

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155778	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/20/2014
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: June 16-20, 2014</p> <p>Facility Number: 000323 Provider Number: 155778 AIM Number: 100288440</p> <p>Survey Team: Laura Brashear, RN, TC Megan Burgess, RN Vickie Nearhoof, RN Ashley Barnett, RN Sherry Nagel-Smith, RN Deb Barth, RN</p> <p>Census Bed Type: SNF/NF: 51 Total: 51</p> <p>Census Payor Type: Medicare: 6 Medicaid: 28 Other: 17 Total: 51</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p>	F000000		
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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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F000241 SS=D	<p>Quality review completed 6/27/2014 by Brenda Marshall, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to provide services to enhance each resident's dignity during dining for 1 of 4 residents (Resident #7) observed during meal service in the Restorative Dining Room.</p> <p>Finding includes:</p> <p>On 6/16/14 at 11:35 a.m., residents were observed in the Restorative Dining Room. Four residents were observed seated at a horseshoe shaped table (utilized to assist residents with eating) which was pushed against the wall. The staff did not utilize the table by being seated inside of the table, and the residents were all facing a blank wall. One visitor was seated in between two residents to assist their relative with the</p>	F000241	<p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Review both main dining room and restorative dining room. Arrange tables so that residents are not facing a blank wall. As per policy residents will still be able to sit where they want in the dining room. Review of the current hand washing procedures and policy during meal service. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: For review of the Interdisciplinary (IDT) and Nutrition at Risk(NAR)teams to determine residents best environment for dining to meet the resident's needs.Re-inservice kitchen staff, during the dining</p>	07/09/2014

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F000244 SS=E	<p>meal.</p> <p>CNAs #14 and #12 were observed setting up meals for the residents. Residents at the same table were not served at the same time and were sporadically served from table to table. When three of the four residents were served at the horseshoe table were served the visitor said to staff "Where's is [resident's name] Resident #7's tray? He's starving."</p> <p>On 6/19/14 at 4:00 p.m. The Administrator and Director of Nursing (DON) were interviewed. They indicated staff had been trained to serve residents at the same table at the same time. On 6/19/14 at 4:14 p.m., the DON provided a policy titled "Dining Service and Passing meal trays. Effective Date 6/19/14." The DON indicated a prior written policy had not been in place. The new policy included, but was not limited to "It is the policy of [name of facility] to attempt to serve all residents at the same table consistently at meal times...."</p> <p>3.1-3(t)</p> <p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p>		<p>process to serve occupied tables before moving to the next table. Re-inservice staff that serves during mealtime proper hand washing procedures during meal time. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur:New policy titled"Dining Service and Passing Meal Trays" effective 6/19/14. Staff inserviced on the policy "Dining Service and Passing Meal Trays." Reinservice staff on resident rights and dignity. Describe 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: DON or designee will monitor dining process weekly for 1 month then monthly thereafter. If during the audits non compliance reoccurs then the cycle of daily audits will restart until 100% of compliance is achieved. They will report findings to the QA monthly. Completed 7/9/14.</p>				

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	<p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to ensure grievances voiced by the resident council were acted upon. This had the potential to affect all 51 residents who resided in the facility.</p> <p>Findings include:</p> <p>Resident Council minutes were provided by the Activity Director (AD) on 6/18/14 at 3:50 p.m. The minutes indicated the following concerns by the Resident Council:</p> <ol style="list-style-type: none"> <li>1. Televisions being on late at night and loud</li> <li>2. Call lights not being answered</li> <li>3. Request to have pizza for a meal</li> <li>4. Rooms not being cleaned</li> <li>5. More activities during day and evening</li> <li>6. Concerns about laundry</li> </ol> <p>During an interview on 6/18/14 at 3:15 p.m., with the Resident Council President, Resident #22, indicated the Activities Director (AD) took minutes for the Resident Council meetings but the facility staff did not respond to the group's concerns and there was not any</p>	F000244	<p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Reviewed current process and form for how resident council meetings and/or any concern voiced by a resident are documented. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Review current concern forms on file. All documented concerns will be addressed immediately to include dietary, housekeeping, laundry, and call light response times. Redesign our concern form to include signature lines for department heads, DON, and Administrator review. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Inservice all staff on the process of resident concerns /grievances. New process to include that all concerns/grievances go through the administrative staff. The facility developed a grievance tracking log that will be initiated</p>	07/09/2014

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	<p>follow up from the facility.</p> <p>During an interview with the AD on 6/19/14 at 3:15 p.m., indicated that she takes minutes for the meetings and writes the grievances for department heads. The Activity Director indicated that she makes notes to different department heads and lets the department heads handle their own grievances.</p> <p>During an interview with Director of Nursing (DON) on 6/20/14 at 10:08 a.m., indicated she had received the grievances and had addressed the concerns with the nursing staff, held in-services, and tried to follow up with the Resident whom voiced the concern.</p> <p>The record lacked documentation of the grievances being addressed by the AD and DON.</p> <p>3.1-3(l)</p>		<p>by the social service director when a grievance is received. The tracking log will state the date of the grievance the initial of department manager who is responsible for addressing and developing a plan of resolution. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Activity Director and/or staff taking a concern will ensure all grievances are given to social services. The social service director will ensure the grievance was addressed to the satisfaction of the resident. The HFA will review the logs weekly for 4 weeks and then monthly there after to ensure continued compliance. Review for completion through QA meetings. Completed 7/9/14.</p>		

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to assess and analyze contributing factors and/or risks factors for the prevention of falls for 1 of 2 residents reviewed who met the criteria for falls (Resident #17); and failed to maintain a siderail to prevent accidents for 1 of 14 residents observed with siderails in the raised position. (Resident #34)</p> <p>Findings include:</p> <p>1. Review of clinical record for Resident #17 on 6/18/14 at 9:30 AM, revealed current physician orders dated 5/30/14, with diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease. Parkinson's, Insomnia, Anxiety, Depression and Bipolar Disorder. A quarterly Minimum Data Set (MDS) assessment dated 6/4/14,</p>	F000323	<p>Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Reviewed every resident in the facility for current fall assessment and care plan as indicated. Review current fall program. Administrator and maintenance supervisor to review all current work orders for completion. Bed rail for resident 34 fixed at the time noted on 6/17. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Update our fall program to include discussing falls every morning meeting with IDT. Fall prevention policy initiated. Discuss falls and make sure they are care planned correctly every week during the fall meeting. Maintenance supervisor to monitor beds and bed rails and</p>	07/09/2014

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	<p>coded the resident as cognitively Intact. The assessment indicated the resident received antipsychotic, antidepressant, hypnotic and antianxiety medications.</p> <p>Nurses' notes revealed the resident had six falls between 1/2/14 and 6/5/14. Four falls occurred on the 3-11 shift and two falls occurred on the 7-3 shift.</p> <p>The most recent fall risk assessment dated 3/5/14, indicated the resident was at high risk for falls. The DON was interviewed on 6/20/14 at 10:35 AM. The DON revealed that fall risk assessments are to be completed every three months. On 6/20/14 at 11:30 AM the MDS Coordinator indicated that the June 2014 fall risk assessment was missed.</p> <p>A fall care plan for Resident #17 was initially dated 12/29/11 with last review dated 6/10/14. The problem stated "Past falls at home," then listed falls dated between 4/6/2010 and 6/5/2014. Additional notations included the resident getting up from recliner with foot rest in position and getting up with sock feet often. Problem did not address needs and strengths of resident, nor identify all hazards or risk factors of resident to prevent falls.</p> <p>Care Plan Goals were originally dated</p>		<p>make sure they are working properly and report to QA committee. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Inservice staff on fall prevention program to include a fall prevention policy. Every resident with a fall assessment score of 10 or higher are considered at risk for falls and have a fall prevention care plan in place. Fall assessment and care plans to be utilized with MDS schedule. Maintenance supervisor to do bed maintenance bi-weekly and with concerns. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: MDS will present to QA committee that all care plan interventions are in place and current. The frequency of the monitoring will occur monthly for 3 months and then bi monthly for 3 months. The director of nursing or assistant director of nursing will be responsible to ensure compliance with the care plan. This will be monitored by random audits of fall prevention care plans by the DON or ADON at a rate of 50% of the care plans monthly for 3 months and then 25% of the care plans monthly for 3 months and then on going random audits monthly thereafter. DON or designee will supervise. Maintenance supervisor will report monthly to QA committee</p>		

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	<p>12/29/2011, with last review dated 6/10/14, and included "Will be free of falls daily through next review" and "Will get out of recliner safely through next review." Interview with CNA #8 on 6/19/14 at 1:30 PM, revealed the resident only sometimes uses recliner chair and does not try to get out of recliner. Goals were not modified on an on-going basis, nor were measurable.</p> <p>Care Plan Interventions included: "...Keep call light within reach, Instruct on use of call light, Encourage to call for assist, Keep pathways free of clutter, Encourage to wear non-skid shoes or slippers, Encourage use of walker for support, Remind to lower recliner foot rest prior to transfer, Side rail to assist mobility, Encourage use of walker, Agreeable to call for assist when moving furniture, Encourage resident to put recliner foot rest down when up before he transfers, assist as needed, Remind him of safety concern regarding transfer with recline foot rest in up position, Encourage gripper socks when not wearing shoes, Position (bed side table) and phone within reach, Remind to wait for assist if feeling dizzy..."</p> <p>On 6/19/14 at 9:45 AM, Fall Progress notes from 1/2/14 through 6/5/14 were reviewed and on 6/20/14 at 10:33 AM,</p>		<p>preventative maintenance program. Administrator or designee will supervise. Completed 7/9/14.</p>				

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	<p>Fall Committee notes for the past six months were reviewed. Comprehensive data collection and organization of facts surrounding the falls, a thorough analysis of any possible causes of falls or a determination of contributing factors and/or risk factors of falls were not documented in order to identify specific issues in order to develop targeted interventions to reduce falls.</p> <p>The DON indicated on 6/20/14 at 10:35 AM, the facility did not have a Fall Prevention Policy and Procedure</p> <p>2. On 6/17/14 at 12:50 p.m., Resident #34's room was observed. A quarter side rail was in the raised position on the right side of the resident's bed. The rail was observed to have bolts for the purpose of holding the rail together that were loose which made parts of the railing pull apart and a potential hazard for getting fingers caught in between the two parts. The resident, present in the room, indicated she utilized the rail for bed mobility and to help her be able to sit up.</p> <p>On 6/17/14 at 1:46 p.m. with the Administrator, the rail was observed. The Administrator agreed the rail was loose and needed to be tightened up, and he would have the Maintenance Supervisor tighten the bolts.</p>			

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F000329 SS=E	<p>The Maintenance Supervisor was interviewed on 6/19/14 at 2:43 p.m. The Supervisor provided a form titled "Maintenance Work Request. The Supervisor indicated if a concern is found staff are to fill out a work request and put in his mail box outside of his office door. He indicated he checks the box throughout the day. The Maintenance Supervisor indicated he had not been made aware of the loose railing.</p> <p>3.1-45(a)(1)</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</p>			

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	<p>these drugs.</p> <p>Based on interview and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs or adequate monitoring of drugs for 2 of 5 residents who met the criteria for unnecessary medication use. (Resident #17 and Resident #51)</p> <p>Findings include:</p> <p>1. Resident #51's clinical record was reviewed on 6/19/14 at 9:00 a.m. Resident #51 was admitted to the facility on 6/21/13. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, weakness, anxiety, anemia, hypertension, atrial fibrillation, and hypopotassemia.</p> <p>The resident's record was reviewed on 6/19/14 at 9:05 a.m. The record indicated Resident #51's current medication list was last updated on 6/10/14. The resident's medication regimen included '...lorazepam [anti-anxiety medication] 1 milligram (mg) tablet, give 1 tablet (1 mg) by oral route once daily at bedtime as needed for anxiety...'</p> <p>The record lacked documentation of consultation reports from pharmacy or doctor's orders for attempted Gradual Dose Reduction (GDR) of lorazepam</p>	F000329	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Registered pharmacist consultant was contacted to review resident 17 and 51 clinical records. IDT reviewed care plans for the three residents and updated care plans. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Contacted consulting pharmacist to do a complete audit of every resident for psychotropic medications and GDR reviews. Review our process of how recommendations for unnecessary drugs from pharmacy are followed through. Social Service to review care plans for all residents on psychotropic medications for appropriate interventions. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: DON to do an inservice on psychotropic medications and the GDR process. Inservice staff on the changed process for tracking GDR recommendations. When the pharmacist makes a recommendation for a GDR, the recommendation will be given to the Director of Nursing, the DON will be responsible for ensuring	07/09/2014			

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	<p>since 9/25/13.</p> <p>During an interview with the Social Service Designee on 6/20/14 at 11:20 a.m., she indicated there had not been a GDR attempted for Resident #51 since 9/25/13.</p> <p>2. Review of Resident #17's clinical record on 6/18/14 at 9:30 AM, revealed current physician orders dated 5/30/14, with diagnoses of, but not limited to, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease. Parkinson's, Insomnia, Anxiety, Depression and Bipolar Disorder. A quarterly Minimum Data Set (MDS) assessment dated 6/4/14, coded the resident as cognitively intact and received antipsychotic, antidepressant, hypnotic and antianxiety medications.</p> <p>In an interview on 6/20/2014 at 1:30 PM, CNA #8 described the resident as being anxious. The CNA's assignment sheet reviewed on 6/20/14 at 1:40 PM, stated "Very OCD [obsessive compulsive disorder] about everything" relative to resident. The DON indicated in an interview on 6/20/14, the resident was anxious. The Social Service Designee indicated in an interview on 6/20/14 at 1:40 PM, the resident was anxious.</p>		<p>that the physician is made aware of GDR recommendation. The DON shall be responsible for tracking GDR recommendations on a tracking sheet/tool. The tracking sheet/tool will contain the date the GDR recommendation was received and the date the physician reviewed and considered the GDR. DON or designee will track for completion. IDT will discuss appropriate interventions and social service to update care plans. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Consulting pharmacist to report compliance during quarterly QA. DON or designee will report monthly completion of recommendations with QA. Social Services will report compliance of completion with care plans monthly to QA. Monitoring will be ongoing. Completed 7/9/14</p>				

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	<p>A current care plan with last review dated 6/10/14, stated a problem of "Extreme anxiety and depression, resident constantly seeking attention DX [diagnosis]: Bipolar disorder" and identified medications of antidepressant, antipsychotic and antianxiety/sedation. Additional problem stated "At risk for s/e [side effects] or adverse reaction."</p> <p>Care plan goals were "Resident anxiety will deescalate with staff intervention through next review," Resident will be free of s/e or adverse reaction through next review" and "Resident will not have expression of sadness more than 2x's [times] per week through next review."</p> <p>Care plan interventions were "Administer meds [medications] per Rx (Prescription), Monitor mood and BX (Behavior) every shift and document, Ask MD (Medical Doctor) for possible GDR (Gradual Dose Reduction) as indicated through pharmacy review, Assess for fall risk, Observe for possible s/eas [sic] indicated on BX monitoring form, SS 1:1 PRN (As needed), Encourage out of room activities, Encourage family visits, Address resident issue as they occur, Decrease Ablify (Antipsychotic medication) to 1 mg QD (Every day) 2/15/13, Refer to psychiatric eval [evaluation] and TX (Treatment) by</p>			

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	<p>Vericare, increase Zoloft (Antidepressant medication) 150 mg daily 2/10/14."</p> <p>When asked on 6/20/14 at 1:30 PM what staff interventions were to deescalate resident's anxiety, the MDS Coordinator indicated the care plan that addressed anxiety was not a nursing care plan, but a social service care plan. On 6/20/14 at 1:40 PM, Social Service Designee indicated the care plan for anxiety was not a social service care plan, but nursing because it addressed medications.</p> <p>A care plan was not available for review that identified specific behaviors of resident related to psychoactive meds, including causative and preventative factors, that had specific and measurable goals and that had individualized interventions, including non-pharmaceutical.</p> <p>On 6/20/14 at 1:40 PM, the Social Service Designee indicated there was no social service care plan that addressed behaviors related to psychoactive med use.</p> <p>On 6/18/14 at 1:43 p.m. the SSD provided a summary of how the facility addressed psychotropic medications. The summary indicated medications are reviewed by the consulting pharmacist and any recommendations are reviewed</p>						

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F000332 SS=E	<p>by the SSD. If previous attempts to reduce or discontinue had caused distress for the resident a comment would be made by the SSD and recommendations placed in folder for the physician to review. The physician would either agree or disagree with the recommendation.</p> <p>The SSD was interviewed on 6/19/14 at 11:00 a.m. The SSD indicated specific behaviors are to be documented on a behavior monitoring form. CNAs report behaviors to nursing staff who are responsible for documenting on the form. A nursing communication book is also kept and utilized for review in daily interdisciplinary team meetings.</p> <p>3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(b)(1) 3.1-48(b)(2)</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, interviews, and record review the facility failed to ensure it was free from medication error rates of 5 percent or greater in that 3 errors in the opportunity for 27 errors were observed which resulted in a 11.11 percent error</p>	F000332	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Reviewed residents 21, 27, and 6 blood sugar tracking records to confirm no adverse effects occurred while the insulin was administered. Describe how the	07/09/2014			

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	<p>rate (Residents #21, #6, and #27).</p> <p>Findings include:</p> <p>1. On 6/19/14 at 10:58 a.m., LPN #4 was observed to administer Novolog (short acting) insulin 25 units subcutaneously (sq) to Resident #6. On 6/19/14 at 11:41 a.m. the resident was observed to receive his lunch meal.</p> <p>The resident's physician's orders were reviewed on 6/20/14 at 11:09 a.m. An order was noted dated 6/2/14, of Novolog 100 unit/ml subcutaneous solution inject 25 units by subcutaneous route three times per day.</p> <p>The Nursing 2014 Drug Handbook, 34th edition, copyrighted 2014, included, but was not limited to, "Give 5 to 10 minutes before start of meal by subcutaneous injection in the abdominal wall, thigh, up upper arm."</p> <p>2. On 6/19/14 at 3:36 p.m., QMA #11 was observed to administer Metforman (oral Antidiabetic) to Resident #21.</p> <p>Resident #21's physician's orders were reviewed on 6/19/14 at 11:45 a.m. An order dated 6/10/14, was noted for Metformin 500 mg tablet by oral route two times per day. Every day at 8:00</p>		<p>facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Consulting pharmacist provided inservice on insulin administration on 6-25-14. Review MAR's to assure that medication should be given with food or within the appropriate time frame with meals. In-service nurses on new protocol for insulin administration. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Stock med carts with food items to be given to the resident that has medications that require to be given with food. New protocol on insulin administration. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Random medication administration observations shall be conducted by the DON or designee to ensure there are no errors. The random audits shall be performed at a frequency of weekly for 4 weeks then monthly for 3 months to ensure continued compliance. ADON or designee will monitor MAR's for indication if food is needed with medications on monthly change over. DON or designee will monitor random checks for appropriate time frame</p>				

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	<p>a.m. and 5:00 p.m.</p> <p>Documentation in the Nursing 2014 Drug Handbook, 34th edition, copyrighted 2014, included, but was not limited to "Give drug with meals." Food was not provided with the medication.</p> <p>3. On 6/19/14 at 3:51 p.m., QMA #11 was observed to administer Carvedilol (Antihypertensives) 6.25 mg by mouth to Resident #27. Food was not given with the medication.</p> <p>Resident #27's physician's orders were reviewed on 6/19/14 at 11:47 a.m. An order, dated 6/2/14, was noted for Carvedilol 6.25 mg tablet one by oral route two times per day with food at 8:00 a.m. and 4:00 p.m.</p> <p>The DON was interviewed on 6/20/14 at 1:43 p.m. The DON indicated it was the policy of the facility to check blood sugars at 6:00 a.m., 11:00 a.m., 4:00 p.m. and provide sliding scale insulin coverage if ordered and required. The DON did not indicate there was a policy to address the timing of giving short acting insulins in relationship with meal times. The DON indicated meal times were 7:30 a.m., 11:30 a.m., and 5:00 p.m. with snacks at 10:00 a.m. 2:00 p.m. and 8:00 p.m.</p>		of insulin administration.Both will report to QA monthly to ensure compliance. Completed 7/9/14.				

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F000371 SS=F	<p>3.1-48(c)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure the dishwasher's sanitizer function performed properly during 1 of 3 kitchen observations. This practice had the potential to affect 51 of 51 residents.</p> <p>B. Based on observation and interview, the facility failed to distribute food to residents in a sanitary manner during meal service on 1 of 2 dining rooms. This had the potential to affect 7 of 7 residents in the Restorative Dining Room.</p> <p>Findings include:</p> <p>A. During the initial observation of the kitchen on 6/16/2014 at 9:45 a.m., the</p>	F000371	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: GFS was notified of dishwasher malfunction and repair was completed on 6/16/14. Day staff was immediately notified to not touch ready to eat food. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Inservice dietary staff on sanitation checks and if dish washing machine is functioning properly. Hand washing inservice for all staff on facility hand washing. Inservice staff on new protocol of "Dining Service and Passing Meal Trays" to include washing hands after each tray	07/09/2014

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	<p>Dietary Manager started the chemical sanitizing dish machine and no sanitizer was observed to flush into the rinse. The Dietary Manager tested for sanitation and the test strip showed an improper sanitation level less than 50 ppm (parts per million).</p> <p>During an observation on 6/16/2014 at 9:50 a.m., a second run of the dishwasher by the Dietary Manager indicated malfunction of the sanitizing operation of the dishwasher.</p> <p>During an interview on 6/16/2014 at 9:48 a.m., Dietary Aide #9 (DA) indicated the sanitizer function had worked earlier that morning but had not provided temperature or sanitation level documentation on the Dishwasher Temperature Chart.</p> <p>During an interview on 6/16/2014 at 10:00 a.m., the Dietary Manager indicated DA #9 should have checked the temperature and sanitizer ppm of the dishwasher before washing any dishes and recorded her findings on the Dishwasher Temperature Chart.</p> <p>The Dishwasher Temperature Chart Log for June 2014 had been located on the wall adjacent to the dish machine in the kitchen, and during review on 6/16/2014</p>		<p>and not touching resident food. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Updated sanitation and dishwasher temperature charts to assure staff held accountable for initial. Updated the policy for hand sanitation during meal pass. The DON or designee will be responsible to ensure hand washing compliance by using a tracking sheet/tool. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager will monitor these logs for daily compliance and will report to the QA monthly. DON or designee will do dining observation to include compliance with hand sanitation which shall be completed daily. DON will report to the QA committee. Completed 7-9-14.</p>				

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	<p>at 9:45 a.m., this document indicated no record of temperature or sanitation level logs from 6/1/2014 to 6/4/2014 and 6/10/2014 to 6/16/2014</p> <p>An undated document titled "Dishwashing Policy" was provided Dietary Manager on 6/16/2014 at 2:50 p.m. This current policy indicated the following: "...PROCEDURE: WASH: Check gauge, making sure temperature is 120 degrees before starting procedure. RINSE/SANITATION: Check with test strips provided for proper sanitation level of 50 ppm (parts per million.) Testing occurs for sanitation upon starting machine, and prior to doing dishes following each meal service. Record the testing at each meal time. If at any time the sanitation does not test properly, notify supervisor and/or maintenance department...</p> <p>B. The noon meal service in the Restorative Dining Room was observed on 6/16/14 which began at 11:35 a.m. CNAs #14 and #12 were observed serving seven residents.</p> <p>The CNAs set up the residents' meals. Individual trays were removed from a delivery cart and placed in front of the residents. Packages of condiments and</p>						

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F000412 SS=D	<p>coverings over drinks and/or dishes were opened, bread was removed from individual wrapper, and food was cut as needed. The staff touched exterior surfaces of items throughout the dining room, touched residents at times without washing hands or utilizing hand sanitizer in between residents served.</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview and record review, the facility failed to ensure residents were provided routine dental services for 1 of 1 resident reviewed who met the criteria for dental services. (Resident #35)</p> <p>Finding includes:  On 6/17/14 at 9:42 a.m. Resident #35 was interviewed. The resident indicated she utilized dentures, but did not have a bottom plate. Resident #35 indicated she</p>	F000412	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Resident 35 displays no adverse effects while waiting for her dentures. The resident's weight is stable and has no problem of eating her regular diet of choice. Calls to the previous LTC facility and to the dental company were made after admission on 4/14/14 and request for delivery were denied. Describe how the facility reviewed all clients in the facility that could be affected by the	07/09/2014

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	<p>had been admitted to the facility April 14, 2014. Prior to that the resident resided in another facility where dentures had been made for her. The resident indicated she had discharged to a hospital and did not return to the previous facility. The resident indicated she had not received the bottom plate and has meat ground now to aid in chewing.</p> <p>Resident #35's clinical record was reviewed on 6/19/14 at 10:30 a.m. The admission Minimum Data Set Assessment (MDS) dated 4/27/14, coded the resident with no cognitive impairment. The admission assessment coded the resident as set up assistance with eating, had no natural teeth. A plan of care dated 4/14/14 included, but was not limited to, Resident has dental issues, has a new dental plate coming in. Has potential for oral health problems. Interventions included, but were not limited to, coordinate arrangements for dental care, transportation as needed/as ordered.</p> <p>On 6/18/14 at 1:40 p.m. the Social Service Director (SSD) was interviewed. The SSD indicated the dental service who had made the resident's dentures did not come to their facility. The SSD indicated she had called the dental company and was told they do not come to their facility</p>		<p>same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Upon admission residents and families are given information about contracted dental services the facility has to offer. Reinservice staff on dental care. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Continue contract with dentist, Dr. Jon Inman. For resident that prefer their own dentist the facility will help accommodate to make transportation arrangements for resident to see dentist of their choice. Dentures for resident 35 were delivered on 6/30/14. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Social Services will monitor new admission charts for dental services the resident wishes to receive. Will continue to schedule visits with Dr. Inman or dentist with choice. Completed 7/9/14.</p>				

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	<p>and the Administrator was aware and had been involved with obtaining the denture.</p> <p>The Administrator was interviewed on 6/18/14 at 2:00 p.m. The Administrator indicated he had called the previous facility and was informed the resident was not allowed to return to that facility to receive the denture due to an on going legal issue and that was all he knew about it.</p> <p>On 6/19/20 at 10:10 a.m. a representative of the dental company was interviewed by telephone. The Customer Service Representative indicated the "wax try in," had been made March 5, 2014 and dentures were to be delivered to the resident on 4/8/14. The representative indicated the resident had discharged to another facility and they were unable to locate her. The Representative indicated if a resident resides in a facility who does not utilize their service, but is not too far away from a facility that does, they can see resident. The representative indicated the resident was removed from their service on 5/1/14. The Customer Service Representative indicated the balance had been paid in full by Medicaid, and Medicaid had been made aware of the removal of services.</p> <p>3.1-24(a)(1)</p>						

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

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to ensure</p>	F000431	Describe what the facility did to correct the deficient practice for each client cited in the deficiency:	07/09/2014			

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	<p>documentation on medications concerning open dates, failed to ensure timely disposal of expired medications, and failed to ensure accurate medication reconciliation for 2 of 2 medication carts and 1 of 1 medication rooms reviewed for medication storage.</p> <p>Findings include:</p> <p>An observation of the medication cart for Harmony hall with Qualified Medication Aide (QMA) #2 on 6/18/14 at 2:09 p.m., Chloraseptic throat spray was stored in the medication cart opened and did not have an open date documented on the medication.</p> <p>On 6/18/14 at 2:10 p.m. the medication cart for Sunshine Hall with QMA #1 was observed. Two different sized white pills were lying loose in the bottom of the narcotic drawer. QMA #1 was observed to give the two unidentified medications to LPN #4. LPN #4 disposed of the two unidentified medications in the sharps container located in the medication room.</p> <p>On 6/18/14 at 2:18 p.m. with Licensed Practical Nurse (LPN) #4 the medication room was observed:</p> <p>1. One vial of Humulin 70/30 insulin was expired, out of 17 opened insulin vials.</p>		<p>All medications in med carts and refrigerator were reviewed for open dates. Med carts were cleaned to remove loose pills. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Reinservice staff on "storage and expiration of medications, biological, syringes, and needles," "Disposal/Destruction of expired or discontinued medications," and med cart maintenance/sanitation. Review of the medication reconciliation policies then inserviced staff. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Assign cleaning of the med carts weekly. The DON or designee will use a tracking tool to monitor and track accurate medication reconciliation,destruction of discontinued/outdated medications and a monitoring tool will be used to ensure outdated/discontinued medications are removed from the carts/refrigerator. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: The DON or designee will monitor the reconciliation document in the resident charts weekly for 4</p>	

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	<p>The Humulin 70/30 insulin had an expiration sticker dated 6/17/14.</p> <p>2. A tube of lubricating gel with an expiration sticker dated 5/31/14 was on the counter top.</p> <p>3. In an unlocked cabinet in the medication room, two bottles of Tylenol were observed in an open basket. The only label observed on the two bottles of Tylenol was the manufacturer label that included the name of the drug.</p> <p>4. During further observation of the medication room, an open bottle of liquid Morphine in the Hospice Emergency Drug Kit (EDK) was observed to have 20 milliliters (mL) of blue liquid remaining in the bottle.</p> <p>During an interview on 6/18/14 at 2:09 p.m., QMA #2 indicated when medication is opened, staff are to write an open date on it. QMA #2 indicated the Chloraseptic spray, in the medication cart for Harmony Hall, should have had an open date on it. She indicated there was no documented open date on the Chloraseptic spray.</p> <p>During an interview on 6/18/14 at 2:10 p.m., QMA #1 indicated she could not identify the two white pills found in the</p>		<p>weeks and then monthly thereafter to ensure accuracy of medication reconciliation. DON will be responsible to oversee this process and report the results to the QA committee. Will report to QA monthly. Completed 7-9-14.</p>		

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	<p>bottom of the narcotic drawer of the medication cart for Sunshine Hall. She indicated when medications are found outside of the storage containers intended for the medications, she would report it to the nurse.</p> <p>During an interview on 6/18/14 at 2:18 p.m., LPN #4 indicated the two bottles of Tylenol observed in a cabinet of the medication room were to be destroyed. She indicated she did not know how long the Tylenol had been sitting in the cabinet for destruction.</p> <p>During an interview on 6/18/14 at 2:24 p.m., LPN #4 indicated the open bottle of liquid Morphine observed in the Hospice EDK contained 20 mL of remaining medication. She indicated the amount of liquid Morphine documented in the narcotic count for this bottle was 16 mL. She indicated the remaining medication documented in the narcotic count did not match the level of medication observed in the bottle.</p> <p>Review of the Hospice EDK narcotic count on 6/18/14 2:25 p.m., indicated the open bottle of liquid Morphine was documented as having 16 mL of medication remaining in the bottle.</p> <p>Review of a current policy, dated</p>			

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	<p>12/01/07, titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles," which was provided by the DON on 6/20/14 at 1:36 p.m., indicated the following:</p> <p>"... Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels....10. Facility should ensure that the medications and biologicals for each resident are stored in the original containers in which they were originally received..."</p> <p>Review of a current policy, dated 12/01/07, titled "Disposal/Destruction of Expired or Discontinued Medications," provided by the DON on 6/20/14 at 1:36 p.m., indicated the following:</p> <p>"11. Facility should destroy discontinued or out-dated non-controlled medications by one of two (2) methods: ...11.2 An authorized Facility staff member should place medication containers in a container or box. Facility staff member should then seal the box with strong tape and label the box as "MEDICATION FOR DESTRUCTION."</p>						

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F000456 SS=D	<p>3.1-25(j) 3.1-25(o)</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Based on observation and interview, the facility failed to ensure the kitchen's walk-in freezer doors were free of an accumulation of ice build up and could close and latch properly for 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>During an observation on 6/16/2014 at 9:40 a.m., the walk-in freezer door was open seven inches. A heavy accumulation of ice was around the bottom exterior of the doorway. The walk-in freezer door was unable to be latched when closed by the Dietary Manager.</p> <p>On 6/18/2014 at 10:25 a.m., the walk-in freezer door was observed with an ice accumulation on the lower exterior of the</p>	F000456	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: De-iced the walk in door on 6-20-14 so that it can close properly. Review of temperature logs shows the walk in temperature has remained in an acceptable range despite ice buildup. Contacted manufacturer to get a copy of the owner manual. Maintenance to service the walk-in due to ice issues. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected: Meeting with maintenance and dietary supervisors to review preventative maintenance on the	07/09/2014	

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	<p>door entrance. The freezer was opened five inches, with the door handle unable to be latched when closed.</p> <p>During an interview on 6/16/2014 at 9:41 a.m., the Dietary Manager indicated the walk-in freezer was very old and staff kicked the ice off of the door to get it to close when the ice accumulated on the entrance of the freezer.</p> <p>During an interview on 6/17/2014 at 3:10 p.m., the Administer indicated there was no de-icing policy for the walk-in freezer and that maintenance could not provide records of servicing the freezer's ice accumulation. He indicated the maintenance man would kick the ice off of the door to get it closed when informed by the Dietary Manager of the ice accumulation.</p> <p>During an interview on 6/19/2014 at 2:43 p.m., the Maintenance Supervisor indicated staff would fill out maintenance work request forms located by his office door if a maintenance issue was observed in the facility. The Supervisor indicated he checked the maintenance work request logs daily but did not keep them on file. He indicated he inspected the walk-in freezer daily for ice accumulation and proper temperatures Monday through Friday.</p>		<p>walk in freezer. Dietary manager will utilize maintenance work order slips Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Dietary manager will monitor for appropriate temperature range of walk-in per protocol. Dietary staff to use a tracking tool daily to monitor for ice buildup. Staff will continue to use maintenance request forms to report any issues. Maintenance to service walk-in will be complete on 7-25-14. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Dietary manager or designee to oversee the process. Dietary Manager and Maintenance will report compliance monthly to QA. Administrator to monitor. Completed 7-9-14.</p>				

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F000465 SS=E	<p>During an interview on 6/20/2014 at 2:40 p.m., the Administrator indicated the facility could not provide manufacturer's instructions for the walk-in freezer.</p> <p>3.1- 19(bb)</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, interview and record review, the facility failed to provide maintenance and housekeeping services to keep the facility clean and in good repair for 2 of 2 nursing units, common areas, and storage areas.</p> <p>Findings include:</p> <p>During initial tour on 6/16/2014 at 9:43 AM and environmental tour on 6/19/2014 at 3:10 PM, the following was observed:</p> <ol style="list-style-type: none"> <li>1. The veneer covering on the bottom of the Chapel Room door was missing or had exposed splinters.</li> <li>2. Siderails were loose on each side of</li> </ol>	F000465	Describe what the facility did to correct the deficient practice for each client cited in the deficiency: Took maintenance supervisor and housekeeping supervisor on a tour of the building and made a list of all maintenance and housekeeping issues requiring immediate attention. Findings 2,3,5,6,11, were completed on 6/20/14. Findings 9,10,14,15,16 were completed on 6/25/14. Finding 8 was completed on 7/3/14. Finding 13 completed on 7/9/14. Findings 1,4,7,12,17 to be completed by 8/15/14. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client	07/09/2014

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	<p>hallways on Harmony and Sunshine units.</p> <p>3. Cover to pipe access hole on upper wall in medication room was loose and tilted exposing open space behind the wall section. Tile floor around the refrigerator was discolored the color of rust and rust-colored flakes were on the floor.</p> <p>4. In Soiled Utility Room floor appeared dirty with wax and dirt build-up around the edges. The paint on the white metal cabinets was nicked and marred exposing rusted metal.</p> <p>5. A cover to attic hatch in the clean utility room was not secure and exposed an open space in the attic. One section of wood trim around attic hatch was partially missing with only a large piece of splinter hanging from a fastener. The floor appeared dirty with wax and dirt build-up around the edges. Paint on white metal cabinets was nicked and marred with exposed rusted metal.</p> <p>6. A shower room labeled "storage" had sections of ceramic tile either cracked or missing on floors,walls and curved tile base that exposed rough and sharp edges. Drain floor covers had dust and dirt residue. A ceiling vent cover was</p>		<p>the facility identified as being affected: Preventative maintenance policy developed on 6/20/14 and presented to maintenance supervisor. Training ongoing. Reviewed and updated cleaning schedule with housekeeping supervisor. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur: Maintenance request will be reviewed for completion by the administrator. Random maintenance rounds shall be conducted by the maintenance supervisor to ensure the facility is free of any maintenance issues. Facility developed a preventative maintenance tool that will be initiated by the maintenance supervisor. The tool will be used to monitor and ensure compliance for the facility's preventative maintenance program. Housekeeping will monitor facility for cleanliness and floors for wax build up. To ensure routine cleaning the housekeeping supervisor will utilize a tool/sheet that will monitor/track cleaning of the facility. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur: Maintenance and Housekeeping supervisor to meet with administrator weekly on building maintenance and housekeeping issues. Housekeeping supervisor</p>		

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	<p>missing. A overhead light in the storage area of room would not light. An outside door to the room had a hole approximately 1/2 inch in diameter.</p> <p>7. A shower room labeled "women" had sections of ceramic tile either cracked or missing on floors,walls and curved tile base with rough and sharp edges. Drain floor covers had dust and dirt residue.</p> <p>8. Floor tiles in the oxygen room were cracked with small gaps that appeared to have dirt residue. A ceiling vent cover had dirt residue. Ceiling area around vent cover was discolored with what appeared to be water damage. Paint on the discolored area was peeling and flaking.</p> <p>9. The ceiling in a storage room next to the storage "shower" room was discolored with what appeared to be water damage.</p> <p>10. Resident #17's bathroom had an open section of wall between the sink and the toilet. A galvanized pipe with rough edges was visible in the hole as well as an open space behind the wall section.</p> <p>11. Various lengths of galvanized pipe were either perpendicular to or at a 90 degree angle to the wall between the sink</p>		<p>to do weekly monitoring for 2 months and then bi-weekly thereafter to ensure compliance. Maintenance supervisor to do weekly monitoring of preventative maintenance program for 2 months and bi-weekly thereafter to ensure compliance. Will report monthly to QA. Completed 7-9-14.</p>				

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	<p>and toilet in resident bathrooms of rooms 117, 119 and 127. Unprotected threaded end of each pipe exposed rough and/or sharp edges.</p> <p>12. Floors in resident rooms 115,117 and 119 and bathrooms of resident rooms 104, 115, 117 and 119 appeared dirty with wax-buildup around edges. Floor tile in Room 119 had small to medium gaps between tiles exposing dirt residue.</p> <p>13. Covers over call light reset button on the walls of rooms 115 and 119 were lacking. The opening was noted to have sharp edges. Face plate to call light system on wall in Room 106 was missing in addition to the reset button cover. At time of tour on 6/16/2014, the Administrator indicated staff had to put finger through the device to turn off call light. On 6/19/2014 at 3:13 PM, the Maintenance Supervisor indicated that the covers had been missing for awhile.</p> <p>14. Stains were noted on the privacy curtain in Room 107. Paint was missing on wall next to bathroom.</p> <p>15. In Room 104 floor tiles were chipped in three areas of the bathroom and the wall panel underneath the bathroom sink was unattached and sitting against the wall. Large scratches were on the wall</p>			

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	<p>and a parts of the wall next to the bed and at the end of the wall were not painted.</p> <p>16. The metal cover of base heater on window wall in beauty shop / rehabilitation room was not completely attached. Part of the cover was lying on floor and sharp edges of the fan elements were exposed. The Administrator indicated during an interview on 6/19/2014 at 3:40 PM, that the base heater was used in the cold weather.</p> <p>17. Walls behind and at the foot of the bed in Room 115 were scratched and marred.</p> <p>On 6/19/2014 at 3:20 PM, the Housekeeping Supervisor indicated staff mopped the floors daily, but that facility had no Policy or Procedure for general eminence of flooring that would include regular, periodic or restorative maintenance of floors.</p> <p>On 6/19/2014 at 3:40 PM, the Maintenance Supervisor indicated the facility had no Policy and Procedure on preventive maintenance. The Supervisor indicated things were taken care of as they were noticed. On 6/20/2014 at 12:30 PM, The Administrator presented a Preventive Maintenance Policy that involved Maintenance and Management</p>			

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	and stated "The above personnel will do a monthly inspection of the building to determine any area(s) that need attention before major problems occur." The Administrator indicated the policy was just developed.  3.1-19(f)			