

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 3, 4, 5, and 6, 2014</p> <p>Facility number: 000559 Provider number: 155719 AIM number: 100267170</p> <p>Survey team: Caitlyn Doyle, RN-TC Jennifer Redlin, RN Heather Hite, RN Julie Ferguson, RN Regina Sanders, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 60 Total: 64</p> <p>Census payor type: Medicare: 9 Medicaid: 31 Other: 24 Total: 64</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March</p>	F000000	<p>March 18, 2014 Miriam Buffington Enforcement Manager, Long Term Care Indiana State Department of Health 2 North Meridian Street Section 4-B Indianapolis, IN 46204-3006 Re: POC for survey event ID H9MB11, for George Ade Memorial Health Care Center, Brook, IN. Dear Miriam: This is the plan of correction for the above mentioned survey conducted on March 6, 2014. This plan of correction is being submitted as our allegation of substantial compliance. We further submit that this facility is in substantial compliance as of the 24th of March, 2014. At this time we are requesting the Indiana State Department of Health conduct a desk review of the Plan of Correction for compliance vs an onsite follow up. We ask this be done as soon as possible to clear any and all findings and stop any and all proposed and or implemented remedies that have been presented at this time. If you have any questions or need further information please call me at 219-275-2531 or email admin@georgeade.org and I will be available to assist you. Thank you. W.R. Scott James Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the</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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	8, 2014, by Janelyn Kulik, RN.		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 federal and state law. This provider maintains that the alleged deficiencies do not individually, or collectively jeopardize the health and safety of it's residents, nor are they of such character as to limit this providers capacity to render adequate resident care. Furthermore, the operation and licensor of the long term care facilities, and this plan of correction in it's entirety, constitutes this providers allegation of compliance. Completion dates are provided for procedural processing purposes to comply with state and federal regulations, 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 compliance with requirements of participation or that corrective action was necessary.		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <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 develop resident care plans, related to medications which can thin the blood (Plavix and aspirin), for 2 of 5 residents reviewed for unnecessary medications. (Residents #13 and #71)</p> <p>Findings include:</p> <p>1. Resident #13's record was reviewed on 3/5/14 at 2:58 p.m. The resident's diagnoses included, but were not limited to hypertension and</p>	F000279	George Ade Memorial Healthcare is requesting that F tag 279 be considered for a desk top review for compliance per the plan of correction. It is the practice of this facility to develop, review and revise the residents plan of care as needed to attain or maintain the residents highest practicable, physical, mental and psychosocial well-being. Care Plans: (Anti-Coagulants) Care plans for residents have been developed to address the specific medication cited. Any residents with blood thinners anti-coagulants reviewed will be care planned to address the specific needs of residents.	03/14/2014			

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	<p>atrial fibrillation.</p> <p>The Physician's Orders, indicated orders for aspirin 81 mg (milligram) daily and Plavix 75 mg daily.</p> <p>There was a lack of documentation to indicate the resident had a care plan to inform the staff of the risks of taking aspirin and Plavix due to the blood thinning action of the medications.</p> <p>During an interview on 3/6/14 at 9:11 a.m., the Minimum Data Set (MDS) Nurse indicated there was not a care plan for the Plavix or aspirin. She indicated she usually does not write a care plan for the medication, but probably should. She indicated a resident who took these medications would be at risk for bleeding and bruising.</p>		<p>Policies on care planning review with updates.Reports for high risk medications due to prolonged medications will be checked weekly to ensure care plans in place. They will continue weekly checks until 100% compliance reached.D.O.N. or designee responsible for follow up.See attachments 1, 2, 3 for F-279Completed: 3/14/2014 3/24/2014</p> <p>Janelyn Kulik RN Surveyor Supervision Long Term Care Division Indiana State Department of Health</p> <p>Facility #000559 Provider #155719 Survey Event ID: H9MB11 Survey Date: March 6, 2014</p> <p>This is the additional information as requested for F-279.</p> <p>It is as follows:</p> <ul style="list-style-type: none"> · Policy including addendum was in-serviced for all licensed nurses on 3/12/2014. See attachment #1 policy and #2 addendum. · Policy was reviewed and approved by facility Medical Director on 3/7/2014. See attachment #3. <p>If any further information is needed, please contact me at 219-275-2531 or via email at</p>		

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	<p>2. Resident #71's record was reviewed on 3/4/14 at 10:35 a.m. The resident's diagnoses included, but were not limited to congestive heart failure, hypertension, and iron deficiency anemia.</p> <p>The Physician's Orders, indicated orders for aspirin 81 mg (milligrams) daily.</p> <p>Review of the February 2014 and March 2014 Medication Administration Record (MAR) indicated the resident had received the Aspirin medication daily.</p> <p>There was a lack of documentation to indicate the resident had a care plan and/or interventions related to the aspirin usage and risk for bleeding and bruising.</p> <p>During and interview on 3/6/14 at 9:13 a.m., the Minimum Data Set (MDS) Nurse indicated there was not a care plan in place for the aspirin. She indicated she was not aware a care plan was needed for aspirin use, but would implement one immediately. She indicated</p>		<p>admin@georgeade.org</p> <p>Thank you W.R. Scott James, HFA</p>				

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F000332 SS=D	<p>residents who receive aspirin daily are at risk for bleeding and bruising.</p> <p>3.1-35(a)</p> <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. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 11 residents observed during 6 medication pass observations. Three errors in medications were observed during 27 opportunities for errors in medication administration. This resulted in a medication error rate of 11.1%. (Residents #60, #85, and #88)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 3/04/14 at 10:51 a.m., LPN #1 prepared Resident #60's insulin and drew up 5 units of Humalog insulin.</p> <p>During an interview at the time of the</p>	F000332	George Ade Memorial Healthcare is requesting that F tag 332 be considered for a desk review for compliance per the plan of corrections. It is the practice of this facility to ensure that the facility is free of medication errors.F-332InsulinAny residents with short acting insulin reviewed. Times adjusted on EMAR to be set for short acting insulins to be given with meals times, of course a physician can supersede a given time frame by specifying and administration time per facility. Time corrected to give insulin with meals medication not given at that time. No adverse reactions. Nurse provided individual counseling.All residents have been reviewed for taking short acting insulins.All residents with the potential for medication to be administered early have been audited and medication pass competency performed	03/20/2014			

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	<p>observation, LPN #1 indicated Humalog insulin was a fast acting insulin (15-30 minutes). She indicated the resident's blood sugar was 130. LPN #1 indicated the resident usually ate lunch at 11:40 a.m.</p> <p>LPN #1 then proceeded to walk towards Resident #60's room and was stopped before the insulin was administered to the resident.</p> <p>LPN #1 then indicated the insulin was ordered for 11:30 a.m., but the computer showed it was due now. LPN #1 then indicated she would not give the insulin and then proceeded to destroy the 5 units of insulin in the syringe.</p> <p>Resident #60's record was reviewed on 03/05/14 at 2 p.m. The resident's diagnoses included, but were not limited to, stroke and diabetes mellitus.</p> <p>A Physician's Order, dated 08/13/13, indicated to give Humalog 5 units with meals at 7:45 a.m., 11:45 a.m., and 5:15 p.m.</p> <p>The scheduled meal delivery times, received as current from the Administrator on 03/03/14, indicated</p>		<p>have been performed for each nurse. Random Auditing 2 to 3x weekly x 4 weeks then at discretion of QA if 95% compliance is achieved and maintained. Completed: 3/20/2014F-332Coumadin LPN #3 upon finding error immediately gave another 1 mg coumadin to equal 2 mg dose ordered. Review of all med pass orders with 6 rights of medication administration. Individual nurse provided with counseling. All residents with similar orders have been reviewed. Licensed nursing staff instructed to follow administration orders as written. All nursing staff inserviced and trained on medication pass. Review of audit, all nurses to complete med pass competency. Pharmacy to provide assistance with medication administration audits. Audits to occur 2 to 3x weekly x 4 weeks. This will be conducted by D.O.N. or designee. When 95% compliance is achieved and maintained continuation will be at discretion of QA team. Completed: 3/20/2014F-332Metamucil and substances such as this will be given to manufacturers recommendation of 8 ounce preferred fluid. Metamucil will be given 2 hours prior or 2 hours after unless contraindicated by MD order. Time corrected that day to be given as ordered according to manufacturer recommendation. MD notified of</p>				

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	<p>the Elm Court lunch meal would be served at 11:45 a.m.</p> <p>The medication administration guidelines, received from the Director of Nursing (DoN) on 03/05/14 at 10:05 a.m., indicated insulin was to be administered before meals. The guidelines indicated a physician could supersede a given time frame by specifying an administration time in the physician's order.</p> <p>During an interview on 03/06/14 at 1:30 p.m., the DoN indicated the policy had no specific time for when the insulin should be given. She indicated the insulin should not be given an hour before the resident consumes a meal.</p> <p>2. During an observation of a medication pass on 03/05/14 at 7:47 a.m., LPN #2 prepared Resident #88's medication, which included aspirin 81 mg (milligrams), isosorbide 30 mg (cardiac), Fiber Smooth (Metamucil) 2 teaspoons, and timolol (cardiac) 10 mg.</p> <p>LPN #2 placed the aspirin, isosorbide, and timolol in a plastic medications cup and placed 2 teaspoons of fiber powder in a glass</p>		<p>medication given without 8 ounce water. No actual harm to resident noted. All residents reviewed for those taking Metamucil. Orders reviewed and given according to manufacturer directions. All medications of this type have potential to be given with wrong amount of fluid. Medication pass audit and medication pass competency performed on every nurse. Auditing to be done 2 to 3x weekly x 4 weeks. This will be conducted by D.O.N. or designee. When 95% compliance is achieved and maintained continuation will be at discretion of QA team. See attachments 4, 5, 6, 7, 8, 9, and 15 for tag F-332. Completed by: 3/17/2014</p>		

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	<p>of water and stirred the powder in the water.</p> <p>During an interview at the time of the observation, LPN #2 indicated there was 60-90 cc's (cubic centimeters) of water in the glass she mixed the fiber powder with.</p> <p>LPN #2, then administered the medication to Resident #88 and the resident drank all of the fiber powder mixed in water.</p> <p>LPN #2 then measured out the exact amount of water she placed in the cup to mix the fiber powder and indicated she had mixed the fiber powder with 90 cc's (less than four ounces) of water.</p> <p>Review of the Fiber Smooth container on 03/05/14 at 7:58 a.m. indicated the medication was to be given with 8 ounces of fluid (240 cc's) and to give the medication two hours before or two hours after prescribed medications taken orally. The container indicated taking the fiber powder with not enough water could cause choking.</p> <p>During an interview on 03/05/14 at 8:25 a.m., the DoN indicated the nurse should have given the Fiber</p>						

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	<p>Smooth with 8 ounces of fluid. She indicated they should change the time for the administration of the Fiber Smooth or the other medications.</p> <p>Resident #88's record was reviewed on 03/05/14 at 2:30 p.m. The resident's diagnoses included, but were not limited to, constipation and hypertension.</p> <p>A Physician's Order, dated 03/05/14, indicated to administer Metamucil 2 teaspoons in 8 ounces of fluids.</p> <p>3. During a medication pass observation on 3/5/14, at 3:16 p.m., LPN #3 prepared Resident #85's medication, which consisted of Coumadin (blood thinner) 1 milligram (mg) and propanolol (medication used to treat hypertension) 40mg. LPN #3 then administered the medication to the resident.</p> <p>Resident #34's record was reviewed on 3/5/14, at 3:40 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure and</p>			

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	<p>hypertension.</p> <p>Current Physician's Orders, dated March 2014, indicated an order for Coumadin 1mg once a day, give 2 days, hold 2 days and alternate with Coumadin 2mg, give 2 days, hold 2 days.</p> <p>According to the current Physician's Orders on 3/5/14, the resident was supposed to receive Coumadin 2mg.</p> <p>Interview with LPN #3 on 3/5/14, at 3:52 p.m., indicated the resident was supposed to receive Coumadin 2mg and only received 1mg of Coumadin.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review, observation, and interview, the facility failed to ensure a medication was destroyed safely, related to the</p>	F000431	George Ade Memorial Healthcare is requesting that F tag 431 be considered for a desk review for compliance per the plan of correction. It is the practice of this	03/20/2014	

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	<p>destruction of a transdermal patch for 1 of 1 resident observed with a transdermal patch during six medication pass observations. (Resident #9)</p> <p>Findings include:</p> <p>During a medication administration observation on 3/5/14, at 3:03 p.m., LPN #3 prepared Resident #9's medications which included Exelon patch (dementia medication) 4.6 milligrams (mg) over 24 hours.</p> <p>LPN #3 applied gloves, placed the Exelon patch on the residents upper back. LPN #3 then removed the prior days patch, removed her gloves with the old patch inside the glove. LPN #3 then washed her hands, exited the room and placed the gloves into the medication cart waste basket. The medication cart waste basket did not have a lid.</p> <p>During an interview on 3/5/14, at 3:10 p.m., LPN #3 indicated the old Exelon patch was placed in the glove she took off in the resident's room and was placed in the waste basket at the medication cart. She further indicated that was where she always disposed of the patch. In further interview LPN #3 indicated</p>		<p>facility to ensure that disposition of controlled drugs is sufficient in detail to enable an accurate account. Further that drugs and biologicals are labeled in accordance with current accepted professional principles. As well Schedule II drugs are stored and distributed in an accountable form.F-431All trans-dermal patches such as exelon and all drugs and biologicals will be disposed of per facility protocol and EPA guidelines. LPN #3 educated immediately after incident and all nursing staff education provided.This has the potential to affect all residents. All drugs and biologicals will be disposed of per federal guidelines.Update Trans-dermal drug delivery system patch application policy and disposal of medication and medication related supplies addendum developed per the QA team. Nursing education to all licensed personnel related to exelon patch, updated policy and addendum nurse competency to be done now and annually on medication pass. D.O.N. or designee will condut the audit of medication pass 2 to 3x weekly x 4 weeks then until 95% compliance. Nursing education on how to dispose of medicaiton per drug disposal guidelines form office of National Control Policy and EPA.See attachments 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 for tag F-431Completed by:</p>				

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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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F000465 SS=E	<p>there could be medication left on the patch in the waste basket and there are confused residents around the area.</p> <p>Interview with the Director of Nursing (DoN) and the Administrator on 3/6/14, at 10:08 a.m., indicated they were not aware that after patches were removed there could be medication still on the patch and the patch should be disposed of in a biohazard receptacle. DoN indicated she would inservice all staff on proper disposal of all patches.</p> <p>3.1-25(o)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE 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 maintain an environment that was safe, clean, and in a state of good repair, related to marred doors, stained pad on chair, loose veneer on dressers and bedside tables, corrosion on pipes, rusted water faucet knobs, yellow stains in sink and ripped armrest on wheelchair for 2 of 2 units throughout the facility. (Main Street</p>	F000465	<p>3/20/2014</p> <p>F-465George Ade Memorial Healthcare is requesting a desk review for compliance per the plan of correction.It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for our residents, staff and the public.F-465Doors noted have been repaired all other resident bathroom doors are being checked for any repairs needed and repaired as needed when found.Dressers have been</p>	03/20/2014

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	<p>Hall and Elm Court Hall)</p> <p>Findings include:</p> <p>During the Environmental tour on 03/06/14 at 9:15 a.m., with the Administrator, Maintenance Director, and Housekeeping and Laundry Supervisor, the following was observed:</p> <p>1. Main Street</p> <p>a. The inside of the bathroom door in Room 29-A, had a long splinter on the outside edge. Two residents resided in this room.</p> <p>b. The veneer on the dresser drawers were coming off at the edges in Room 31-A. Two residents resided in this room.</p> <p>c. The veneer on the dresser drawers were coming off at the edges in Room 32-B. Two residents resided in this room.</p> <p>d. The veneer on the bedside table edges were coming off in room 33-B. Two residents resided in this room.</p> <p>e. The veneer on the edges were coming off on the dresser drawers</p>		<p>repaired or replaced as per the noted rooms, this is to provide a safe hazard free environment. This is to provide a safe hazard free room environment for the residents. Doors are to be checked on a weekly basis with those found in need of repair reported to the maintenance department for repairs. This is done via repair slips which are available to all staff to report needed repairs. MS Unit The bathroom door in 29A has been repaired. The dresser in 31A has been replaced. The dresser in 32B has been replaced. The dresser/bedside table in 33B has been replaced. The dresser in 34B has been replaced and the bathroom door repaired. EC Unit The wheelchair arm for 110A has been replaced. The chair pad for 110B has been removed and replaced with a clean pad. The bathroom door for 112A & B has been repaired. The bathroom door for 114A has been repaired. The water faucet in 116B has been cleaned and repaired. The room door for 123A has been repaired as well as the toilet flush pipe cleaned/repared. Wheelchairs are checked weekly per the CNA assignments for cleaning those in need of repair are reported to maintain for repair as needed. The doors and dressers and bedside cabinets are checked daily as part of the housekeeping checklist. This is done (see</p>		

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	<p>and the inside of the bathroom door was splintered in Room 34-B. Two residents resided in this room.</p> <p>2. Elm Court</p> <p>a. Resident in Room 110-A's left wheelchair armrest was ripped.</p> <p>b. Resident in Room 110-B's recliner chair, had a brown dried substance on the chuck pad on seat of chair. The Brown dried substance was initially observed on 03/03/14 and was still present at the time of the environmental tour. Two residents resided in this room.</p> <p>c. The bottom inside of bathroom door had long gouges in Room 112-A and B. Two residents resided in this room.</p> <p>d. The inside, outside, and bottom of the bathroom door were gouged in Room 114-A. Two residents resided in this room.</p> <p>e. In Room 116-B, the hot water faucet knob had rusted and a yellow stain from the knob to the drain was noted in the sink. Two residents resided in this room.</p> <p>f. The hot water faucet knob had</p>		<p>attachments) to provide for timely repair of items found in need of repair. This is done so as to avoid further safety issues. This is monitored by housekeeping supervisor and or her designees. See attachments 20a, 20b, 21a, 21b, 22a, and 22b. This is done as of 3/20/2014</p>				

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	<p>rusted and the inside of the bathroom was marred in Room 116-B. Two residents resided in this room.</p> <p>g. The inside and the outside of room door had gouges near the bottom of the door in Room 123-A. The pipe on the toilet flusher, was green and corroded. Two residents resided in this room.</p> <p>Interview with Maintenance Director during Environmental Tour indicated, he fixes things, like the doors, when problems are reported to him. He indicated he has spare parts for things like heaters and wheelchairs and is always on call.</p> <p>Interview with Housekeeping and Laundry Supervisor during Environmental Tour indicated, the nurse should have changed the chuck pad with the dried brown substance on it when the bed linens were changed.</p> <p>3.1-19(f)</p>			