

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155660	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/12/2014
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NAME OF PROVIDER OR SUPPLIER  PULASKI HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 624 E 13TH ST WINAMAC, IN 46996
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, and 12, 2014</p> <p>Facility number: 000553 Provider number: 155660 AIM number: 100267430</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Julie Ferguson, RN</p> <p>Census bed type: SNF: 6 SNF/NF: 45 Total: 51</p> <p>Census payor type: Medicare: 5 Medicaid: 30 Other: 16 Total: 51</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September</p>	F000000	<p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care.</p> <p>Furthermore, the operation and licencor of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance.</p> <p>Completion dates are provided for the procedural preceding purposes to comply with state and federal regulation, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in the requirements of participation or that the corrective action was necessary. We are requesting a desk review to clear</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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F000247 SS=A	<p>16, 2014, by Janelyn Kulik, RN.</p> <p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview the facility failed to ensure every resident was notified when there was a change in roommate for 1 of 23 residents reviewed for Admission, Transfer, and Discharge of the 1 resident who met the criteria for Admission, Transfer, and Discharge. (Resident #9)</p> <p>Findings include:</p> <p>On 9/8/14 at 11:15 a.m., Resident #9 was interviewed. The resident indicated she could not remember if she was notified of her new roommate.</p> <p>The clinical record for Resident #9 was reviewed on 9/10/14 at 2:30 p.m. The resident was admitted into the facility on 9/30/11. The resident's diagnoses included, but were not limited to, mild confusion.</p> <p>The Quarterly MDS (Minimum Data Set) assessment completed on 6/11/14 indicated Resident #9 was cognitively</p>	F000247	<p>any and all proposed or implemented remedies that have been presented to date.</p> <p>F 247 1. - Corrective action for residents affected by deficient practice. A late entry was made in resident # 9's chart of notification to resident and family on 9-10-2014. 2. - An audit was conducted on all previous admissions and late entries were made if needed on notification of receiving a new roommate to resident and resident family. 3. - Social Service reviewed the Policies and Procedures for the Pre-Admission process. Social Service will have a checklist for pre-admission process which will include notification of roommate if a new resident will be going into a semi-private room. This notification will be documented in both residents charts. If the resident is cognitively impaired the residents family will be notified and documented as such. Social Service will have a checklist for residents who will be changing rooms in the facility and going into a semi-private room. The notification of a new roommate to resident or resident family will be documented in both residents charts along with</p>	10/08/2014			

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	<p>impaired.</p> <p>An interview on 9/10/14 at 2:55 p.m. the Social Services Director, indicated Resident #9 received a new roommate on 8/18/14. The Social Services Director further indicated the resident was cognitively impaired, and the family should have been notified. She indicated when the resident's roommate passed away, the family should have known the resident would have received another roommate. She further indicated there was a lack of documentation in her notes.</p> <p>On 9/10/14 at 3:36 p.m., the Social Services Director also indicated an audit was completed and inservices were completed on 7/24/14 for notice of transfer/roommate change.</p> <p>On 9/10/14 at 4:04 p.m., the Social Services Director provided the policy for "TRANSFER AND DISCHARGE POLICY AND PROCEDURE," and indicated this document was current. The Transfer and Discharge Policy indicated "...Standards...28. Roommates shall be advised of room changes and introductions provided as necessary by the Social Service Designee...."</p> <p>3.1-3(v)(2)</p>		<p>intra-transfer form will be filled out. 4. - Measures put into place to ensure that the deficient practice does not recur; The Social Service Director will check each admission checklist to insure that notification was made and documented with-in 3 days of admission. The Social Service Director will check each room transfer in facility for notification of a new roommate and documentation in both residents charts concerning this with in 2 days of admission. - Results from the audit will be brought to monthly QA meeting for discussion. This auditing of Room mate notification will continue for each new resident and each new resident room transfer. The audit will continue each week for 4 months.</p> <p>Depending on the results of the audit if no errors occur the monitoring will be stopped. If errors occur the monitoring will be on-going every month for 1 year.</p> <p>5. The Social Service Director will be responsible for this process.</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician Orders were followed as written related to the monitoring and administration of insulin for 1 of 5 residents reviewed for unnecessary medications. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 9/11/14 at 10:10 a.m. The diagnoses included, but were not limited to, IDDM (Diabetes) and dementia.</p> <p>A review of the POS (Physician's Order Summary) dated September 2014 indicated, "Accu-checks (test for blood sugar) QID (Four times a times) with Humalog (insulin) Sub-Q (under the skin injection) sliding scale:&lt;150=0 units, 150-200=5 units, 201-250-10 units, 251-300=15 units, 301-350=20 units, 351-400=25 units, 401-450=30 units, 451-500=35 units, IF &lt;70 or&gt;500 call Dr. (Doctor)"</p> <p>A review of the "Sliding Scale and Blood</p>	F000282	<p><b>F282</b>--- · The nurse who was involved was placed in retraining with another nurse for med/insulin administration x's 2 weeks with disciplinary action and will be monitored x's 3 months and revisited after 3 month time frame for possible extension; if needed regarding disciplinary action. · Licensed Nurse Skills Review/ Sliding Scale Test was given to all nurse's immediately for completion and reviewed per the DON for accuracy. This test will be given to each nursing applicant prior to the interview process. Once a month x's 3 months the nurses will be tested on Blood Sugar Sliding Scales and quarterly thereafter and if concerns noted addressed accordingly. · Meeting held on 09-17-14 (all nurse's) reviewing following plan of care and physician's orders and Blood Sugar monitoring and sliding scale insulin administration. · Weekly QA of Blood Sugar Flow sheet's to ensure Physician Orders are followed as written r/t monitoring and administration of insulin dependent resident's This monitoring will be on-going weekly and results will be discussed in QA meetings. If and</p>	09/25/2014
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	<p>Sugar Check Flow Record" indicated on 9/2/14 at 6 a.m. the resident's blood sugar was 211, the resident did not receive insulin and should have received 10 Units. On 9/5/14 at 6 a.m. the blood sugar was 228, the resident received 5 Units of insulin and should have received 10 Units of insulin.</p> <p>During an interview with the Unit Manager on 9/10/14 at 10:30 a.m., she indicated on 9/2/14 at 6 a.m. the resident should have received 10 units of Humalog subcutaneous for the blood sugar reading of 211, no Humalog was given at that time. On 9/5/14 at 6 a.m. the blood sugar reading was 228 and should have received 10 units and not the 5 units given.</p> <p>The Care Plan initiated on 2/12/10 and updated on 7/15/14, indicated a problem of "At risk for complications due to Diabetes...Approaches ...administer meds (medications) as ord (sic) (ordered) and /or sliding scale...."</p> <p>On 9/11/14 at 3:00 p.m., the Unit Manager provided the policy "DIABETES MELLITUS-ROUTINE CARE" and indicated this document was current. The policy indicated "...GENERAL INFORMATION...MEDICATION...I.c.</p>		<p>when concerns are noted the involved staff will receive additional training and monitoring and if no noted improvement with this process disciplinary action up to and including termination. · Insulin Administration will be monitored per the DON or her designee randomly each month x's 3 and quarterly thereafter.</p>				

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F000329 SS=D	<p>The resident is on the sliding scale...The resident's dosage will be determined by blood glucose parameters as ordered by the physician...."</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician Orders were followed as written related to the monitoring and</p>	F000329	<b>F329</b> · The nurse who was involved was immediately placed on retraining with another nurse for medication administration x's 2 weeks with disciplinary action	09/25/2014

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	<p>administration of insulin for 1 of 5 residents reviewed for unnecessary medications. (Resident #21)</p> <p>Findings include:</p> <p>The clinical record for Resident #21 was reviewed on 9/11/14 at 10:10 a.m. The diagnoses included, but were not limited to, IDDM (Diabetes) and dementia.</p> <p>A review of the POS (Physician's Order Summary) dated September 2014 indicated, "Accu-checks (test for blood sugar) QID (Four times a times) with Humalog (insulin) Sub-Q (under the skin injection) sliding scale:&lt;150=0 units, 150-200=5 units, 201-250=10 units, 251-300=15 units, 301-350=20 units, 351-400=25 units, 401-450=30 units, 451-500=35 units, IF &lt;70 or&gt;500 call Dr. (Doctor)"</p> <p>A review of the "Sliding Scale and Blood Sugar Check Flow Record" indicated on 9/2/14 at 6 a.m. the resident's blood sugar was 211, the resident did not receive insulin and should have received 10 Units. On 9/5/14 at 6 a.m. the blood sugar was 228, the resident received 5 Units of insulin and should have received 10 Units of insulin.</p> <p>During an interview with the Unit</p>		<p>and will be monitored x's 3 months and revisited after 3 month time frame for possible extension; if needed regarding disciplinary action. · QA was immediately conducted on 09-10-14 to ensure that all medications; as ordered were available for administration. Each resident's MAR and modifications were checked with no further concerns. · On 09-10-14 a memo about the "5 Rights of Medication Administration" &amp; the process when administering medication and when medication is not available in medication box. · A meeting was held on 09-17-14 (all nurses' &amp; QMA's) reviewing medication administration process. (Checking MAR and each medication; as ordered) and the process when medication is not available-use of Pyxis; etc.) · Medication Administration QA will be completed each month x's three (3) and quarterly thereafter. If noted concerns with medication administration there will be 1:1 education/ retraining. This will be a random audit with a least 25 opportunities(involving all shifts and routes of administration. Quarterly each nurse to be checked using Medication Pass Competency Tool. · Medication Administration In-service's (monthly) ---on-going for nurses' and QMA's. 1st done on 09-17-14.. The DON or designee will be responsible for this plan of correction</p>				

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F000332	<p>Manager on 9/10/14 at 10:30 a.m., she indicated on 9/2/14 at 6 a.m. the resident should have received 10 units of Humalog subcutaneous for the blood sugar reading of 211, no Humalog was given at that time. On 9/5/14 at 6 a.m. the blood sugar reading was 228 and should have received 10 units and not the 5 units given.</p> <p>The Care Plan initiated on 2/12/10 and updated on 7/15/14, indicated a problem of "At risk for complications due to Diabetes...Approaches ...administer meds (medications) as ord (sic) (ordered) and /or sliding scale...."</p> <p>On 9/11/14 at 3:00 p.m., the Unit Manager provided the policy "DIABETES MELLITUS-ROUTINE CARE" and indicated this document was current. The policy indicated "...GENERAL INFORMATION...MEDICATION...1.c. The resident is on the sliding scale...The resident's dosage will be determined by blood glucose parameters as ordered by the physician...."</p> <p>3.1-48(a)(6)</p> <p>483.25(m)(1)</p>						

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SS=D	<p><b>FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b></p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 9 residents observed during 4 medication pass observations. Two errors in medications were observed during 25 opportunities for errors in medication administration. This resulted in a medication error rate of 8%. (Residents #45 and #54)</p> <p>Findings include:</p> <p>1. During an observation of a medication administration pass on 9/10/14 at 9:38 a.m., LPN #1 prepared Resident #54's medications, which included Pantoprazole (medication used to treat gastroesophageal reflux) 40 milligrams (mg). During an interview with LPN #1, after the observation, LPN #1 indicated the medication was ordered to be administered 30-60 minutes before a meal and Resident #54 had already eaten breakfast.</p> <p>Resident #54's record was reviewed on 9/10/14 at 10:05 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux disease (GERD)</p>	F000332	<p>F 332 The nurse who was involved was immediately placed on retraining with another nurse for medication administration x's 2 weeks with disciplinary action and will be monitored x's 3 months and revisited after 3 month time frame for possible extension; if needed regarding disciplinary action. · QA was immediately conducted on 09-10-14 to ensure that all medications; as ordered were available for administration. Each resident's MAR and modifications were checked with no further concerns. · On 09-10-14 a memo about the "5 Rights of Medication Administration" &amp; the process when administering medication and when medication is not available in medication box. · A meeting was held on 09-17-14 (all nurses' &amp; QMA's) reviewing medication administration process. (Checking MAR and each medication; as ordered) and the process when medication is not available-use of Pyxis; etc.) Medication Administration QA will be completed each month x's three (3) and quarterly thereafter. If noted concerns with medication administration there will be 1:1 education/ retraining. This will be a random audit with a least 25 opportunities involving all shifts</p>	09/25/2014			

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	<p>and duodenal ulcer repair.</p> <p>The Physician's Order Summary (POS), dated September 2014, indicated an order for Pantoprazole 40 mg 1 tablet by mouth upon rising, give 30-60 minutes before meal.</p> <p>2. During an observation of a medication administration pass on 9/10/14 at 9:55 a.m., LPN #1 prepared Resident #45's medications, which included the following tablets by mouth: Colace (stool softener) 100 mg, Calcium 500 mg/ Vitamin D 200 mg, Tramadol (pain medicine) 50 mg, Oxybutynin (medicine for overactive bladder) 5mg, and a multivitamin. LPN #1 indicated at the time of the observation she was giving the resident 5 pills.</p> <p>Resident #45's record was reviewed on 9/10/14 at 10:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, edema (swelling), cardiomegaly (enlarged heart) and diabetes.</p> <p>The Physician's Orders, dated September 2014, indicated an order for Furosemide (diuretic) 20 mg 1 tablet by mouth daily upon rising.</p> <p>Review of the Medication Administration</p>		<p>and routes of administration. Quarterly each nurse to be checked using Medication Pass Competency Tool. . Medication Administration In-service's (monthly --- on-going for nurses' and QMA's . 1st done on 09-17-2014.. The DON or designee will be responsible for this plan of correction.</p>				

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	<p>Record (MAR) dated September 2014, indicated the Furosemide was signed off as given daily.</p> <p>During an interview with LPN #1 at 10:30 a.m. on 9/10/14, she indicated she had signed off the Furosemide and all other morning medications on the MAR after administering Resident #45's medications and was unaware it had not been given. After looking at the medications on the MAR, she indicated the pill count had been verified at 5 pills which had not included the Furosemide. LPN #1 then checked Resident #45's locked medication box &amp; observed the Furosemide was not included in the supply of medications sent by pharmacy and not in a separate bottle supplied by the family.</p> <p>Follow up interview with LPN #1 on 9/10/14 at 10:50 a.m. indicated the Unit Manager (UM) informed her if a medication was not available in a resident's supply, it should be pulled from the unit Pyxis (emergency medication supply system) and given to the resident as ordered.</p> <p>During an interview with the UM on 9/10/14 at 12:10 p.m., she indicated the Furosemide had not been pulled from Pyxis before today. Further indicated the</p>			

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F000441 SS=E	<p>family had been supplying "until recently." She did not know how long Resident #45 had actually been out of the medication and not receiving it since the medication was still signed out as given on the MAR.</p> <p>A written note and interview with LPN #2 on 9/10/14 at 2:00 p.m. indicated the Furosemide was given by her from a family supplied bottle on 9/7/14.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>						

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	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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, record review, and interview, the facility failed to ensure infection control practices and standards were maintained related to uncovered oxygen tubing, incentive spirometer (device to improve lung function), and nebulizer treatments (breathing treatments) masks and mouthpieces. This had the potential to affect 10 people receiving respiratory treatments. (Resident's #9, #29, #4, #55)</p> <p>Findings include:</p> <p>1. Observation on 9/8/14 at 11:19 a.m., Resident #9's oxygen tubing was wrapped up on top of the oxygen concentrator uncovered and the resident's incentive spirometer was on a shelf in the room uncovered.</p>	F000441	<p><b>F441</b> · Each week new tubing for Neb and O2 is changed and PRN. A new bag is added at that time. Both dated for the time changed. If new needed to be added immediately. Process on-going. · On 09-16-14 a memo regarding tubing(Neb &amp; O2) and incentive spirometer when not in use to be stored in plastic sealable bag. All staff (Nurse's, QMA's, and CNA's) to sign acknowledging this process. · This will be audited randomly weekly to ensure compliance and reported to QA meeting-- -on-going. If noted concerns it will be addressed with verbal counseling and if needed disciplinary action. · Don or designee to audit for compliance.</p>	09/25/2014

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	<p>Observation on 9/9/14 at 11:19 a.m., Resident #9's was not present in the room and the oxygen tubing was on the resident's bed uncovered. The incentive spirometer was placed on a lower shelf in the residents room uncovered.</p> <p>2. Observation on 9/8/14 at 4:28 p.m., Resident #4's breathing treatment mouthpiece was beside the machine uncovered.</p> <p>Observation on 9/9/14 at 11:18 a.m., Resident #4's breathing treatment mouthpiece was next to the machine and uncovered.</p> <p>3. Observation on 9/9/14 at 10:43 a.m., Resident #55's breathing treatment mouthpiece was sitting on top of the dresser uncovered.</p> <p>4. Observation on 9/9/14 at 10:56 a.m., Resident #29's breathing treatment mask was on top of the dresser uncovered.</p> <p>Observation on 9/10/14 at 3:40 p.m., Resident #29's breathing treatment mask was on the dresser uncovered.</p> <p>A policy titled "Nebulizer Cleaning Protocol" and received by the Unit Manager on 9/12/14 at 11:56 a.m.,</p>			

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F000465 SS=E	<p>indicated "...the Nebulizer cup and mouthpiece are to be placed in a storage bag in resident's room...."</p> <p>A policy titled "Licensed Nurse Procedure Incentive Spirometry" and received by the Unit Manager on 9/12/14 at 12:15 p.m., indicated "...Clean mouthpiece with alcohol and store entire Spirometry in a sealed plastic bag...."</p> <p>Interview with LPN #3 on 9/10/14 3:40 p.m., indicated there were plastic bags for breathing treatment masks and should be used.</p> <p>Interview with the Unit Manager on 9/12/14 at 10:45 a.m., indicated all nebulizer treatment mouth pieces, masks and oxygen tubing are to be bagged when not in use.</p> <p>3.1-18(a)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to bathroom clothe pull cords</p>	F000465	F 465 1. Plastic pull cords were purchased and installed to replace the cloth pull cords in bathrooms E-1, E-3A, E - 4B and W-4A. New caulking was applied	10/06/2014			

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	<p>were unclean, cracked caulk around a sink, cracked and gapped bathroom floor tile and a reflection from a white shed outside a resident's window for 3 of 4 halls (East, West and South Halls). This had the potential to affect 10 residents residing in the facility.</p> <p>Finding include:</p> <p>During the Environmental tour on 9/12/14 from 10:05 a.m. through 10:30 a.m. with the Unit Manager, the Administrator and the Maintenance Supervisor, the following was observed:</p> <p>1. East Hall</p> <p>a. The resident's bathroom pull cord had a brown substance on the cord in Room E-1. One resident resides in this room.</p> <p>b. The resident's bathroom pull cord had a brown substance on the cord in Room E-3A. One resident resided in this room.</p> <p>c. The resident's bathroom pull cord had a brown substance on the cord in Room E-4B. Two resident's resided in this room.</p> <p>2. West Hall</p> <p>a. The resident's bathroom pull cord had</p>		<p>to the sink and new tiles were installed in bathroom S-4. 3% opening Sheerweave glare reduction Roller Shades were ordered for room S-6A from Direct Supply. 2. All pull cords in all bathrooms were replaced with sanitary plastic pull cords from Direct Supply. All bathrooms were checked for cracked caulking around sinks and cracked or gaped tile. All residents who could be affected by a reflection from Pulaski Memorial Hospital's shed were asked if they had a glare in their room. If they desired the glare reduction blinds were purchased for them. 3. The environmental service department will wipe down all the new sanitary plastic call cords twice daily and when needed. The maintenance supervisor will check all bathrooms weekly for resident monthly if they have any lighting issues that are troublesome, such as but not limited to reflections from outside. 4. The environmental service department will keep a written record of when they sanitize bathroom call cords. The maintenance supervisor will log in his weekly findings. The environmental service supervisor will keep a written log of the resident survey on the lighting in their rooms. The maintenance supervisor will report all findings with paperwork to the Administrator monthly. The</p>				

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	<p>a brown substance on the cord in Room W-4A. Two resident's resided in this room.</p> <p>3. South Hall</p> <p>a. The caulk was cracked around the resident's bathroom sink, and a cracked, gapped bathroom floor tile in Room A-4B. Two resident's resided in this room.</p> <p>b. Outside of Room S-4A's window, a reflection from a white shed caused the resident to keep the curtain closed. Two resident's resided in this room.</p> <p>3.1-19(f)</p>		<p>findings will be reported and discussed in the monthly QA meetings. The roller shades are due to arrive no later than 10-01-2014 per Direct Supply order. 5. Responsible person: Maintenance Director</p>		