

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2013
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NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00129810.</p> <p>Complaint Number IN00129810 - Substantiated, no deficiencies related to allegations are cited.</p> <p>Survey dates: June 18, 19, 20, 24, 25, 2013</p> <p>Facility number: 000054 Provider number: 155126 AIM number: 100287850</p> <p>Survey team: Martha Saull, RN TC Dorothy Watts, RN Terri Walters, RN</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census Payor source: Medicare: 7 Medicaid: 50 Other: 7 Total: 64</p> <p>These deficiencies also reflect state</p>	F000000	<p><i>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. Please find the attached plan of correction for a visit from your office on June 25th, 2013 survey event ID 93MS11 for our annual review. We respectfully request that your office will accept this plan as our facility's compliance and that you will consider a desk review in view there were no tags that were deemed to actual harm or immediately jeopardy. If you have any addition questions, please contact me at (812)936-9991. Thank you in advance for your immediate attention in this manner.</i></p>	
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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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	findings in accordance with 410 IAC 16.2. Quality review completed on July 1, 2013, by Jodi Meyer, RN			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	Resident #11 has been	07/25/2013			

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	<p>review, the facility failed to ensure a staff member informed of a resident's allegation of abuse was reported to Administration. Resident #11</p> <p>Findings include:</p> <p>On 6/18/13 at 11:32 A.M., Resident #11 was interviewed. She indicated about 2 months ago, a CNA (certified nursing assistant) came into her room to assist her. She indicated the CNA was "loud and acts like she knows it all." Resident# 11 indicated as the CNA left her room, the CNA turned, looked at the resident and patted her (the CNA's) bottom, while she looked at the resident. The resident stated "You know what they means, don't ya?" Resident #11 indicated she told the nurse working at the time but doesn't remember the nurses name. She indicated she doesn't know the CNA's name, thinks the CNA was still here but the CNA doesn't bother the resident.</p> <p>On 6/18/13 at 1:40 P.M., the Administrator was interviewed and indicated she was not aware of the above allegation by Resident #11. She indicated she would talk to the resident immediately.</p> <p>On 6/18/13 at 2:30 P.M., Resident</p>		<p>re-assessed by the Interdisciplinary Team with care plans updated as deemed appropriate. A one time resident and staff interviews in the same facility location have been completed to ensure staff are aware of concerns from resident. Staff have been re-educated on the policy and procedure Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property. It is the responsibility of staff to immediately report any allegation to the Administrator. The ADM/designee will be responsible to conduct interview/survey staff across shifts, three/week x 4 weeks, then once per week x 2 months, monthly for 3 months, and then 3 times per quarter for 2 quarters across shifts, to ensure staff are responsive on identification/reporting of possible allegations of abuse. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters.. Any further action will be as determined by the QPI Committee.</p>				

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	<p>#11's clinical record was reviewed. Diagnoses included, but were not limited to, the following: Alzheimer ' s disease with dementia and disorientation and hallucinations. The most recent MDS (minimum data set assessment) dated 5/24/13, indicated the resident had a total cognition score of 13 of 15, which was cognitively intact.</p> <p>On 6/18/13 at 3:32 P.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Prevention and Reporting: Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property." The form was dated April 2013 and included, but was not limited to, the following: "...report the incident immediately to the Administrator..."</p> <p>On 6/18/13 (no time documented) the SSD (Social Service Director) and the ADM spoke with the resident. Documentation included, but was not limited to, the following: "Spoke with rsd (resident)...Rsd stated what is going on, why is everyone talking to me and asking me questions...It happened along time ago...stated before Christmas. Rsd stated a nurses aide came in and started</p>						

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	<p>sassing her. Rsd can't remember what it was about but when CNA left the room, CNA turned around and smacked her butt. Asked rsd what that meant. She said, "When I was a kid it meant "kiss my a** and go to h***...Rsd stated everything has been taken care of. Rsd stated I...forgot about it...don't remember (who staff is), she doesn't know what shift she works..."</p> <p>3.1-28(c)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure their current policy and procedure for abuse included, but was not limited to, a thorough and complete investigation of an actual incident and/or allegation of abuse and report applicable incidents to the state agency immediately.</p> <p>Resident #11</p> <p>Findings include:</p> <p>On 6/18/13 at 3:32 P.M. the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Prevention and Reporting: Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property." The form was dated April 2013. At the time, the policy was reviewed. Documentation was lacking in the policy and procedure regarding and thorough and complete investigation to include, but not limited to, interviews from additional alert and oriented residents</p>	F000226	Resident # 11 has been re-assessed by the Interdisciplinary Team with care plan updates as deemed appropriate. The policy, Clinical Administrative manual 1.1.1 Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and misappropriation of resident property, has been reviewed by the IDT. A one time resident and staff interviews in the same facility location have been completed to ensure staff are aware of concerns from resident. Staff have been re-educated on the Policy and Procedure of Prevention and Reporting. It is the expectation that a thorough investigation is conducted by Administrative staff following any allegation of mistreatment, neglect, abuse, including injuries of unknown source, and misappropriation of resident property. The ADM/designee will be responsible to conduct interview/survey staff across shifts, three/week x 4 weeks, then once per week x 2 months, monthly for 3 months, and then 3 times per quarter for	07/25/2013			

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	<p>as well as additional staff members in regards to an actual and/or allegation of abuse.</p> <p>The policy also included, but was not limited to, the following: "Report the incident immediately to the Administrator...who will immediately report any allegations of ...abuse...to applicable state and other agencies. "Immediately" means as soon as possible, but not to exceed 24 hours after discovery of incident..."</p> <p>On 6/20/13 at 1:40 P.M., the ADM was interviewed. She indicated she was informed on 6/18/13 of an alleged incident involving a resident and CNA. She indicated she did speak with the Resident #11 about the incident. She indicated she did not interview additional residents and/or staff in regards to this allegation. She was made aware at the time that a complete and thorough investigation includes interviews with additional staff and /or alert and oriented residents.</p> <p>On 6/20/13 at 2:17 P.M., the ADM was interviewed. At the time, the current policy and procedure for Prevention and Reporting of abuse was reviewed. The ADM indicated the current policy and procedure does not</p>		<p>2 quarters across shifts, to ensure staff are responsive on identification/reporting of possible allegations of abuse. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 3 months, and then quarterly for 3 quarters.. Any further action will be as determined by the QPI Committee.</p>				

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	<p>include to interview additional staff and residents when applicable, as a thorough and complete investigation of an actual and/or allegation of abuse. She also indicated at the time, when she has a reportable incident to the ISDH, she will report it as soon as possible, but not to exceed 24 hours after the discovery of the incident. The ADM indicated at the time, she was not aware the reportable incidents were to be reported "immediately", as soon as the resident was safe and barring any unforeseen disaster circumstances, and not given the time frame of up to 24 hours after the incident.</p> <p>The ADM indicated she was made aware of an allegation of a CNA "being sassy" and using gestures towards a resident on 6/18/13. The ADM indicated at the time, she did not interview additional alert and oriented residents and/or staff of the unit as part of her investigation of the incident.</p> <p>3.1-28(a)</p>				

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure 1 of 4 residents observed during medications administration received medications according to acceptable standards of nursing practice, in that the site a transdermal patch was applied was not rotated as directed. Resident #84</p> <p>Findings include:</p> <p>Resident #84 was observed on 06/24/13 at 9:02 a.m., during medication administration in her room lying on her bed. RN #2 removed the Exelon patch from Resident #84's left back and placed a new Exelon patch on her left shoulder.</p> <p>The clinical record of Resident #84 was reviewed on 06/24/13 at 9:59 A.M. The record indicated the diagnoses of Resident #84 included, but was not limited to, dementia, diabetes mellitus, congestive heart failure and polycystic kidney disease.</p> <p>The most recent Quarterly MDS</p>	F000281	Resident #84 has been re-assessed by the IDT with care plans updated as deemed appropriate. A one-time audit has been completed to review for other patch usage. Licensed Nurses have been re-educated on following manufacturer recommendations on patch placements and administration of medications via an enteral tube. It is the responsibility of the Licensed Supervisory Nurse to complete the medication administration as per expectation. The DON/designee will be responsible to conduct medication pass observations 5 times a week across shifts times 2 weeks, 1 medication pass observation per week across shifts for 10 weeks, then 1 time a month times 3 months, then quarterly for 2 quarters. Any identified concern will be immediately corrected. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters.	07/25/2013	

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	<p>(Minimum Data Set Assessment) dated 03/9/13 indicated Resident #84 had mild cognitive impairment.</p> <p>The June 2013 Physicians order read as follows, "Exelon (a medication used to treat mild to moderate dementia) 9.5 mg/24hr patch *for external use only *alternate site w/each change. Apply 1 patch topically once daily *Do not use same area for 2 weeks. Related to Dementia."</p> <p>The June 2013 (Medication Administration Record) indicated Resident #84 had been administered the Exelon patch daily from June 1, 2013 through June 24, 2013 on the following locations:</p> <p>"June 1, 2013: left upper back June 2, 2013: right upper chest June 3, 2013: left upper back June 4, 2013: left upper chest June 5, 2013: right upper chest June 6, 2013: right upper chest June 7, 2013: right deltoid June 8, 2013: right deltoid June 9, 2013: right upper chest June 10, 2013: right upper chest June 11, 2013: right chest June 12, 2013: right back June 13, 2013: right deltoid June 14, 2013: right chest</p>		Any further action will be as determined by the QPI Committee.				

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	<p>June 15, 2013: right deltoid June 16, 2013: left upper back June 17, 2013: left shoulder June 18, 2013: left chest June 19, 2013: right deltoid June 20, 2013: no documentation of location June 21, 2013: right upper back June 22, 2013: left upper back June 23, 2013: documentation is not legible June 24, 2013: right shoulder</p> <p>The patch location right deltoid was re-used 3 times within a 2 week period. The patch location left upper back was re-used 3 times within a 2 week period. The patch location right upper chest was re-used 7 times within a 2 week period.</p> <p>The Nursing 2013 Drug Handbook 33rd edition page 1203 indicated, "Exelon...Administration...transdermal s...change the site daily, and don't use the same site within 14 days..."</p> <p>During an interview on 06/24/13 at 3:15 P.M., the Director of Nursing indicated I do see the problem, Exelon patches should be rotated.</p> <p>3.1-35(g)(1)</p>				

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation interview and record review the facility failed to follow their policy and procedure for medications administered through a g-tube (gastrostomy tube) for 1 of 1 resident observed for g-tube medication administration. Resident #2</p> <p>Findings include:</p> <p>During an observation of g-tube medication administration on 6/24/13 at 11:21 A.M., LPN #3 crushed a Lorazepam 2 mg tablet and a Bacolofen 10 mg tablet and placed both of them in a plastic medication administration cup. LPN #3 poured 20cc of Valproic Acid 250mg/ml into a</p>	F000322	Resident #2 has been re-assessed by the IDT with care plans updated as deemed appropriate. A one-time audit has been completed to review other residents with G-tube administration of medications for need for intervention/care plan revision as deemed appropriate.. Licensed Nurses have been re-educated on policy & procedure, Clinical Programs Manual 9.12.1, Enteral tubes. It is the responsibility of the Licensed Supervisory Nurse to complete the medication administration as per expectation. The DON/designee will be responsible to conduct enteral tube medication administration observations 5 times a week across shifts times 2 weeks, 1 medication observation per week	07/25/2013			

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	<p>separate plastic medication cup.</p> <p>Before the administration of the medication in the g-tube LPN #3 elevated the head of the bed and checked placement of the g-tube. LPN #3 poured 30 cc of water into the syringe attached to the g-tube. LPN #3 dissolved the 2 crushed medications in water and poured them into the syringe. LPN #3 poured 30 cc of water into the syringe for a flush then poured the liquid 20cc Valproic Acid into the syringe. LPN #3 finished the medication administration by flushing g-tube with 200 cc of water.</p> <p>During an interview with LPN #3 on 6/24/13 at 11:28 A.M., LPN #3 indicated that because there were only 2 crushed medications, the medications could be administered together, but LPN #3 indicated that had there been more than 2 medications, she would have administered them separately and followed each medication with 15 cc of water.</p> <p>The clinical record of Resident #84 was reviewed on 06/24/13 at 9:59 A.M. The record indicated the diagnoses of Resident #2 included, but were not limited to, anxiety,</p>		<p>across shifts for 10 weeks, then 1 time a month times 3 months, then quarterly for 2 quarters. Any identified concern will be immediately corrected. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.</p>		

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	<p>closed head injury, gastroesophageal reflux disease, and agitation.</p> <p>The June 2013 Physician's order read as follows: "Baclofen 10 mg...give 1 tablet per tube four times a day." "Lorazepam 2 mg...give one tablet via g-tube 4 times a day." "Valproic Acid 250mg/ml...give 20ml per g-tube at 5AM &12PM."</p> <p>The facility's policy and procedure for Enteral tubes was reviewed on 06/24/13 at 12:20 P.M. and it read as follows: "13.a. For administering medications via tube feeding, the standard of practice is to administer each medication separately and flush the tubing with 15 ml between each medication or as directed by physician."</p> <p>During an interview with the Director of Nursing (DON) on 6/24/13 at 12:00 P.M., the DON indicated that when administering medication in a g-tube, each medication should be administered separately and flushed with 15 ml water between each medication.</p> <p>3.1-25(b)(9)</p>						

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F000323 SS=D	<p>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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure a resident with diagnosis of osteopenia (low bone density that precedes osteoporosis) had support stockings (TED hose) gently applied by a CNA (certified nursing assistant) for 1 of 2 residents reviewed with support stockings. Resident #13</p> <p>B. Based on interview and record review the facility failed to ensure adequate supervision to prevent falls for 1of 3 residents who met the criteria for falls in stage 2. Resident # 28</p> <p>Findings include:</p> <p>A. The clinical record of Resident #13 was reviewed on 6/19/13 at 10 A.M. The resident was admitted to the facility on 12/2/12. Diagnoses included, but were not limited to, the following: restless leg syndrome, osteoarthritis and paraplegia.</p>	F000323	Resident # 28 has been re-assessed by the IDT with care plans updated as deemed appropriate. Resident #13 has been re-assessed by the IDT with care plans updated as deemed appropriate. A one-time review of residents with a history of previous ankle injury has been completed to ensure TED hose application is conducted as per manufacturer recommendations. A one-time review of residents with falls out of bed has been completed for the last 30 days to ensure interventions are in place as per plan of care. Nursing staff have been re-educated on TED hose placement as well as providing ADL care interventions as per plan of care. It is the responsibility of the Nursing Staff to provide the necessary care and services as per the plan of care. The DON/designee will be responsible to observe TED hose applications to non-weight bearing residents 5 times a week times 2 weeks, 1 observation per week for 10 weeks, then 1 time a month times 3 months, then quarterly for 2 quarters. Any identified concern will be immediately corrected. Any	07/25/2013			

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	<p>The MDS (Minimum Data Set Assessment) dated 3/9/13 indicated the following: cognitively intact and extensive assistance required for transfers.</p> <p>On 6/18/13 at 11:07 A.M., Resident #13 was interviewed. She indicated her foot was broken at the facility about 2 months ago by a CNA (certified nursing assistant). She indicated a CNA was putting on her support stockings (TED hose) and the CNA "jerked them up" and twisted the resident's ankle. Resident #13 indicated at the time, the CNA no longer worked at the facility. During the interview, the resident was observed in her wheelchair with a splint in place to her left ankle. The resident's left foot was observed to be in a position with the foot extended and turned inward somewhat.</p> <p>On 6/18/13 at 2:30 P.M., the DON (Director of Nursing), ADON (Assistant Director of Nursing) and ADM (Administrator) were interviewed. They indicated a CNA was helping the resident put on her TED hose and the CNA's hand slipped and Resident #13 indicated at that time, her ankle popped. The DON and ADON indicated when the CNA tried to get the TED hose over</p>		<p>further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.</p>		

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	<p>the resident's heel, the resident's ankle popped. The DON indicated at the time, an X-ray was obtained and a fracture was found. The ADM indicated at the time, the resident has osteoporosis and had a history of a previous fracture in the ankle.</p> <p>On 6/18/13 at 3:04 P.M., the DON provided a copy of the facility investigation of the incident on 4/2/13. The following was documented by the ADM: 6:30 P.M., "...returned to facility to interview resident regarding fracture. I asked (resident name) if she knew how her ankle got hurt. She told me she thinks it happened a few days ago when a CNA was trying to apply her TED hose. She said the hose were tight and really hard to get on. She described the CNA in question. She said the CNA does everything fast, walks fast...This CNA was trying to get the TED hose over (resident's name) and as she pulled it up over the heel, the foot turned in toward the other foot, (resident name) heard a pop. (Resident name) was then asked if the CNA was at fault for the incident and she said "no" she was just trying to get those hose on" when the foot turned. (Resident name) stated that she does not feel that the incident was intentional, she likes this CNA, she could have slowed</p>			

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	<p>down, maybe that would have helped the situation. (Resident name) stated that staff are good to her...feels this was an accident."</p> <p>At the time, the DON also provided a copy of her follow up with the resident on 4/3/13 at 7:30 A.M. "...This girl here (name of CNA) was helping me with my white hose et (and) my foot turned et popped. She went on to say "Those are so hard to get on you know, it was an accident...She (resident) stated, "...she was doing her job and maybe hurried a little but I hurt that ankle before..."</p> <p>A physical therapy note dated 3/15/13 included, but was not limited to, the following: "...Precautions:...paraparesis (muscle weakness)...past L ankle...fracture."</p> <p>The April 2013 treatment record indicated the following undated order: "Resident to wear TED hose (tight fitting stockings that maintain mild pressure on the legs to prevent blood from clotting) on in A.M. and off at HS (bedtime)." This was documented as done for the first two days of April.</p> <p>A radiology report dated 4/2/13 indicated the following: "There is fracture involving the anterior distal</p>				

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	<p>tibia with minimal displacement. The joint alignment is maintained. There is associated soft tissue swelling."</p> <p>A physician order dated 4/2/13 indicated the following: "Wear rigid ankle brace, no wt (weight bearing) x 4 weeks, repeat L (left) ankle x ray in 4 weeks)."</p> <p>A radiology report dated 4/29/13 was provided by the ADM (Administrator) on 6/25/13 at 3:20 P.M. The report indicated the following: "...joint space narrowing, osteophytes (also known as bone spurs that form along the joint as a reparative response by a cartilage to degenerating joints) and osteopenia (low bone density that precedes osteoporosis)...stable appearance of the bony fragment at the anterior distal tibia..."</p> <p>On 6/20/13 at 1:40 P.M., the ADM was interviewed. She indicated she knows the resident did not fall. She indicated the resident's left ankle was observed and documented to have "plantarflexion contracture." She indicated when the resident was in the hospital in November 2012, it was documented the resident had a history of previous ankle fracture to her left ankle.</p>						

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	<p>On 6/25/13 at 3:30 P.M. the ADM was interviewed. She also provided a copy of the "In-service Training Record" dated 4/4/13. The form indicated the objective: "Please take special time and attention when handling Resident's extremities due to muscle weakness." Twenty two nurses and CNAs had signed the training record. At the time, the ADM indicated the program content was regarding Resident #13 and her care. She indicated the content of the inservice was the objective documented.</p> <p>B. A progress note dated 6/10/13 at 9:20 A.M., indicated, "Res (resident) sitting on her butt between her bed and over the bed table. Staff report that they were changing her brief and turned to throw the brief in the trash and her (sic) a thud and found res sitting on her butt on the floor." The documentation indicated no pain on physical examination.</p> <p>Resident #28's clinical record was reviewed on 6/24/13 at 11:38 A.M. Diagnoses included but were not</p>						

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	<p>limited to: unsteady gait with frequent falls, history of transient ischemic attack, chronic pain disorder, and generalized anxiety disorder. Her current Minimum Data Set Assessment (MDS) dated 4/12/13, indicated extensive assistance of 2 or more staff for transfers and bed mobility.</p> <p>Resident #28's clinical record included a care plan entitled, " Fall/Injury Assessment: Prevention and Management Plan of Care." The care plan had an initiation date of 10/16/12 and latest update of 6/12/13. Fall risk factors included but were not limited to: antianxiety and narcotic medications, osteoarthritis, pain, weakness, and visual impairment.</p> <p>Interventions included but were not limited to: low bed, perimeter mattress (with an opening), hemiheight wheelchair, and bilateral grab bars (bed).</p> <p>On 6/24/13 at 4:50 P.M., the Director of Nursing (DON), was interviewed regarding the 6/10/13 fall. She indicated the resident had fallen during care. She indicated the resident had rolled off the bed when a CNA had turned away to throw away trash during care. She indicated 2</p>			

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	<p>CNAs had been providing care when the resident had fallen during care.</p> <p>On 6/25/13 at 3:53 P.M., the DON was made aware in regard to the 6/10/13 fall, in which supervision by staff had been lacking. The DON agreed and indicated 2 CNAs had been providing care. She indicated CNA #10 had turned away to throw trash away and the resident had rolled off the bed. She indicated CNA #10 had been inserviced in regard to care provided during the 6/10/13 fall.</p> <p>On 6/25/13 at 3:55 P.M., an inservice training record dated 6/10/13 was reviewed. The program content section of the form had been completed with Resident's name (Resident #28) fall. "Objectives: 1. Ensure residents in center of bed prior to turning back. 2. Make sure she keeps good leg stable while on side to avoid rolling out during care." CNA #10 had signed the inservice training record.</p> <p>3.1-45(a)(2)</p>				

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication rate of less than 5 percent. Four residents were observed for medication administration. Two errors in medication administration were observed during 25 opportunities. This resulted in a medication error rate of 8% . Resident #84, Resident #76</p> <p>Findings include:</p> <p>1. During an observation on 6/24/13 at 9:45 A.M., of medication administration on the North Hall, RN #2 removed a Lantus Solostar insulin pen from the medication cart and indicated Resident #84 was to be administered 20 units of Lantus insulin in the morning. The pen was dialed to 20. The Lantus Solostar insulin pen had no name documented on the pen. The Lantus injectable pen did not have packaging from the manufacturer or the pharmacy with a label identifying to whom the pen belonged.</p>	F000332	<p>Resident # 84 has been re-assessed by the IDT with care plans updated as deemed appropriate. Resident # 76 has been re-assessed by the IDT with care plans updated as deemed appropriate. Licensed Supervisory Nurses have been re-educated on the 5 rights of medication administration. It is the responsibility of the Licensed Nurses to pass medications as per physician orders. The DON/designee will be responsible to conduct medication pass observations 5 times a week across shifts times 2 weeks, 1 medication pass observation per week across shifts for 10 weeks, then 1 time a month times 3 months, then quarterly for 2 quarters. Any identified concern will be immediately corrected. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI</p>	07/25/2013	

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	<p>The clinical record of Resident #84 was reviewed on 06/24/13 at 9:59 A.M. The record indicated the diagnoses of Resident #84 included, but was not limited to, dementia, diabetes mellitus, congestive heart failure and polycystic kidney disease.</p> <p>The June 2013 Physicians order read as follows, "Lantus Solostar 100units/ml: Inject 10 units sub-Q once a day"</p> <p>On 6/24/13 at 3:00 P.M., the DON provided the facility's policy and procedure for insulin injections. The facility's policy and procedure read as follows: "...Verify, a total of three times before administration, correct medication dose, dosage form, route, and time."</p> <p>During an interview on 6/24/13 at 10:00 A.M. with RN #2 she indicated the order for the Resident's Lantus insulin had been changed recently and Resident #84 was to receive 20 units in the A.M. and 5 units in the P.M. RN #2 reviewed the Medication administration record and said, "I've made a mistake the order has not been changed, Resident #84 is supposed to get 10 units of Lantus insulin in the morning."</p>		Committee.	

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	<p>2. During an observation on 6/24/13 at 9:45 A.M., of medication administration on the North Hall, RN #2 instilled 1 drop of Refresh in the left and right eye of Resident #76.</p> <p>The clinical record of Resident #76 was reviewed on 06/24/13 at 10:15 A.M. The record indicated the diagnoses of Resident #76 included, but was not limited to, seizure disorder, weakness, osteoarthritis.</p> <p>The June 2013 Physicians order read as follows, "Refresh Optic Eye Drops...instill 1 drop into the left eye 3 times a day for dry eyes."</p> <p>Review of the facility's policy and procedure for eye drops administration read as follows: "...Verify, a total of three times before administration, correct medication dose, dosage form, route, and time."</p> <p>3.1-25(b)(9)</p>			

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to ensure a resident receiving Lantus insulin with a Lantus Solorstar pen received the correct dosage. The resident was administered twice the amount of insulin prescribed by the physician during 1 of 2 observation of insulin administration.</p> <p>Resident # 84</p> <p>Findings include:</p> <p>During an observation on 6/24/13 at 9:45 A.M., of medication administration on the North Hall, RN #2 removed a Lantus Solostar insulin pen from the medication cart and indicated Resident #84 was to be administered 20 units of Lantus insulin in the morning. The pen was dialed to 20. The Lantus Solostar insulin pen had no name documented on the pen. The Lantus injectable pen did not have packaging from the manufacturer or the pharmacy with a label identifying to whom the pen belonged.</p> <p>The clinical record of Resident #84 was reviewed on 06/24/13 at 9:59</p>	F000333	<p>Resident # 84 has been re-assessed by the IDT with care plans updated as deemed appropriate. Licensed Supervisory Nurses have been re-educated on the 5 rights of medication administration. It is the responsibility of the Licensed Supervisory Nurses to pass medications as per physician orders. The DON/designee will be responsible to conduct medication pass observations 5 times a week across shifts times 2 weeks, 1 medication pass observation per week across shifts for 10 weeks, then 1 time a month times 3 months, then quarterly for 2 quarters. Any identified concern will be immediately corrected. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.</p>	07/25/2013	

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	<p>A.M. The record indicated the diagnoses of Resident #84 included, but was not limited to, dementia, diabetes mellitus, congestive heart failure and polycystic kidney disease.</p> <p>The June 2013 Physicians order read as follows, "Lantus Solostar 100units/ml: Inject 10 units sub-Q once a day"</p> <p>On 6/24/13 at 3:00 P.M., the DON provided the facility's policy and procedure for insulin injections. The facility's policy and procedure read as follows: "...Verify, a total of three times before administration, correct medication dose, dosage form, route, and time."</p> <p>During an interview on 6/24/13 at 10:00 A.M. with RN #2 she indicated the order for the Resident's Lantus insulin had been changed recently and Resident #84 was to receive 20 units in the A.M. and 5 units in the P.M. RN #2 reviewed the Medication administration record and said, "I've made a mistake the order has not been changed, Resident #84 is supposed to get 10 units of Lantus insulin in the morning."</p> <p>3.1-25(b)(9)</p>				

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to store and/or label a multidose insulin pen with proper identification as to</p>	F000431	Residents # 29, 13, and 11 have been re-assessed by the IDT with care plans updated as deemed appropriate. Resident #29 was correct resident, #84 was	07/25/2013			

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	<p>whom the insulin pen belonged one of one resident #84 and/or dispose of medication that was intended to have been administered the night before for three of three resident's whose drugs were set up (Residents #13, 29, 11).</p> <p>Resident #84, Resident #13, Resident #29, Resident #11</p> <p>Findings include:</p> <p>1. During an observation on 6/24/13 at 9:45 A.M., of medication administration on the North Hall, RN #2 removed a Lantus Solostar insulin pen from the medication cart and indicated Resident #84 was to be administered 20 units of Lantus insulin in the morning. The pen was dialed to 20. The Lantus Solostar insulin pen had no name documented on the pen. The Lantus injectable pen did not have packaging from the manufacturer or the pharmacy with a label identifying to whom the pen belonged.</p> <p>During an interview with RN #2 on 6/24/13 at 10:00 A.M., RN #2 indicated she knew the insulin pen belonged to Resident #84 because Resident #84 was the only resident on this hall that used a Lanus</p>		<p>incorrect. A one time review of the medication room has been completed to ensure medication storage is as per expectation. The Licenses Supervisory Nurses have been re-educated on Medication Storage. It is the responsibility of the Licensed Supervisory Nurse to store medications as per policy. The DON/designee will be responsible to conduct observations of the medication room to ensure medications are stored as per policy 5 times a week times 2 weeks, 1 observation per week thereafter ongoing.. Any identified concern will be immediately corrected. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.</p>		

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	<p>Solostar insulin pen.</p> <p>During interview with the DON on 6/24/13 at 10:05 A.M., the DON indicated that all medication, including the Lantus Solostar insulin pen, needed to be stored in packaging which identified the person to whom the medication belonged or to have the resident's name written on the medication dispenser unit.</p> <p>2. During an observation of the medication storage room on the North Hall on 6/25/13 at 12:20 P.M., three plastic medication administration cups were observed to be sitting on the first shelf of an unsecured cabinet above the counter. The medication cups contained one pill each. Each medication cup was labeled with a resident's name in black magic marker.</p> <p>During an interview with RN #2 on 6/25/13 at 12:23 P.M., RN #2 indicated the medication in the cups were from the previous evening's 6:00 P.M. medication pass. RN #2 identified the medication at that time. RN #2 indicated she had intended to administer the medications to Resident #11 (Tramadol 50 mg), Resident #84 (Oxycodone 5-325mg), and Resident #13 (Requip 1mg), but</p>						

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	<p>RN #2 indicated she was called to another resident's room unexpectedly. RN#2 indicated she had placed the medications in the medication administration cups and put the cups on the shelf in the medication storage room before responding to the unexpected situation and, because of the distraction, had forgotten she had not administered the medications to the residents.</p> <p>During an interview with the DON on 6/25/13 12:20 P.M., the DON indicated any medication in medication administration cups should not be stored, left or located in the medication storage room.</p> <p>3.1-25(o)</p>			

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review the facility failed to ensure resident rooms and/or bathrooms were maintained in a sanitary, clean and/or homelike manner for 10 of 28 resident rooms and/or bathrooms.</p> <p>Rooms 127, 131, 129, 134, 126, 114, 129, 127, 133, 118</p> <p>Findings include:</p> <p>During the first two days of survey on 6/18/13 and 6/19/13, from 8:30 A.M. to 3:30 P.M. each day, the following observations were made:</p> <p>1. Room 127 was observed to have the toilet had caulking missing around the base of the toilet and was observed to have an accumulation of dark matter, dust and dirt.</p> <p>2. Room 131 the pin on top of the left bi-fold closet door was not in the track frame, which prevented the closet door from being closed and staying closed. Both closet doors were banged up and marred, which exposed various layers and colors of</p>	F000465	<p>1. Room 127 Bathroom has been deep cleaned and the toilet caulking has been replaced.2. The pin on top of the left bi-fold closet door in Room 131 has been put back in the track. The doors of the closet have been repaired.3. The air-conditioning unit in Room 129 will be replaced. The left side of the bi-fold closet door was put back in the track.4. The wall spacing for the air conditioner has been repaired.5. Room 126 has been scheduled to be re-modeled and re-painted.6. Room 114 Bathroom has been deep cleaned and the toilet caulking has been replaced. The left side of the closet door was put back in the track. The doors of the closet have been repaired.7. The air-conditioning unit in Room 129 will be replaced. The left side of the bi-fold closet door was put back in the track. Room 129 has been scheduled to be re-modeled and painted.8. Room 127 Bathroom has been deep cleaned and the toilet caulking has been replaced.9. Room 133 has been scheduled to be re-modeled and re-painted.10. Room 114 Bathroom has been deep cleaned and the toilet caulking has been replaced.11. Room 118</p>	07/25/2013			

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	<p>paint.</p> <p>3. Room 129 was observed to have the Louver vents to the wall air-conditioner were missing. The air conditioner was positioned in the wall below the level of the window. The lower edge of the air conditioner was approximately 6 inches from the floor. The left side of the bi-fold closet door was hanging loose from the track.</p> <p>4. Room 134 was observed to a gap, approximately 1 1/2 inch wide extended the entire length of the right side of the wall mounted air conditioner. The backing to the material on the wall was observed in the space.</p> <p>5. Room 126 was observed to have the baseboard to the right of the closet was missing entirely about 8 inches total around the corner of the closet, exposing various paint color and also metal and the white plaster beneath. To the right side of the resident's bed, there was a 2 foot tall section, with scratched wall surface, exposing the white plaster beneath the pale yellow paint. Black mars were noted to the area as well.</p> <p>6. Room 114 bathroom floor when wiped with a wet cloth, shows dirt and</p>		<p>Bathroom has been deep cleaned. The toilet has been cleaned, with a request for a change in the commode. A request has been submitted with the request of new flooring to be laid.14. The contractor has been contacted to repair the commode in Room 118.A one time audit of the center has been completed to ensure no other areas have not been identified for maintenance or housekeeping services. Staff have been re-educated on completing maintenance and housekeeping tasks as per expectation.It is the responsibility of the Maintenance and Housekeeping staff to ensure resident rooms and/or bathrooms are maintained in a sanitary, clean, and/or homelike manner. The ADM/designee will be responsible to conduct center tours 1 time a week for 12 weeks, 1 time a month for 3 months, and then quarterly for 2 quarters. Any further notified non-compliance will result in 1:1 re-education, up to and including termination as per policy. The ADM/designee will review the results of the audits as per schedule. The reviews will be forwarded to the Quality Performance Improvement Committee monthly for 6 months, and then quarterly for 2 quarters. Any further action will be as determined by the QPI Committee.</p>		

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	<p>hair adhered to the wet cloth, especially around the floor edges and behind the toilet. The base of the toilet had visible dust and dirt on the base edges and the caulking around the toilet base was jagged and observed with dark matter. The closet doors are banged up and marred with dark marks, the closet doors were off white in color on the top coat. A greenish coat of paint below the off white layer was exposed on the bottom portion of all 4 closet doors. The left closet door was not on the closet track.</p> <p>7. Room 129 wall near the air conditioner was observed to be positioned below the level of the window. The level of the lower edge of the air condition was approximately 6 inches off the floor. The protective vents were missing to the front of the unit. The left side of the closet did not close. Scattered tears and rips of wallpaper were observed to the wall behind the resident's bed.</p> <p>8. Room 127 in the resident bathroom, no caulking around the base of the toilet and had an accumulation of dark dust and matter around the base of the toilet.</p> <p>9. Room 133 the following were</p>			

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	<p>observed: various scrapes to the wall to the right of the resident's bed exposing a variety of colors of paint below and the spackling and old, unfilled holes.</p> <p>10. During observation on 6/18/13 at 2:30 P.M. of the bathroom in Room 114, the floor of the bathroom had dirt and debris accumulated in the corners and behind the commode. There was also a stained, waxy buildup observed over the entire floor. Caulking that was observed around the base of the commode was jagged and had an accumulation of dark matter observed. When a wet paper towel was wiped across the flooring, there was hair, dirt and debris observed on the paper towel.</p> <p>11. On 6/18/13 at 2:45 P.M., the bathroom in Room 118 was observed. The flooring was observed to have dark stains on the floor throughout the bathroom. These stains were not removable when wiped with a wet cloth. The base of the commode was observed to have a greyish cement type material around the base at the juncture of the floor. Splatters of the greyish material were observed to be on the base of the commode as well. When a wet paper towel was wiped across the</p>			

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	<p>flooring, there was hair, dirt and debris observed on the paper towel.</p> <p>12. On 6/25/13 at 4 P.M., the Administrator was made aware of the condition of the following rooms: room 134, 129, 133 and 114. She indicated she was aware of the condition of the rooms. She indicated they were replacing the old bi-fold closet doors as they could and trying to remove old wall paper and redo rooms as they could also. She indicated they did not have a due date for completion of the project. She indicated they had renovated other parts of the building in the past such as the lobby, dining room and the hallways.</p> <p>13. On 6/25/13 at 4:38 P.M., the Housekeeping Supervisor (HS) was interviewed. She indicated all resident rooms were cleaned daily. She indicated the daily cleaning included high and low dusting, cleaning bathrooms, sweeping and mopping the floors, dusting the windowsills and dressers, cleaning the interior and exterior of the toilets/sinks/mirrors/paper towel holder/toilet paper and soap dispensers. The HS indicated if the toilet paper roll was missing and/or there was torn wall paper and/or gash</p>						

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	<p>in the wall and/or paint missing, her staff tell her about the concern. Then she, the HS, makes out a maintenance request. The HS indicated staff would also inform her if there was any problem with the air conditioner units. The HS indicated she doesn't currently have any maintenance request submitted. The HS indicated one resident room was deep cleaned on each hall daily. She also indicated the housekeeping staff would report any issues with the closet doors being broken or not working and/or maintenance would just fix them."</p> <p>During interview on 6/25/13 at 4:45 P.M., the Housekeeping Supervisor indicated the flooring was very old and they have been stripped and waxed in the past, but the stains could not be removed.</p> <p>14. On 6/25/13 at 4:52 P.M., the Maintenance Supervisor (MS) was interviewed. He indicated some of the air conditioner units in the building have been discontinued and he can't get replacement parts. He indicated he checks rooms quarterly and on an as needed basis. He indicated he tries to fix holes in the walls and replace closet doors as needed. He indicated he does not have a</p>						

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	<p>schedule per say but tries to fix rooms as the budget allows. Stated he was in the process of phasing out the old white bi-folding closet doors and replacing them with the new brown sliding closet doors. He indicated the pins on the tops of the bi-fold closet doors break off easily and the doors don't close properly. At the time, the toilet in the bathroom which is shared by rooms 118 and 120 was brought to the MS attentions. He indicated the grayish caulking/cement at the base of the toilet and floor was unacceptable work and he will call the contractor back in to correct the problem. The MS indicated the work was done 1 week ago by a contractor. The MS indicated he would fix the toilet paper holder which was observed to have one side of the holder partially hanging off the wall and with the spring loaded bar missing which was to hold the toilet paper in place. The MS indicated at the time, he will order new vents for the air conditioners in rooms 138 and 114.</p> <p>3.1-19(f)</p>			