

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/07/2016
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NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00208789, IN00208868, and IN00209204.</p> <p>Complaint IN00208789 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F282, F309, F312 and F353.</p> <p>Complaint IN00208868 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F309, 312 and F353.</p> <p>Complaint IN00209204 - Substantiated. Federal/State deficiencies related to the allegations are cited at F166, 312, and F353.</p> <p>Survey dates: 9-6, and 9-7-2016</p> <p>Facility number: 000476 Provider number: 155446 AIM number: 100290870</p> <p>Census bed type: SNF/NF: 68 Total: 68</p> <p>Census payor type: Medicare: 10</p>	F 0000	<p>This facility is requesting paper compliance. This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth on the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0166 SS=E Bldg. 00	<p>Medicaid: 54 Other: 4 Total: 68</p> <p>Sample: 7</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on September 9, 2016 by 17934.</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on observation, interview, and record review, the facility failed to resolve resident concern regarding ice water. This had the potential to affect 48 of 68 residents residing in the facility.</p>	F 0166	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Ice water was passed for residents, including resident Z, on 9/7/16 by ED.</p>	10/07/2016			

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	<p>Findings include:</p> <p>During observations on the days of the survey, ice water was not observed to be given to the residents. Further, there was no ice water in Resident #Z's water pitcher on 9-6-2016 at 10 AM and on 9-7-2016 at 10:22 AM.</p> <p>In an interview on 9-6-201 at 10:05 AM, Resident #Z indicated there was not enough staff to ensure ice water had been given daily to the residents.</p> <p>A review of Resident #Z's quarterly Minimum Data Set dated 7-19-2016 indicated she had a Basic Interview for Mental Status (BIMS) score of 15, which indicated Resident #A was alert, oriented, and able to make appropriate decisions.</p> <p>A review of Resident Council minutes for May 9, 2016 indicated ice water was not given to the residents consistently; June, 28, 2016 indicated ice water was not given to the residents consistently; July 2, 2016 indicated ice water was not given to the residents consistently, and August 31, 2016 indicated ice water was not given to the residents consistently.</p> <p>In an interview on 9-7-2016 at 12:21 PM, CNA #1 indicated because of the lack of</p>		<p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Ice water was passed for residents, including resident Z, on 9/7/16 by ED. Charge nurses will assign a CNA to pass water daily. Resident Council will meet monthly with Social Services. A grievance form will be completed for concerns voiced with resolution of grievance by next monthly meeting.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur?Re-education will be conducted for nursing staff regarding passing ice water to residents, as well as, completing a grievance form for concerns from residents or families. (Initiated on 9/26/16 by DON) Social Service was re-educated to ensure all grievances are resolved by next Resident Council meeting.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: and Observation per quality rounds will be conducted by Department Managers 5 times per week times 8 weeks, then 1 time per week times 8 weeks, then 1 time per month</p>	

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F 0282 SS=D Bldg. 00	<p>staff in the facility, sometimes ice water did not get passed.</p> <p>This Federal Tag is related to Complaint IN00209204.</p> <p>3.1-7(a)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was given according to physician's orders for 1 of 3 residents reviewed with physician's orders (Resident #U). Further, the facility failed to ensure care was given according to care plan for 1 of 3 residents reviewed with care plans (Resident #W) in a sample of 7.</p> <p>Findings include:</p> <p>1. Resident #U's record was reviewed on 9-6-2016 at 2:19 PM. Resident #U's</p>	F 0282	<p>times 2 months, to ensure ice water is passed daily to residents. Grievances from Resident Council will be presented and discussed at daily clinical meeting until resolved. Resolution will be reported to next monthly Resident Council meeting by Social Services. Negative findings will be presented to monthly QA times 6 months.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? New orders were obtained for Resident U on 09/07/16 by LPN. A skin assessment was completed for Resident W on 09/16/16 by LPN.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? A review of residents receiving treatments was conducted to ensure residents are receiving treatment according to physician's orders on 09/21/16 by nurse management. A skin</p>	10/07/2016

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	<p>diagnoses included, but were not limited to, dementia, depression, and anxiety.</p> <p>A physician's order dated 8-29-2016 indicated Resident #U should have ACE wraps applied to both lower legs in the morning and taken off in the evening.</p> <p>An observation on 9-6-2016 at 1:50 PM indicated Resident #U was up walking in the hallway and did not have ACE wraps on his legs.</p> <p>An observation on 9-7-2016 at 9:50 AM indicated Resident #U was sitting up in his chair in his room while a family member combed his hair. Resident #U was not wearing ACE wraps on his legs.</p> <p>A review of Resident #U's Treatment Record dated September 2016, did not indicate ACE wraps were to be applied to lower legs.</p> <p>In an interview on 9-6-2016 at 11:42 AM, LPN #2 indicated Resident #U did not have ACE wraps, but had some swelling in his legs. LPN #2 further indicated if Resident #U was supposed to have ACE wraps, they would have been on.</p> <p>In an interview on 9-7-2016 at 11:10 AM, the Administrator indicated it was</p>		<p>assessment for residents was initiated on 09/14/16 by nursing.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur? Nursing staff was re-educated on following physician orders and care plans for skin assessments initiated on 09/26/16.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: and Order listing report and will be run 5 times per week by HIM/designee, for DON and UM to ensure all new orders are in PCC, and being followed times 6 months. HIM/Designee will run assessment history report from PCC 5 times per week. Any missed skin assessment will be completed with re-education provided to nurse missing the assessment. Negative findings will be presented to monthly QA times 6 months.</p>				

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	<p>understood physician's orders were to be followed.</p> <p>2. Resident #W's record was reviewed 9-7-2016 at 10:29 AM. Resident #W's diagnoses included, but were not limited to, high blood pressure, diabetes, and chronic kidney disease.</p> <p>A care plan dated 3-2016 titled actual pressure ulcer indicated under interventions to assess Resident #W's pressure ulcer weekly.</p> <p>A review of wound assessment documentation indicated Resident #W's area had been assessed on 8-23-2016, then on 8-30-2016. There was no further documentation of assessment of the wound by a licensed nurse.</p> <p>In an interview on 9-7-2016 at 12:14 PM, LPN #3 indicated there was no time to assess the area during Resident #W's the dressing change on 9-6-2016. LPN #3 further indicated the care plan should have been followed.</p> <p>This Federal tag is related to Complaint IN00208789.</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to assess residents after a condition change for 3 of 4 residents reviewed with condition changes in a sample of 7 (Resident #U, Resident #V, Resident #W)</p> <p>Findings include:</p> <p>1. Resident #U's record was reviewed on 9-6-2016 at 2:19 PM. Resident #U's diagnoses included, but were not limited to, dementia, depression, and anxiety.</p> <p>A physician's order dated 8-29-2016 indicated Resident #U should have ACE wraps applied to both lower legs in the morning and taken off in the evening.</p> <p>A review of Resident #U's Treatment Record dated September 2016, did not indicate ACE wraps were to be applied to</p>	F 0309	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? An assessment for resident U was completed on 09/07/16 by LPN, with physician notification and new orders received. Resident V is currently in the hospital. A wound assessment for Resident W was completed by LPN on 09/06/16.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? A wound assessment with appropriate documentation was completed for residents with skin areas on 09/21/16 by nurse management.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur? Re-education for nursing staff in regards to completing an SBAR for</p>	10/07/2016

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	<p>lower legs.</p> <p>A review of Resident #U's progress notes did not indicate why the physician had ordered the ACE wraps to both lower legs.</p> <p>A review of Resident #U's Assessment and IDT notes dated 8-25-2016 did not indicate Resident #U had any swelling.</p> <p>A review of Resident #U's Skin Inspection Assessment dated 9-2-2016 did not indicate Resident #U had any swelling.</p> <p>There was no other documentation in the progress notes, from the nurse practitioner, or the physician available for review.</p> <p>In an interview on 9-6-2016 at 11:42 AM, LPN #2 indicated Resident #U did not have ACE wraps, but had some swelling in his legs.</p> <p>In an interview on 9-7-2016 at 10:32 AM, a corporate RN indicated the facility charted by exception and if the resident would have had swelling, it would have been noted in the record. She further indicated if there was an order from the doctor for swelling, then the swelling should have been assessed.</p>		<p>change of condition, as well as proper documentation, for assessment of skin areas was initiated on 09/26/16 by DON.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: and HIM/Designee will print new SBAR's 5 times per week for 6 months to ensure change of conditions have been documented and reported to physician. The wound assessment scoring report will be reviewed by DON/UM to ensure assessments are complete with measurements and appropriate description weekly times 12 weeks and then monthly times 12 weeks. Negative findings to monthly QA for review times 6 months.</p>	

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	<p>2. Resident #V's record was reviewed 9-7-2016 at 2:35 PM. Resident #V's diagnoses included, but were not limited to, diabetes, depression, and high blood pressure.</p> <p>A Skin Inspection Assessment dated 8-29-2016 indicated Resident #V's skin was intact except for a previously identified area on the foot.</p> <p>A Change of Condition form dated 9-2-2016 indicated Resident #V had moisture associated dermatitis to both buttocks. There was no description or measurements of the areas on the form.</p> <p>A review of progress notes did not indicate the size or characteristics of Resident #V's areas.</p> <p>In an interview on 9-7-2016 at 12:14 PM, LPN #3 indicated sometimes there was not enough time to fully assess all the resident's skin areas.</p> <p>3. Resident #W's record was reviewed 9-7-2016 at 10:29 AM. Resident #W's diagnoses included, but were not limited to, high blood pressure, diabetes, and chronic kidney disease.</p> <p>A review of Wound Assessment</p>			

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F 0312 SS=D Bldg. 00	<p>documentation indicated Resident #W's areas on her buttocks had been assessed on 8-23-2016, then on 8-30-2016. There was no further documentation of assessment of the wound by a licensed nurse.</p> <p>In an interview on 9-7-2016 at 12:14 PM, LPN #3 indicated there was no time to assess the areas during Resident #W's dressing change on 9-6-2016.</p> <p>This Federal tag is related to Complaints IN00208789 and IN00208868.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation and interview, the facility failed to ensure assistance with personal grooming was given as needed for 2 of 3 residents reviewed for personal grooming in a sample of 7. (Resident #Z</p>	F 0312	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident Z was provided a shower and the facial hair has been shaved on 9/11/16. Resident A was provided with a</p>	10/07/2016

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	<p>and Resident #A)</p> <p>Findings include:</p> <p>1. Resident #Z's record was reviewed 9-7-2016 at 4:12 PM. Resident #Z's diagnoses included, but were not limited to, high blood pressure, anxiety, and depression.</p> <p>A review of Resident #Z's quarterly Minimum Data Set dated 7-19-2016 indicated she had a Basic Interview for Mental Status (BIMS) score of 15, which indicated Resident #A was alert, oriented, and able to make appropriate decisions.</p> <p>In an interview on 9-6-2016 at 10:05 AM, Resident #Z indicated showers were not given on a regular basis, and only "every now and then" Resident #Z was observed to have long facial hairs. Resident #Z indicated she did not like long facial hair, but there was not enough staff to assist her to pluck them.</p> <p>In an interview on 9-7-2016 at 11:44 AM, CNA #4 indicated there was not enough staff to have time to assist residents with showers or grooming consistently, so showers were not being completed twice weekly as needed..</p> <p>2. Resident #A's record was reviewed</p>		<p>shower, hair was shampooed and the facial hairs have been shaved on 9/15. Resident A prefers to feed self per staff interview. (care planned)</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Residents were shaved, nails were trimmed and filed, and a shower was completed by 09/23/16.</p> <p>3. What measures will be put into place or what systemic changes will be make to ensure that the deficient practice does not recur? The shower schedule is located on POC for the CNA staff to document completion or refusal. The charge nurse is to review completion of duties on POC before CNA is dismissed for the day. Re-education was provided to nursing staff regarding completion of showers to include shampooing hair, trimming nails, and shaving as needed. (Initiated on 09/26/16 by DON.)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: and The HIM/Designee will bring missed ADL documentation to clinical meeting 5 times per week for 6 months with negative findings to monthly QA. Re-education will be provided for aide missing</p>		

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F 0353 SS=E	<p>9-7-2016 at 12:21 PM. Resident #A's diagnoses included, but were not limited to, diabetes, depression, and high blood pressure.</p> <p>On 9-6-2016 at 11:50 AM, Resident #A was observed sitting in the Assisted Dining area attempting to eat with her fingers. Resident #A was observed with oily hair, and long facial hairs.</p> <p>On 9-7-2016 at 11:48 AM, Resident #A was observed in bed resting. her hair remained oily, and there were still long facial hairs present.</p> <p>In an interview on 9-7-2016 at 11:56 AM, CNA #5 indicated there was not enough staff to assist residents to eat and to ensure showers and personal hygiene was given consistently.</p> <p>This Federal tag is related to Complaints IN00208789, IN00208868, and IN00209204.</p> <p>3.1-38 (a)(3)(A)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER</p>		completion of showers by nurse management.		

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Bldg. 00	<p>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 observation and interview, the facility failed to ensure sufficient nursing staffing to complete personal hygiene, bathing and care consistently for 3 of 3 residents reviewed for personal hygiene completion. (Resident #Z, Resident #A and Resident #W). The facility further failed to ensure sufficient staffing to enable residents to receive fresh ice water on a regular basis. This had the potential to affect all residents residing in the facility.</p> <p>Findings include:</p>	F 0353	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Ice water was passed for residents, including resident Z, on 9/7/16 by ED. New orders were obtained for Resident U on 09/07/16 by LPN. A skin assessment was completed for Resident W on 09/16/16 by LPN. An assessment for resident U was completed on 09/07/16 by LPN, with physician notification and new orders received. Resident V is currently in the hospital. A wound assessment for Resident W was completed by LPN on 09/06/16.</p> <p>2. How other residents having the</p>	10/07/2016	

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	<p>1. Resident #Z's record was reviewed 9-7-2016 at 4:12 PM. Resident #Z's diagnoses included, but were not limited to, high blood pressure, anxiety, and depression.</p> <p>A review of Resident #Z's quarterly Minimum Data Set dated 7-19-2016 indicated she had a Basic Interview for Mental Status (BIMS) score of 15, which indicated Resident #A was alert, oriented, and able to make appropriate decisions.</p> <p>In an interview on 9-6-2016 at 10:05 AM, Resident #Z indicated showers were not given on a regular basis, and only "every now and then" Resident #Z was observed to have long facial hairs. Resident #Z indicated she did not like long facial hair, but there was not enough staff to assist her to pluck them.</p> <p>In an interview on 9-7-2016 at 11:44 Am, CNA #4 indicated there was not enough staff to have time to assist residents with showers or grooming consistently, so showers were not being completed twice weekly as needed..</p> <p>2. Resident #A's record was reviewed 9-7-2016 at 12:21 PM. Resident #A's diagnoses included, but were not limited to, diabetes, depression, and high blood</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Ice water was passed for residents, including resident Z, on 9/7/16 by ED. Charge nurses will assign a CNA to pass water daily and document completion. Resident Council will meet monthly with Social Services. A grievance form will be completed for concerns voiced with resolution of grievance by next monthly meeting. A review of residents receiving treatments was conducted to ensure residents are receiving treatment according to physician's orders on 09/21/16 by nurse management. A skin assessment for residents was initiated on 09/14/16 by nursing. A review of residents receiving treatments was conducted to ensure residents are receiving treatment according to physician's orders was conducted on 09/21/16 by nurse management. A wound assessment with appropriate documentation was completed for residents with skin areas on 09/21/16 by nurse management.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Managers will conduct quality rounds to ensure ice water has been passed and needs of residents are being met 5 times per week. Re-education will be provided to</p>		

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	<p>pressure.</p> <p>On 9-6-2016 at 11:50 AM, Resident #A was observed sitting in the Assisted Dining area attempting to eat with her fingers. Resident #A was observed with oily hair, and long facial hairs.</p> <p>On 9-7-2016 at 11:48 AM, Resident #A was observed in bed resting. her hair remained oily, and there were still long facial hairs present.</p> <p>In an interview on 9-7-2016 at 11:56 AM, CNA #5 indicated there was not enough staff to assist residents to eat and to ensure showers and personal hygiene was given consistently.</p> <p>3. Resident #W's record was reviewed 9-7-2016 at 10:29 AM. Resident #W's diagnoses included, but were not limited to, high blood pressure, diabetes, and chronic kidney disease.</p> <p>A care plan dated 3-2016 titled actual pressure ulcer indicated under interventions to assess Resident #W's pressure ulcer weekly.</p> <p>A review of wound assessment documentation indicated Resident #W's area had been assessed on 8-23-2016, then on 8-30-2016. There was no further</p>		<p>staff regarding quality of care to include passing fresh ice water, assisting residents in the dining room, completing assessment and change of conditions, and providing showers according to schedule and resident's preference. (Initiated on 9/26/16 by DON.) A contract has been put into place with a nursing placement agency in order to interview/hire additional staff. A CNA class started for 9 students on 9/20/16 in order to increase available staff.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: and Department managers will interview 3 residents, regarding adequate staffing weekly times 6 months using the ABAQIS staffing questions. Negative findings will be presented to monthly QA times 6 months.</p>	

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	<p>documentation of assessment of the wound by a licensed nurse.</p> <p>In an interview on 9-7-2016 at 12:14 PM, LPN #3 indicated there was no time to assess the area during Resident #W's the dressing change on 9-6-2016. LPN #3 further indicated the care plan should have been followed.</p> <p>A review of Resident Council minutes for May 9, 2016 indicated ice water was not given to the residents consistently; June, 28, 2016 indicated ice water was not given to the residents consistently; July 2, 2016 indicated ice water was not given to the residents consistently, and August 31, 2016 indicated ice water was not given to the residents consistently.</p> <p>In an interview on 9-7-2016 at 12:21 PM, CNA #1 indicated because of the lack of staff in the facility, sometimes ice water did not get passed.</p> <p>This Federal tag is related to Complaints IN00208789, IN00208868, and IN00209204.</p> <p>3.1-17(a)</p>			