

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155733	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/24/2015
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NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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F 0000  Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: July 20, 21, 22, 23, and 24, 2015</p> <p>Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370</p> <p>Census Bed Type: SNF/NF: 25 NF: 15 Total: 40</p> <p>Census Payor Type: Medicare: 5 Medicaid: 28 Other: 7 Total: 40</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0225 SS=D Bldg. 00	<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</p>			

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>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 record review and interview, the facility failed to report an allegation of abuse timely to the Administrator of the facility for 1 of 3 abuse allegations reviewed. (Resident #46)</p>	F 0225	1. As it relates to resident #42, we respectfully submit that upon receipt of the allegation of abuse, the facility commenced a detailed investigation and reported the allegation to the Indiana State Department of Health. The staff	08/11/2015

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	<p>Finding includes:</p> <p>The record for Resident #46 was reviewed on 7/24/15 at 11:53 a.m. The resident's diagnoses included, but were not limited to, hypertension and Alzheimer's disease.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 6/5/15, indicated the resident was cognitively impaired.</p> <p>Review of an incident investigation dated 6/2/15, indicated an incident was reported by the Activity Director that occurred on 6/1/15 at 7:00 pm. The Activity Director reported LPN #1 was speaking in a loud voice to Resident #46. Resident #46 was requesting resident room doors be closed and LPN #1 responded by stating "shut up" in a loud voice.</p> <p>The immediate action take included LPN #1 was placed on leave of absence until the investigation was completed.</p> <p>Interview with the Administrator on 7/24/15 at 10:36 a.m. indicated the Activity Director had called her on the night of 6/1/15 to report the incident. She indicated the Activity Director reported LPN #1 was speaking in a loud voice to Resident #46. The Activity</p>		<p>member in question was immediately removed from the schedule and subsequently terminated from employment. The individual that reported the incident after the fact was provided a written warning and additional education on facility protocols for responding to possible abuse.</p> <p>2.After meeting with each staff member individually, no outstanding allegations of abuse have been identified. Immediately following the cited incident, all staff were in-serviced on identifying andreporting possible abuse.</p> <p>3.Each staff member has signed a contract detailing the facility policy for reportingallegations of abuse. This contract includes an acknowledgement that failure to report an allegation of abuse immediately to the Administrator shall result in discipline up to and including termination. Additionally, this contract has been added to the facility orientation packet to be completed by all newemployees.</p> <p>4.On a monthly basis the facility Administrator or designee will survey 10% of all staff on the above referenced abuse protocols. The result of these surveys will be submitted to the Quality Assurance Committee for review on a monthly basis for no less than 1 year.</p>	

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F 0226 SS=D Bldg. 00	<p>Director had the phone so the Administrator could hear what LPN #1 was saying. She indicated all she heard was a loud voice and LPN #1 was known to speak loudly. She further indicated when she was taking statements the next morning the Activity Director reported LPN #1 had told Resident #46 to "shut up." She indicated the Activity Director had not reported that LPN #1 had said "shut up" to her immediately and she was not made aware until the next day. She indicated the Activity Director should have reported the information to her immediately.</p> <p>3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow the facility's abuse policy, related to reporting an allegation of abuse to the Administrator immediately for 1 of 3 abuse allegations reviewed. (Resident #46)</p> <p>Finding includes:</p>	F 0226	1. As it relates to resident #42, we respectfully submit that upon receipt of the allegation of abuse, the facility commenced a detailed investigation and reported the allegation to the Indiana State Department of Health. The staff member in question was immediately removed from the schedule and subsequently	08/10/2015

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	<p>The record for Resident #46 was reviewed on 7/24/15 at 11:53 a.m. The resident's diagnoses included, but were not limited to, hypertension and Alzheimer's disease.</p> <p>Review of an incident investigation dated 6/2/15, indicated an incident was reported by the Activity Director that occurred on 6/1/15 at 7:00 pm. The Activity Director reported LPN #1 was speaking in a loud voice to Resident #46. Resident #46 was requesting resident room doors be closed and LPN #1 responded by stating "shut up" in a loud voice.</p> <p>The immediate action take included LPN #1 was placed on leave of absence until the investigation was completed.</p> <p>Interview with the Administrator on 7/24/15 at 10:36 a.m. indicated the Activity Director had called her on the night of 6/1/15 to report the incident. She indicated the Activity Director reported LPN #1 was speaking in a loud voice to Resident #46. The Activity Director had the phone so the Administrator could hear what LPN #1 was saying. She indicated all she heard was a loud voice and LPN #1 was known to speak loudly. She further indicated when she was taking statements the next</p>		<p>terminated from employment. The individual that reported the incident after the fact was provided a written warning and additional education on facility protocols for responding to possible abuse.</p> <p>2. After meeting with each staff member individually, no outstanding allegations of abuse have been identified. Immediately following the cited incident, all staff were in-serviced on identifying and reporting possible abuse.</p> <p>3. Each staff member has signed a contract detailing the facility policy for reporting allegations of abuse. This contract includes an acknowledgement that failure to report an allegation of abuse immediately to the Administrator shall result in discipline up to and including termination. Additionally, this contract has been added to the facility orientation packet to be completed by all new employees.</p> <p>4. On a monthly basis the facility Administrator or designee will survey 10% of all staff on the above referenced abuse protocols. The result of these surveys will be submitted to the Quality Assurance Committee for review on a monthly basis for no less than 1 year.</p>	

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F 0279 SS=D Bldg. 00	<p>morning the Activity Director reported LPN #1 had told Resident #46 to "shut up." She indicated the Activity Director had not reported that LPN #1 had said "shut up" to her immediately and she was not made aware until the next day. She indicated the Activity Director should have reported the information to her immediately.</p> <p>A facility policy titled "Abuse Prevention", dated 9/2011, and received as current from the Administrator, indicated, "...VII...2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately...3. The Administrator must be immediately notified of suspected abuse, allegations of abuse, or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator must be called at home or must be paged and informed of such incident..."</p> <p>3.1-28(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>			

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	<p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a resident had a comprehensive care plan related to a medication that thins the blood (Xarelto) and a medication that treats fluid retention (Lasix) for 1 of the 5 residents reviewed for unnecessary medications. (Resident # 37)</p> <p>Finding includes:</p> <p>Record review was completed on 7/23/15 at 10:02 a.m., for Resident #37. The resident's diagnoses included, but were not limited to, atrial fibrillation (abnormal heart rhythm), deep vein thrombosis (blood clot), and hypertension.</p>	F 0279	<p>1. Resident #37 - Upon surveyor observation a care plan was put into place addressing the use of Lasix. Resident # 37 – Upon surveyor observation a care plan was put into place addressing the use of Xarelto. 2. A chart review was completed to identify all residents receiving Lasix. Each resident's plan of care was reviewed to ensure that a care plan was in place for the use of the medication. A chart review was completed to identify all residents receiving Xarelto. Each resident's plan of care was reviewed to ensure that a care plan was in place for the use of the medication. 3. The MDS Coordinator will assume the responsibility of ensuring that each resident receiving the medication Lasix or Xarelto has a care plan in place. 4. An audit</p>	08/10/2015

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F 0280 SS=D Bldg. 00	<p>The Quarterly Admission Minimum Data Set (MDS) assessment completed on 6/25/15, indicated the resident received an anticoagulant (medication that thins the blood) and a diuretic (medication that treats fluid retention) 7 times for each medication out of the 7 day assessment period.</p> <p>Review of the July 2015 Physician Order Summary (POS) indicated an order for Xarelto 20 mg (milligrams) every day. The POS further indicated an order for Lasix 40 mg every day.</p> <p>The record lacked any indication there were care plans related to the medication Xarelto or the medication Lasix.</p> <p>Interview with the MDS Coordinator on 7/23/15 at 10:45 a.m., indicated the resident did not have care plans completed for the Xarelto and the Lasix and there should have been care plans already in place for the medications. She further indicated she would complete the care plans right away for the medications.</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p>		<p>tool has been created to ensure that all required care plans relating to the use of Lasix or Xarelto are in place. The audit will be completed on a monthly basis by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of six months.</p>		

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	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to update and revise care plans related to activities of daily living (ADLs) for 1 of 21 residents reviewed for care plans. (Resident #3)</p> <p>Finding includes:</p> <p>The record for Resident #3 was reviewed on 7/22/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and osteoarthritis.</p> <p>Review of the 4/13/15 Quarterly Minimum Data Set (MDS) assessment indicated the resident was totally dependent on staff and required assistance of one staff member for bed</p>	F 0280	. Resident # 3– Upon surveyor observation the resident's ADL care plan was revised and updated. 2. Each resident's ADL care plans were reviewed and updated in accordance with their last MDS assessment date. 3. The MDS Coordinator will assume the responsibility of ensuring that a comprehensive AD Lcare plan is developed, revised or updated within seven days of the resident's comprehensive assessment. 4. An audit tool has been created to ensure that all ADL care plans are revised or updated as warranted. The audit will be completed on a weekly basis by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance	08/10/2015

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F 0441 SS=D	<p>mobility, dressing, toilet use, and personal hygiene. The resident was totally dependent on staff and required assistance of two staff members for transfers.</p> <p>Review of the current care plan dated 3/20/14 and last updated on 4/13/15 indicated the resident required extensive assist with ADLs related to bed mobility and transfers.</p> <p>Interview with CNA #1 on 7/24/15 at 9:37 a.m. indicated the resident was dependent on staff for transfers, required an assist of two, and used the sit to stand lift. She further indicated the resident was usually dependent on staff for assistance with bed mobility and dressing.</p> <p>Interview with the MDS Coordinator on 7/22/15 at 10:05 a.m. indicated the care plan should have been updated to indicate the resident was totally dependent on staff for ADLs.</p> <p>3.1-35(d)(2)(B)</p> <p>483.65 INFECTION CONTROL, PREVENT</p>		Committee for review. This audit will be completed for a minimum of six months.		

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Bldg. 00	<p><b>SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to ensure infection control practices and standards were maintained</p>	F 0441	1. Upon surveyor observation the bed pan identified was checked for cleanliness, placed in a plastic bag and stored in the resident's	08/10/2015

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	<p>related to an uncovered and unlabeled bed pan for 1 of 4 hallways observed. (Room #121)</p> <p>Finding includes:</p> <p>During initial tour on 7/21/15 at 9:46 a.m., in Room #121's bathroom, a bed pan was observed between the wall and the handrail uncovered.</p> <p>On 7/21/15 at 11:28 a.m., the bed pan in Room #121's bathroom was observed uncovered, between the wall and the handrail.</p> <p>During the Environmental Tour on 7/24/15 at 9:30 a.m., the bed pan was observed between the bathroom wall and the handrail. Two residents resided in the room.</p> <p>Interview with Administrator and the Director of Nursing during the Environmental Tour on 7/24/15, indicated the bed pan should have been covered and labeled with the resident's name.</p> <p>3.1 -18(b)(2)</p>		<p>bedside table. 2. All resident bathrooms were checked to ensure that bedpans were stored appropriately. 3. An in-service was completed with the nursing staff in regards to the proper storage of bed pans. 4. An audit tool has been created to ensure that bedpans are stored appropriately. The audit will be completed weekly by the DON/designee. The results of this audit will be compiled monthly and presented to the Quality Assurance Committee for review. This audit will be completed for a minimum of six months.</p>		

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F 0458 SS=E Bldg. 00	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT</p> <p>Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on record review, observation and interview, the facility failed to provide at least 80 square feet (sq ft) per resident in multiple resident rooms and 100 sq ft in single occupancy rooms. This was evidenced in 8 of 30 resident rooms in the facility. (Rooms 101, 104, 111, 201, 202, 204, 206, 208)</p> <p>Findings include:</p> <p>Review of the facility's Room Size Certification, received from the Administrator on 7/21/15, the following measurements of the rooms were:</p> <p>1. The floor area of the following single resident room measured:</p> <p>*a. Room 111-1 bed, 96.2 SQ (Square) FT (feet). NF.</p> <p>2. The floor areas of the following multiple resident room's measured:</p> <p>*a. Room 101-2 beds, 150.3 SQ FT, 75.2</p>	F 0458	<p>1.All affected rooms were measured and floor planned including necessary furnishings.</p> <p>1.All affected residents conditions were reviewed for safety, comfort, nursing care delivery and privacy to ensure there were noadverse side effects to placement in room with waivers related to square footage.</p> <p>2.Prior to admission, residents needs will be reviewed to determine appropriate room assignment. Additionally, during quarterly care plan conferences the interdisciplinary team will review appropriateness of room assignments. If the team feels a room transfer is necessary Social Service will arrange a smooth transition to a newroom.</p> <p>3.The results of the above mentioned reviews will be submitted to the Quality Assurance Committee on a quarterly basis for no less than 1 year.</p>	08/10/2015

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NAME OF PROVIDER OR SUPPLIER  COLONIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 119 N INDIANA AVE CROWN POINT, IN 46307
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	<p>SQ FT per bed. NF.</p> <p>*b. Room 104-2 beds, 145.0 SQ FT, 72.5 SQ FT per bed. NF.</p> <p>*c. Room 201-2 beds, 149.0 SQ FT, 74.5 SQ FT per bed. NF.</p> <p>*d. Room 202-2 beds, 144.0 SQ FT, 72.0 SQ FT per bed. NF.</p> <p>*e. Room 204-2 beds, 144.0 SQ FT, 72.0 SQ FT per bed. NF.</p> <p>*f. Room 206-2 beds, 140.0 SQ FT, 70.5 SQ FT per bed. NF.</p> <p>*g. Room 208-2 beds, 146.9 SQ FT, 73.4 SQ FT per bed. NF.</p> <p>The facility rooms with room variances were observed on 7/24/15 at 10:40 a.m. The rooms were observed to have the following amounts of beds: Room 101-2 beds Room 104-2 beds Room 111-1 bed Room 201-2 beds Room 202-2 beds Room 204-2 beds Room 206-2 beds Room 208-2 beds</p> <p>An interview with the Administrator on</p>			

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F 0465 SS=E Bldg. 00	<p>7/21/15 at 1:00 p.m. indicated these were the rooms which had the variance waivers.</p> <p>3.1-19(1)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 and interview, the facility failed to ensure the resident's environment was clean and in good repair related to black discolorations on the wall underneath the dishwasher in the Kitchen, and gouged closet doors, rusted sink drains, stained ceiling tiles, and a chipped call light cover throughout the facility. (Kitchen, A Hall, B Hall, C Hall, and Second Floor)</p> <p>Findings include:</p> <p>1. During the initial tour of the Kitchen with the Dietary Manager, on 7/20/15 at 8:53 a.m., the wall underneath the dishwasher was observed to have black discolorations. Interview with the Dietary Manager at the time of the observation indicated the discolorations were a build up of dirt and the wall did</p>	F 0465	<p>1.All of the cited areas have been cleaned,replaced or repaired.</p> <p>2.A kitchen cleaning audit and full round of each resident room has been completed to ensure the environment meets with regulatory compliance. Additionally, all dietary employees have been in-serviced on requirements for kitchen cleaning following each shift, specifically the all area below and above the dish machine.</p> <p>3.As it relates to kitchen cleanliness, a kitchen cleanliness audit is to be completed by the Dietary Manager on a weekly basis. This audit will include the area under the dish machine. As it relates to the other environmental concerns, the cited areas have been added to the current weekly maintenance inspection to be completed by the Maintenance Director on a weeklybasis.</p>	08/10/2015

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	<p>not look like it had been cleaned for awhile. She further indicated the wall should be cleaned daily by the dietary staff.</p> <p>Interview with the administrator on 7/23/15 at 2:58 p.m., indicated the expectation of the dietary staff would be to clean the area under the dishwasher on the wall every day. She indicated the wall should have not gotten that bad.</p> <p>2. On 7/24/15 from 9:30 a.m. through 10:00 a.m., the following was observed during the Environmental Tour on the first floor hallways with the Administrator and the Director of Nursing:</p> <p>A. In Room # 112, the bottom of the closet door was gouged and marred and the radiator cover along the bottom of the wall was loose. There were two resident who resided in this room.</p> <p>B. In Room #114, the dresser was marred and gouged. There was one resident who resided in this room.</p> <p>C. In Room #118, the bathroom ceiling tiles were yellow stained and had rust stains in the sink bowl. There were two resident who resided in this room.</p> <p>D. In Room #120, the dresser was</p>		<p>4. The findings of the aforementioned audits will be submitted to the Quality Assurance Committee on a monthly basis for no less than 1 year.</p>	

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	<p>marred and gouged. There was one resident who resided in this room.</p> <p>E. In Room #123, the sink drain was observed to be rusted. There were two residents who resided in this room.</p> <p>F. In Room #124-bed 2, the call light cover had jagged edges by the red button.</p> <p>G. In Room #125, the bathroom sink drain was rusted. There was one resident who resided in this room.</p> <p>3. On 7/24/15 from 9:30 a.m. through 10:00 a.m., the following was observed during the Environmental Tour on the Second floor hallway with the Administrator and the Director of Nursing:</p> <p>A. In Room #201, the closet door was gouged. There was one resident who resided in this room.</p> <p>B. In Room #205, multiple ceiling tiles had a brown discoloration. There was one resident who resided in this room.</p> <p>An interview with Administrator on 7/24/15 at 10:00 a.m., indicated all of the above were in need of repair.</p> <p>3.1-19(f)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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