

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/23/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
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F0000	<p>This visit was for a the investigation of Complaint IN00104242.</p> <p>Complaint IN00104242-Substantiated, Federal/State deficiencies related the allegations are cited at F-164, F-241, F-246, F-253, F-311, F-315, F-318, F-332, F-353, &amp; F-467.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: March 22, &amp; 23, 2012</p> <p>Facility number: 000341 Provider number: 155459 AIM Number: 100286550</p> <p>Survey team: Angel Tomlinson, RN-TC Leslie Parrett, RN Barbara Gray, RN Sharon Lasher, RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 2 Medicaid: 25 Other: 6</p>	F0000		

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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	<p>Total: 33</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 29, 2012 by Bev Faulkner, RN</p>			

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F0164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview and record review, the facility failed to provide privacy for a resident using the bathroom for 1 of 3 residents sampled for privacy in a total sample of 11 (Resident #A).</p> <p>Finding include:</p>	F0164	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited</p>	04/22/2012	

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	<p>Review of the record of Resident #A on 3-22-12 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's dementia, depression, osteoarthritis and anxiety.</p> <p>The Minimum Data Set (MDS) assessment for Resident #A, dated 2-7-12, indicated the resident required extensive assistance for bathroom use of two people.</p> <p>During observation on 3-22-12 at 1:55 p.m., CNA #7 and CNA #6 assisted Resident #A to the bathroom in the facility hallway, the bathroom door was not shut and a curtain was pulled across the doorway. CNA #7 left the bathroom twice while Resident #A was sitting on the toilet, exposing the resident to two female residents sitting in the hallway. Interview with CNA #7 during this time, indicated she did not shut the bathroom door because there was no ventilation in the bathroom and the bathroom was too hot with the door shut.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-3(p)(4)</p>		<p>correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 4/22/12.</p> <p><u>F164</u></p> <p>-</p> <p>It is the policy of this facility to provide privacy for residents, including when they are using the bathroom.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The privacy curtains have been removed from the doorways of all bathrooms.</u></p>				

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			<p>-</p> <p><u>A replacement motor for the ventilation fan has been ordered and will be replaced by 4/22/12.</u></p> <p>-</p> <p><u>All staff will be inserviced on 4/12/12 regarding the need to protect residents' privacy while they are using the bathroom by shutting the bathroom doors when the bathroom is in use.</u></p> <p>-</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents using the bathroom have the potential to be affected by this practice.</u></p> <p><u>If the Administrator or any manager observes that a resident's privacy is not being protected, including during times of bathroom use, he/she will immediately take measures to provide privacy for the resident. Once that is done, the Administrator or involved department manager will inservice the staff involved on the</u></p>	

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			<p><u>facility policy regarding providing privacy to residents during care and toileting. Progressive disciplinary action will also be rendered for instances of continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The department managers will observe for protection of resident privacy as part of their Guardian Angel rounds which occurs at least 5 days a week. In addition, the Administrator and all department managers will observe for privacy protection as part of their routine rounds that occur several times during each tour of duty. If any issues are identified regarding the provision of privacy for residents, the Administrator or department managers will proceed as indicated in question #2.</p> <p>-</p>		

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			<p>4. <u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The Administrator will bring the results of the Guardian Angel rounds and observations made during other rounds to the monthly QA&amp;A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&amp;A Committee meeting. The monitoring for resident privacy will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p>		

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F0241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure 2 of 11 residents (#B and #C) were not left in dirty clothes and failed to ensure 7 dependent residents were not left sitting in the hallway of the facility for an extended amount of time for 7 of 7 residents randomly observed in a total sample of 11 (Resident #A, #B, #C, #H, #I, #J and #K)</p> <p>Findings include:</p> <p>1.) The record of Resident #B was reviewed on 3/22/12 at 11:30 a.m.</p> <p>Resident #B's MDS (Minimum Data Set) assessment, dated 1/31/12, indicated the resident had scored 8 on the BIMS (Brief Interview for Mental Status). The range of 8-12 indicates moderately impaired cognition. The MDS indicated the resident required extensive assistance with dressing.</p>	F0241	<p>F241</p> <p>-</p> <p><u>It is the policy of this facility to ensure that residents are not left in dirty clothing and not left sitting in the hallway for extended periods of time.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>All staff will be inserviced on 4/12/12 regarding provision of dignity and respect for the residents, including cleaning their clothing and engaging them in other activities, rather than leaving them to sit in the hallways.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p>	04/12/2012			

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	<p>On 3/22/12 at 10:10 a.m., Resident #B was observed up in hallway with a large amount of food on his sweat pants.</p> <p>On 3/22/12 at 12:30 p.m., Resident #B was observed eating lunch with his right hand, not using his left hand. Resident #B had on the same sweat pants and spilled more food on his sweat pants with almost every bite attempted.</p> <p>During interview with CNA #1 on 3/22/12 at 2:30 p.m., the CNA indicated she was not aware of Resident #B's sweat pants being dirty because she was not taking care of him until now.</p> <p>2.) The record of Resident #C was reviewed on 3/23/12 at 8:45 a.m.</p> <p>Resident #C's MDS assessment, dated 3/2/12, indicated the resident had scored 6 on the BIMS. The range of 0-7 indicates severe impaired cognition. The MDS indicated the resident required extensive assistance with dressing.</p> <p>Resident #C was observed up in his wheelchair in the hallway on 3/22/12 at 10:10 a.m., with a large amount of food crumbs on his shirt.</p> <p>Resident #C was observed up in his wheelchair in the hallway on 3/22/12 at</p>		<p>-</p> <p><u>All residents have the potential to be affected. In the future, if the Administrator or department manager observes that a resident is not wearing clean clothing or that he/she is sitting in the hallway for long periods of time, they will intercede at that time to get the resident cleaned up and clothed in clean clothing and/or will also get the resident moved to another area for an alternate activity. Once that is done, the DON or Administrator will retrain the staff involved regarding the facility policy for making sure that residents wear clean clothing and that they are offered and assisted, if necessary, to participate in some type of activity, if they choose. Ongoing noncompliance will be dealt with by means of progressive discipline.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The nursing staff will be retrained on post-meal grooming that is to take place before the resident</p>		

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	<p>2:45 p.m., with the same shirt on and the crumbs of food were smeared on his shirt.</p> <p>3.) During initial tour of the facility on 3-22-12 at 10:00 a.m., Residents #A, #B, #C, #H, #I, #J and #K were sitting in the hallway of the facility. Interview the Minimum Data Set (MDS) coordinator at this time, indicated Resident #A was totally dependent on staff for care, Resident #B was totally dependent on staff for care, Resident #C was totally dependent on staff for care, Resident #H was totally dependent on staff for care, Resident # I required assistance from staff for care, Resident #J was totally dependent on staff for care and Resident #K required assistance from staff for care.</p> <p>During observation on 3-22-12 at 10:25 a.m., Resident #A was sitting in the hallway asleep.</p> <p>Review of the activity schedule provided by the Administrator on 3-22-12 at 11:00 a.m., the facility had an activity movie scheduled on 3-22-12 at 10:00 a.m., and an activity called "Roll it" at 2:00 p.m on 3-22-12.</p> <p>During observation on 3-22-12 at 11:10 a.m., Resident #A was sitting in the hallway with her eyes closed and was</p>		<p>leaves the dining room. There is a container of warm wet washcloths that are to be used to wipe the resident's face and hands or to assist him/her to do it by him/herself. The staff will also wipe out any food crumbs or residue that is in the wheelchairs and on the resident's clothing. Once that is completed, the resident will be assisted to leave the dining room. If the resident has a large spill on his/her clothing that cannot be cleaned as indicated previously, the nursing staff will change the clothing that is soiled.</p> <p>The Activity Director will assess the residents who are observed to sit in the hallways for a length of time in order to determine the type of activity that can be offered to them. Once that is done, the Activity Director will provide the opportunity for these activities, as indicated by her assessment. The Activity</p>				

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	<p>talking, there were no residents or staff talking with the resident.</p> <p>During observation on 3-22-12 at 12:00 p.m., Resident #A was sitting in the hallway, no residents or staff were with the resident.</p> <p>During observation on 3-22-12 at 12:15 p.m., Resident #A was taken by facility staff to the dining room for lunch.</p> <p>During observation on 3-22-12 at 2:15 p.m., Resident #A was sitting in the hallway in her wheelchair.</p> <p>During observation on 3-22-12 at 2:45 p.m., Resident #A, #B, #C, #H, #I, #J and #K were sitting in the hallway of the facility. These residents were observed sitting in the hallway throughout the day except when taken to the dining room for lunch.</p> <p>During interview with the Dietary Manager on 3-23-12 at 10:00 a.m., indicated the Activity Director was off on 3-22-12 and the Maintenance Supervisor was responsible to have the 10:00 a.m. activity of the movie. The Dietary Manager indicated the cook was responsible for the 2:00 p.m. activity. The Dietary Manager indicated on 3-22-12 at 10:10 a.m., she realized the movie had not</p>		<p>Director will also update each one's care plan, document their participation or refusal, and their adjustment to the newly defined activity program(s) that they are being offered.</p> <p><u>The Administrator, Department Managers, and other designees will monitor the appearance of the residents after meal time to make sure that post meal grooming has occurred. In addition they will monitor for resident placement in the hallways and the alternate activities that are being offered to the residents as part of their rounds made throughout each tour of duty. Any concerns that are observed will be handled as indicated in question #2.</u></p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The Administrator will bring the results of their monitoring of the residents' post meal grooming to the monthly QA&amp;A Committee meeting for review and further recommendations for process.</u></p>				

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	<p>been started and put the movie in. When queried why no residents were taken to the movie to watch, the Dietary Manager indicated normally the Activity Director and the Aides would bring the residents to activities.</p> <p>During interview with the Maintenance Supervisor on 3-23-12 at 10:10 a.m., indicated he was not aware he was responsible for the activity on 3-22-12 at 10:00 a.m.</p> <p>During interview with the Maintenance Supervisor on 3-23-12 at 10:20 a.m., indicated he asked the facility about the 10:00 a.m. activity and he was supposed to put a movie in for residents on 3-22-12 at 10:00 a.m. and he did not do this. The Maintenance Supervisor indicated the nursing staff would have been responsible to bring the residents to the activity.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-3(t)</p>		<p><u>improvement. The Activity Director will bring the results of her assessments of the activity needs for those residents who are sitting in the hallway for long periods of time, as well as their participation in the activities that have been made part of their care plan. The Committee will review and give recommendations for further improvement, as well, in this area.</u></p> <p>-</p> <p><u>This monitoring and follow up will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/12/12</u></p>		

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F0246 SS=D	<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, interview and record review, the facility failed to ensure a resident who required eye glasses for vision was provided the glasses for 1 of 3 residents sampled for missing items in a total sample of 11 (Resident #A).</p> <p>Finding include:</p> <p>During observation on 3-22-12 at 10:25 a.m., Resident #A was sitting in the hallway in front of the nursing station, the resident did not have on eye glasses.</p> <p>Review of the record of Resident #A on 3-22-12 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's dementia, depression, osteoarthritis and anxiety.</p> <p>The Minimum Data Set (MDS) assessment for Resident #A, dated 2-7-12, indicated the resident's ability to see in adequate light (with glasses or other</p>	F0246	<p>F246</p> <p>-</p> <p><u>It is the policy of this facility to ensure that residents who require assistive devices, such as eyeglasses for vision, are provided with them.</u></p> <p>-</p> <p><u>The facility wishes to clarify this particular issue. Upon receipt of the 2567, the facility Administrator attempted to contact Resident #A's son regarding her eyeglasses. After some time, the son responded and told the Administrator that he had taken the resident's eyeglasses home with him about a year ago, because she didn't wear them and destroyed her previous pair. That conversation has since been noted in the social service progress notes in the resident's chart.</u></p> <p>-</p> <p><u>1. What corrective action will be</u></p>	04/22/2012	

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	<p>visual appliances)- impaired- sees large print, but not regular print in newspaper/books and corrective lenses-yes.</p> <p>During observation on 3-22-12 at 2:45 p.m., Resident #A was sitting in the hallway in front of the nursing station, the resident did not have on eye glasses.</p> <p>During observation on 3-23-12 at 9:30 a.m., Resident #A was sitting in the hallway in front of the nursing station looking at a magazine. The resident did not have on glasses.</p> <p>During observation on 3-23-12 at 9:40 a.m., the Activity Director pushed Resident #A down to the dining room for an activity. When queried about Resident #A's eye glasses, the Activity Director indicated she would look for them.</p> <p>During observation on 3-23-12 at 10:20 a.m., Resident #A was sitting in the dining room in an activity and was not wearing glasses. Interview with the Activity Director at this time indicated she had looked for Resident #A's eye glasses and was not able to find them.</p> <p>Interview with CNA #2 on 3-23-12 at 10:40 a.m., indicated she was caring for Resident #A. CNA #2 indicated the</p>		<p><u>done by the facility?</u></p> <p>-</p> <p><u>In order to ascertain whether or not Resident #A can read any more, she is being provided the opportunity to look at large print material. Her response to it is being documented in her medical record. If she can read or shows interest in reading, the facility will contact the son regarding his returning her eyeglasses to the facility for her use. If she is unable to read or shows no interest or ability to read, the facility will document that as well. Her care plan will be updated according to her current status when it is determined by the staff. If she cannot read or is not interested in reading, she will be supplied with another type of activity suitable for her current condition.</u></p> <p>-</p> <p><u>The staff will be retrained on the need to provide assistive devices, such as glasses, for those residents who require them. They will also be reminded to follow up with the Social Services Director (SSD), another department manager, or the Administrator if an assistive device cannot be found. The notification and any subsequent efforts made to find the device or to provide another one will be documented in the</u></p>				

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	<p>resident's eye glasses should be in her top drawer of her dresser. During observation at this time, CNA #2 searched for the resident's eye glasses and was unable to locate them. CNA #2 indicated maybe one of the resident's family member had taken the eye glasses home. CNA #2 indicated the resident takes her eye glasses off and lays them down sometimes.</p> <p>Interview with LPN #8 on 3-23-12 at 10:45 a.m., indicated she did not know where Resident #A's eye glasses were. LPN #8 indicated she was not sure if a family member had taken them home. LPN #8 indicated Social Services may have documentation on the eye glasses.</p> <p>Review of Resident #A's Social Service notes on 3-23-12 at 10:45 a.m., indicated no documentation of the resident's eye glasses being taken home by a family member.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-3(v)(1)</p>		<p><u>resident's medical record and on a resident concern form.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>Residents using assistive devices have the potential to be affected by this practice.</u></p> <p><u>If the Administrator or other staff person is aware that a resident is missing an assistive device, he/she will report that to his/her supervisor, the SSD, another department manager, or the Administrator. The follow up to that report will be coordinated by the SSD, and the notification and any subsequent efforts made to find the device or to provide another one will be documented in the resident's medical record and on the resident concern form.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>In addition to notifying the</p>		

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			<p>immediate supervisor, SSD, Department Manager, or Administrator when an assistive device is found missing, the Charge Nurse will note the missing item on the 24 hour report and in the focus charting. The DON and SSD will review these items as part of their daily routine during each tour of duty that occurs at least 5 days a week. The missing item will also be reported by the DON or SSD as a resident concern at the next scheduled morning management meeting for further recommendations for follow up. As part of the investigation, the family member or legal representative will be contacted by the facility to notify them that an item is missing. That notification and the family/legal representative's response will be documented in the resident's medical record and on the concern form.</p> <p>-</p>		

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			<p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The SSD will bring the results of resident/family/legal representative's concerns regarding missing assistive devices and the results of the investigation done to find them to the next scheduled monthly QA&amp;A Committee meeting for review. This will continue on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p>		

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure the environment was maintained in a state of good repair and free of odor; in that broken and stained tiles were observed in 3 of 4 bathrooms and a strong urine odor was noted in Room # 12 and permeated through 1 of 3 hallways observed for odors. This had the potential to affect 33 residents who utilized the facility bathrooms and hallways.</p> <p>Findings include:</p> <p>1.) An environmental tour was conducted with the Maintenance Supervisor on 3/22/12 at 10:10 A.M. In Bathroom #2 there were 3 areas of tile missing on the floor, approximately the size of a quarter to half dollar. The 3 areas were filled in with grout. There was 1-1 Inch tile missing on the shower floor. There was a blackish and brownish substance on the shower room walls.</p> <p>In Bathroom #3 there were two 1 inch tiles missing on the bathroom floor. There was a 1/4 inch wide by 4 inch long section of tile missing on the bathroom</p>	F0253	<p><u>F253</u></p> <p>-</p> <p><u>It is the policy of this facility to maintain resident bathrooms in a state of good repair and free of odor.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The bathrooms will be deep cleaned and scrubbed. In addition, the broken tile and grout will be replaced. The Maintenance Supervisor will also re-</u></p> <p><u>caulk some areas that have uneven areas around the tile by 4/22/12.</u></p> <p>-</p> <p><u>A replacement motor for the ventilation fan that controls the bathroom air and ventilation has been ordered and will be replaced by 4/22/12.</u></p>	04/22/2012			

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	<p>floor that was filled in with caulking. The caulking had worn down resulting in unevenness of the floor. There were 16 - 1 inch tiles on the bathroom floor with sections missing surrounding the floor drain, filled in with grout. The grout was worn down resulting in unevenness of the floor. There were numerous small chunks of tile missing on the remainder of the bathroom floor.</p> <p>In Bathroom #4 there was one 1 inch tile missing from the bathroom floor. There was a brownish and blackish substance on the shower walls.</p> <p>An interview with Housekeeping/Laundry Staff #9 on 3/22/12 at 11:00 A.M., indicated the brownish and blackish areas on the shower walls would not come off. Housekeeping/Laundry Staff #9 indicated the facility bathrooms were cleaned at least daily and often several times a day.</p> <p>An interview with the Administrator on 3/23/12 at 10:42 A.M., indicated all 33 residents utilized all 4 bathrooms in the facility.</p> <p>2.) On 3/22/12 at 10:10 A.M., a very strong urine odor was noted in the north hallway of the facility. A closer observation indicated the strong urine odor was coming from Bedroom #12.</p>		<p>-</p> <p><u>The housekeeping and maintenance staff will be inserviced by the Administrator regarding the need for cleaning of the bathrooms on a regular basis, including deep cleaning and scrubbing of all areas. In addition, the condition of the bathroom physical plant, including the tile, grout, caulking, and ventilation will be reviewed with the Maintenance Supervisor. All retraining will be done by 4/22/12.</u></p> <p>-</p> <p><u>The nursing staff will be inserviced by the Administrator and DON by 4/22/12 regarding the location of replacement urinary drainage bags. The flooring of Bedroom #12 has been removed, the concrete has been cleaned and sealed, and new flooring has been installed.</u></p> <p>-</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents have the potential to be affected. If the Administrator</u></p>		

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	<p>The entire bedroom smelled strongly of urine.</p> <p>An interview with the Minimum Data Set (MDS) Coordinator on 3/22/12 at 10:36 A.M., indicated a resident's urinary drainage bag had leaked during the night. The MDS Coordinator indicated the night shift nurse was unable to locate any urinary drainage bags and had laid blankets on the floor to absorb the leaking urine.</p> <p>On 3/22/12 at 2:08 P.M., Bedroom #12 still had a strong urine odor that could easily be smelled in the hallway.</p> <p>On 3/22/12 at 2:34 P.M., LPN #3 indicated the night shift nurse reported to her at the beginning of day shift, a resident's urinary drainage bag had leaked during the night. The night shift nurse was unable to locate any urinary drainage bags and had laid blankets on the floor to absorb the leaking urine. LPN #3 indicated she had changed the resident's urinary drainage bag that morning. LPN #3 indicated the blankets were off of the floor at the time she changed the urinary drainage bag. LPN #3 indicated Bedroom #12 had been cleaned after the odor was noted that morning. LPN #3 indicated "evidently they didn't clean the floor." LPN #3 indicated she could still smell the</p>		<p><u>finds that any resident care area, including the bathrooms, is in need of cleaning or repair. she will follow up with the manager responsible for those areas to make sure that they are corrected quickly. Once that is done she will retrain the staff involved regarding the facility policy for cleaning and maintaining the specific areas of concern. Progressive disciplinary action will be used for continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The Maintenance Supervisor will check the bathrooms' physical plant, including the ventilation as part of the facility's preventive maintenance program and will document those checks and the findings. He will bring the findings to the Administrator at the next scheduled morning management meeting which occurs at least 5 days a week for review and further direction,</p>				

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	<p>strong urine odor 15 to 20 feet down the north hallway.</p> <p>An interview with the Administrator on 3/22/12 at 3:15 P.M., indicated Bedroom #12 had been cleaned after the strong urine odor was noted that morning. The Administrator indicated Bedroom #12 continued to smell strongly of urine. The Administrator indicated the floor tile would have to be removed.</p> <p>On 3/23/12 at 9:03 A.M., Bedroom #12 continued to smell strongly of urine.</p> <p>An interview with the Maintenance Supervisor on 3/23/12 at 10:08 A.M., indicated he planned to remove the floor tile in Bedroom #12 and use a product on the concrete that would remove the strong urine odor.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-19(f)</p>		<p>if needed.</p> <p>The Administrator and department managers will check the condition of the bathrooms and resident bedrooms as part of the Guardian Angel program that occurs at least 5 days a week. In addition, they will check resident care areas for cleanliness, repair, and odor as part of their routine rounds that occur as part of each tour of duty. Any identified issues will be addressed immediately as indicated in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The Administrator will bring the results of the Guardian Angel and other rounds, as well as the preventive maintenance checks to the monthly QA&amp;A Committee meeting for review and recommendations for process improvement. This will continue</u></p>		

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			<u>on an ongoing basis.</u>  -  <u>Date of Compliance: 4/22/12</u>	

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F0311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review, the facility failed to provide an restorative ambulation and toileting program for 1 of 3 residents sampled for specialized rehabilitation in an total sample of 11 (Resident #A).</p> <p>Fining include:</p> <p>During observation on 3-22-12 at 10:10 a.m., Resident #A was sitting in a wheelchair in the facility hallway in front of the nursing station.</p> <p>Review of the record of Resident #A on 3-22-12 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's dementia, depression, osteoarthritis and anxiety.</p> <p>The Minimum Data Set (MDS) assessment for Resident #A, dated 8-19-11, indicated the resident required extensive assistance of one person to walk in the corridor.</p> <p>The Minimum Data Set (MDS)</p>	F0311	<p>F311</p> <p>-</p> <p><u>It is the policy of this facility to provide appropriate treatment and services including provision of restorative ambulation and toileting programs for residents.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>A new staff member was not aware that Resident #A had a restorative program for toileting and ambulation. She saw the resident sitting in the wheelchair and thought that she was simply waiting for someone to take her to the dining room for lunch. The restorative programs for this resident were reviewed with the new staff member on 3/30/12.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the</u></p>	04/22/2012	

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	<p>assessment for Resident #A, dated 2-7-12, indicated the following : the resident required extensive assistance for bathroom use of two people, transfer-extensive assistance of two people, walk in corridor- extensive assistance of two people and bowel and bladder continence-frequently incontinent.</p> <p>The restorative self care program for Resident #A, dated March 2012, indicated the resident would participate in an scheduled toileting program and will not have more than 5 incontinent episodes during waking hours. The resident would be assisted to the bathroom when she woke up in the morning, after breakfast, before and after lunch and supper and before she went to bed.</p> <p>The restorative self care program for Resident #A, dated March 2012, indicated the resident would participate in an restorative ambulation program and would be able to walk to and from meals daily with assistance from two staff and a gait belt.</p> <p>During observation on 3-22-12 at 12:15 p.m., Resident #A was taken to the dining room in her wheelchair by facility staff. The resident had not been offered to go to the bathroom or to ambulate to the meal.</p>		<p><u>same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents who have restorative programs could be affected by this practice. If the Administrator or DON find that a resident is not receiving restorative programs that have been planned for him/her, they will intervene immediately and retrain the staff as necessary to make sure that the resident receives the necessary programs. Once that is done, the DON will retrain all staff involved regarding the facility policy for provision of restorative programs and render progressive disciplinary action for continued instances of noncompliance. For new staff members, the DON will review the CNA assignment sheets with them so that they know where to get the information regarding resident care, including restorative programs.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON and MDS Coordinator will review the restorative programs for all residents to make sure that</p>				

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	<p>During observation on 3-22-12 at 1:55 p.m., CNA #6 and CNA #7 assisted Resident #A with a gait belt from the dining room to the bathroom. Resident #A's pants and brief were soaked with urine and the resident had a strong smell of urine. In interview at this time, CNA #7 indicated Resident #A should have been taken to the bathroom prior to going to lunch and the resident should have been assisted with walking to the dining room for lunch.</p> <p>The Restorative Program policy provided by the nurse consultant on 3-23-12 at 11:00 a.m., indicated "each resident will receive the necessary care to attain or maintain the highest practicable physical, mental and psychosocial well being, in accordance with the comprehensive assessment and plan of care." "Restorative nursing is an integral component in maintaining the resident's overall well being and functional abilities at his/her highest level."</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-38(a)(2)(B) 3.1-38(a)(2)(C)</p>		<p>they are still in place and appropriate for each resident. When that is done, the DON will update the CNA assignment sheets to reflect those restorative programs. In addition, the MDS Coordinator will make sure that each resident care plan is updated to match the current restorative programs being provided, and she will check the restorative nursing forms at least weekly for documentation that those programs have been provided. If the Administrator, DON, or MDS Coordinator identifies issues with the provision of restorative nursing programs, action will be taken as outlined in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The MDS Coordinator will bring the list of residents on restorative</u></p>		

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			<p><u>programs, along with their current status regarding participation in those programs, to the monthly QA&amp;A Committee meeting for review and recommendations for improvement. This will occur on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p>	

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure the scheduled toileting program was followed to promote urinary continence resulting in the resident having urine soaked clothing for 1 of 3 residents sampled for toileting in a sample of 11 (Resident #A).</p> <p>Fining include:</p> <p>During observation on 3-22-12 at 10:10 a.m., Resident #A was sitting in a wheelchair in the facility hallway in front of the nursing station.</p> <p>Review of the record of Resident #A on 3-22-12 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's dementia, depression, osteoarthritis and anxiety.</p>	F0315	<p><u>F315</u></p> <p>-</p> <p><u>It is the policy of this facility to ensure that scheduled toileting programs are followed in order to promote urinary continence.</u></p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>A new staff member was not aware that Resident #A had a restorative program for toileting. She saw the resident sitting in the wheelchair and thought that she was simply waiting for someone to take her to the dining room for lunch. The restorative programs for this resident were reviewed with the new staff member on 3/30/12.</u></p>	04/22/2012	

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	<p>The Minimum Data Set (MDS) assessment for Resident #A, dated 2-7-12, indicated the following : the resident required extensive assistance for bathroom use of two people, transfer-extensive assistance of two people, walk in corridor- extensive assistance of two people and bowel and bladder continence-frequently incontinent.</p> <p>The restorative self care program for Resident #A, dated March 2012, indicated the resident would participate in an scheduled toileting program and will not have more than 5 incontinent episodes during waking hours. The resident would be assisted to the bathroom when she woke up in the morning, after breakfast, before and after lunch and supper and before she went to bed.</p> <p>During observation on 3-22-12 at 12:15 p.m., Resident #A was taken to the dining room in her wheelchair by facility staff. The resident had not been offered to go to the bathroom before being taken to the dining room.</p> <p>During observation on 3-22-12 at 1:55 p.m., CNA #6 and CNA #7 assisted Resident #A with a gait belt from the dining room to the bathroom. Resident #A's pants and brief were soaked with urine and the resident had a strong smell</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents who have restorative programs could be affected by this practice. If the Administrator or DON find that a resident is not receiving restorative programs that have been planned for him/her, they will intervene immediately and retrain the staff as necessary to make sure that the resident receives the necessary programs. Once that is done, the DON will retrain all staff involved regarding the facility policy for provision of restorative programs and render progressive disciplinary action for continued instances of noncompliance. For new staff members, the DON will review the CNA assignment sheets with them so that they know where to get the information regarding resident care, including restorative programs.</u></p> <p>-</p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p>				

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	<p>of urine. In interview at this time, CNA #7 indicated Resident #A should have been taken to the bathroom prior to going to lunch. This indicated the resident had not been assisted to the bathroom for 3 hours and 45 minutes.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-41(a)(2)</p>		<p>The DON and MDS Coordinator will review the restorative programs for all residents to make sure that they are still in place and appropriate for each resident. When that is done, the DON will update the CNA assignment sheets to reflect those restorative programs. In addition, the MDS Coordinator will make sure that each resident care plan is updated to match the current restorative programs being provided, and she will check the restorative nursing forms at least weekly for documentation that those programs have been provided. If the Administrator, DON, or MDS Coordinator identifies issues with the provision of restorative nursing programs, action will be taken as outlined in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient</u></p>		

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			<p><u>practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The MDS Coordinator will bring the list of residents on restorative programs, along with their current status regarding participation in those programs, to the monthly QA&amp;A Committee meeting for review and recommendations for improvement. This will occur on an ongoing basis.</u></p> <p>-</p> <p>Date of Compliance: 4/22/12</p>	

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's range of motion was monitored and did not decline for 1 of 3 residents reviewed for range of motion in a sample of 11. (Resident #B)</p> <p>Findings include:</p> <p>The record of Resident #B was reviewed on 3/22/12 at 11:30 a.m. Resident #B's diagnoses included but were not limited to Parkinson's Disease, Alzheimer's disease and subdural hematoma (a collection of blood on the surface of the brain).</p> <p>Resident #B's MDS (Minimum Data Set) assessment, dated 1/31/12, indicated the following:</p> <ul style="list-style-type: none"> <li>- BIMS (Brief Interview for Mental Status) score of 8. 8-12 indicates moderately impaired.</li> <li>- transfer, required extensive assistance</li> <li>- walk in room or corridor, activity did not occur</li> </ul>	F0318	<p><u>F318</u></p> <p>-</p> <p><u>It is the policy of this facility to ensure that a resident's range of motion is monitored and does not decline.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>In reviewing the 2567 and Resident #B's MDS, it was noted that the MDS Coordinator coded the MDS for range of motion in error. Since the resident's admission in July of 2010 there has been no change in his functional status under Section G. It was marked in error, but has been corrected. Therefore, the resident has not had a decline in his range of motion since admission.</u></p>	04/22/2012	

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	<p>- functional limitation in range of motion, upper extremity (shoulder, elbow, wrist and hand), impairment on one side</p> <p>Resident #B's MDS assessment, dated 11/10/11, indicated functional limitation in range of motion, no impairment</p> <p>Resident #B's care plan, dated 2/2/12, indicated "problem, at risk for decline in mobility related to cognitive loss and weakness. Goal, I will participate in a restorative AROM (active range of motion, resident performs range of motion) problem and will do at least 5 reps to each extremity 6 times weekly during funercise. Interventions, provide cueing encouragement, assistance, make sure I am in the dining room by 11:00 a.m., Monday thru Saturday, monitor for increase difficulty moving extremities and licensed nurse to re-eval at least quarterly."</p> <p>A document titled "Monthly Restorative Self-Care Program" in Resident #B's clinical record, dated 3/12, indicated "plan, I will participate in a restorative AROM program and will do at least 5 reps to each extremity 6 times weekly during funercise with only cueing from staff. The document indicated Resident #B had attended the funercise 17 days of the 29 days in February.</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents requiring restorative care to prevent decline in their functional status have the potential to be affected by this practice.</u></p> <p>-</p> <p><u>If the Administrator or DON find that a resident is not receiving restorative programs that have been planned for him/her, they will intervene immediately and retrain the staff as necessary to make sure that the resident receives the necessary programs. Once that is done, the DON will retrain all staff involved regarding the facility policy for provision of restorative programs and render progressive disciplinary action for continued instances of noncompliance. For new staff members, the DON will review the CNA assignment sheets with them so that they know where to get the information regarding resident care, including restorative programs.</u></p> <p><u>3. What measures will be</u></p>				

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	<p>During an interview with the Activity Director on 3/23/12 at 8:35 a.m., indicated Resident #B attends the funercise group program and can exercise his right arm on command. She also indicated Resident #B can only raise his left arm a small amount and some days not at all. The Activity Director stated "he can not move his legs but he taps his feet."</p> <p>During an interview with CNA #1 on 3/23/12 at 8:25 a.m., indicated Resident #B does AROM "you just have to tell him what to do and he will bend his legs, right arm but his left arm is very weak sometimes he uses his right arm and lifts his left arm.</p> <p>During an interview with Occupational Therapist #4 on 3/23/12 at 9:25 a.m., indicated when Resident #B's was discharged from therapy on 8/31/11 his left arm had 120 degrees of range of motion in his left shoulder and his left elbow had 45 degrees of range of motion.</p> <p>Resident #B's treatment record, dated 2/12, indicated AROM performed twice a day during February, 2012.</p> <p>On 3/23/12 at 9:15 a.m., CNA #2 was observed assisting Resident #B with range</p>		<p><u>put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON and MDS Coordinator will review the restorative programs for all residents to make sure that they are still in place and appropriate for each resident. When that is done, the DON will update the CNA assignment sheets to reflect those restorative programs. In addition, the MDS Coordinator will make sure that each resident care plan is updated to match the current restorative programs being provided, and she will check the restorative nursing forms at least weekly for documentation that those programs have been provided. If the Administrator, DON, or MDS Coordinator identifies issues with the provision of restorative nursing programs, action will be taken as outlined in question #2.</p>	
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	<p>of motion. Resident #B was observed doing AROM with his right arm, he raised his left arm approximately 1 inch, his left leg approximately 1 inch off the floor and his right leg 4 to 5 inches off the floor. Resident #B was not able to bend his left arm, right or left leg. CNA #2 did PROM (passive range of motion) on Resident #B's left arm and right and left leg.</p> <p>During an interview with CNA #2 on 3/23/12, at 9:20 a.m., indicated Resident #B was unable to perform AROM with his left arm or either of his legs and needed PROM (passive range of motion, caregiver performs range of motion).</p> <p>During an interview on 3/23/12 at 10:05 a.m., Restorative LPN #3, indicated residents assessment for ROM (range of motion) are completed quarterly and a form was not used. "I do not use a form now but we had an old form that I no longer have but I remember what was on the form." Restorative LPN #3 indicated there was no documentation of any of the ROM quarterly assessments.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-42(a)(2)</p>		<p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The MDS Coordinator will bring the list of residents on restorative programs, along with their current status regarding participation in those programs, to the monthly QA&amp;A Committee meeting for review and recommendations for improvement. This will occur on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p>				

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on record review and observation, the facility failed to ensure a medication error rate of less than 5 percent for 4 of 9 residents reviewed during medication pass. 22 medication errors were observed during 48 opportunities for error in medication administration. This resulted in a medication error rate of 45.8 %. (Resident # D, # E, # F, and #H)</p> <p>Findings include:</p> <p>1. ) Observation of medication administration on 3/22/12 beginning at 11:05 a.m., the following medications were administered to Resident # D at 11:05 a.m. Clonidine 0.2 mg- ordered three times a day 9 a.m., 4 p.m., 8 p.m. lisinopril 40 mg- ordered twice daily 9 a.m., 4 p.m. Plavix 75 mg every day 9 a.m. potassium chloride 20 meq- ordered twice a day 9 a.m., 4 p.m. Isordil 10 mg- ordered twice a day 9 a.m., 4 p.m. Depakote 125 mg- ordered twice a day 9 a. m., 4 p.m.</p>	F0332	<p><u>F332</u></p> <p>-</p> <p><u>It is the policy of this facility to ensure that medications are given on a timely basis, thereby resulting in no medication errors.</u></p> <p>-</p> <p><u>It should be noted that when the surveyor observed medication administration on the second day of survey, they were given timely and no medication errors were noted.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The Administrator and DON are developing a staffing contingency plan by 4/22/12 that can be put into place whenever circumstances arise that reduce the number of staff working in the facility on a specific day or shift. This will include the use of licensed nurses or QMAs that are working in other positions in the</u></p>	04/22/2012	

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	<p>Cymbalta 60 mg every day at 9 a.m. Vicodin 5-500 mg every morning at 9 a.m. Ativan 1 mg- ordered twice a day 9 a.m., 4 p.m.</p> <p>Review of Physician recapitulation orders,dated 3/2012, indicated these medications were scheduled for administration at 9 a.m.</p> <p>2.) Observation of medication administration at 11:10 a.m., to Resident # E, the following medications were administered:: Isocort herbal supplement 2 pellets four times a day- ordered for 9 a.m., 1 p.m., 4 p.m., 8 p.m. Cranberry 2000 mg tab, 1 tab every day 9 a.m. Aggrenox 25-200 mg ordered twice a day 9 a.m., 4 p.m. Citrucel 500 mg 1 tablet daily at 9 a.m. Centrum 1 tablet daily at 9 a.m.</p> <p>Review of Physician recapitulation orders,dated 3/2012, indicated these medications were scheduled for 9 a.m. administration.</p> <p>3.) Observation of medication administration at 11:15 a.m., to Resident # F, the following medications were administered:</p>		<p><u>facility, such as the Activity Director (QMA) and the MDS Coordinator (LPN) to assist with medication administration.</u></p> <p>-</p> <p><u>In addition, all nurses will be re-trained by 4/22/12 on the importance of making sure that medications are given within a 60 minute time frame of any specified time for administration of each medication. The nurses will also be reminded that they must communicate any difficulties that they are having in administering medications on time immediately to the Administrator or DON, so that assistance of another nurse or QMA can be made available as quickly as possible.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>All residents who take medication have the potential to be affected by this practice. In the future, if the DON or Administrator is notified that medication administration is being delayed for any reason, they will immediately respond by using a</u></p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Advair Diskus 250/50 inhale 1 puff twice daily- ordered for 9 a.m., 4 p.m. Spiriva 18 mcg inhale contents of 1 cap daily at 9 a.m. Zyprexa 2.5 mg daily at 9 a.m. Premarin 0.3 mg daily at 9 a.m. Norvasc 2.5 mg every day at 9 a.m. Ecotrin 81 mg daily at 9 a.m. Spironolact 25 mg daily at 9 a.m.</p> <p>Review of Physician recapitulation orders, dated 3/2012, indicated these medications were scheduled for 9 a.m. administration.</p> <p>4.) Observation of medication administration at 1:50 p.m., to Resident # H included medication administered of Novolog R insulin 65 units subcutaneously. The order indicated to inject 65 units subcutaneously (under the skin) three times daily 7:30 a.m., 12:30 p.m., and at 5:30 p.m.</p> <p>Review of Physician recapitulation orders, dated 3/2012, indicated this medication was scheduled for 12:30 p.m.</p> <p>Review of a document provided by the Administrator on 3/22/12 at 11:00 a.m., indicated: "NURSES: PLEASE USE THE FOLLOWING MED TIMES..." "QD (every day) = 9 AM/OR 4 PM</p>		<p><u>QMA or nurse to assist the shift nurse with the medication administration. Once that is done and the residents have received their medications timely, the Administrator and DON will examine the issue that caused the delay in medication administration for improvements or changes that might be needed to keep the circumstance from happening again.</u></p> <p>-</p> <p><u>If the Administrator or DON find that medications were not given timely and no one notified either of them of this concern, they will first make sure that the physicians have been notified of the late medications and that there has been the appropriate follow through and monitoring of the resident conditions as deemed necessary by the physicians.</u></p> <p>-</p> <p><u>Once the residents' conditions are stable, the DON will re-train the nurse/QMA involved in the facility policy for timeliness of medication administration. Progressive discipline, including possible termination, will be rendered as indicated for continued noncompliance.</u></p>				

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	<p>BID (twice daily) 9 AM/4 PM TID (three times a day) 9 AM/1 PM/4 PM/8 PM HS (bedtime) 8 PM..."</p> <p>Review of a document provided by the Administrator on 3/22/12 at 2:25 p.m., titled "PREPARATION AND GENERAL GUIDELINES" included: "IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions... Administration... 2) Medications are administered in accordance with written orders of the attending physician... 10) Medications are administered within 60 minutes of scheduled time...</p> <p>This Federal tag relates to Complaint IN00104242.</p> <p>3.1-48(c)(1) 3.1-25(b)(9)</p>		<p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON will monitor the timeliness of medication administration at least 5 days a week at various times for the next 30 days, then to 2 times a week for the following 30 days. If she identifies any issues, she will address them as indicated in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The DON will bring the results of her monitoring to the QA &amp; A Committee at the monthly meetings for review and recommendations for process improvement. She will follow up on any recommendations that are made and will report on their progress at the next scheduled monthly meeting. Her documented monitoring can be discontinued by the committee when the 60 day period has been</u></p>	

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			<p><u>completed and the nurses have reached 100% compliance. However, even when the documented monitoring is stopped by the committee, the DON will continue to randomly monitor the timeliness of medication administration on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p> <p>-</p>	

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F0353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on record review, observation and interview, the facility failed to administer medications in a timely manner due to staff shortage to 4 of 9 residents sampled for medications in a total sample of 11. (Resident # D, # E, # F &amp; # H)</p> <p>Findings include:</p> <p>1. ) Observation of medication administration on 3/22/12 beginning at 11:05 a.m., indicated medications administered to Resident # D at 11:05 a.m., included:</p>	F0353	<p><u>F353</u></p> <p>-</p> <p><u>It is the policy of this facility to have sufficient staff in place and on duty to administer medications on a timely basis.</u></p> <p>-</p> <p><u>It should be noted that when the surveyor observed medication administration on the second day of survey, they were given timely and no medication errors were noted.</u></p>	04/22/2012			

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	<p>clonidine 0.2 mg three times a day- ordered for 9 a.m., 4 p.m., 8 p.m. lisinopril 40 mg twice daily- ordered for 9 a.m., 4 p.m. Plavix 75 mg every day 9 a.m. potassium chloride 20 meq twice a day- ordered for 9 a.m., 4 p.m. Isordil 10 mg twice a day ordered for 9 a.m., 4 p.m. Depakote 125 mg twice a day ordered for 9 a. m., 4 p.m. Cymbalta 60 mg every day at 9 a.m. Vicodin 5-500 mg every morning at 9 a.m. Ativan 1 mg twice a day- ordered at 9 a.m., 4 p.m. Review of Physician recapitulation orders, dated 3/2012, indicated these medications were scheduled for 9 a.m.</p> <p>2.) Observation of medication administration at 11:10 a.m., to Resident # E indicated medications administered included: Isocort herbal supplement 2 pellets four times a day-ordered for 9 a.m., 1 p.m., 4 p.m., 8 p.m. cranberry 2000 mg tab 1 tab every day 9 a.m. Aggrenox 25-200 mg twice a day- ordered for 9 a.m., 4 p.m. Citrucel 500 mg 1 tablet daily 9 a.m. Centrum 1 tablet daily 9 a.m. Review of Physician recapitulation</p>		<p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The Administrator and DON are developing a staffing contingency plan by 4/22/12 that can be put into place whenever circumstances arise that reduce the number of staff working in the facility on a specific day or shift. This will include the use of licensed nurses or QMAs that are working in other positions in the facility, such as the Activity Director (QMA) and the MDS Coordinator (LPN) to assist with medication administration.</u></p> <p>-</p> <p><u>In addition, all nurses will be re-trained by 4/22/12 on the importance of making sure that medications are given within a 60 minute time frame of any specified time for administration of each medication. The nurses will also be reminded that they must communicate any difficulties that they are having in administering medications on time immediately to the Administrator or DON, so that assistance of another nurse or QMA can be made available as quickly as possible.</u></p>				

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	<p>orders, dated 3/2012, indicated these medications were scheduled for 9 a.m.</p> <p>3.) Observation of medication administration at 11:15 a.m., to Resident # F indicated medications administered included: Advair Diskus 250/50 inhale 1 puff twice daily ordered for 9 a.m., 4 p.m. Spiriva 18 mcg inhale contents of 1 cap daily 9 a.m. Zyprexa 2.5 mg daily 9 a.m. Premarin 0.3 mg daily 9 a.m. Norvasc 2.5 mg every day 9 a.m. Ecotrin 81 mg daily 9 a.m. Spironolact 25 mg daily 9 a.m. Review of Physician recapitulation orders, dated 3/2012, indicated these medications were scheduled for 9 a.m.</p> <p>4.) Observation of medication administration at 1:50 p.m., to Resident # H included administration of Novolog R insulin, inject 65 units Sub Q. The physician order was for three times daily at 7:30 a.m., 12:30 p.m., 5:30 p.m. Review of Physician recapitulation orders, dated 3/2012, indicated this medication was scheduled for 12:30 p.m.</p> <p>Interview on 3/22/12 at 11:40 a.m., with LPN # 8 indicated a CNA had called in and she had gotten behind with medication pass because she was helping</p>		<p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p><u>All residents who take medication have the potential to be affected by this practice. In the future, if the DON or Administrator is notified that medication administration is being delayed for any reason, they will immediately respond by using a QMA or nurse to assist the shift nurse with the medication administration. Once that is done and the residents have received their medications timely, the Administrator and DON will examine the issue that caused the delay in medication administration for improvements or changes that might be needed to keep the circumstance from happening again.</u></p> <p>-</p> <p><u>If the Administrator or DON find that medications were not given timely and no one notified either of them of this concern, they will first make sure that the physicians have been notified of the late medications and that there has been the appropriate follow through and monitoring of</u></p>				

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	<p>the CNA's do resident care.</p> <p>Interview with the Director of Nursing (DON) on 3/22/12 at 2:45 p.m., indicated that there was a call in today and she was going to reevaluate staffing issues. She indicated that Physicians, families and pharmacy would be notified of the medication errors.</p> <p>Review of a document provided by the Administrator on 3/22/12 at 11:00 a.m., indicated: "NURSES: PLEASE USE THE FOLLOWING MED TIMES..." "QD(every day) = 9 AM/OR 4 PM BID(twice daily) 9 AM/4 PM TID(three times a day) 9 AM/1 PM/4 PM/8 PM HS(bedtime) 8 PM..."</p> <p>Review of a document provided by the Administrator on 3/22/12 at 2:25 p.m., titled "PREPARATION AND GENERAL GUIDELINES..." "IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with</p>		<p><u>the resident conditions as deemed necessary by the physicians.</u></p> <p>-</p> <p><u>Once the residents' conditions are stable, the DON will re-train the nurse/QMA involved in the facility policy for timeliness of medication administration. Progressive discipline, including possible termination, will be rendered as indicated for continued noncompliance.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON will monitor the timeliness of medication administration at least 5 days a week at various times for the next 30 days, then to 2 times a week for the following 30 days. If she identifies any issues, she will address them as indicated in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient</u></p>				

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	<p>the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions...</p> <p>Administration...</p> <p>2) Medications are administered in accordance with written orders of the attending physician...</p> <p>10) Medications are administered within 60 minutes of scheduled time...</p> <p>This Federal tag relates to Complaint IN00104242.</p> <p>3.1-17(a)</p>		<p><u>practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The DON will bring the results of her monitoring to the QA&amp; A Committee at the monthly meetings for review and recommendations for process improvement. She will follow up on any recommendations that are made and will report on their progress at the next scheduled monthly meeting. Her documented monitoring can be discontinued by the committee when the 60 day period has been completed and the nurses have reached 100% compliance. However, even when the documented monitoring is stopped by the committee, the DON will continue to randomly monitor the timeliness of medication administration on an ongoing basis.</u></p> <p>-</p> <p><u>Date of Compliance: 4/22/12</u></p>		

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F0431 SS=A	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; 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 record review, observation and interview, the facility failed ensure the date on the date-opened label for an insulin flex pen was legible for 1 of 9</p>	F0431	F431  -	04/22/2012	

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	<p>residents sampled for medications in a total sample of 11. (Resident # G)</p> <p>Findings include:</p> <p>During observation of medication administration on 3/22/12 at 11:45 a.m., to Resident # G, the resident received 7 units of Humalog Flex Pen as ordered for sliding scale coverage.</p> <p>The Humalog Flex Pen had a date open label, but the date was not legible, making it unable to determine how long the medication had been in use.</p> <p>On 3/23/12/at 3:25 p.m., interview with LPN # 8 indicated she could not read the date the Humalog Flex Pen was opened.</p> <p>Review of a document provided by the Administrator on 3/22/12 at 2:25 p.m., titled "PREPARATION AND GENERAL GUIDELINES..." "IIA2: MEDICATION ADMINISTRATION-GENERAL GUIDELINES..." Policy: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal..." "Procedures..." "B. The date opened and the initials of the person to use the vial are recorded on the</p>		<p><u>It is the policy of this facility to ensure that the date on the date-opened label of an insulin flex pen is legible.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The nurses had marked the date on the flex pen when it was opened, but the ink had faded with use and could not be read.</u></p> <p>-</p> <p><u>The DON has obtained a permanent ink pen for the nurses to use when dating the insulin flex pens when they are opened, and all nurses will be inserviced on the use of the pen by 4/22/12.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>Residents who receive insulin from the flex pen have the potential to be affected.</u></p> <p>-</p>				

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	<p>multidose vials on the vial label or an accessory label affixed for that purpose..."</p> <p>"F. Medication in multidose vials may be used until the manufacturer's expiration date if unopened. Once opened, insulins may be used for 28 days and other multidose vials may be used for 30 days (unless manufacturer's guidelines state otherwise) if inspection reveals no problems during that time."</p> <p>3.1-25(j)</p>		<p><u>If the DON should find that a date on a flex pen is illegible, she will make sure that it is labeled clearly and retrain the nurse(s) involved on using the permanent ink pen for labeling from that point forward. If she finds continued noncompliance, she will address with disciplinary action as deemed necessary.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>The DON will check the flex pens at least weekly for the next month to make sure they are appropriately dated with the permanent ink pen. After that time, she will check them every 2 weeks for the next month.</p> <p>If she finds any issues she will address them as indicated in question #2.</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p>	

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			-  <u>The DON will report the results of her monitoring of the flex pens to the monthly QA&amp;A Committee meeting for the next 60 days. After that the committee may decide to stop the monitoring activities once the nurses have achieved 100% compliance.</u>  -  <u>Date of Compliance: 4/22/12</u>		

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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT NEW CASTLE				STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362			
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F0467 SS=F	<p>483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.</p> <p>Based on observation and interview, the facility failed to provide sufficient bathroom ventilation for 2 of 4 bathrooms observed for sufficient ventilation. This had the potential to affect the 33 residents who utilized the bathrooms.</p> <p>Findings include:</p> <p>An environmental tour was conducted with the Maintenance Supervisor on 3/22/12 at 10:10 A.M. At that time the ventilation fan was not on in Bathrooms #1 and #2. The Maintenance Supervisor indicated there were 4 vents on the roof that provided the bathrooms with ventilation. The Maintenance Supervisor indicated he was not sure why the ventilation fans weren't working in Bathroom #1 and #2.</p> <p>An interview with the Maintenance Supervisor on 3/22/12 at 11:50 A.M., indicated he had climbed on the roof and heard the ventilation motor kick back on and remembered they shut off periodically to prevent overheating the motor. The ventilation was checked in Bathroom #1</p>	F0467	<p><u>F467</u></p> <p>-</p> <p><u>It is the policy of this facility to provide sufficient ventilation for resident care areas, including bathrooms.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>The privacy curtains have been removed from the doorways of all bathrooms.</u></p> <p>-</p> <p><u>A replacement motor for the ventilation fan has been ordered and will be replaced by 4/22/12.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p>	04/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/23/2012
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	<p>and #2 at that time and were working. Bathroom #2 had a strong odor.</p> <p>On 3/22/12 at 1:55 P.M., CNA #6 and CNA #7 were observed assisting Resident #A in Bathroom #2. A curtain was pulled across the doorway and the bathroom door was left open. CNA #7 indicated she did not shut the bathroom door while toileting Resident #A because there was no ventilation in the bathroom. CNA #7 indicated there was no switch in the bathroom to turn on the ventilation fan.</p> <p>An interview with the Maintenance Supervisor on 3/22/12 at 2:00 P.M., indicated the bathroom ventilation fans were not connected to a switch in the bathrooms. The Maintenance Supervisor indicated the bathroom ventilation fans ran continuously except when the motor shut off periodically to prevent overheating. The Maintenance Supervisor indicated he was unsure how often and for how long the ventilation motor shut off.</p> <p>An observation on 3/22/12 at 2:15 P.M., indicated the ventilation fan in Bathrooms #1 and #2 wasn't working.</p> <p>An interview with Housekeeping/Laundry Staff #9 on 3/22/12 at 2:52 P.M., indicated the bathrooms were usually</p>		<p>-</p> <p><u>All residents using the bathrooms have the potential to be affected by this practice.</u></p> <p>-</p> <p><u>The Maintenance Supervisor will be inserviced by the Administrator regarding the need for adequate ventilation in the by 4/22/12.</u></p> <p>-</p> <p><u>If the Administrator finds that the ventilation in the bathrooms is not working, she will notify the Maintenance Supervisor immediately so that he can assess the situation and repair/replace the ventilation fan as needed.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The Administrator and Department Managers will check the bathrooms for adequate ventilation during their Guardian Angel rounds which take place at least 5 days a week. In addition, the Maintenance</p>		

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	<p>odorous in the mornings due to so many residents being toileted. The Housekeeping/Laundry Staff #9 indicated it was difficult to keep odors out of the bathrooms due to toileting so many residents. The Housekeeping/laundry Staff #9 indicated the bathrooms had air fresheners on the wall that automatically sprayed every 9 minutes. The Housekeeping/laundry Staff #9 indicated Bathroom #2 smelled odorous and pushed the wall air freshener to release a spray of freshener.</p> <p>An observation on 3/23/12 at 8:48 A.M., indicated Bathroom #2 was odorous. At that time the Administrator indicated Bathroom #2 was odorous.</p> <p>An interview with the Maintenance Supervisor on 3/23/12 at 1:00 P.M., indicated he was unable to locate any factory recommendations on the bathroom ventilation motors. The Maintenance Supervisor indicated he had spoken with his Corporate Supervisor and was informed the bathroom ventilation motors should run continuously and should not shut down periodically. The Maintenance Supervisor indicated the motor that shut down periodically was the motor that ran the ventilation system for Bathrooms #1 and #2. The Maintenance Supervisor indicated he intended to order another</p>		<p>Supervisor will check the functioning and effectiveness of the ventilation fans as part of the preventive maintenance program for the facility. The results of those rounds and the preventive maintenance checks will be reviewed with the Administrator and brought the next scheduled morning management meeting which occurs at least 5 days a week. The Administrator will follow through as indicated in question #2.</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p><u>The Administrator will bring the results of the Guardian Angel and other rounds, as well as the preventive maintenance checks to the monthly QA&amp;A Committee meeting for review and recommendations for process improvement. This will continue on an ongoing basis.</u></p> <p>-</p>		

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	<p>ventilation motor to replace the one that kept shutting off periodically.</p> <p>An interview with the Administrator on 3/23/12 at 10:42 A.M., indicated all 33 residents utilized all 4 bathrooms in the facility.</p> <p>This federal tag relates to Complaint IN00104242.</p> <p>3.1-19(f)(2)</p>		<u>Date of Compliance: 4/22/12</u>	