN00181862.</p> <p>3.1-3(t)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review, and interview, the facility failed to accommodate the resident's needs related to call lights not in reach for 3 of 3 residents reviewed for call light positioning in a sample of 15. (Residents #M, #P, and #Q)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 9/14/15 at 8:40 a.m., Resident #M was observed in</p>	F 0246	<p>F246</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident's M, P &amp; Q had their call</p>	10/16/2015

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	<p>bed. The resident's call light was wrapped around the assist rail on left side of the bed. The call button was on the floor and not in the resident's reach. The resident was not receiving care at this time.</p> <p>On 9/14/15 at 8:47 a.m. and 9:00 a.m., the resident was observed in bed. The resident's call button remained wrapped around the assist rail on the left side of the bed. The call button was on the floor and not in the resident's reach. No staff members or visitors were in the room at the above times. The resident was awake and responded to questions.</p> <p>The record for Resident #M was reviewed on 9/15/15 at 1:12 p.m. The resident's diagnoses included, but were not limited to, aneurysm, joint contractures, high blood pressure, and sepsis.</p> <p>Review of the 8/28/15 Minimum Data Set (MDS) significant change assessment indicated the resident was dependent on staff for bed mobility, transfers, dressing and bathing. The assessment also indicated the resident required extensive assistance of one staff member for eating and personal hygiene.</p> <p>The assessment also indicated the resident had impairment in range of</p>		<p>lights put within reach.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>All residents requiring use of a call light have the potential to be affected. Rounds were completed on 9/16/15 to ensure all residents had their call light within reach.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p><b>During rounds on all three shifts unit managers will audit residents to ensure residents have their call light within reach. Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months.</b></p>	

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	<p>motion in both her upper and lower extremities and the right and left sides.</p> <p>The resident's current Care Plans were reviewed. A current Care Plan initiated on 3/15/15 indicated the resident had a physical functioning deficit related to self care impairment and mobility. Care Plan interventions included, but were not limited to, keep the call bell in reach and provide assistance with bed mobility.</p> <p>2. During Orientation Tour on 9/14/15 at 9:39 a.m., Resident #P was observed in bed. The resident's bed was in the low position. The resident's call light cord extended from the wall outlet to the floor on the side next to the bedside chest of drawers. The call button was next to the side of the dresser and not in the resident's view or reach. The resident was not receiving care from staff at this time.</p> <p>On 9/14/15 at 10:15 a.m., the resident was observed in bed. CNA #3 entered resident's room and walked over to the foot of the resident's bed. The CNA indicated the resident was still asleep. The call button remained in the same position at this time. The CNA left the resident's room without picking the call light up off the floor and placing in the resident's reach.</p>				<p><b>DNS or designee will bring results of audits to QAPI for 6 months to identify any trends or patterns.</b></p> <p>By what date the systemic changes will be completed?</p> <p>October 16, 2015</p>		

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	<p>On 9/14/15 at 11:06 a.m., the resident was observed in bed. The privacy curtain was pulled and the resident's bed could not be visualized from the hall way. The call light button remained in the same position. No staff members or visitors were in the room at this time.</p> <p>The record for Resident #P was reviewed on 9/15/15 at 2:10 p.m. The resident's diagnoses, included, but were not limited to, depressive disorder, anxiety state, anorexia, and osteoarthritis.</p> <p>Review of the 8/31/15 Minimum Data Set (MDS) quarterly assessment indicated the resident required limited assistance with bed mobility, transfers, dressing and personal hygiene.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 7/30/14 indicated the resident had an alteration in bowel and bladder elimination. Care Plan interventions included, but were not limited to, keep the call bell in reach and staff to prompt the resident to use the toilet. A Care Plan initiated on 10/17/14 indicated the resident had a physical functioning deficit and needed some assistance with her ADL's (Activities of Daily Living). Care Plan interventions included, but were not</p>			

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	<p>limited to, provide assistance with personal hygiene, dressing and toileting, and to keep the resident's call bell within reach.</p> <p>3. During Orientation Tour on 9/14/15 at 9:39 a.m., Resident #Q was observed in bed. The resident's call light cord was clipped together and hanging from the wall outlet. The cord and call button were not in the resident's reach.</p> <p>On 9/15/15 at 9:20 a.m., the resident was observed in bed. The call light cord was clipped together and hanging from the wall outlet. The cord and call button were not in the resident's reach. There were no staff members in the resident's room at this time.</p> <p>The record for Resident #Q was reviewed on 9/15/15 at 1:59 p.m. The resident's diagnoses included, but were not limited to, depressive disorder, Alzheimer disease, and heart disease.</p> <p>Review of the 7/29/15 Minimum Data Set (MDS) quarterly assessment indicated the resident required supervision for bed mobility, transfers, and ambulation in her room.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on</p>			

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F 0282 SS=D Bldg. 00	<p>9/22/2012 indicated the resident had a physical functioning deficit related to self care impairment. Care Plan interventions included, but were not limited to, keep the call bell within reach when the resident was in her room.</p> <p>When interviewed on 9/16/15 at 9:50 a.m., the Director of Nursing indicated the resident's call lights should be kept in reach of the residents.</p> <p>This Federal tag relates to Complaint IN00181676.</p> <p>3.1-3(v)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure Physician orders were followed related to TED ( support stockings) hose in place for 1 of 3 residents reviewed for TED hose use in a sample of 15. (Resident # F)</p>	F 0282	F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident F had her ted hose replaced and put on both legs on 9/15/15. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/16/2015

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	<p>Finding includes:</p> <p>On 9/14/15 at 11:30 a.m., Resident #F was observed sitting in a high back wheel chair in the B- wing Dining Room. The resident did not have TED hose stocking on her right foot.</p> <p>On 9/14/15 at 12:50 p.m., the resident was observed in the Unit Dining room. The resident's lunch meal tray had been removed from the table. The resident did not have TED hose stocking on her right foot.</p> <p>The record for Resident #F was reviewed on 9/15/15 at 11:44 a.m. The resident's diagnoses included, but were not limited to, edema (swelling) shortness of breath, congestive heart failure, and dementia.</p> <p>The current Physician orders were reviewed. An order was written on 7/7/15 for the resident to wear TED hose to both legs while out of bed.</p> <p>Review of the 6/9/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (9). A score of (9) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident</p>		<p>action(s) will be taken. All residents who wear ted hoses have the potential to be affected by the alleged deficient practice. Orders for ted hose were run and compared to resident care plan sheets. Rounds were completed on 9/15/15 to ensure residents had ted hose in place as ordered. No other residents were found to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Nursing staff will be re-educated regarding following resident care sheets to ensure items such as ted hose are in place as ordered.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p><b>During rounds on all three shift Unit managers will audit to ensure items such as ted hose are in place as ordered.</b></p> <p><b>Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months. DNS or designee will bring results of audits to QAPI for 6 months to identify any trends or patterns.</b></p> <p>By what date the systemic changes will be completed? October 16, 2015</p>		

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F 0465 SS=E Bldg. 00	<p>involved in activity with staff providing weight bearing support) of one staff member for dressing and personal hygiene.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 8/17/15 indicated the resident was at risk for alterations in skin integrity related to chronic edema and develops blisters to both of her lower extremities. Care plan interventions included, but were not limited to, TED hose to be worn as ordered and her legs were to be elevated as ordered.</p> <p>When interviewed on 9/16/15 at 10:50 a.m., the Staff Development Nurse indicated the resident was to have TED hose on as ordered by the Physician.</p> <p>This Federal tag relates to Complaint IN00181676.</p> <p>3.1-35(g)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the</p>	F 0465		10/16/2015

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	<p>facility failed to ensure the resident's environment remained sanitary related to dirty seat belts, floors, chairs, walls, bed rails on 2 of 3 Wings. (Resident #D and the B and C Wings)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 9/14/15 at 8:30 a.m. the following was observed on the C-wing:</p> <p>a. The floor in front of the Nursing Station was dirty. There were dried red spots on the floor. There was dried spillage on the base board. The floor tiles around the water cooler next to the Station were dirty.</p> <p>b. There was dried tan colored spillage on the bed rails and frame in Room 221-1. Two residents resided in this room.</p> <p>c. There was dried tan colored spillage on the floor in Room 222. One resident resided in this room.</p> <p>2. The following was observed in the Dining Room on the unsecured section of B- wing on 9/14/15 at 11:40 a.m.:</p> <p>a. There was a food tray on the counter top. The lid was not covering the tray.</p>		<p>F465</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p><b>Resident D had self-releasing alarming belt changed out for a new belt on 9/16/15.</b></p> <p><b>Food tray was removed from the B wing dining room.</b></p> <p><b>Maintenance and Housekeeping immediately started working on cleaning and repairing the facility areas found deficient.</b></p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p><b>Other residents with self releasing belts have the potential to be affected. Rounds were completed on 9/16/15 and one additional belt was changed out for a new</b></p>	

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	<p>Servings of ground meat and a hot cereal were uncovered.</p> <p>b. There was spillage on the sides of the garbage can.</p> <p>c. There was dried spillage on the side of the counter top and along the base board of the counter. A door was missing to one of the shelves in the counter.</p> <p>d. There was spillage on the lower sections of the wall to the left of the entrance and the wall with the television.</p> <p>e. There was an accumulation of dirt and debris on the floor along the base board under the window.</p> <p>f. Food crumbs and debris were observed under a table next to the stove.</p> <p>g. There was dried spillage under the counter by the stove.</p> <p>h. The base of the standing fan was dirty. There was an accumulation of dust on the fan blades.</p> <p>i. There was an accumulation of dirt along the bottom of the exit door.</p> <p>j. There was dried spillage on the wall just outside of the entrance.</p>		<p><b>belt.</b></p> <p><b>Other residents who eat in the dining rooms have the potential to be affected by the alleged deficient practice.</b></p> <p><b>All residents who reside on C and B wing have the potential to be effected by the spillage on floors, baseboards, bedrails, garbage cans, countertops, walls, and on curtains.</b></p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p><b>Staff will be re-educated regarding cleaning self releasing belts when soiled.</b></p> <p><b>Staff will be re-educated to ensure all food trays are removed from dining rooms prior to the start of the next meal.</b></p>	

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	<p>3. The following was observed on 9/15/15 at 10:00 a.m. in the Dining Lounge area on secured section of the B-wing:</p> <p>a. There was dried spillage on the wall under the hand sanitizer pump.</p> <p>b. There was an accumulation of dirt and dust on the floors along the walls by the desk and counter areas.</p> <p>c. There was a drawer missing on the desk.</p> <p>d. There was dried dirt and spillage along the base board under the window.</p> <p>e. There was a dark stain on a window curtain.</p> <p>f. The dark blue chair in the corner had stains on the arms and lower section under the seat.</p> <p>4. On 9/14/14 at 9:14 a.m., Resident #D was observed sitting in a wheel chair in the Dining Room on the unsecured hall of the B-wing. There was an accumulation of dried spillage on the resident's self release alarming belt.</p> <p>When interviewed on 9/14/15 at 2:30</p>		<p><b>Housekeeping staff will be re-educated regarding spillage and stains along with appropriate cleaning of floors, rooms, bathrooms and walls.</b></p> <p><b>Housekeeping Manager was replaced and new manager is in house and working on the POC as of 9-25-15.</b></p> <p><b>Maintenance will be re-educated about facility rounding to include the condition of cabinets in facility.</b></p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p><b>During rounds on all three shifts unit managers will audit residents to ensure residents are wearing clothing protectors as care planned and clothing is clean and dry. Rounds will be completed 5x week for 4 weeks, 2x week x 4 weeks and then weekly for a total of 6 months.</b></p>	

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	<p>p.m. the Director of Nursing indicated the resident rooms and dining areas should have been cleaned.</p> <p>3.1-19(f)</p>		<p><b>DNS or designee will bring results of audits to QAPI for 6 months to identify any trends or patterns.</b></p> <p><b>Housekeeping will be rounding daily for 5 weeks for 4 weeks, then 2 x a week for 4 weeks and then weekly for a total of 6 months. Housekeeping will be bringing all audits and findings to QAPI for 6 months.</b></p> <p><b>Maintenance will monitor the cabinet condition 5 x a week for 4 weeks, x 2 weeks for 4 weeks and then weekly for a total of 6 months. Maintenance will bring audits to QAPI for 6 months.</b></p> <p><b>Date of Compliance</b></p> <p><b>October 16, 2015</b></p>	